BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS
CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
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TELECONFERENCE BOARD MEETING NOTICE & AGENDA

Thursday, May 15, 2014

Glendale Adventist Medical Center
West Tower – 2nd Floor
Cardiac Conference Room
1509 Wilson Terrace
Glendale, CA 91206
(818) 521-7858 Directions Only

981 Fairway Drive
Gardnerville, NV 89460
(530) 318-4700 Directions Only

THURSDAY
12:30 pm - Board Meeting

The public may provide comment on any issue before the Board at the time the agenda item is discussed.

1. Call to order, roll call, establishment of a quorum.

2. Introduction and swearing in of new Board Members: Richard Bookwalter and Jeffrey Ferro. *(D. Miller)*

3. President's remarks. (D. Miller)

4. Board member updates/activities. (All Board members)

5. Consideration and modification or adoption of proposed regulatory language to amend Title 16, CCR Section 4110, Application, Section 4112, Review of Application, Section 4120, Renewal of License or Certificate – Forms, Section 4121, Renewal of Expired License or Certificate, Application, Fees; Effective Date of Renewal, Section 4123, Limited Permit, and Section 4127, Inactive License. *(H. Martin)*

6. Discussion and possible action regarding proposed legislation, including:
   a) Senate Bill (SB) 626 (Beall), Workers' Compensation.
   b) SB 1445 (Evans), Developmental Services: Regional Centers…Telehealth.
   c) Assembly Bill (AB) 809 (Logue), Telehealth.
   d) AB 1890 (Chau), Athletic Trainers.

7. Proposed Agenda Items for June 24, 2014, meeting.
   - Discussion and consideration of records retention requirement if a business is closed or sold or if the practitioner is no longer in private practice.
   - Administrative hearings

8. Public Comment session for items not on the agenda.

   Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125 and 11125.7(a)]

The Board may convene in CLOSED SESSION pursuant to Government Code Section 11126(c)(3) to deliberate on disciplinary matters.

Adjournment.

Public comments will be taken on agenda items at the time the item is heard. Discussion and action may be taken on any item listed on the agenda. Agenda items may be taken out of order for convenience, to accommodate speakers or to maintain a quorum. The Board may discuss agenda items in any order on each day, unless noticed as "time certain." Any opportunity for public comment is provided for each open agenda item and at the end of each Committee's report. All items are approximate and subject to change. Time limitations for discussion and comment will be determined by the President. For further information on this meeting and agenda, contact Tabatha Montoya at (916) 263-2294 or submit a written request to her at 2005 Evergreen Street, Suite 2050, Sacramento, California, 95815.

The meeting is accessible to the physically disabled. A person who needs disability related Accommodations or modifications in order to participate in the meeting shall make a request to Tabatha Montoya at (916) 263-2294 or by mailing a written request to 2005 Evergreen Street, Suite 2050, Sacramento, California, 95815. Providing at least five working days' notice before the meeting will help ensure the availability of accommodations or modifications. This agenda as well as Board meeting minutes can be found at the Board's website at www.bot.ca.gov.

AGENDA ITEM 5

CONSIDERATION AND MODIFICATION OR ADOPTION OF PROPOSED REGULATORY LANGUAGE TO AMEND TITLE 16, CCR SECTION 4110, APPLICATION, SECTION 4112, REVIEW OF APPLICATION, SECTION 4120, RENEWAL OF LICENSE OR CERTIFICATE – FORMS, SECTION 4121, RENEWAL OF EXPIRED LICENSE OR CERTIFICATE, APPLICATION, FEES; EFFECTIVE DATE OF RENEWAL, SECTION 4123, LIMITED PERMIT, AND SECTION 4127, INACTIVE LICENSE.

Attached for your review and consideration are the following documents:

- Proposed Second Modified Text
- Modified Text Noticed on December 19, 2013

California Board of Occupational Therapy
Department of Consumer Affairs

Title 16. Division 39, California Code of Regulations

PROPOSED SECOND MODIFIED TEXT

Proposed amendments are shown by ~~strikeout~~ for deleted text and underline for new text.

Modifications to regulatory language are shown by ~~double strikeout~~ for deleted text and double underline for new text.

Second modifications to the regulatory language are shown by ~~*italic double strikeout*~~ for deleted text and *italic double underline* for new text.

a. Section 4110, Article 2, is amended to read as follows:

§ 4110. Application

(a) An application for a license~~, certificate,~~ or limited permit shall be submitted on the form entitled Initial Application for Licensure, Form ILA, Rev. 8/2012), hereby incorporated by reference, *or by on-line submission, if available,* and shall contain the information required by sections 30, 144, 851, 2570.5, 2570.6, 2570.7, 2570.8, 2570.9, 2570.14, and 2570.16 of the Code and Family Code section 17520, accompanied by the appropriate fees.
(b) For an applicant applying for licensure pursuant to section 2570.15 of the Code, "substantially equal" means that the applicant has successfully completed the academic requirements of an educational program, including the educational program and supervised fieldwork requirements, for an occupational therapist or an occupational therapy assistant that are approved by the board and approved by the foreign credentialing review process of the National Board of Certification in Occupational Therapy ~~(NBCOT)~~, the American Occupational Therapy Certification Board, or the American Occupational Therapy Association.

Note: Authority cited: Section 2570.20, Business and Professions Code. Reference: Sections 30, 144, 850, 851, 2570.5, 2570.6, 2570.7, 2570.8, 2570.9, 2570.14, 2570.15 and 2570.16, Business and Professions Code; and Section 17520, Family Code.

b. Section 4112, Article 2, is amended to read as follows:

§ 4112. Review of Application

~~(a)~~ Within thirty (30) days after receipt of an application for a license~~, certificate,~~ or limited permit, the board shall inform the applicant, in writing, whether the application is complete and accepted for filing or that it is deficient and what specific information or documentation is required to complete the application.
~~*(b) Within ten (10) days after receipt of an application for a license submitted by an applicant that is:*~~

~~(b) Within ten (10) days after receipt of an application for a license submitted by an applicant that is:~~
~~(1) Married to, or in a domestic partnership or other legal union with an active duty member of the military who is assigned to a duty station in California, and~~
~~(2) Holds a current, unrestricted, occupational therapist or occupational therapy assistant license, certificate or registration issued by another state, district, or territory of the United States, the board shall inform the applicant, in writing, whether the application is complet and accepted for filing or that it is deficient and what specific information or documentation is required to complete the application.~~

Note: Authority cited: Section 2570.20, Business and Professions Code. Reference: Sections 115.5, 144, 2570.5, 2570.6, 2570.7, 2570.8, 2570.9, 2570.14, and 2570.16, Business and Professions Code and Section 15376, Government Code.

c. Section 4120, Article 3, is amended to read as follows:

§ 4120. Renewal of License ~~or Certificate~~ – Forms

(a) The term of a license ~~or certificate~~ shall be two years.
(1) Unless renewed, a license ~~or certificate~~ issued by the board shall expire at 12 midnight on the last day of the holder's birth month during an odd year if the licensee was born in an odd year or during an even year, if the licensee was born in an even year. The initial license fee shall be prorated from the month of issuance based on the holder's birth month and birth year.
(2) To renew an unexpired license ~~or certificate~~, the holder shall, before the time at which the license ~~or certificate~~ would otherwise expire, apply for renewal, pay the renewal fee, and certify that the licensee's ~~or certificate holder's~~ representations on the renewal form are true, correct, and contain no material omissions of fact, signed under penalty of perjury.
(3) The renewal application shall include a statement specifying whether the licensee ~~or certificate holder~~ was convicted of a crime or disciplined by another public agency during the preceding renewal period, and whether the continuing competency requirements have been met if renewing in an active status.
(4) For a license ~~or certificate~~ that expires on or after July 1, 2010, as a condition of renewal, an applicant for renewal not previously fingerprinted by the board, or for whom a record of the submission of fingerprints no longer exists, is required to furnish to the Department of Justice, as directed by the board, a full set of fingerprints for the purpose of conducting a criminal history record check and to undergo a state and federal level criminal offender record information search conducted through the Department of Justice. Failure to submit a full set of fingerprints to the Department of Justice on or before the date required for renewal of a license ~~or certificate~~ is grounds for discipline by the board. It shall be certified on the renewal form whether the fingerprints have been submitted. This requirement is waived if the license ~~or certificate~~ is renewed in an inactive status, or the licensee or certificate holder is actively serving in the military outside the country.
(5) An inactive license ~~or certificate~~ may be renewed.
(6) Failure to provide all of the information required by this section renders any application for renewal incomplete and not eligible for renewal.
(b) A limited permit cannot be renewed.

~~(c) Licensees who possess a current and valid license and who are called to active duty as a member of the United States Armed Forces or the California National Guard do not have to:~~
~~(1) Pay the renewal fee set forth in section 4130; or~~
~~(2) Complete the continuing competency requirements set forth in section 4161.~~
~~These requirements are waived only during the period in which the licensee is on active duty service.~~
~~(d) Licensees may not engage in the practice of occupational therapy during the period of active duty service and renewal waiver unless he or she wishes to practice, at which time the licensee shall request the license be placed on military active status. A licensee whose license is on military active status may practice occupational therapy but shall not engage in private practice.~~
~~(e) Licensees who are on active duty service must notify the board, in writing, within 60 days of his or her notice of discharge.~~
~~(f) In order to activate their license, the licensee must meet all necessary renewal requirements within six (6) months from the licensee's discharge from active duty service, including the requirements of sections 4130 and 4161.~~
~~*(c) Licensees who possess a current and valid license and who are called to active duty as a member of the United States Armed Forces or the California National Guard shall have all renewal requirements waived, upon submission of documentation verifying the licensee's active duty service. The renewal requirements are waived only for the period during which the licensee is on active duty service.*~~
~~*(d) Licensees may not engage in the practice of occupational therapy during the period of active duty service and renewal waiver. In order to provide occupational therapy services a licensee may request that his or her license be placed on "Military Active" status. A licensee whose license is on "Military Active" status shall not engage in private practice or render services to the public.*~~
~~*(e) A licensee who applies to reactive his or her license within six (6) months of their discharge from active duty service, shall be granted waivers as follows:*~~
~~*(1) A licensee who applies to reactive his or her license within two (2) years from the expiration date of their license shall be exempted from paying the renewal fee, delinquent fee, and meeting the continuing competence requirement; or*~~
~~*(2) A licensee who applies to reactivate his or her license more than two (2) years from the expiration date of their license shall be exempted from paying any accrued renewal or delinquent fees but shall complete the continuing competence requirement set forth in Section 4161 or otherwise request and qualify for the continuing competence exemption set forth in Section 4163.*~~
~~*(f) Licensees who are on active duty service must notify the board, in writing, within 60 days of his or her notice of discharge in order to meet the renewal waiver requirement.*~~
~~*(g) Any licensee who fails to apply to reactive his or her license within six (6) months of discharge shall make the waivers specified in Sections 4120(e)(1) and (2) null and void. The license shall then be subject to the standard license renewal requirements as set forth in Sections 4130 and 4161.*~~

Note: Authority cited: Sections 134, 152.6, 462, and 2570.20, Business and Professions Code. Reference: Sections 114.3, 134, 152.6, 462, 2570.5, 2570.9, 2570.10, and 2570.11, Business and Professions Code.

d. Section 4121, Article 3, is amended to read as follows:

§ 4121. Renewal of Expired License ~~or Certificate~~; Application; Fees; Effective Date of Renewal

~~(a)~~ Except as otherwise provide in the Code, a license ~~or certificate~~ which has expired may be renewed at any time within five years after its expiration on filing of an application for renewal on a form prescribed by the board, and payment of all accrued and unpaid renewal fees. If a license ~~or certificate~~ is renewed after its expiration, the licensee ~~or certificate holder~~, as a condition precedent to renewal, shall also pay a delinquency fee. Renewal under this section shall be effective on the date on which the application is ~~filed~~ received by the Board, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license ~~or certificate~~ shall continue in effect through the expiration date provided in section 4120, ~~above which next occurs after the effective date of renewal, when it~~ at which time, it shall expire if it is not renewed.

~~*(b) This section shall not apply to licensees who are on active duty service as a member of the United States Armed Forces or the California National Guard.*~~

Note: Authority cited: Section 2570.20, Business and Professions Code. Reference: Sections 114.3, 163.5, 2570.9, and 2570.10, Business and Professions Code.

Section 4123, Article 3, is amended to read as follows:

§ 4123. Limited Permit

(a) To qualify for a limited permit, a person must have applied to the National Board for Certification in Occupational Therapy (NBCOT) to take the licensing examination within four (4) months of completing the education and fieldwork requirements for licensure or certification and request NBCOT provide their examination score report be forwarded to the Board.
(1) Upon receipt from NBCOT, the applicant must forward to the Board a copy of the Authorization to Test (ATT) letter.
(2) The applicant must provide documentation or other evidence to the Board, to prove that the applicant requested their examination score be sent from NBCOT to the Board, before a limited permit may be issued.
(3) A limited permit shall only be valid for three (3) months from the date of issuance by the Board, upon receipt of a failing result, or two (2) weeks following the expiration of the applicants' eligibility to test period, whichever occurs first.
(4) The limited permit holder must immediately notify the Board of the results of the examination.
(5) The limited permit holder must provide to the Board the name, address and telephone number of his or her employer and the name and license number of his or her supervising occupational therapist (OT). Any change of employer or supervising OT must be provided to the Board, in writing, within ~~10~~ five (5) days of the change.
(b) A limited permit shall not be denied to an applicant that has completed the fingerprint, education, and examination requirements, yet is unable to provide transcripts due to the college or university's inability to make the transcripts available to the student or the Board

in a timely manner. A limited permit issued pursuant to this section shall only be valid for three (3) months from the date of issuance by the Board.
~~(b)~~ (c) The limited permit will be cancelled, and the fee forfeited, upon notification to the Board or the limited permit holder by the test administrator that the holder failed to pass the first examination.

Note: Authority cited: Sections 2570.5 and 2570.20, Business and Professions Code. Reference: Sections 2570.5, 2570.6, 2570.7, 2570.9, 2570.16 and 2570.26, Business and Professions Code; and Sections 4100, 4102, 4110, 4111, 4112, 4114, 4120 and 4130, California Code of Regulations.

e. Section 4127, Article 3.5, is amended to read as follows:

§ 4127. Inactive Status

(The renumbering of Section 4127 (formerly Section 4122) is part of a pending rulemaking action-reference: Z-202-0814-22)

Upon written request, the board may grant inactive status to a license ~~or certificate~~ holder under the following conditions:
(a) At the time of application for inactive status, the holder's license ~~or certificate~~ shall be current and not suspended, revoked, or otherwise punitively restricted by the board.
(b) The holder of an inactive license ~~or certificate~~ shall not engage in any activity for which a license ~~or certificate~~ is required.
(c) An inactive license ~~or certificate~~ shall be renewed during the same time period in which an active license or certificate is renewed. The holder of an inactive license ~~or certificate~~ need not comply with any continuing education requirement for renewal of an active license.
(d) The renewal fee for a license ~~or certificate~~ in an active status shall apply also for a renewal of a license ~~or certificate~~ in an inactive status, unless a lesser renewal fee is specified by the board.
(e) In order for the holder of an inactive license ~~or certificate~~ to restore his or her license ~~or certificate~~ to an active status, he or she shall comply with all of the following:
(1) Pays the renewal fee.
(2) ~~If the board requires completion of continuing education for renewal of an active license,~~ Provides proof of completion of ~~complete~~ continuing education equivalent to that required for a single renewal period of an active license, pursuant to Section 4161 ~~or certificate, unless a different requirement is specified by the board on a case-by-case basis~~.

Note: Authority cited: Sections 462, 700, 701, and 2570.20, Business and Professions Code. Reference: Sections 462, 700, 701, and 2570.11, Business and Professions Code.

AVAILABILITY OF MODIFIED TEXT

NOTICE IS HEREBY GIVEN that the Board of Occupational Therapy has proposed modifications to the text of CCR Sections 4110, 4112, 4120, 4121, 4123, and 4127 in Division 39, Title 16. A copy of the modified text is enclosed.

Any person who wishes to comment on the proposed modifications may do so by submitting written comments on or before 5:00 PM on January 3, 2014, to the following:

Jeff Hanson
California Board of Occupational Therapy
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815
Telephone: (916) 263-2294
Fax: (916) 263-2701
E-mail: cbot@dca.ca.gov

DATED: December 19, 2013

HEATHER MARTIN
Executive Officer
Board of Occupational Therapy

California Board of Occupational Therapy
Department of Consumer Affairs

Title 16. Division 39, California Code of Regulations

MODIFIED TEXT

Proposed amendments are shown by ~~strikeout~~ for deleted text and underline for new text.

Modifications to regulatory language are shown by ~~double strikeout~~ for deleted text and double underline for new text.

a. Section 4110, Article 2, is amended to read as follows:

§ 4110. Application

(a) An application for a license~~, certificate,~~ or limited permit shall be submitted on the form entitled Initial Application for Licensure, Form ILA, Rev. 8/2012), hereby incorporated by reference, and shall contain the information required by sections 30, 144, 851, 2570.5, 2570.6, 2570.7, 2570.8, 2570.9, 2570.14, and 2570.16 of the Code and Family Code section 17520, accompanied by the appropriate fees.
(b) For an applicant applying for licensure pursuant to section 2570.15 of the Code, "substantially equal" means that the applicant has successfully completed the academic requirements of an educational program, including the educational program and supervised fieldwork requirements, for an occupational therapist or an occupational therapy assistant that are approved by the board and approved by the foreign credentialing review process of the National Board of Certification in Occupational Therapy ~~(NBCOT)~~, the American Occupational Therapy Certification Board, or the American Occupational Therapy Association.

Note: Authority cited: Section 2570.20, Business and Professions Code. Reference: Sections 30, 144, 850, 851, 2570.5, 2570.6, 2570.7, 2570.8, 2570.9, 2570.14, 2570.15 and 2570.16, Business and Professions Code; and Section 17520, Family Code.

b. Section 4112, Article 2, is amended to read as follows:

§ 4112. Review of Application

(a) Within thirty (30) days after receipt of an application for a license~~, certificate,~~ or limited permit, the board shall inform the applicant, in writing, whether the application is complete and accepted for filing or that it is deficient and what specific information or documentation is required to complete the application.
(b) Within ten (10) days after receipt of an application for a license submitted by an applicant that is:
(1) Married to, or in a domestic partnership or other legal union with an active duty member of the military who is assigned to a duty station in California, and
(2) Holds a current, unrestricted, occupational therapist or occupational therapy assistant license, certificate or registration issued by another state, district, or territory of the United

States, the board shall inform the applicant, in writing, whether the application is complet and accepted for filing or that it is deficient and what specific information or documentation is required to complete the application.

Note: Authority cited: Section 2570.20, Business and Professions Code. Reference: Sections 115.5, 144, 2570.5, 2570.6, 2570.7, 2570.8, 2570.9, 2570.14, and 2570.16, Business and Professions Code and Section 15376, Government Code.

c. Section 4120, Article 3, is amended to read as follows:

§ 4120. Renewal of License ~~or Certificate~~ – Forms

(a) The term of a license ~~or certificate~~ shall be two years.
(1) Unless renewed, a license ~~or certificate~~ issued by the board shall expire at 12 midnight on the last day of the holder's birth month during an odd year if the licensee was born in an odd year or during an even year, if the licensee was born in an even year. The initial license fee shall be prorated from the month of issuance based on the holder's birth month and birth year.
(2) To renew an unexpired license ~~or certificate~~, the holder shall, before the time at which the license ~~or certificate~~ would otherwise expire, apply for renewal, pay the renewal fee, and certify that the licensee's ~~or certificate holder's~~ representations on the renewal form are true, correct, and contain no material omissions of fact, signed under penalty of perjury.
(3) The renewal application shall include a statement specifying whether the licensee ~~or certificate holder~~ was convicted of a crime or disciplined by another public agency during the preceding renewal period, and whether the continuing competency requirements have been met if renewing in an active status.
(4) For a license ~~or certificate~~ that expires on or after July 1, 2010, as a condition of renewal, an applicant for renewal not previously fingerprinted by the board, or for whom a record of the submission of fingerprints no longer exists, is required to furnish to the Department of Justice, as directed by the board, a full set of fingerprints for the purpose of conducting a criminal history record check and to undergo a state and federal level criminal offender record information search conducted through the Department of Justice. Failure to submit a full set of fingerprints to the Department of Justice on or before the date required for renewal of a license ~~or certificate~~ is grounds for discipline by the board. It shall be certified on the renewal form whether the fingerprints have been submitted. This requirement is waived if the license ~~or certificate~~ is renewed in an inactive status, or the licensee or certificate holder is actively serving in the military outside the country.
(5) An inactive license ~~or certificate~~ may be renewed.
(6) Failure to provide all of the information required by this section renders any application for renewal incomplete and not eligible for renewal.
(b) A limited permit cannot be renewed.
~~(c) Licensees who possess a current and valid license and who are called to active duty as a member of the United States Armed Forces or the California National Guard do not have to:~~
~~(1) Pay the renewal fee set forth in section 4130; or~~
~~(2) Complete the continuing competency requirements set forth in section 4161.~~

~~These requirements are waived only during the period in which the licensee is on active duty service.~~

~~(d) Licensees may not engage in the practice of occupational therapy during the period of active duty service and renewal waiver unless he or she wishes to practice, at which time the licensee shall request the license be placed on military active status. A licensee whose license is on military active status may practice occupational therapy but shall not engage in private practice.~~

~~(e) Licensees who are on active duty service must notify the board, in writing, within 60 days of his or her notice of discharge.~~

~~(f) In order to activate their license, the licensee must meet all necessary renewal requirements within six (6) months from the licensee's discharge from active duty service, including the requirements of sections 4130 and 4161.~~

(c) Licensees who possess a current and valid license and who are called to active duty as a member of the United States Armed Forces or the California National Guard shall have all renewal requirements waived, upon submission of documentation verifying the licensee's active duty service. The renewal requirements are waived only for the period during which the licensee is on active duty service.

(d) Licensees may not engage in the practice of occupational therapy during the period or active duty service and renewal waiver. In order to provide occupational therapy services a licensee may request that his or her license be placed on "Military Active" status. A licensee whose license is on "Military Active" status shall not engage in private practice or render services to the public.

(e) A licensee who applies to reactive his or her license within six (6) months of their discharge from active duty service, shall be granted waivers as follows:

(1) A licensee who applies to reactive his or her license within two (2) years from the expiration date of their license shall be exempted from paying the renewal fee, delinquent fee, and meeting the continuing competence requirement; or

(2) A licensee who applies to reactivate his or her license more than two (2) years from the expiration date of their license shall be exempted from paying any accrued renewal or delinquent fees but shall complete the continuing competence requirement set forth in Section 4161 or otherwise request and qualify for the continuing competence exemption set forth in Section 4163.

(f) Licensees who are on active duty service must notify the board, in writing, within 60 days of his or her notice of discharge in order to meet the renewal waiver requirement.

(g) Any licensee who fails to apply to reactive his or her license within six (6) months of discharge shall make the waivers specified in Sections 4120(e)(1) and (2) null and void. The license shall then be subject to the standard license renewal requirements as set forth in Sections 4130 and 4161.

Note: Authority cited: Sections 134, 152.6, 462, and 2570.20, Business and Professions Code. Reference: Sections 114.3, 134, 152.6, 462, 2570.5, 2570.9, 2570.10, and 2570.11, Business and Professions Code.

d. Section 4121, Article 3, is amended to read as follows:

§ 4121. Renewal of Expired License ~~or Certificate~~; Application; Fees; Effective Date of Renewal

(a) Except as otherwise provide in the Code, a license ~~or certificate~~ which has expired may be renewed at any time within five years after its expiration on filing of an application for renewal on a form prescribed by the board, and payment of all accrued and unpaid renewal fees. If a license ~~or certificate~~ is renewed after its expiration, the licensee ~~or certificate holder~~, as a condition precedent to renewal, shall also pay a delinquency fee. Renewal under this section shall be effective on the date on which the application is ~~filed~~ received by the Board, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license ~~or certificate~~ shall continue in effect through the expiration date provided in section 4120, ~~above which next occurs after the effective date of renewal, when it~~ at which time, it shall expire if it is not renewed.
(b) This section shall not apply to licensees who are on active duty service as a member of the United States Armed Forces or the California National Guard.

Note: Authority cited: Section 2570.20, Business and Professions Code. Reference: Sections 114.3, 163.5, 2570.9, and 2570.10, Business and Professions Code.

Section 4123, Article 3, is amended to read as follows:

§ 4123. Limited Permit

(a) To qualify for a limited permit, a person must have applied to the National Board for Certification in Occupational Therapy (NBCOT) to take the licensing examination within four (4) months of completing the education and fieldwork requirements for licensure or certification and request NBCOT provide their examination score report be forwarded to the Board.
(1) Upon receipt from NBCOT, the applicant must forward to the Board a copy of the Authorization to Test (ATT) letter.
(2) The applicant must provide documentation or other evidence to the Board, to prove that the applicant requested their examination score be sent from NBCOT to the Board, before a limited permit may be issued.
(3) A limited permit shall only be valid for three (3) months from the date of issuance by the Board, upon receipt of a failing result, or two (2) weeks following the expiration of the applicants' eligibility to test period, whichever occurs first.
(4) The limited permit holder must immediately notify the Board of the results of the examination.
(5) The limited permit holder must provide to the Board the name, address and telephone number of his or her employer and the name and license number of his or her supervising occupational therapist (OT). Any change of employer or supervising OT must be provided to the Board, in writing, within ~~10~~ five (5) days of the change.
(b) A limited permit shall not be denied to an applicant that has completed the fingerprint, education, and examination requirements, yet is unable to provide transcripts due to the college or university's inability to make the transcripts available to the student or the Board

in a timely manner. A limited permit issued pursuant to this section shall only be valid for three (3) months from the date of issuance by the Board.
~~(b)~~ (c) The limited permit will be cancelled, and the fee forfeited, upon notification to the Board or the limited permit holder by the test administrator that the holder failed to pass the first examination.

Note: Authority cited: Sections 2570.5 and 2570.20, Business and Professions Code. Reference: Sections 2570.5, 2570.6, 2570.7, 2570.9, 2570.16 and 2570.26, Business and Professions Code; and Sections 4100, 4102, 4110, 4111, 4112, 4114, 4120 and 4130, California Code of Regulations.

e. Section 4127, Article 3.5, is amended to read as follows:

§ 4127. Inactive Status

(The renumbering of Section 4127 (formerly Section 4122) is part of a pending rulemaking action-reference: Z-202-0814-22)

Upon written request, the board may grant inactive status to a license ~~or certificate~~ holder under the following conditions:
(a) At the time of application for inactive status, the holder's license ~~or certificate~~ shall be current and not suspended, revoked, or otherwise punitively restricted by the board.
(b) The holder of an inactive license ~~or certificate~~ shall not engage in any activity for which a license ~~or certificate~~ is required.
(c) An inactive license ~~or certificate~~ shall be renewed during the same time period in which an active license or certificate is renewed. The holder of an inactive license ~~or certificate~~ need not comply with any continuing education requirement for renewal of an active license.
(d) The renewal fee for a license ~~or certificate~~ in an active status shall apply also for a renewal of a license ~~or certificate~~ in an inactive status, unless a lesser renewal fee is specified by the board.
(e) In order for the holder of an inactive license ~~or certificate~~ to restore his or her license ~~or certificate~~ to an active status, he or she shall comply with all of the following:
(1) Pays the renewal fee.
(2) ~~If the board requires completion of continuing education for renewal of an active license,~~ Provides proof of completion of ~~complete~~ continuing education equivalent to that required for a single renewal period of an active license, pursuant to Section 4161 ~~or certificate, unless a different requirement is specified by the board on a case-by-case basis~~.

Note: Authority cited: Sections 462, 700, 701, and 2570.20, Business and Professions Code. Reference: Sections 462, 700, 701, and 2570.11, Business and Professions Code.

DISCUSSION AND POSSIBLE ACTION REGARDING LEGISLATION

Attached for your review and consideration are the following documents:

a) Senate Bill (SB) 626 (Beall), Workers' Compensation. Amended April 18, 2013.

b) SB 1445 (Evans), Developmental Services: Regional Centers...Telehealth. Amended April 10, 2014.
   - Analysis by Senate Human Services Committee
   - Analysis by Senate Appropriations Committee

c) Assembly Bill (AB) 809 (Logue), Telehealth. Amended June 25, 2013.
   - Analysis by Senate Committee on Business, Professions and Economic Development
   - Analysis by Senate Committee on Health

d) AB 1890 (Chau), Athletic Trainers. Amended April 28, 2014,
   - Analysis by Assembly Committee on Business, Professions, and Consumer Protection
   - Board staff Issue Paper
   - AB 1890, amended 4/21/2014
   - AB 864, last amended 4/29/2013
   - Analysis of AB 864 by Assembly Committee on B, P, CP
   - Analysis of AB 864 by Assembly Committee on Appropriations
   - *Athletic Trainer Services: An Overview of Skills and Services Performed by a Certified Athletic Trainer* (NATA 1/2010)
   - Professional (entry-level) education requirements and Post-Professional (Master's level) education overview
   - Accredited Bachelor & Masters programs in CA, OR, NV, and AZ
   - Athletic Trainer Education Competencies (2011) {for professional or 'entry level'}
   - Extract from the *Standards for the Accreditation of Post-Professional Athletic Training Degree Programs* (8/16/2013) describing the core-competencies
   - Crosswalk analysis: *BOC Role Delineation Study/Practice Analysis, 6th Edition and NATA Athletic Training Education Competencies, 5th Edition*
   - BOC *Standards of Professional Practice* (1/2006)
   - BOC *Professional Practice and Discipline Guidelines* (1/2014)
   - Various state's disciplinary action reported to BOC
   - Information on state regulatory bodies
   - Extract from *Changes in Healthcare Professions' Scope of Practice: Legislative Consideration.*
   - Legislation proposing licensure for ATs in Alaska
   - Multiple state's statutes

California LEGISLATIVE INFORMATION

SB-626 Workers' compensation. (2013-2014)

AMENDED IN SENATE APRIL 18, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL No. 626

Introduced by Senator Beall

February 22, 2013

An act to amend Sections *75,* 4600, *4604.5,* 4610, 4610.6, 4616, **and** 4660.1 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 626, as amended, Beall. Workers' compensation.

Existing law establishes a worker's compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in

*the course of his or her employment. Existing law creates the Commission on Health **and** Safety **and** Workers' Compensation consisting of 8 voting members, that includes 4 voting members representing organized labor **and** 4 voting members representing employers.*

*This bill would increase the number of commission voting members to 10 by adding one voting member representing injured workers **and** one additional voting member representing employers, appointed by the Governor.*

Existing~~ law establishes a worker's compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing~~ law generally provides for the reimbursement of medical providers for services rendered in connection with the treatment of a worker's injury. Existing law authorizes, with some exceptions, the employee to be treated by a physician of his or her own choice or at a facility of his or her own choice after 30 days from the date the injury is reported. Existing law prohibits a chiropractor from being the treating physician after the employee has received the maximum number of chiropractic visits.

This bill would delete that~~ provision **and** would instead provide that a physician, as defined, may remain the patient's primary treating physician even if additional treatment has been denied as long as the physician complies with specified reporting requirements~~ *prohibition.*

*Existing law requires that the recommended guidelines set forth in the medical treatment utilization schedule adopted by the administrative director be presumptively correct on the issue of extent **and** scope of medical treatment. Notwithst**and**ing the medical treatment utilization schedule, for injuries occurring on **and** after January 1, 2004, an employee is entitled to no more than 24 chiropractic, 24 **occupational therapy**, **and** 24 physical **therapy** visits per industrial injury.*

*This bill would delete the limitation on chiropractic, **occupational therapy**, **and** physical **therapy** visits per industrial injury.*

Existing law requires an employer to establish a medical treatment

utilization review process **and**, in this regard, prohibits any person other than a licensed physician from modifying, delaying, or denying requests for authorization of medical treatment for reasons of medical necessity to cure **and** relieve. Existing law also provides for an independent medical review process to resolve disputes over a utilization review decision for injuries occurring on or after January 1, 2013, **and** for any decision that is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

This bill would revise these provisions to require that medical treatment utilization reviews **and** independent medical reviews be conducted by physicians or medical professionals, as applicable, who hold the same California license as the requesting physician. The bill would delete the requirement that *an* independent medical review organization keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization.

Existing law prohibits a workers' compensation administrative law judge, the appeals board, or any higher court from making a determination of medical necessity contrary to the determination of the independent medical review organization.

This bill would delete that provision.

Existing law provides certain methods for determining workers' compensation benefits payable to a worker or his or her dependents for purposes of permanent partial disability **and** permanent total disability for injuries occurring on or after January 1, 2013. Existing law requires that the nature of the physical injury or disfigurement, the occupation of the injured employee, **and** his or her age at the time of injury be taken into account in determining the percentages of permanent partial disability or permanent total disability. Existing law, with some exceptions, prohibits increases in impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder, or any combination thereof, as specified.

This bill would delete the prohibition on increases in impairment ratings for psychiatric disorder **and** would make related changes.

Vote: majority Appropriation: no Fiscal Committee: ~~no~~*yes* Local Program: no

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. *Section 75 of the Labor Code is amended to read:*

75. (a) There is in the department the Commission on Health **and** Safety **and** Workers' Compensation. The commission shall be composed of ~~eight~~ *10* voting members. Four voting members shall represent organized labor, *one voting member shall represent injured workers,* **and** ~~four~~ *five* voting members shall represent employers. Not more than one employer member shall represent public agencies. ~~Two~~ *Three* of the employer ~~**and**~~ *members,* two of the labor members, ***and*** *the member representing injured workers* shall be appointed by the Governor. The Senate Committee on Rules **and** the Speaker of the Assembly shall each appoint one employer **and** one labor representative. The public employer representative shall be appointed by the Governor. No action of the commission shall be valid unless agreed to by a majority of the membership **and** by not less than two members representing organized labor **and** two members representing employers.

(b) The commission shall select one of the members representing organized labor to chair the commission during the 1994 calendar year, **and** thereafter the commission shall alternatively select an employer **and** organized labor representative to chair the commission for one-year terms.

(c) The initial terms of the members of the commission shall be four years, **and** they shall hold office until the appointment of a successor. However, the initial terms of one employer **and** one labor member appointed by the Governor shall expire on December 31, 1995; the initial terms of the members appointed by the Senate Committee on Rules shall expire December 31, 1996; the initial terms of the members appointed by the Speaker of the Assembly shall expire on December 31, 1997; **and** the initial term of one employer **and** one

labor member appointed by the Governor shall expire on December 31, 1998. Any vacancy shall be filled by appointment to the unexpired term.

(d) The commission shall meet every other month **and** upon the call of the chair. Meetings shall be open to the public. Members of the commission shall receive one hundred dollars ($100) for each day of their actual attendance at meetings of the commission **and** other official business of the commission **and** shall also receive their actual **and** necessary traveling expenses incurred in the performance of their duty as a member. Payment of per diem **and** traveling expenses shall be made from the Workers' Compensation Administration Revolving Fund, when appropriated by the Legislature.

~~**SECTION 1.**~~***SEC. 2.*** Section 4600 of the Labor Code is amended to read:

4600. (a) Medical, surgical, chiropractic, acupuncture, **and** hospital treatment, including nursing, medicines, medical **and** surgical supplies, crutches, **and** apparatuses, including orthotic **and** prosthetic devices **and** services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

(b) As used in this division **and** notwithst**and**ing any other provision of law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27.

(c) Unless the employer or the employer's insurer has established or contracted with a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area. ~~A physician, as defined in Section 3209.3, may remain the employee's primary treating physician even if additional medical treatment, as~~

~~specified in the medical treatment utilization schedule adopted under Section 5307.27, has been denied, as long as the physician complies with the reporting requirements set forth by the administrative director.~~

(d) (1) If an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury if the employee has health care coverage for non**occupational** injuries or illnesses on the date of injury in a plan, policy, or fund as described in subdivisions (b), (c), **and** (d) of Section 4616.7.

(2) For purposes of paragraph (1), a personal physician shall meet all of the following conditions:

(A) Be the employee's regular physician **and** surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business **and** Professions Code.

(B) Be the employee's primary care physician **and** has previously directed the medical treatment of the employee, **and** who retains the employee's medical records, including his or her medical history. "Personal physician" includes a medical group, if the medical group is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non**occupational** illnesses **and** injuries.

(C) The physician agrees to be predesignated.

(3) If the employee has health care coverage for non**occupational** injuries or illnesses on the date of injury in a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health **and** Safety Code, **and** the employer is notified pursuant to paragraph (1), all medical treatment, utilization review of medical treatment, access to medical treatment, **and** other medical treatment issues shall be governed by Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health **and** Safety Code. Disputes regarding the provision of medical treatment shall be resolved

pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health **and** Safety Code.

(4) If the employee has health care coverage for non**occupational** injuries or illnesses on the date of injury in a group health insurance policy as described in Section 4616.7, all medical treatment, utilization review of medical treatment, access to medical treatment, **and** other medical treatment issues shall be governed by the applicable provisions of the Insurance Code.

(5) The insurer may require prior authorization of any nonemergency treatment or diagnostic service **and** may conduct reasonably necessary utilization review pursuant to Section 4610.

(6) An employee shall be entitled to all medically appropriate referrals by the personal physician to other physicians or medical providers within the non**occupational** health care plan. An employee shall be entitled to treatment by physicians or other medical providers outside of the non**occupational** health care plan pursuant to st**and**ards established in Article 5 (commencing with Section 1367) of Chapter 2.2 of Division 2 of the Health **and** Safety Code.

(e) (1) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, the employee submits to examination by a physician, he or she shall be entitled to receive, in addition to all other benefits herein provided, all reasonable expenses of transportation, meals, **and** lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination.

(2) Regardless of the date of injury, "reasonable expenses of transportation" includes mileage fees from the employee's home to the place of the examination **and** back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director of Human Resources pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage **and** tolls shall be paid to the employee at the time he or she is given notification of the time **and** place of the examination.

(f) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, an employee submits to examination by a physician **and** the employee does not proficiently speak or understand the English language, he or she shall be entitled to the services of a qualified interpreter in accordance with conditions **and** a fee schedule prescribed by the administrative director. These services shall be provided by the employer. For purposes of this section, "qualified interpreter" means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.

(g) If the injured employee cannot effectively communicate with his or her treating physician because he or she cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments. To be a qualified interpreter for purposes of medical treatment appointments, an interpreter is not required to meet the requirements of subdivision (f), but shall meet any requirements established by rule by the administrative director that are substantially similar to the requirements set forth in Section 1367.04 of the Health **and** Safety Code. The administrative director shall adopt a fee schedule for qualified interpreter fees in accordance with this section. Upon request of the injured employee, the employer or insurance carrier shall pay for interpreter services. An employer shall not be required to pay for the services of an interpreter who is not certified or is provisionally certified by the person conducting the medical treatment or examination unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code.

(h) Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of his or her injury **and** prescribed by a physician **and** surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business **and** Professions Code, **and** subject

to Section 5307.1 or 5703.8. The employer shall not be liable for home health care services that are provided more than 14 days prior to the date of the employer's receipt of the physician's prescription.

SEC. 3. *Section 4604.5 of the Labor Code is amended to read:*

4604.5. (a) The recommended guidelines set forth in the medical treatment utilization schedule adopted by the administrative director pursuant to Section 5307.27 shall be presumptively correct on the issue of extent **and** scope of medical treatment. The presumption is rebuttable **and** may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.

(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are evidence **and** scientifically based, nationally recognized, **and** peer reviewed. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation **and** treatment of injured workers, **and** shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.

~~(c)(1)Notwithst**and**ing the medical treatment utilization schedule, for injuries occurring on **and** after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 **occupational therapy**, **and** 24 physical **therapy** visits per industrial injury.~~

~~(2)(A)Paragraph (1) shall not apply when an employer authorizes, in writing, additional visits to a health care practitioner for physical medicine services. Payment or authorization for treatment beyond the limits set forth in paragraph (1) shall not be deemed a waiver of the limits set forth by paragraph (1) with respect to future requests for authorization.~~

~~(B)The Legislature finds **and** declares that the amendments made to subparagraph (A) by the act adding this subparagraph are declaratory of existing law.~~

~~(3)Paragraph (1) shall not apply to visits for postsurgical physical medicine **and** postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27.~~

~~(d)~~

(c) For all injuries not covered by the official utilization schedule adopted pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are recognized generally by the national medical community **and** scientifically based.

~~**SEC. 2.**~~***SEC. 4.*** Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review **and** approve, modify, delay, or deny, based in whole or in part on medical necessity to cure **and** relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies **and** procedures. These policies **and** procedures shall ensure that decisions based on the medical necessity to cure **and** relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. These policies **and** procedures, **and** a description of the utilization process, shall be filed with the administrative director **and** shall be disclosed by the employer to employees, physicians, **and** the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine

whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business **and** Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews **and** approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a physician who holds the same California license as that held by the requesting physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, **and** where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure **and** relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.

(3) Evaluated at least annually, **and** updated if necessary.

(4) Disclosed to the physician **and** the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying **and** postage expenses related to disclosing criteria or guidelines pursuant to this paragraph.

Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements shall be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

(2) When the employee's condition is such that the employee faces an imminent **and** serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions

resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, **and** to the physician **and** employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision **and** a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure **and** relieve, **and** an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure **and** relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure **and** relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure **and** relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board **and** in such a way as to minimize reporting costs both to the board **and** to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear **and** concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, **and** the clinical reasons for the decisions regarding medical necessity. If a

utilization review decision to deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision **and** specify the information that is needed.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary **and** requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable **and** consistent with good medical practice, the employer shall immediately notify the physician **and** the employee, in writing, that the employer cannot make a decision within the required timeframe, **and** specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician **and** employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary **and** requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(6) A utilization review decision to modify, delay, or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), **and** it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the

employer's liability becomes final, **and** the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, **and** an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

~~**SEC. 3.**~~***SEC. 5.*** Section 4610.6 of the Labor Code is amended to read:

4610.6. (a) Upon receipt of a case pursuant to Section 4610.5, an independent medical review organization shall conduct the review in accordance with this article **and** any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment.

(b) Upon receipt of information **and** documents related to a case, the medical reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the employee, provider reports, **and** any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any of the parties, a copy of the request **and** the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria

set forth in subdivision (c).

(c) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the employee **and** the st**and**ards of medical necessity as defined in subdivision (c) of Section 4610.5.

(d) The organization shall complete its review **and** make its determination in writing, **and** in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the request for review **and** supporting documentation, or within less time as prescribed by the administrative director. If the disputed medical treatment has not been provided **and** the employee's provider or the administrative director certifies in writing that an imminent **and** serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate **and** serious deterioration of the health of the employee, the analyses **and** determinations of the reviewers shall be expedited **and** rendered within three days of the receipt of the information. Subject to the approval of the administrative director, the deadlines for analyses **and** determinations involving both regular **and** expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

(e) The medical professionals' analyses **and** determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employee's medical condition, the relevant documents in the record, **and** the relevant findings associated with the provisions of subdivision (c) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(f) The independent medical review organization shall provide the administrative director, the employer, the employee, **and** the employee's provider with the analyses **and** determinations of the medical professionals reviewing the case, **and** a description of the

qualifications of the medical professionals. Independent medical reviews shall be conducted by medical professionals who hold the same California license as the requesting physician. If more than one medical professional reviewed the case **and** the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses **and** determinations.

(g) The determination of the independent medical review organization shall be deemed to be the determination of the administrative director **and** shall be binding on all parties.

(h) A determination of the administrative director pursuant to this section may be reviewed only by a verified appeal from the medical review determination of the administrative director, filed with the appeals board for hearing pursuant to Chapter 3 (commencing with Section 5500) of Part 4 **and** served on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be presumed to be correct **and** shall be set aside only upon proof by clear **and** convincing evidence of one or more of the following grounds for appeal:

(1) The administrative director acted without or in excess of the administrative director's powers.

(2) The determination of the administrative director was procured by fraud.

(3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.

(4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.

(5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 **and** not a matter that is subject to expert opinion.

(i) If the determination of the administrative director is reversed, the dispute shall be rem**and**ed to the administrative director to submit the dispute to independent medical review by a different independent review organization. In the event that a different independent medical review organization is not available after rem**and**, the administrative director shall submit the dispute to the original medical review organization for review by a different reviewer in the organization.

(j) Upon receiving the determination of the administrative director that a disputed health care service is medically necessary, the employer shall promptly implement the decision as provided by this section unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement for services already rendered, the employer shall reimburse the provider or employee, whichever applies, within 20 days, subject to resolution of any remaining issue of the amount of payment pursuant to Sections 4603.2 to 4603.6, inclusive. In the case of services not yet rendered, the employer shall authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employee's medical condition, **and** shall inform the employee **and** provider of the authorization.

(k) Failure to pay for services already provided or to authorize services not yet rendered within the time prescribed by subdivision (l) is a violation of this section **and**, in addition to any other fines, penalties, **and** other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thous**and** dollars ($5,000) for each day the decision is not implemented. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(l) The costs of independent medical review **and** the administration of the independent medical review system shall be borne by employers through a fee system established by the administrative director. After considering any relevant information on program costs, the administrative director shall establish a reasonable, per-case

reimbursement schedule to pay the costs of independent medical review organization reviews **and** the cost of administering the independent medical review system, which may vary depending on the type of medical condition under review **and** on other relevant factors.

(m) The administrative director may publish the results of independent medical review determinations after removing individually identifiable information.

(n) If any provision of this section, or the application thereof to any person or circumstances, is held invalid, the remainder of the section, **and** the application of its provisions to other persons or circumstances, shall not be affected thereby.

~~**SEC. 4.**~~ ***SEC. 6.*** Section 4616 of the Labor Code is amended to read:

4616. (a) (1) On or after January 1, 2005, an insurer, employer, or entity that provides physician network services may establish or modify a medical provider network for the provision of medical treatment to injured employees. The network shall include physicians primarily engaged in the treatment of **occupational** injuries. The administrative director shall encourage the integration of **occupational and** non**occupational** providers. The number of physicians in the medical provider network shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner. The provider network shall include an adequate number **and** type of physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged, **and** the geographic area where the employees are employed.

(2) Medical treatment for injuries shall be readily available at reasonable times to all employees. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees. With respect to availability **and** accessibility of treatment, the administrative director shall consider the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart **and** areas in which there is a health care shortage.

(3) Commencing January 1, 2014, a treating physician shall be included in the network only if, at the time of entering into or renewing an agreement by which the physician would be in the network, the physician, or an authorized employee of the physician or the physician's office, provides a separate written acknowledgment in which the physician affirmatively elects to be a member of the network. Copies of the written acknowledgment shall be provided to the administrative director upon the administrative director's request. This paragraph shall not apply to a physician who is a shareholder, partner, or employee of a medical group that elects to be part of the network.

(4) Commencing January 1, 2014, every medical provider network shall post on its Internet Web site a roster of all treating physicians in the medical provider network **and** shall update the roster at least quarterly. Every network shall provide to the administrative director the Internet Web site address of the network **and** of its roster of treating physicians. The administrative director shall post, on the division's Internet Web site, the Internet Web site address of every approved medical provider network.

(5) Commencing January 1, 2014, every medical provider network shall provide one or more persons within the United States to serve as medical access assistants to help an injured employee find an available physician of the employee's choice, **and** subsequent physicians if necessary, under Section 4616.3. Medical access assistants shall have a toll-free telephone number that injured employees may use **and** shall be available at least from 7 a.m. to 8 p.m. Pacific St**and**ard Time, Monday through Saturday, inclusive, to respond to injured employees, contact physicians' offices during regular business hours, **and** schedule appointments. The administrative director shall promulgate regulations on or before July 1, 2013, governing the provision of medical access assistants.

(b) (1) An insurer, employer, or entity that provides physician network services shall submit a plan for the medical provider network to the administrative director for approval. The administrative director shall approve the plan for a period of four years if he or she determines that the plan meets the requirements of this section. If the administrative

director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved. Commencing January 1, 2014, existing approved plans shall be deemed approved for a period of four years from the most recent application or modification approval date. Plans for reapproval for medical provider networks shall be submitted at least six months before the expiration of the four-year approval period. Upon a showing that the medical provider network was approved or deemed approved by the administrative director, there shall be a conclusive presumption on the part of the appeals board that the medical provider network was validly formed.

(2) Every medical provider network shall establish **and** follow procedures to continuously review the quality of care, performance of medical personnel, utilization of services **and** facilities, **and** costs.

(3) Every medical provider network shall submit geocoding of its network for reapproval to establish that the number **and** geographic location of physicians in the network meets the required access st**and**ards.

(4) The administrative director shall at any time have the discretion to investigate complaints **and** to conduct r**and**om reviews of approved medical provider networks.

(5) Approval of a plan may be denied, revoked, or suspended if the medical provider network fails to meet the requirements of this article. Any person contending that a medical provider network is not validly constituted may petition the administrative director to suspend or revoke the approval of the medical provider network. The administrative director may adopt regulations establishing a schedule of administrative penalties not to exceed five thous**and** dollars ($5,000) per violation, or probation, or both, in lieu of revocation or suspension for less severe violations of the requirements of this article. Penalties, probation, suspension, or revocation shall be ordered by the administrative director only after notice **and** opportunity to be heard. Unless suspended or revoked by the administrative director, the administrative director's approval of a medical provider network shall be binding on all persons **and** all courts. A determination of the administrative director may be reviewed only by an appeal of the determination of the administrative director filed as an original

proceeding before the reconsideration unit of the workers' compensation appeals board on the same grounds **and** within the same time limits after issuance of the determination as would be applicable to a petition for reconsideration of a decision of a workers' compensation administrative law judge.

(c) Physician compensation may not be structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment.

(d) If the employer or insurer meets the requirements of this section, the administrative director may not withhold approval or disapprove an employer's or insurer's medical provider network based solely on the selection of providers. In developing a medical provider network, an employer or insurer shall have the exclusive right to determine the members of their network.

(e) All treatment provided shall be provided in accordance with the medical treatment utilization schedule established pursuant to Section 5307.27.

(f) No person other than a physician who holds the same California license as the requesting physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, may modify, delay, or deny requests for authorization of medical treatment.

(g) Commencing January 1, 2013, every contracting agent that sells, leases, assigns, transfers, or conveys its medical provider networks **and** their contracted reimbursement rates to an insurer, employer, entity that provides physician network services, or another contracting agent shall, upon entering or renewing a provider contract, disclose to the provider whether the medical provider network may be sold, leased, transferred, or conveyed to other insurers, employers, entities that provide physician network services, or another contracting agent, **and** specify whether those insurers, employers, entities that provide physician network services, or contracting agents include workers' compensation insurers.

(h) On or before November 1, 2004, the administrative director, in

consultation with the Department of Managed Health Care, shall adopt regulations implementing this article. The administrative director shall develop regulations that establish procedures for purposes of making medical provider network modifications.

~~**SEC. 5.**~~***SEC. 7.*** Section 4660.1 of the Labor Code is amended to read:

4660.1. This section shall apply to injuries occurring on or after January 1, 2013.

(a) In determining the percentages of permanent partial or permanent total disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, **and** his or her age at the time of injury.

(b) For purposes of this section, the "nature of the physical injury or disfigurement" shall incorporate the descriptions **and** measurements of physical impairments **and** the corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th edition) with the employee's whole person impairment, as provided in the guides, multiplied by an adjustment factor of 1.4.

(c) There shall be no increases in impairment ratings for sleep dysfunction or sexual dysfunction, or both, arising out of a compensable physical injury. Nothing in this section shall limit the ability of an injured employee to obtain treatment for sleep dysfunction or sexual dysfunction, if any, that are a consequence of an industrial injury.

(d) The administrative director may formulate a schedule of age **and occupational** modifiers **and** may amend the schedule for the determination of the age **and occupational** modifiers in accordance with this section. The Schedule for Rating Permanent Disabilities pursuant to the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th edition) **and** the schedule of age **and occupational** modifiers shall be available for public inspection **and**, without formal introduction in evidence, shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule. Until the schedule of

age **and occupational** modifiers is amended, for injuries occurring on or after January 1, 2013, permanent disabilities shall be rated using the age **and occupational** modifiers in the permanent disability rating schedule adopted as of January 1, 2005.

(e) The schedule of age **and occupational** modifiers shall promote consistency, uniformity, **and** objectivity.

(f) The schedule of age **and occupational** modifiers **and** any amendment thereto or revision thereof shall apply prospectively **and** shall apply to **and** govern only those permanent disabilities that result from compensable injuries received or occurring on **and** after the effective date of the adoption of the schedule, amendment, or revision, as the case may be.

(g) Nothing in this section shall preclude a finding of permanent total disability in accordance with Section 4662.

(h) In enacting the act adding this section, it is not the intent of the Legislature to overrule the holding in Milpitas Unified School District v. Workers' Comp. Appeals Bd. (Guzman) (2010) 187 Cal.App.4th 808.

(i) The Commission on Health **and** Safety **and** Workers' Compensation shall conduct a study to compare average loss of earnings for employees who sustained work-related injuries with permanent disability ratings under the schedule, **and** shall report the results of the study to the appropriate policy **and** fiscal committees of the Legislature no later than January 1, 2016.

SB-1445 Developmental services: regional centers: individual program plans: telehealth.
(2013-2014)

AMENDED IN SENATE APRIL 10, 2014

AMENDED IN SENATE MARCH 25, 2014

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL No. 1445

Introduced by Senator Evans

February 21, 2014

An act to amend Section 4512 of the Welfare and Institutions Code, relating to developmental services.

LEGISLATIVE COUNSEL'S DIGEST

SB 1445, as amended, Evans. Developmental services: regional centers: individual program plans: telehealth.

Under existing law, the Lanterman Developmental Disabilities Services

Act, the State Department of Developmental Services contracts with regional centers to provide services and supports to individuals with developmental disabilities. The services and supports to be provided to a regional center consumer are contained in an individual program plan, developed in accordance with prescribed requirements, and may include, but are not limited to, diagnosis, treatment, personal care, information and referral services, ~~and~~ counseling, *and specialized medical and dental care*.

This bill would include telehealth services and supports ~~among the services and supports~~ *as part of the specialized medical and dental care that is* authorized to be included ~~as part of~~ *in* an individual program plan.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4512 of the Welfare and Institutions Code is amended to read:

4512. As used in this division:

(a) "Developmental disability" means a disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

(b) "Services and supports for persons with developmental disabilities" means specialized services and supports or special adaptations of

generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, and normal lives. The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. Services and supports listed in the individual program plan may include, but are not limited to, ~~telehealth services and support, as defined in Section 2290.5 of the Business and Professions Code,~~ diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, physical, occupational, and speech therapy, training, education, supported and sheltered employment, mental health services, recreation, counseling of the individual with a developmental disability and of his or her family, protective and other social and sociolegal services, information and referral services, follow-along services, adaptive equipment and supplies, advocacy assistance, including self-advocacy training, facilitation and peer advocates, assessment, assistance in locating a home, child care, behavior training and behavior modification programs, camping, community integration services, community support, daily living skills training, emergency and crisis intervention, facilitating circles of support, habilitation, homemaker services, infant stimulation programs, paid roommates, paid neighbors, respite, short-term out-of-home care, social skills training, specialized medical and dental care, *including telehealth services and support, as defined in Section 2290.5 of the Business and Professions Code,* supported living arrangements, technical and financial assistance, travel training, training for parents of children with developmental disabilities, training for parents with developmental disabilities, vouchers, and transportation services necessary to ensure delivery of services to persons with developmental disabilities. Nothing in this subdivision is intended to expand or authorize a new or different service or support

for any consumer unless that service or support is contained in his or her individual program plan.

(c) Notwithstanding subdivisions (a) and (b), for any organization or agency receiving federal financial participation under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, *Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code,* as amended, "developmental disability" and "services for persons with developmental disabilities" mean the terms as defined in the federal act to the extent required by federal law.

(d) "Consumer" means a person who has a disability that meets the definition of developmental disability set forth in subdivision (a).

(e) "Natural supports" means personal associations and relationships typically developed in the community that enhance the quality and security of life for people, including, but not limited to, family relationships, friendships reflecting the diversity of the neighborhood and the community, associations with fellow students or employees in regular classrooms and workplaces, and associations developed through participation in clubs, organizations, and other civic activities.

(f) "Circle of support" means a committed group of community members, who may include family members, meeting regularly with an individual with developmental disabilities in order to share experiences, promote autonomy and community involvement, and assist the individual in establishing and maintaining natural supports. A circle of support generally includes a plurality of members who neither provide nor receive services or supports for persons with developmental disabilities and who do not receive payment for participation in the circle of support.

(g) "Facilitation" means the use of modified or adapted materials, special instructions, equipment, or personal assistance by an individual, such as assistance with communications, that will enable a consumer to understand and participate to the maximum extent possible in the decisions and choices that ~~effect~~ *affect* his or her life.

(h) "Family support services" means services and supports that are provided to a child with developmental disabilities or his or her family

and that contribute to the ability of the family to reside together.

(i) "Voucher" means any authorized alternative form of service delivery in which the consumer or family member is provided with a payment, coupon, chit, or other form of authorization that enables the consumer or family member to choose his or her own service provider.

(j) "Planning team" means the individual with developmental disabilities, the parents or legally appointed guardian of a minor consumer or the legally appointed conservator of an adult consumer, the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548 and subdivision (e) of Section 4705, one or more regional center representatives, including the designated regional center service coordinator pursuant to subdivision (b) of Section 4640.7, any individual, including a service provider, invited by the consumer, the parents or legally appointed guardian of a minor consumer or the legally appointed conservator of an adult consumer, or the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548 and subdivision (e) of Section 4705, and including a minor's, dependent's, or ward's court-appointed developmental services decisionmaker appointed pursuant to Section 319, 361, or 726.

(k) "Stakeholder organizations" means statewide organizations representing the interests of consumers, family members, service providers, and statewide advocacy organizations.

(l) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.

(2) Receptive and expressive language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(7) Economic self-sufficiency.

Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

(m) "Native language" means the language normally used or the preferred language identified by the individual and, when appropriate, his or her parent, legal guardian or conservator, or authorized representative.

SENATE HUMAN SERVICES COMMITTEE

Senator Carol Liu, Chair

BILL NO:	**SB 1445**	**S B 1 4 4 5**
AUTHOR:	**Evans**	
VERSION:	**March 25, 2014**	
HEARING DATE:	**April 8, 2014**	
FISCAL:	**Yes**	
CONSULTANT:	**Mareva Brown**	

SUBJECT

Developmental services: regional centers: individual program plans: telehealth

SUMMARY

This bill includes telehealth services and supports among the services and supports authorized to be included as part of an individual program plan (IPP).

ABSTRACT

Existing Law:

1) Establishes the Lanterman Developmental Disabilities Services Act, which declares California's responsibility for providing an array of services and supports to meet the needs of each person with developmental disabilities in the least restrictive environment, regardless of age or degree of disability, and to support their integration into the mainstream life of the community. (*WIC 4500 et seq.*)

2) Establishes a system of nonprofit Regional Centers (RCs) to provide fixed points of contact in the community for all persons with developmental disabilities and their families, to coordinate services and supports best suited to them throughout their lifetime. (*WIC 4620)*

3) Establishes the IPP and defines that planning process as the vehicle to ensure that services and supports are customized to meet the needs of consumers who are served by regional centers. (*WIC 4512*)

4) Defines permissible services and supports to be listed in the IPP to include diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, physical, occupational, and speech therapy, training, education, supported and sheltered employment, mental health services, recreation, counseling of the individual with a developmental disability and of his or her family, protective and other social and sociolegal services, information and

Continued—

referral services, follow-along services, adaptive equipment and supplies, advocacy assistance, including self-advocacy training, facilitation and peer advocates, assessment, assistance in locating a home, child care, behavior training and behavior modification programs, camping, community integration services, community support, daily living skills training, emergency and crisis intervention, facilitating circles of support, habilitation, homemaker services, infant stimulation programs, paid roommates, paid neighbors, respite, short-term out-of-home care, social skills training, specialized medical and dental care, supported living arrangements, technical and financial assistance, travel training, training for parents of children with developmental disabilities, training for parents with developmental disabilities, vouchers, and transportation services necessary to ensure delivery of services to persons with developmental disabilities. (*WIC 4512 (b)*)

5) Creates the Telehealth Advancement Act of 2011 and defines "Telehealth" as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. (*BPC 2290.5*)

This bill:

1) Adds telehealth services and support, as defined in BPC 2290.5, to the lengthy list of permissible services and supports listed in WIC 4512 (b) (see #4 above).

FISCAL IMPACT

This bill has not been analyzed by a fiscal committee.

BACKGROUND AND DISCUSSION

Purpose of the bill

The author states that despite the implication in law that permits regional centers to integrate telehealth into their service models for individuals with developmental disabilities, many regional centers have been reluctant to use the treatment model. SB 1445 is intended to clarify that existing services and supports may be provided through telehealth by regional centers under the provisions of the Lanterman Act.

Regional Centers

In California, 21 nonprofit regional centers are part of a system of care that delivers services and supports to individuals with developmental disabilities. The regional centers are overseen by the California Department of Developmental Services (DDS). With a proposed budget of $5.2 billion for community-based services in 2014-2015, DDS is responsible for coordinating care and providing services for more than 265,000 people who receive services and supports to live in their communities, as well as 1,300 people who reside in developmental centers.

A developmental disability is defined in statute as a substantial disability that originates before the age of 18 and continues, or can be expected to continue, indefinitely, such as intellectual disabilities, cerebral palsy, epilepsy, and autism. Disabling conditions found to be closely related to an intellectual disability or that require treatment similar to that required for individuals with an intellectual disability also qualify.

Telehealth

The Telehealth Advancement Act of 2011 (*AB 415 (Logue) Chapter 547, Statutes of 2011*) defines "Telehealth" as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. The bill's stated intent was to provide better access to primary care and specialty providers to patients in medically underserved rural and urban areas, and to ensure a continuum of care in those areas. Telehealth was defined as s tool to create parity in those areas and to create new models of care as part of a multi-faceted approach to health care.

A 2008 report, "Meeting the Health Care Needs of California's Children: the Role of Telemedicine," by the Children's Partnership, stated that "Quality health care no longer requires a health care provider and patient to be in the same room at the same time. With the advancement of information and communications technology, children and adults can receive high-quality health care from a distance through telemedicine. In fact, telemedicine is rapidly becoming a viable solution to meeting the health care needs of patients in rural and other underserved areas."

California was one of the first states to adopt legislation to define and support the role of telemedicine in health care delivery. In 1996, California adopted the Telemedicine Development Act of 1996, identifying telemedicine as a legitimate means of providing health care. Current statute prohibits a health care service plan from requiring that in-person contact occur between a health care provider and a patient before payment is made for a covered service appropriately provided through telehealth.

Related legislation

AB 1231 (V. Manuel Perez, 2013) would have required DDS to inform all regional centers that any appropriate health care service and dentistry may be provided through the use of telehealth, as defined, to consumers of regional center services. The bill was vetoed by the governor who stated the bill's goals were permissible under current law.

SB 764 (Steinberg, 2012) would have required each regional center's IPP team to consider the use of telehealth, whenever applicable, to improve access to intervention and therapeutic services for consumers and family members. This bill was vetoed by the governor who stated the bill's goals could be accomplished under current law.

AB 415 (Logue), Chapter 547, Statutes of 2011, established the Telehealth Advancement Act of 2011 and stated legislative intent to use telehealth to expand consumers' access to convenient and quality care.

Comments:

Twice in the last two years, Governor Brown has vetoed similar bills that sought to require the state to inform regional centers about their ability to use telehealth services, when appropriate. In both cases, the governor noted that telehealth services are currently permissible under California law. This bill seeks a different approach by simply adding telehealth to the list of authorized regional center services within the Lanterman Act. In the author's proposed version of the bill, telehealth is listed prior to other fundamental services and supports in the list of permissible items.

Staff recommends amending the bill to move telehealth to a place on the list commensurate with similar services, as follows:

WIC 4512 (b)

> ... Services and supports listed in the individual program plan may include, but are not limited to, ~~**telehealth services and support, as defined in Section 2290.5 of the Business and Professions Code,**~~ diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, physical, occupational, and speech therapy, training, education, supported and sheltered employment, mental health services, recreation, counseling of the individual with a developmental disability and of his or her family, protective and other social and sociolegal services, information and referral services, follow-along services, adaptive equipment and supplies, advocacy assistance, including self-advocacy training, facilitation and peer advocates, assessment, assistance in locating a home, child care, behavior training and behavior modification programs, camping, community integration services, community support, daily living skills training, emergency and crisis intervention, facilitating circles of support, habilitation, homemaker services, infant stimulation programs, paid roommates, paid neighbors, respite, short-term out-of-home care, social skills training, specialized medical and dental care, ***including telehealth services and support, as defined in Section 2290.5 of the Business and Professions Code,*** supported living arrangements, technical and financial assistance, travel training, training for parents of children with developmental disabilities, training for parents with developmental disabilities, vouchers, and transportation services necessary to ensure delivery of services to persons with developmental disabilities. Nothing in this subdivision is intended to expand or authorize a new or different service or support for any consumer unless that service or support is contained in his or her individual program plan.

POSITIONS

Support: Center for Autism and Related Disorders
Special Needs Network

Oppose: None received.

-- END --

Senate Appropriations Committee Fiscal Summary
Senator Kevin de León, Chair

SB 1445 (Evans) – Developmental services: regional centers: individual program plans: telehealth.

Amended: April 10, 2014
Urgency: No
Hearing Date: May 5, 2014

Policy Vote: Human Services 5-0
Mandate: No
Consultant: Brendan McCarthy

This bill meets the criteria for referral to the Suspense File.

Bill Summary: SB 1445 would explicitly authorize telehealth services and supports authorized to be included in an individual program plan under the Lanterman Act.

Fiscal Impact:

- Minor costs to provide technical assistance to regional centers by the Department of Developmental Services (General Fund).

- Unknown impact on the use of services by regional center consumers (General Fund and federal funds). To the extent that the bill results in regional center consumers using telehealth services, there could be both increased utilization of services and reduced costs for current services. To date, there has been limited use of telehealth in the regional center system, so predicting utilization impacts is difficult.

  There may be circumstances where greater knowledge of the availability of telehealth services by consumers and their families increases the utilization services. For example, in rural areas of the state there may be limited numbers of providers for certain services. For services that are recurring or of long duration (such as behavioral health services), greater access to providers in other areas of the state through telehealth may increase the demand for those services by consumers from rural areas.

  On the other hand, services provided through telehealth may be less expensive than services provided in person. In such cases, greater use of telehealth may reduce costs to the regional centers.

Background: California provides community-based services to approximately 250,000 persons with developmental disabilities and their families through a statewide system of 21 regional centers. Regional centers are private, nonprofit agencies under contract with the Department of Developmental Services for the provision of various services and supports to people with developmental disabilities. As a single point of entry, regional centers provide diagnostic and assessment services to determine eligibility, convene planning teams to develop an Individual Program Plan for each eligible consumer, and either provide or obtain from generic agencies appropriate services for each consumer in accordance with the Individual Program Plan.

Proposed Law: SB 1445 would explicitly authorize telehealth services and supports authorized to be included in an individual program plan under the Lanterman Act.

Related Legislation:

- AB 1231 (V.M. Perez, 2013) would have required the Department of Developmental Services to inform all regional centers that appropriate services may be provided to regional center consumers through the use of telehealth. That bill was vetoed by Governor Brown.
- SB 764 (Steinberg, 2012) would have required the use of telehealth to be considered when developing each Individual Program Plan. That bill was vetoed by Governor Brown.
- SB 1050 (Alquist, 2012) would have require the Department of Developmental Services to establish an autism telehealth taskforce. That bill was vetoed by Governor Brown.

Comments: There is nothing in current law that prohibits the use of telehealth services to provide appropriate services to regional center consumers. Prior bills on this subject have been vetoed by Governor Brown, citing the ability of regional centers to authorize appropriate telehealth services under current law. However, by placing an explicit authorization for the use of telehealth in the Lanterman Act, it is possible that the bill will increase awareness of, and interest in, telehealth services as a way to access services and supports by regional center consumers and their families. Such an increase in awareness may lead to increased utilization of services, as described above.

California LEGISLATIVE INFORMATION

AB-809 Healing arts: telehealth. (2013-2014)

AMENDED IN SENATE JUNE 25, 2013

AMENDED IN ASSEMBLY APRIL 29, 2013

AMENDED IN ASSEMBLY APRIL 03, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

ASSEMBLY BILL No. 809

Introduced by Assembly Member Logue
(Coauthor: Senator Galgiani)

February 21, 2013

An act to amend Section 2290.5 of the Business and Professions Code, relating to telehealth, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 809, as amended, Logue. Healing arts: telehealth.

Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct.

This bill would ~~allow the verbal consent for the use of telehealth to apply in the present instance and for any subsequent use of telehealth.~~ *require the health care provider initiating the use of telehealth at the originating site to obtain verbal or written consent from the patient for the use of telehealth, as specified. The bill would require that health care provider to document the consent in the patient's medical record and to transmit that documentation with the initiation of any telehealth to any distant-site health care provider from whom telehealth is requested or obtained. The bill would require a distant-site health care provider to either obtain confirmation of the patient's consent from the originating site provider or separately obtain and document consent from the patient about the use of telehealth, as specified.*

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3 Appropriation: no Fiscal Committee: no Local Program: no

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 2290.5 of the Business and Professions Code is amended to read:

2290.5. (a) For purposes of this division, the following definitions shall apply:

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means a person who is licensed under this division.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

(6) "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth at the originating site shall ~~verbally~~ inform the patient about the use of telehealth and ~~request the patient's~~ *obtain* verbal *or written* consent~~, which may apply in the present instance and for any subsequent use of telehealth.~~ *from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health during a specified course of health care and treatment.* The ~~verbal~~ consent shall be documented in the patient's medical ~~record.~~ *record, and the documentation shall be transmitted with the initiation of any telehealth for that specified course of health care and treatment to any distant-site health care provider from whom telehealth is requested or obtained. A distant-site health care provider shall either obtain confirmation of the patient's consent from the originating site provider or separately obtain and document consent from the patient about the use of telehealth as an acceptable mode of delivering health care services and public health*

during a specified course of health care and treatment.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a *specified* course of *health care and* treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

SEC. 2. This act is an urgency statute necessary for the immediate

preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the health and safety of the public due to a lack of access to health care providers in rural and urban medically underserved areas of California, the increasing strain on existing providers expected to occur with the implementation of the federal Patient Protection and Affordable Care Act, and the assistance that further implementation of telehealth can provide to help relieve these burdens, it is necessary for this act to take effect immediately.

Hearing Date: June 17, 2013 Bill No: AB 809

SENATE COMMITTEE ON BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
Senator Ted W. Lieu, Chair

Bill No: AB 809 Author: Logue
As Amended: April 29, 2013 Fiscal: No

SUBJECT: Healing arts: telehealth.

SUMMARY: This bill is an urgency measure which repeals the segment of the Telehealth Advancement Act of 2011 requiring a physician to obtain oral consent prior to each delivery of telehealth services.

Existing law:

1) Defines "telehealth" as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers. (Business and Professions Code (BPC) § 2290.5 (a)(6))

2) Defines "asynchronous store and forward" as the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient. (BPC § 2290.5 (a)(1))

3) Defines "synchronous interaction" as a real-time interaction between a patient and a health care provider located at a distant site. (BPC § 2290.5 (a)(5))

4) Defines "distant site" as a site where a health care provider who provides health care services is located while providing these services via a telecommunications system. (BPC § 2290.5 (a)(2))

5) Defines "originating site" as a site where a patient is located at the time health care services are provided via telecommunications system or where the asynchronous store and forward service originates. (BPC § 2290.5 (a)(4))

6) Requires a health care provider to verbally inform the patient that telehealth may be used, obtain verbal consent from the patient for this use and requires the verbal consent to be documented in the patient's medical record. (BPC § 2290.5 (b))

7) Establishes that failure to inform the patient that telehealth may be used and to obtain their informed consent constitutes unprofessional conduct. (BPC § 2290.5 (c))

8) States that all laws regarding the confidentiality of health care information and a patient's rights to his or her medical information apply to telehealth interactions. (BPC § 2209.5 (e))

This bill:

1) Specifies that the health care provider initiating the use of telehealth at the originating site shall verbally inform the patient about the use of telehealth and request the patient's verbal consent, which may apply in that instance and for any subsequent use of telehealth.

2) Specifies that verbal consent shall be documented in the patient's medical record.

3) Contains an urgency clause allowing the bill to take effect immediately upon enactment in order to protect the health and safety of the public due to a lack of access to health care providers in rural and urban medically underserved areas of California, the increasing strain on existing providers expected to occur with the implementation of the federal Patient Protection and Affordable Care Act and the assistance that further implementation of telehealth can provide to help relieve these burdens.

FISCAL EFFECT: This bill has been keyed "non-fiscal" by Legislative Counsel.

COMMENTS:

1. **Purpose.** The Author is the sponsor of the bill. According to the Author, "Under AB 415, in order to ensure that both physicians and patients understood that telehealth may be used to treat a patient a physician is required to obtain verbal consent for each and every visit with the patient. One year after implementation, physicians have reported that this constant requirement is onerous and burdensome on their ability to treat patients efficiently."

2. **Background.** Telehealth. Telehealth is the practice of health care by using information and communication technologies such as audio, video or data communications to facilitate in diagnosis, consultation, treatment, education or management of a patient's health care. These types of communications include real time face to face interactions with the patient (synchronous) or near real time where the patient is not present (asynchronous) two-way transfer of medical information. Telehealth helps reduce barriers by connecting patients and providers over great distances (e.g., those in remote parts of the state, those with disabilities or those with dialects not commonly found in their area).

   Telemedicine Development Act of 1996 (SB 1665). California was one of the first states to utilize telemedicine (now referred to as "telehealth") beginning in the 1990s. The purpose of the Telemedicine Development Act of 1996 (TDA of 1996) was to reach underserved populations who, due to geographic and/or economic barriers, could not access health care.

   - Insurance Reimbursement. Included in the TDA of 1996 was the requirement that health insurers establish reimbursement policies for telemedicine providers. It required every insurer issuing group or individual policies of disability insurance to reimburse claims for those expenses within 30 working days after the receipt of claim unless contested; prohibited health care service disability insurers, non-profit plans and the Medi-Cal program, from requiring face-to-face contact between patient and physician as a condition of payment for services and required service plans to adopt

reimbursement policies to compensate telemedicine services. In 2000, AB 2877 was passed which indefinitely extended the provisions for telemedicine coverage by Medi-Cal.

- Patient Protections. In 1997, the TDA of 1996 was amended to exclude from the definition of telemedicine telephone conversations and electronic mail messages between a health care practitioner and a patient. The law also extended the rights granted to a patient of telemedicine to the patient's legal representative and it revised protections granted to patients of telemedicine to require application of existing laws regarding patient access to medical information and copies of medical records and surrogate decision-making.

Executive Orders Related to Telemedicine. In 2006 and 2007, a number of Executive Orders that would provide funding for telemedicine went into effect.

- Executive Order S-12-06 allocated $240 million to achieve full information exchange between health care providers and stakeholders within ten years.

- Executive Order S-23-06 established a broadband task force to promote broadband internet access and usage.

- Executive Order S-06-07 advanced the adoption of health information technology, increased transparency of quality and pricing information and promoted quality and efficiency of health care services.

Teleheath Advancement Act of 2011 (AB 415). In 2011, the TDA of 1996 was updated. The law replaced the term "telemedicine" with "telehealth." It allowed for the provision of a broader range of telehealth services, expansion of teleheatlh providers to include all licensed healthcare professionals, expansion of telehealth care settings and the ability for California hospitals to establish medical credentials for telehealth providers more easily.

3. **Arguments in Support.** The Medical Board of California supports the bill. They believe that the bill will allow the Telemedicine Advancement Act of 2011 to be better implemented, which will help to improve access to care via telehealth and further the Board's mission of improving access to care.

   The Association of California Healthcare Districts also supports the bill. They write in their letter, "The majority of California's healthcare districts are located in rural areas, and many utilize telehealth services to provide healthcare to the community...Telehealth has the potential to reduce costs, increase access and improve quality of care in a patient's life. In the most rural healthcare districts, the ability to bring patients together with specialized physicians through telehealth removes the obstacle of remoteness in patient care. In areas of the state lack specialty physicians, telehealth provides patients the opportunity to get specialized care, as needed."

   The California Academy of Physician Assistants supports the bill. In their letter they state, "Telehealth services have proven to be an important and efficient tool in the delivery of healthcare services. Removing barriers to use this critical technology allows patients and healthcare providers greater choice and a broader range of healthcare services."

The California Association of Physician Groups (CAPG) indicates their support in their letter when they write, "Telehealth is a critical component of the strategy to expand access to healthcare across California. CAPG member groups are busy implementing telehealth into their daily practice on an increasingly more frequent level. Many hurdles remain and it will take some years for this technology to come into its own. AB 809 provides important clean-up provisions to help this process move along."

4. **Arguments in Opposition.** The American Federation of State, County and Municipal Employees (AFSCME) opposes the bill. In their letter they write, "AFSCME believes that a one time verbal consent for the use of telelhealth removes a key part of the communication process between a physician and a patient. This bill should be amended to require a physician to obtain ongoing consent for treatment, so that the physician is able to educate the patient on what is happening and prevent any misunderstanding that could create future liability issues for the physician. Obtaining a one time verbal consent for telehealth services is not a common sense approach to practicing comprehensive health care."

5. **Current Related Legislation.** AB 318 (Logue, 2013) authorizes Medi-Cal payments for teledentistry services provided to individuals participating in the Medi-Cal program. *(Status: AB 318 is currently pending in Assembly Health Committee.)*

   AB 1174 (Bocanegra, 2013) expands the scope of practice for registered dental assistants, registered dental assistants in extended functions, and registered dental hygienists to better enable the practice of teledentistry in accordance with the findings of a Health Workforce Pilot Program, and enables reimbursement by Medi-Cal for Virtual Dental Home treatment. *(Status: AB 1174 is currently pending in Assembly Health Committee.)*

6. **Prior Related Legislation.** SB 764 (Steinberg, 2012) would have required the Department of Developmental Services (DDS) to pilot the use of "telehealth systems," defined as a mode of delivering services that utilizes information and communications technologies to facilitate the diagnosis, evaluation and consultation, treatment, education, care management supports, and self-management of consumers in the provision of Applied Behavioral Analysis and Intensive Behavioral Intervention. *(Status: SB 764 was vetoed by Governor Brown. The Governor's veto message noted that the goal of the bill could already be accomplished under existing law and mandating every individual program planning team to consider telehealth appeared to be excessive.)*

   SB 1050 (Alquist, 2012) would have required DDS to establish an autism telehealth taskforce to be administered and led by a public or nonprofit entity, would have provided that the lead administrator appoint members to the taskforce and would have provided that the taskforce provide technical assistance and recommendations in the area of telehealth services for individuals with autism spectrum disorder. *(Status: SB 1050 was vetoed by Governor Brown. The Governor's veto message indicated that he signed the Telehealth Advancement Act of 2011 in the prior year in order to update statutes on the use of telehealth. He noted that advancements and collaboration were occurring at the time of the bill and a privately funded, disease-specific task force set forth in statute did not appear to be warranted.)*

   AB 1733 (Logue, Chapter 782, Statutes of 2012) updated several code sections to replace the term "telemedicine" with "telehealth" and expanded the potential for telehealth use in health care programs administered by the Department of Health Care Services.

AB 415 (Logue, Chapter 547, Statutes of 2011) established the Telehealth Advancement Act of 2011 which revised and updated laws to facilitate the advancement of telehealth in managed care and the Medi-Cal program.

AB 175 (Galgiani, Chapter 419, Statutes of 2010) expanded the definition of "teleophthalmology and teledermatology by store and forward" to include services of an optometrist who is trained to diagnose and treat eye diseases until January 1, 2013.

AB 2120 (Galgiani, Chapter 260, Statutes of 2008) extended the Medi-Cal telemedicine reimbursement authorization until January 1, 2013.

AB 329 (Nakanishi, Chapter 386, Statutes of 2007) authorized the Medical Board of California (MBC) to establish a pilot program to expand the practice of telemedicine, and authorized the MBC to implement the program by convening a working group. The bill specified that the purpose of the pilot program was to develop methods, using a telemedicine model, of delivering health care to those with chronic diseases and delivering other health information. It also required the MBC to make recommendations to the Legislature within one year of the commencement date of the program.

AB 1224 (Hernandez, Chapter 507, Statutes of 2007) defined the practice of optometry as including the treatment of primary open-angle glaucoma with the participation of a collaborating ophthalmologist. It made a licensed optometrist subject to "interactive" telemedicine provisions and defined "collaborating ophthalmologist" for purposes of his or her participation in treating primary open angle glaucoma.

AB 234 (Eng, Chapter 586, Statutes of 2007) imposed a 125 hour limitation on experience for the marriage and family therapist licensure examination earned providing personal psychotherapy services via telemedicine and modified the definition of professional enrichment activities for these purposes.

AB 354 (Cogdill, Chapter 449, Statutes of 2005) until January 1, 2009, authorized under the Medi-Cal program, to the extent that federal financial participation was available, "teleophthalmology and teledermatology by store and forward."

AB 116 (Nakano, Chapter 20, Statutes of 2003) included that the provisions of law regulating telemedicine applied to the practice of a dentist, podiatrist, psychologist, marriage and family therapist and a clinical social worker.

AB 442 (Assembly Committee on Budget, Chapter 1151, Statutes of 2002) required the State Department of Health Services to allow psychiatrists to receive fee-for-service Medi-Cal reimbursement for services provided through telemedicine until June 30, 2004, or until a method for reimbursement was developed.

AB 2780 (Gallegos, Chapter 310, Statutes of 1998) established minimum standards for audio and visual telemedicine systems and would require the Department of Health Services to report to the appropriate committees of the Legislature by January 1, 2000, on the application of telemedicine to provide various types of care. Also defined "interactive" to mean an audio,

video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

SB 1665 (Thompson, Chapter 864, Statutes of 1996) established California's Telemedicine Development Act (TDA) to set standards for the use of telemedicine by health care practitioners and insurers. TDA specifies, in part, that face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telemedicine, when those services are otherwise covered by the Medi-Cal program, and requires a health care practitioner to obtain verbal and written consent prior to providing services through telemedicine.

SUPPORT AND OPPOSITION:

Support:

Medical Board of California
Association of California Healthcare Districts
California Academy of Physician Assistants
California Association of Physician Groups

Opposition:

American Federation of State, County and Municipal Employees

Consultant: Le Ondra Clark, Ph.D.

ASSEMBLY THIRD READING
AB 809 (Logue)
As Amended April 29, 2013
2/3 vote. Urgency

HEALTH	15-0	BUSINESS & PROFESSIONS	12-0
Ayes:	Pan, Logue, Ammiano, Atkins, Bonilla, Bonta, Chesbro, Maienschein, Mansoor, Mitchell, Nazarian, Nestande, V. Manuel Pérez, Wagner, Wilk	Ayes:	Gordon, Jones, Bocanegra, Campos, Dickinson, Eggman, Hagman, Maienschein, Mullin, Skinner, Ting, Wilk

SUMMARY: Requires prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth at the originating site to verbally inform the patient about the use of telehealth and request the patient's verbal consent, which may apply in the present instance and for any subsequent use of telehealth. Provides that nothing in this bill precludes a patient from receiving in-person health care delivery services during a course of treatment after agreeing to receive services via telehealth.

EXISTING LAW:

1) Defines telehealth as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

2) Requires prior to the delivery of health care via telehealth, the health care provider at the originating site to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Requires the verbal consent to be documented in the patient's medical record.

3) States that all laws regarding the confidentiality of health care information and a patient's rights to his or her medical information apply to telehealth interactions.

4) Exempts a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

5) States notwithstanding any other provision of law and for purposes of 1) through 4) above that the governing body of the hospital, whose patients are receiving the telehealth services, may grant privileges to and verify and approve credentials for providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in federal regulations. States legislative intent to authorize a hospital to grant privileges to and verify and approve credentials for providers of telehealth.

6) States that "telehealth" includes "telemedicine," as specified.

7) Makes the failure of a health care provider to comply with 1) through 6) above unprofessional conduct.

8) Provides that 1) through 7) above shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting or in a manner not otherwise authorized by law.

FISCAL EFFECT: None

COMMENTS: According to the author, this bill would address a problem in existing law amended by AB 415 (Logue), Chapter 547, Statutes of 2011, the Telemedicine Advancement Act of 2011. The author states that AB 415 replaced and updated the outdated terminology of "telemedicine" with "telehealth," to reflect the current use of telehealth in California's healthcare system, providing a broader range of services than contained in the outdated 1996 model statute. Under AB 415, in order to ensure that both physicians and patients understood that telehealth may be used to treat a patient, a physician is required to obtain verbal consent for each and every visit with the patient. Within a year after implementation, physicians have reported that this constant requirement is onerous and burdensome on their ability to treat patients efficiently. This bill will allow the first instance of consent to serve as consent for subsequent telehealth uses.

The California Association of Physician Groups supports this bill because telehealth is a critical component of the strategy to expand access to health care across California and this provides important clean-up provisions to help this technology come into its own. The Association of California Healthcare Districts states that eliminating the need for health care workers to obtain oral consent to receive telehealth services during every visit, allows a patient to be comfortable with the standard, that telehealth may be used when receiving health care services.

Analysis Prepared by: Teri Boughton / HEALTH / (916) 319-2097

FN: 0000405

AMENDED IN ASSEMBLY APRIL 28, 2014

AMENDED IN ASSEMBLY APRIL 21, 2014

AMENDED IN ASSEMBLY APRIL 10, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1890

Introduced by Assembly Member Chau

February 19, 2014

An act to add Chapter 2.7 (commencing with Section 18898) to Division 8 of the Business and Professions Code, relating to athletic trainers.

LEGISLATIVE COUNSEL'S DIGEST

AB 1890, as amended, Chau. Athletic trainers.

Existing law provides for the regulation of various professions and vocations, including those of an athlete agent.

This bill would make it unlawful for any person to hold himself or herself out as *an athletic trainer or* a certified athletic trainer, *or to use specified terms to imply or suggest that the person is an athletic trainer,* unless he or she ~~has been~~ *is* certified by the Board of Certification, Inc., and has either graduated from a college or university, after completing an accredited athletic training education program, as specified, or completed *eligibility* requirements for certification by the Board of Certification, Inc., prior to January 1, 2004. The bill would make it an unfair business practice to ~~violate these provisions~~ *use the title "athletic trainer," "certified athletic trainer," or other specified terms that imply or suggest that the person is an athletic trainer if he or she does not meet the requirements described above.*

This bill, notwithstanding these provisions, would authorize a person who has practiced athletic training in California for a period of 20 consecutive years prior to January 1, 2015, and who is not otherwise eligible to use the title of "athletic trainer," to use that title.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Chapter 2.7 (commencing with Section 18898) is added to Division 8 of the Business and Professions Code, to read:

CHAPTER 2.7. ATHLETIC TRAINERS

18898. (a) ~~No~~ *A* person shall *not* hold himself or herself out to be *an athletic trainer or* a certified athletic ~~trainer~~ *trainer, or use the term "AT," "ATC," or "CAT" to imply or suggest that the person is an athletic trainer,* unless he or she meets the following requirements:

(1) He or she has done either of the following:

(A) Graduated from a college or university after completing an athletic training education program accredited by the Commission on Accreditation of Athletic Training Education, or its predecessors or successors.

(B) Completed *eligibility* requirements for certification by the Board of Certification, Inc., prior to January 1, 2004.

(2) He or she ~~has been~~ *is* certified by the Board of Certification, Inc.

(b) It is an unfair business practice within the meaning of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 for any person to use the title of *"athletic trainer,"* "certified athletic trainer" or any other term, such as *"certified,"* "licensed," "registered," ~~or~~ *"AT,"* "ATC," *or "CAT,"* that implies or suggests that the person is ~~certified as~~ an athletic trainer, if ~~the person~~ *he or she* does not meet the requirements of subdivision (a).

18899. Notwithstanding Section 18898, a person who has practiced athletic training in California for a period of 20 consecutive years prior to January 1, 2015, and who is not

otherwise eligible to use the title of "athletic trainer," may use the title "athletic trainer."

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Date of Hearing: May 6, 2014

ASSEMBLY COMMITTEE ON BUSINESS, PROFESSIONS AND CONSUMER PROTECTION
Susan A. Bonilla, Chair
AB 1890 (Chau) – As Amended: April 28, 2014

SUBJECT: Athletic trainers.

SUMMARY: Establishes title protection for certified athletic trainers. Specifically, this bill:

1) Prohibits a person from holding himself or herself out to be an athletic trainer or a certified athletic trainer, or from using the term "AT," "ATC," or "CAT" to imply or suggest that the person is an athletic trainer unless he or she meets both of the following requirements:

   a) He or she has done either of the following:

      i) Graduated from a college or university after completing an athletic training education program accredited by the Commission on Accreditation of Athletic Training Education, or its predecessors or successors; or

      ii) Completed requirements for certification by the Board of Certification, Inc. (BOC), prior to January 1, 2004; and,

   b) He or she is certified by BOC.

2) Deems that it is an unfair business practice for any person to use the title of "athletic trainer," "certified athletic trainer," or any other term, such as "certified," "licensed," "registered," "AT," "ATC," or "CAT," that implies or suggests that the person is certified as an athletic trainer, if the person does not meet the specified requirements.

3) Provides that a person who has practiced athletic training in California for a period of 20 consecutive years prior to January 1, 2015, and who is not otherwise eligible to use the title of "athletic trainer," may use the title "athletic trainer."

EXISTING LAW provides for the regulation of various professions and vocations, including those of an athlete agent.

FISCAL EFFECT: None. This bill is keyed non-fiscal by the Legislative Counsel.

COMMENTS:

1) Purpose of this bill. This bill would enact title protection for athletic trainers certified by BOC, meaning that individuals who are not certified athletic trainers would be prohibited from holding themselves out to the public as athletic trainers. An exemption is provided to uncertified individuals who have practiced athletic training in California for 20 consecutive years prior to 2015. This bill is sponsored by the California Athletic Trainers' Association

(CATA).

2) Author's statement. According to the author, "Although many high school and college sports teams already employ [athletic trainers], and several California State University campuses offer bachelor degrees in athletic training, California is one of only 2 states that do not regulate this vital and growing profession. Currently, anyone can label him[self] or herself an athletic trainer without the proper education, training, or certification. Without state oversight, the public could be harmed by relying on someone who calls themselves an [athletic trainer] without the appropriate background. AB 1890 would protect Californians by ensuring that only those people who have the proper education, training, and certification may call themselves an athletic trainer."

3) The practice of athletic training. According to the sponsor, athletic trainers are physical medicine and rehabilitation specialists who generally work in institutional settings under the direction of a physician. In practice, they may be the first healthcare providers on the scene when injuries occur (whether at sporting events or on job sites), and must be able to recognize, evaluate and assess injuries and provide immediate care when needed.

   Athletic trainers are considered "health care professionals" by the American Medical Association, which states that "athletic training encompasses the prevention, diagnosis and intervention of emergency, acute, and chronic medical conditions involving impairment, functional limitations, and disabilities." Athletic trainers are distinct from "personal trainers", who are generally thought of as individuals who prescribe, monitor and modify individual exercise programs in a fitness or sports setting. Athletic training and physical therapy are also different professions, although there are certainly substantial areas of overlap.

   The US Department of Labor describes the areas of expertise for certified athletic trainers as: application of protective or injury-preventative devices; evaluation of injuries; first aid and emergency care; development and execution of rehabilitation programs for injured athletes; and program planning for injury and illness prevention of athletes.

   Athletic trainers are usually employed by organizations such as professional sports teams, colleges and universities, high schools, outpatient rehabilitation clinics, hospitals, corporations, performing arts groups, physicians groups, the military and health clubs. Roughly 44% of certified athletic trainers nationwide work with athletes in educational or professional sports settings, with nearly 19% working in health care facilities, and more than 10% working in industry, public safety and the military. The sponsor reports that large employers use athletic trainers in part because of their utility in reducing employee injuries and workers' compensation costs.

4) Current state of regulation for athletic trainers. The educational system for athletic training has been standardized and accredited by a national agency, the Commission on Accreditation of Athletic Training Education (CAATE). According to the author, all 48 states currently regulating athletic training utilize the BOC certification examination, which is based on CAATE educational principles. BOC is the only entity that currently provides athletic training certification, which means that it would be the sole provider of the certification exam

required by this bill. Certification is not currently required to practice athletic training in California, and noncertified individuals are not subject to regulatory discipline.

Despite its widespread adoption, BOC has a limited ability to investigate complaints against certified athletic trainers because they have no subpoena power and limited staff with no authority in California. Its sole disciplinary power is the suspension or revocation of the national certification which is not recognized in California and thus poses no barrier to an individual's continued practice here.

According to the sponsor, there are 48 states that regulate athletic trainers, 39 of which provide licensure (five require registration and four require certification).

There are 16 accredited athletic training programs in California. In 2010, 182 Californians became certified athletic trainers.

Currently, there are approximately 2,500 certified athletic trainers practicing in California. The sponsor of this bill, CATA, represents roughly 2,300 athletic trainers in California.

4) The role of title protection. This bill would provide BOC-certified athletic trainers with what is termed "title protection". Title protection means that certified athletic trainers would have an exclusive right to use the title "athletic trainer", while noncertified athletic trainers who advertise the same title risk legal action. The only exception would be individuals who have been practicing continuously in California for 20 years or more before 2015, who would be allowed to use the title as well.

   Title protection is generally intended to be a means of market differentiation, whereas a "practice act" would literally prohibit individuals from engaging in the practice regardless of how it is described. In this case, other individuals could still practice athletic training in California, but they would not be permitted to call themselves athletic trainers.

   Legislation providing title protection or registration for athletic trainers has been passed and vetoed three separate times in recent years: AB 1647 (Hayashi) of 2010, SB 284 (Lowenthal) of 2007, and SB 1397 (Lowenthal) of 2006. Governor Schwarzenegger's veto message of AB 1647 stated "This bill is similar to legislation I have vetoed twice before in the past because there is no evidence that regulating the use of the term "certified athletic trainer" poses any threat to the public health and safety."

5) Evidence of substandard practice. According to the author, "[a] survey of 760 certified athletic trainers....found more than 60 cases of harm as the result of improper care provided by non-certified 'athletic trainers.'

   "According to the U.S. Department of Labor Division of Practitioner Data Banks, a voluntary reporting repository for sanctions made by state boards, there were 469 reports of sanctions to athletic trainers – both certified and uncertified – from 2000 to 2010. These sanctions were based upon misconduct including incompetent practice/harm, practicing beyond the scope of practice, and sexual misconduct. The BOC reported over 2,700 violations [nationwide] of professional practice standards in five years (2005-10) with nearly 300 violations in California, including three sexual offenses. In a 2011 case, a collegiate athlete

died because of negligence of a collegiate athletic trainer, although no lawsuit has been filed to date. Two additional athletic trainers were fired after being arrested on sexual abuse charges."

The sponsor reports that it is aware of at least 150 individuals practicing as athletic trainers without BOC certification in California high schools, and seven individuals working in California community colleges who are similarly uncertificated.

Finally, the sponsor contends that "the lack of oversight of athletic trainers is a consumer protection problem. The athletes with whom these unqualified individuals work, and the employers who hire them, have no way of knowing that these individuals are not qualified to be athletic trainers. The public has no way to determine if someone practicing athletic training is qualified. The public has no way to file a complaint, or ask for a practitioner to be investigated and/or sanctioned for incompetence, unethical practice, etc. This creates a huge regulatory gap in the healthcare system."

5) Arguments in support. According to the sponsor, CATA, "The unregulated status of the athletic training profession is a major public concern, which would be partially addressed if AB 1890 were to pass. Unqualified individuals are posing as athletic trainers and providing healthcare to our children without the proper education or training. Also, individuals who have lost their national certification or license in other states are coming to practice in California with impunity. Currently, there is no mechanism for the public to lodge a complaint or to remove an individual that is practicing incompetently. Only licensure will rectify the aforementioned issues however, AB 1890 would at least ensure that individuals who call themselves athletic trainers have had the proper education and training and are certified by a nationally recognized certifying agency."

6) Arguments in opposition. According to the California Federation of Teachers (CFT), which has an Opposed Unless Amended position, "CFT is concerned that this bill does not have a provision to exempt from the licensure requirements persons who are currently employed and have worked as athletic trainers for years. CFT represents athletic trainers who have worked in this field for years and the enactment of this bill could result in the termination of their employment. Therefore, we respectfully request an amendment that would grandfather in persons who have worked in this profession for 15 years and allow them to continue to practice as athletic trainers and use the title of an athletic trainer."

7) Technical amendment. Given that the bill restricts its effects to those working as athletic trainers (which title is restricted) rather than those practicing athletic training (which remains unrestricted), the exemption granting title protection to uncertified individuals in practice more than 20 years should be recast to apply to those who have actually worked as athletic trainers, rather than anyone who practiced athletic training.

Page 2, line 29, strike the words "practiced athletic training" and insert "worked as an athletic trainer"

8) Previous legislation. AB 864 (Skinner) of 2013 would have established the Athletic Training Practice Act to license and regulate athletic trainers through the creation of an Athletic

Trainer Licensing Committee under the Physical Therapy Board of California. AB 864 was held in the Assembly Appropriations Committee.

AB 252 (Yamada and Eggman) of 2013 would have prohibited an individual from holding himself or herself out professionally as a "social worker" unless he or she has received a degree from an accredited academic institution. AB 252 was held in the Assembly Appropriations Committee.

SB 1273 (Lowenthal) of 2012 was very similar to AB 864 in most respects. SB 1273 failed passage in the Senate Business, Professions and Economic Development Committee.

AB 374 (Hayashi) of 2011 in its most recent version would have extended title protection to athletic trainers. AB 374 was amended in the Assembly Appropriations Committee to address an unrelated issue.

AB 1647 (Hayashi) of 2010 would have extended title protection to athletic trainers. AB 1647 was vetoed by Governor Schwarzenegger.

SB 284 (Lowenthal) of 2007 would have provided for registration of ATs. SB 284 was vetoed by the Governor.

SB 1397 (Lowenthal) of 2006 would have provided for registration of ATs. SB 1397 was vetoed by the Governor.

AB 614 (Lowenthal) of 2003 would have required the Department of Consumer Affairs to review the need for licensing of ATs. AB 614 was held in the Senate Business, Professions and Economic Development Committee.

AB 2789 (Lowenthal) of 2002 would have required the Department of Consumer Affairs to review the need for licensing of ATs and undertake an occupational analysis. AB 2789 was held on the Assembly Appropriations Committee Suspense file.

REGISTERED SUPPORT / OPPOSITION:

Support

California Athletic Trainers' Association (sponsor)
American Medical Society for Sports Medicine (4/10/14 version)
2333 private individuals (2/19/2014 version)

Opposition

California Federation of Teachers (4/21/14 version)
301 private individuals (2/19/2014 version)

Analysis Prepared by: Hank Dempsey / B.,P. & C.P. / (916) 319-3301

Issue Paper

Date: April 22, 2014

Prepared for: CBOT Members

Prepared by: Heather Martin, Executive Officer

Subject: Assembly Bill 1890 (Chau). Athletic Trainers.

Issue:

WHAT IS THE BOARD'S POSITION ON ASSEMBLY BILL 1890, WHICH PROVIDES FOR THE LICENSURE OF ATHLETIC TRAINERS?

Background:

On January 13, 2010, Assembly Bill (AB) 1647 (Hayashi) was introduced. The bill proposed to provide title protection for athletic trainers and ensure that only those properly trained and certified may use the term 'athletic trainer' or "certified athletic trainer.' The bill was amended numerous times and ultimately passed in both the Assembly and the Senate; the bill was vetoed by the Governor in September 2010.

On February 23, 2012, Senate Bill 1273 (Lowenthal) was introduced. The bill proposed to enact the Athletic Trainer Practice Act, which would require licensure and regulation of athletic trainers under the jurisdiction of the newly created Athletic Trainer Licensing Committee, within the Physical Therapy Board of California. The bill was amended April 9, 2012, and died in Committee.

On February 21, 2013, AB 864 (Skinner) was introduced. The bill proposed to enact the Athletic Trainer Practice Act, which would require licensure and regulation of athletic trainers under the jurisdiction of the newly created Athletic Trainer Licensing Committee, within the Physical Therapy Board of California. The bill was amended April 1, 2013, and April 29, 2013; the bill died in Committee. (Copy attached)

On February 19, 2013, AB 1890 (Chau) was introduced. The bill proposes to enact the Athletic Trainer Practice Act, which would require licensure and regulation of athletic trainers under the jurisdiction of the newly created Athletic Trainer Licensing Committee. The bill was amended April 10, 2014, and will be heard by the Assembly Committee on Business, Professions and Consumer Protection (B, P, CP) on April 29, 2014. (Copy attached)

(In your meeting materials, the first four items are as follows: AB 1890, the current bill, followed by AB 864 and the two legislative committee analyses of AB 864. We're sorry for any confusion caused by the background information above not being consistent with the placement of the materials in the meeting packet.)

What is an Athletic Trainer?

According to the National Athletic Trainers Association (NATA):

> Athletic Trainers are healthcare professionals who collaborate with physicians to optimize activity and participation of patients and clients. Athletic training encompasses the prevention, diagnosis an intervention of emergency, acute and chronic medical conditions involving impairment, functional limitations and disabilities. According to the National Athletic Trainers' Association, Athletic Training is recognized by the American Medical Association as a healthcare profession.

Additional information is available in the attached document entitled: *Athletic Trainer Services: An Overview of Skills and Services Performed by a Certified Athletic Trainer* (NATA 1/2010).

Information on professional (entry-level) and post-professional degree programs is included, followed by information on educational bachelor/Masters education programs in CA and bordering states.

Description of the Athletic Trainer Education:

According to information obtained from the Commission on Accreditation of Athletic Training Education (updated 8/16/2013) hereafter 'Commission', the athletic trainer's post-professional education is based on developing students' knowledge, skills, and abilities, beyond the professional level, as determined by the Commission.

Athletic trainer professional {entry-level} education is set forth in the attached *Athletic Trainer Education Competencies* (2011).

Post-professional athletic training degree programs incorporate core competencies required for advanced clinical practice. The prost-professional core competencies are:

- Evidence-Based Practice
- Interprofessional Education and Collaborative Practice
- Quality Improvement
- Healthcare Informatics
- Professionalism
- Patient-Centered Care

For the post-professional education of athletic trainers, educational "core competencies" are broadly defined as professional behavior that involves *the habitual and judicious use of communication, knowledge, clinical skills, clinical reasoning, emotions, values, and reflection in daily practice.*

Descriptions of the post-professional core competencies are provided as an attachment in pages three through six of the Commission's *Standards for the Accreditation of Post-Professional Athletic Training Degree Programs.* {Please let me know if you would like the entire document emailed to you.}

National Certification

The Board of Certification (BOC) functions similarly to the National Board for Certification in Occupational Therapy - the BOC provides the required national examination and athletic trainers may maintain the certification issued by the BOC. Athletic trainers can maintain their certification (which also allows the use of the initials 'ATC') by completing 50 contact hours every two years and maintain continuous (annual) certification in emergency cardiac care, which includes: adult CPR, Pediatric CPR, 2nd rescuer, Automated External Defibrillator (AED), airway obstruction, and barrier devices (e.g., pocket mask, bag valve mask).

Enclosed is a document entitled *Crosswalk analysis: BOC Role Delineation Study/Practice Analysis, 6th Edition and NATA Athletic Training Education Competencies, 5th Edition.* This document, prepared by BOC staff, is a "crosswalk" analysis between the role delineation study/practice analysis and the competencies, or educational content expected of students enrolled in accredited training programs.

The BOC has established the *Standards of Professional Practice* (implemented 1/1/2006), which includes practice standards and a code of professional responsibility. Athletic trainers are expected to comply with the *BOC Standards of Professional Practice* at all times, including for renewal purposes of their certification and ATC credential. The BOC also established the *Professional Practice and Discipline Guidelines* (effective 3/22/2007, updated 1/1/2014). Both BOC documents are attached for your review.

Similar to NBCOT, the BOC posts disciplinary action(s) reported to them by state regulatory agencies. There were three actions posted on the BOC website; these have also been included for your review.

State Regulation of Athletic Trainers

A review of information on the website of the NATA indicates that only two states have no form of regulation: California and Alaska. (The use of the term regulation includes licensure, certification, and registration). Attached is a listing of the state regulatory bodies that oversee the athletic profession.

Here is a summary of state regulatory information:

- 21 states have a Board of Athletic Trainers;
- 16 states have Athletic Trainer Programs (includes program under general State dept.);
- 9 states have an Athletic Trainer Committee or Athletic Trainer Council;
- Ohio regulates OT/PT/AT together at the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board.
- Delaware has a Board of Physical Therapists and Athletic Trainers;
- West Virginia has a Board of Physical Therapy (ATs are required to register with PT Board)

Several national boards for various healthcare professions collaborated on a document entitled *Changes in Healthcare Professions' Scope of Practice: Legislative Consideration.*

Per the document, it is "...the result of collaboration between the following organizations:

Association of Social Work Boards
Federation of State Boards of Physical Therapy
Federation of State Medical Board of the United States, Inc.
National Association of Boards of Pharmacy
National Board for Certification in Occupational Therapy, Inc.
National Council of State Boards of Nursing."

Given the national collaboration on the issue of scopes of practice, which affect so many healthcare professionals, I've included pages 5 - 11 of the document. The extract covers legislative considerations of changes in healthcare professions' scope of practice, the purpose of regulation, and the basis for decisions related to changes in scope of practice. {Please let me know if you would like the entire document emailed to you.}

For your reference, I've also provided the text of the pending legislation in Alaska which would require an AT be licensed in order to practice.

Lastly, since statutory language varies greatly from state to state, to give you an idea of how loose or strict the oversight is, statutes are provided for the following states: Alabama, Arizona (both laws and regulations provided), Florida, Michigan Nevada, Oregon, Washington. Attached for your review and consideration are the following documents:

- AB 1890, amended 4/10/2014 (no analysis available as of 4/17)
- AB 864, last amended 4/29/2013
- Analysis of AB 864 by Assembly Committee on B, P, CP
- Analysis of AB 864 by Assembly Committee on Appropriations
- *Athletic Trainer Services: An Overview of Skills and Services Performed by a Certified Athletic Trainer* (NATA 1/2010)
- Professional (entry-level) education requirements and Post-Professional (Master's level) education overview
- Accredited Bachelor & Masters programs in CA, OR, NV, and AZ
- Athletic Trainer Education Competencies (2011) {for professional or 'entry level'}
- Extract from the *Standards for the Accreditation of Post-Professional Athletic Training Degree Programs* (8/16/2013) describing the core-competencies
- Crosswalk analysis: *BOC Role Delineation Study/Practice Analysis, 6th Edition and NATA Athletic Training Education Competencies, 5th Edition*
- BOC *Standards of Professional Practice* (1/2006)
- BOC *Professional Practice and Discipline Guidelines* (1/2014)
- Various state's disciplinary action reported to BOC
- Information on state regulatory bodies
- Extract from *Changes in Healthcare Professions' Scope of Practice: Legislative Consideration.*
- Legislation proposing licensure for ATs in Alaska
- Multiple state's statutes

Information from NATA on ATs in other states:

District 07			
ARIZONA	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	478	75	**553**
Certified Nonmembers	0	197	**197**
COLORADO	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	507	96	**603**
Certified Nonmembers	0	204	**204**
NEW MEXICO	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	142	18	**160**
Certified Nonmembers	0	58	**58**
UTAH	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	343	50	**393**
Certified Nonmembers	0	152	**152**
WYOMING	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	62	7	**69**
Certified Nonmembers	0	12	**12**
District 08			
CALIFORNIA	ACTIVE	SUSPENDED	**MEMBER COUNT**
Certified Members	1800	316	**2,116**
Certified Nonmembers	0	621	**621**
HAWAII	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	171	32	**203**
Certified Nonmembers	0	33	**33**
NEVADA	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	141	30	**171**
Certified Nonmembers	0	65	**65**
District 10			
ALASKA	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	43	8	**51**
Certified Nonmembers	0	14	**14**

IDAHO	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	161	26	**187**
Certified Nonmembers	0	63	**63**
MONTANA	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	127	19	**146**
Certified Nonmembers	0	42	**42**
OREGON	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	301	44	**345**
Certified Nonmembers	0	74	**74**
WASHINGTON	ACTIVE	SUSPENDED	MEMBER COUNT
Certified Members	542	61	**603**
Certified Nonmembers	0	164	**164**

AB-1890 Athletic trainers. (2013-2014)

AMENDED IN ASSEMBLY APRIL 21, 2014

AMENDED IN ASSEMBLY APRIL 10, 2014

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

ASSEMBLY BILL No. 1890

Introduced by Assembly Member Chau

February 19, 2014

~~An act to add and repeal Chapter 5.8 (commencing with Section 2697.2) of Division 2 of the Business and Professions Code, relating to athletic trainers.~~*An act to add Chapter 2.7 (commencing with Section 18898) to Division 8 of the Business and Professions Code, relating to athletic trainers.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1890, as amended, Chau. Athletic trainers.

Existing law provides for the regulation of various professions and vocations, including those of an athlete agent.

This bill would make it unlawful for any person to hold himself or herself out as a certified athletic trainer unless he or she has been certified by the Board of Certification, Inc., and has either graduated from a college or university, after completing an accredited athletic training education program, as specified, or completed requirements for certification by the Board of Certification, Inc., prior to January 1, 2004. The bill would make it an unfair business practice to violate these provisions.

~~Existing law provides for the regulation of various professions and vocations, including those of an athlete agent.~~

~~This bill would enact the Athletic Training Practice Act which would, until January 1, 2020, provide for the licensure and regulation of athletic trainers, as defined. The bill would establish the Athletic Trainer Licensing Committee to implement these provisions, including issuing and renewing athletic training licenses and imposing disciplinary action. Under the bill, the committee would be comprised of 7 members, to be appointed to 4-year terms except as specified. Commencing July 1 of the year in which this bill becomes operative, the bill would prohibit a person from practicing as an athletic trainer or using certain titles without a license issued by the committee, except as specified. The bill would specify the requirements for licensure, including the payment of a license application fee established by the committee. The bill would define the practice of athletic training and prescribe supervision requirements on athletic trainers. The bill would establish the Athletic Trainers' Fund for the deposit of license application and renewal fees, and would make those fees available to the committee for the purpose of implementing these provisions upon appropriation by the Legislature. The bill would authorize the Director of Consumer Affairs to seek and receive donations from the California Athletic Trainers Association for purposes of obtaining funds for the startup costs of implementing the act. The bill would require the director to determine that sufficient funds for that purpose have been obtained by a specified date and make the operation of these provisions contingent upon that determination. The bill would require~~

~~the director to provide notice to the Legislature, the Governor, and on the department's Internet Web site of the determination, as specified.~~

Vote: majority Appropriation: no Fiscal Committee: ~~yes~~*no* Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. *Chapter 2.7 (commencing with Section 18898) is added to Division 8 of the Business and Professions Code, to read:*

CHAPTER 2.7. Athletic Trainers

18898. *(a) No person shall hold himself or herself out to be a certified athletic trainer unless he or she meets the following requirements:*

(1) He or she has done either of the following:

(A) Graduated from a college or university after completing an athletic training education program accredited by the Commission on Accreditation of Athletic Training Education, or its predecessors or successors.

(B) Completed requirements for certification by the Board of Certification, Inc., prior to January 1, 2004.

(2) He or she has been certified by the Board of Certification, Inc.

(b) It is an unfair business practice within the meaning of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 for any person to use the title of "certified athletic trainer" or any other term, such as "licensed," "registered," or "ATC," that implies or suggests that the person is certified as an athletic trainer, if the person does not meet the requirements of subdivision (a).

~~SECTION 1.The Legislature finds and declares the following:~~

~~(a)California is one of only two states that does not currently regulate the practice of athletic training. This lack of regulation creates the risk~~

~~that individuals who have lost or are unable to obtain licensure in another state will come to California to practice, thereby putting the public in danger and degrading the standards of the profession as a whole.~~

~~(b)There is a pressing and immediate need to regulate the profession of athletic training in order to protect the public health, safety, and welfare. This need is particularly important because athletic trainers often work with schoolage children.~~

~~SEC. 2.Chapter 5.8 (commencing with Section 2697.2) is added to Division 2 of the Business and Professions Code, to read:~~

~~5.8.Athletic Trainers~~

~~2697.2.This chapter shall be known, and may be cited, as the Athletic Training Practice Act.~~

~~2697.4.For the purposes of this chapter, the following definitions apply:~~

~~(a)"Athletic trainer" means a person who meets the requirements of this chapter, is licensed by the committee, and practices under the direction of a licensed physician or surgeon.~~

~~(b)"Committee" means the Athletic Trainer Licensing Committee.~~

~~2697.6.(a)A person shall not engage in the practice of athletic training unless licensed pursuant to this chapter.~~

~~(b)A person shall not use the title "athletic trainer," "licensed athletic trainer," "certified athletic trainer," "athletic trainer certified," "a.t.," "a.t.l.," "c.a.t.," "a.t.c.," or any other variation of these terms, or any other similar terms indicating that the person is an athletic trainer unless that person is licensed pursuant to this chapter.~~

~~(c)Notwithstanding subdivisions (a) and (b), a person who practiced athletic training in California for a period of 20 consecutive years prior to July 1, 2015, and is not eligible on that date for an athletic training license may engage in the practice of athletic training and use the title "athletic trainer" without being licensed by the committee, upon registration with the committee.~~

AB-864 Athletic trainers. (2013-2014)

AMENDED IN ASSEMBLY APRIL 29, 2013

AMENDED IN ASSEMBLY APRIL 01, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

ASSEMBLY BILL No. 864

Introduced by Assembly Member Skinner

February 21, 2013

An act to add Chapter 5.8 (commencing with Section 2697.2) to Division 2 of, and to repeal Section 2697.8 of, the Business and Professions Code, relating to athletic trainers.

LEGISLATIVE COUNSEL'S DIGEST

AB 864, as amended, Skinner. Athletic trainers.

Existing law provides for the regulation of various professions and

vocations, including those of an athlete agent.

This bill would enact the Athletic Training Practice Act which would provide for the licensure and regulation of athletic trainers, as defined. The bill would establish, until January 1, 2019, the Athletic Trainer Licensing Committee within the Physical Therapy Board of California to implement these provisions, including issuing and renewing athletic training licenses and imposing disciplinary action. Under the bill, the committee would be comprised of 7 members, to be appointed to 4-year terms as specified. Commencing July 1, 2014, the bill would prohibit a person from practicing as an athletic trainer or using certain titles without a license issued by the committee, except as specified. The bill would prohibit, on and after January 1, 2017, a person from using the title "athletic trainer," unless licensed by the committee. The bill would specify the requirements for licensure, including the payment of a license application fee established by the committee. The bill would define the practice of athletic training and prescribe supervision requirements on athletic trainers. The bill would establish the Athletic Trainers' Account within the Physical Therapy Fund for the deposit of license application and renewal fees, and would make those fees available to the committee for the purpose of implementing these provisions upon appropriation by the Legislature.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares the following:

(a) California is one of only two states that does not currently regulate the practice of athletic training. This continued lack of regulation creates the risk that individuals who have lost or are unable to obtain licensure in another state will come to California to practice, thereby putting the public in danger and degrading the standards of the profession as a whole.

(b) There is a pressing and immediate need to regulate the profession

of athletic training in order to protect the public health, safety, and welfare. This need is particularly important because athletic trainers often work with school-age children.

SEC. 2. Chapter 5.8 (commencing with Section 2697.2) is added to Division 2 of the Business and Professions Code, to read:

CHAPTER 5.8. Athletic Trainers

2697.2. This chapter shall be known and may be cited as the Athletic Training Practice Act.

2697.4. For the purposes of this chapter, the following definitions shall apply:

(a) "Athletic trainer" means a person who meets the requirements of this chapter, is licensed by the committee, and practices under the direction of a licensed physician or surgeon.

(b) "Board" means the Physical Therapy Board of California.

(c) "Committee" means the Athletic Trainer Licensing Committee.

2697.6. (a) A person shall not engage in the practice of athletic training unless licensed pursuant to this chapter.

(b) A person shall not use the title "athletic trainer," "licensed athletic trainer," "certified athletic trainer," "athletic trainer certified," "a.t.," "a.t.l.," "c.a.t.," "a.t.c.," or any other variation of these terms, or any other similar terms indicating that the person is an athletic trainer unless that person is licensed pursuant to this chapter.

(c) Notwithstanding subdivisions (a) and (b), a person who practiced athletic training in California for a period of 15 consecutive years prior to July 1, 2014, and is not eligible for an athletic training license may use the title "athletic trainer" without being licensed by the committee, upon registration with the board. However, on and after January 1, 2017, no person may use the title "athletic trainer" unless he or she is licensed by the committee pursuant to this chapter.

(d) This section shall become operative on July 1, 2014.

2697.8. (a) There is established the Athletic Trainer Licensing Committee within the Physical Therapy Board of California. The committee shall consist of seven members.

(b) The seven committee members shall include the following:

(1) Four licensed athletic trainers. Initially, the committee shall include four athletic trainers who have satisfied the requirements of subdivision (a) of Section 2697.12 and who will satisfy the remainder of the licensure requirements described in Section 2697.12 as soon as it is practically possible.

(2) One public member.

(3) One physician and surgeon licensed by the Medical Board of California or one osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California.

(4) One physical therapist licensed by the Physical Therapy Board of California.

(c) Subject to confirmation by the Senate, the Governor shall appoint two of the licensed athletic trainers, the public member, and the physician and surgeon or osteopathic physician and surgeon. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a licensed athletic trainer. The Physical Therapy Board of California shall appoint the licensed physical therapist.

(d) (1) All appointments shall be for a term of four years and shall expire on June 30 of the year in which the term expires. Vacancies shall be filled for any unexpired term.

(2) Notwithstanding paragraph (1), for initial appointments made on or after January 1, 2014, the public member appointed by the Governor shall serve a term of one year. The athletic trainers appointed by the Senate Committee on Rules and the Speaker of the Assembly shall serve terms of three years, and the remaining members shall serve terms of four years.

(e) Each member of the committee shall receive per diem and expenses as provided in Section 103.

(f) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date. ~~The repeal of this section renders the committee subject to the review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code.~~

2697.10. (a) The committee shall adopt, repeal, and amend regulations as may be necessary to enable it to carry into effect the provisions of this chapter. All regulations shall be in accordance with this chapter.

(b) In promulgating regulations, the committee may consult the professional standards issued by the National Athletic Trainers' Association (NATA), the Board of Certification, Inc. (BOC), the Commission on Accreditation of Athletic Training Education (CAATE), or any other nationally recognized professional organization.

(c) The committee shall approve programs for the education and training of athletic trainers.

(d) The committee shall investigate each applicant, before a license is issued, in order to determine whether the applicant meets the qualifications required by this chapter.

(e) Protection of the public shall be the highest priority for the committee in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

2697.12. Except as otherwise provided in this chapter, the committee shall issue an athletic training license to an applicant who meets all of the following requirements:

(a) Has submitted an application developed by the committee that includes evidence that the applicant has graduated from a professional degree program in athletic training accredited by the Commission on Accreditation of Athletic Training Education, or its predecessors or successors, and approved by the committee, at an accredited postsecondary institution or institutions approved by the committee.

The professional degree program shall consist of didactic, clinical, and research experiences in athletic training using critical thinking and weighing of evidence.

(b) Has passed an athletic training certification examination offered by the Board of Certification, Inc., its predecessors or successors, or another nationally accredited athletic trainer certification agency approved and recognized by the committee.

(c) Possesses an emergency cardiac care certification from a certification body, approved by the committee, that adheres to the most current international guidelines for cardiopulmonary resuscitation and emergency cardiac care.

(d) Has paid the application fee established by the committee.

2697.14. Notwithstanding Section 2697.12, the committee shall issue an athletic training license to an applicant who did not graduate from an accredited athletic training education program as described in subdivision (a) of Section 2697.12, but who received athletic training via an internship, if the applicant meets all of the following requirements:

(a) Furnishes evidence satisfactory to the committee of completion of a degree at an accredited postsecondary institution that included instruction in basic sciences related to, and on the practice of, athletic training.

(b) Passes the examination described in subdivision (b) of Section 2697.12.

(c) Completes at least 1500 hours of clinical experience under an athletic trainer certified by the Board of Certification, Inc.

(d) Possesses an emergency cardiac care certification from a certification body, approved by the committee, that adheres to the most current international guidelines for cardiopulmonary resuscitation and emergency cardiac care.

(e) Has paid the application fee established by the committee.

2697.16. A license issued by the committee pursuant to Section 2697.12 or 2697.14 shall be valid for two years and thereafter shall be subject to the renewal requirements described in Sections 2697.18 and 2697.20.

2697.18. The committee shall establish license application and renewal fees in an amount sufficient to cover the reasonable regulatory costs of carrying out this chapter.

2697.20. The committee shall renew a license if an applicant meets all of the following requirements:

(a) Pays the renewal fee as established by the committee.

(b) Submits proof of all of the following:

(1) Satisfactory completion of continuing education, as determined by the committee.

(2) Current athletic training certification from a certification body approved by ~~te~~ *the* committee, including, but not limited to, the Board of Certification, Inc., or its predecessors or successors.

(3) Current emergency cardiac care certification meeting the requirements of subdivision (d) of Section 2697.12.

2697.21. (a) The committee may deny a license or the renewal of a license for an applicant or licensee who is described by any of the following:

(1) Does not meet the requirements of this chapter.

(2) Has had an athletic training license, certification, or registration revoked or suspended by an accredited organization, state, or territory.

(3) Has been convicted of a felony or any other crime that substantially relates to the functions or duties of an athletic trainer.

(4) Has committed unprofessional conduct, as described in subdivision (b).

(b) The committee may order any of the following actions relative to an athletic training license after a hearing for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, any regulation adopted by the committee pursuant to this chapter, and revocation or suspension of an athletic training license, certification, or registration by an accredited organization, state, or territory:

(1) Issuance of the athletic training license subject to terms and conditions.

(2) Suspension or revocation of the athletic training license.

(3) Imposition of probationary conditions upon the athletic training license.

2697.22. (a) The practice of athletic training includes all of the following:

(1) Risk management and injury or illness prevention.

(2) The clinical evaluation and assessment of an injury or an illness sustained or exacerbated while participating in physical activity, or both.

(3) The immediate care and treatment of an injury or an illness sustained or exacerbated while participating in physical activity, or both.

(4) The rehabilitation and reconditioning from an injury or an illness sustained or exacerbated while participating in physical activity, or both.

(b) The practice of athletic training does not include the practice of physical therapy, the practice of medicine, the practice of osteopathic medicine, the practice of chiropractic medicine, the practice of nursing, or medical diagnosis or treatment.

(c) An athletic trainer shall refer a patient to an appropriate licensed health care provider when the treatment or management of the injury, illness, or condition does not fall within the practice of athletic training.

(d) An athletic trainer shall not provide, offer to provide, or represent

that he or she is qualified to provide any treatment that he or she is not qualified to perform by his or her education, training, or experience, or that he or she is otherwise prohibited by law from performing.

(e) For purposes of this section, "injury" or "illness" means an injury or illness sustained as a result of, or exacerbated by, participation in athletics or physical activity for which the athletic trainer has had formal training during his or her professional education program, including nationally recognized educational competencies and clinical proficiencies for the entry-level athletic trainer or advanced postprofessional study, and falls within the practice of athletic training.

(f) This section shall become operative on July 1, 2014.

2697.24. (a) An athletic trainer shall render treatment within his or her scope of practice under the direction of a physician and surgeon licensed by the Medical Board of California or an osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California. This direction shall be provided by verbal order when the directing physician and surgeon or osteopathic physician and surgeon is present and by written order or by athletic training treatment plans or protocols, to be established by the physician and surgeon or osteopathic physician and surgeon, when the directing physician and surgeon or osteopathic physician and surgeon is not present.

(b) Notwithstanding any other law, and consistent with this chapter, the committee may establish other alternative mechanisms for the adequate direction of an athletic trainer.

(c) This section shall become operative on July 1, 2014.

2697.26. The requirements of this chapter do not apply to the following:

(a) An athletic trainer licensed, certified, or registered in another state or country who is in California temporarily, traveling with a team or organization, to engage in the practice of athletic training for, among other things, an athletic or sporting event.

(b) An athletic trainer licensed, certified, or registered in another state who is invited by a sponsoring organization, such as the United States Olympic Committee, to temporarily provide athletic training services under his or her state's scope of practice for athletic training.

(c) A student enrolled in an athletic training education program, while participating in educational activities during the course of his or her educational rotations under the supervision and guidance of an athletic trainer licensed under this chapter or other licensed health care provider.

(d) A member or employee of the United States Armed Forces, licensed, certified, or registered in another state, as part of his or her temporary federal deployment or employment in California for a limited time.

2697.28. This chapter does not limit, impair, or otherwise apply to the practice of any person licensed and regulated under any other chapter of Division 2 (commencing with Section 500).

2697.30. This chapter does not require new or additional third-party reimbursement for services rendered by an individual licensed under this chapter.

2697.32. The Athletic Trainers' Account is hereby established in the Physical Therapy Fund. All fees collected pursuant to this chapter shall be paid into the account. These fees shall be available to the committee, upon appropriation by the Legislature, for the regulatory purpose of implementing this chapter.

Date of Hearing: April 23, 2013

ASSEMBLY COMMITTEE ON BUSINESS, PROFESSIONS AND CONSUMER PROTECTION
Richard S. Gordon, Chair
AB 864 (Skinner) – As Amended: April 1, 2013

SUBJECT: Athletic trainers.

SUMMARY: Establishes the Athletic Training Practice Act (Act) to license and regulate athletic trainers (ATs) through the creation of an Athletic Trainer Licensing Committee (Committee) under the Physical Therapy Board of California (Board), to commence on July 1, 2014 and expire on January 1, 2019. Specifically, this bill:

1) Declares that the provisions enacted by this bill may be known and cited as the Athletic Training Practice Act.

2) Prohibits any individual from engaging in the practice of athletic training unless duly licensed under the Act.

3) Prohibits a person from using the title "athletic trainer," "licensed athletic trainer," "certified athletic trainer," "athletic trainer certified," "a.t.," "a.t.l.," "c.a.t.," "a.t.c.," or any other variation of these terms, or any other similar terms indicating that the person is an AT, unless that person is duly licensed under the Act.

4) Permits an individual who has practiced athletic training in California for a period of 15 consecutive years prior to July 1, 2014, and is not eligible for an athletic training license, to use the title "athletic trainer" without being licensed by the Committee, upon registration with the Board; provided that no person may use the title "athletic trainer" on or after January 1, 2017 without being duly licensed under the Act.

5) Establishes the Committee within the Board, which shall consist of seven members, organized in the following manner:

   a) Four licensed athletic trainers, as specified;

   b) One public member;

   c) One physician and surgeon licensed by the Medical Board of California or one osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California; and,

   d) One physical therapist licensed by the Board.

6) Provides that the Committee shall sunset on January 1, 2019, unless it is deleted or extended beyond that date, and further subjects the Committee to the authority of the Joint Sunset Review Committee after its sunset date.

7) Provides that, subject to confirmation by the Senate, the Governor shall appoint two of the licensed ATs, the public member, and the physician and surgeon or osteopathic physician and surgeon; the Senate Committee on Rules and the Speaker of the Assembly shall each appoint a licensed athletic trainer; and the Board shall appoint the licensed physical therapist.

8) Provides that all appointments shall be for a term of four years and shall expire on June 30 of the year in which the term expires, with vacancies to be filled for any unexpired term.

9) Provides that, for initial appointments made on or after January 1, 2014, the public member appointed by the Governor shall serve a term of one year. The athletic trainers appointed by the Senate Committee on Rules and the Speaker of the Assembly shall serve terms of three years, and the remaining members shall serve terms of four years.

10) Provides that each member of the committee shall receive per diem and expenses, as specified.

11) Authorizes the Committee to adopt, repeal, and amend regulations as may be necessary to enable it to carry into effect the provisions of the Act.

12) Authorizes the Committee, in promulgating regulations, to consult the professional standards issued by the National Athletic Trainers' Association (NATA), the Board of Certification, Inc. (BOC), the Commission on Accreditation of Athletic Training Education (CAATE), or any other nationally recognized professional organization.

13) Requires the Committee to approve programs for the education and training of ATs.

14) Requires the Committee to investigate each applicant before a license is issued in order to determine whether the applicant meets the qualifications required by the Act.

15) Requires that protection of the public be the highest priority for the Committee in exercising its licensing, regulatory, and disciplinary functions, and that whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

16) Requires the Committee, except as otherwise provided, to issue an athletic training license to an applicant who meets all of the following requirements:

    a) Has submitted an application demonstrating that the applicant has graduated from an accredited and approved professional degree program in athletic training at an accredited and approved post-secondary institution or institutions, as specified;

    b) Has passed an athletic training certification examination offered by BOC, its predecessors or successors, or another nationally accredited athletic trainer certification agency approved and recognized by the Committee;

    c) Possesses an emergency cardiac care certification from a certification body approved by the Committee that adheres to the most current international guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiac care; and,

d) Has paid the application fee established by the Committee.

17) Requires the Committee to issue an athletic training license to an applicant who did not graduate from an accredited athletic training education program as described above, but who received athletic training via an internship, if the applicant meets all of the following requirements:

a) Furnishes satisfactory evidence of completion of a degree at an accredited post-secondary institution that included instruction in basic sciences related to, and on the practice of, athletic training;

b) Has passed an athletic training certification examination offered by the BOC, its predecessors or successors, or another nationally accredited AT certification agency approved and recognized by the Committee;

c) Completed at least 1500 hours of clinical experience under an AT certified by the BOC;

d) Possesses an emergency cardiac care certification from a certification body, approved by the committee, that adheres to the most current international guidelines for CPR and emergency cardiac care; and

e) Has paid the application fee established by the Committee.

18) Declares that a license issued by the Committee to be valid for two years and thereafter shall be subject to renewal requirements.

19) Authorizes the Committee to establish license application and renewal fees in an amount sufficient to cover the reasonable regulatory costs of carrying out the Act.

20) Authorizes the Committee to renew a license if an applicant meets all of the following requirements:

a) Pays the renewal fee as established by the Committee; and,

b) Submits proof of all of the following:

i) Satisfactory completion of continuing education;

ii) Current athletic training certification from a certification body approved by the committee, including, but not limited to, the BOC, or its predecessors or successors; and,

iii) Current emergency cardiac care certification from a certification body approved by the Committee that adheres to the most current international guidelines for CPR and emergency cardiac care.

21) Authorizes the Committee to deny a license or the renewal of a license for an applicant or licensee who is described by any of the following:

a) Does not meet the requirements of the Act;

b) Has had an athletic training license, certification, or registration revoked or suspended by an accredited organization, state, or territory;

c) Has been convicted of a felony or any other crime that substantially relates to the functions or duties of an AT; or,

d) Has committed unprofessional conduct, as specified.

22) Authorizes the Committee to order any of the following actions relative to an athletic training license after a hearing for unprofessional conduct, which includes, but is not limited to, a violation of the Act, any regulation adopted by the Committee pursuant to the Act, and revocation or suspension of an athletic training license, certification, or registration by an accredited organization, state, or territory:

a) Issue a training license subject to terms and conditions;

b) Suspend or revoke the athletic training license; and,

c) Impose probationary conditions upon the athletic training license.

23) Declares that the practice of athletic training includes all of the following:

a) Risk management and injury or illness prevention;

b) The clinical evaluation and assessment of an injury or an illness sustained or exacerbated while participating in physical activity, or both;

c) The immediate care and treatment of an injury or an illness sustained or exacerbated while participating in physical activity, or both; and,

d) The rehabilitation and reconditioning from an injury or an illness sustained or exacerbated while participating in physical activity, or both.

24) Declares that the practice of athletic training does not include the practice of physical therapy, the practice of medicine, the practice of osteopathic medicine, the practice of chiropractic medicine, the practice of nursing, or medical diagnosis or treatment.

25) Requires an AT to refer a patient to an appropriate licensed health care provider when the treatment or management of the injury, illness, or condition does not fall within the practice of athletic training.

26) Prohibits an AT from providing, offering to provide, or representing that he or she is qualified to provide any treatment that he or she is not qualified to perform by his or her education, training, or experience, or that he or she is otherwise prohibited by law from performing.

27) Defines "injury" or "illness" means an injury or illness sustained as a result of, or exacerbated by, participation in athletics or physical activity for which the AT has had formal training during his or her professional education program, including nationally recognized educational competencies and clinical proficiencies for the entry-level AT or advanced post-professional study, and falls within the practice of athletic training.

28) Requires an AT to render treatment within his or her scope of practice under the direction of a physician and surgeon licensed by the Medical Board of California or an osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California, with such direction provided by:

a) Verbal order when the directing physician and surgeon or osteopathic physician and surgeon is present; and,

b) Written order or by athletic training treatment plans or protocols, to be established by the physician and surgeon or osteopathic physician and surgeon, when the directing physician and surgeon or osteopathic physician and surgeon is not present.

29) Authorizes the Committee, notwithstanding any other law and consistent with the Act, to establish other alternative mechanisms for the adequate direction of an AT.

30) Exempts from the requirements of the Act the following individuals:

a) An AT licensed, certified, or registered in another state or country who is in California temporarily, traveling with a team or organization, to engage in the practice of athletic training for, among other things, an athletic or sporting event;

b) An AT licensed, certified, or registered in another state who is invited by a sponsoring organization, such as the United States Olympic Committee, to temporarily provide athletic training services under his or her state's scope of practice for athletic training;

c) A student enrolled in an athletic training education program, while participating in educational activities during the course of his or her educational rotations under the supervision and guidance of an athletic trainer licensed under the Act chapter or other licensed health care provider; or,

d) A member or employee of the United States Armed Forces, licensed, certified, or registered in another state, as part of his or her temporary federal deployment or employment in California for a limited time.

31) Declares that the Act does not limit, impair, or otherwise apply to the practice of any person licensed and regulated as a healing arts professional.

32) Declares that the Act does not require new or additional third party reimbursement for services rendered by an individual licensed under the Act.

33) Creates the Athletic Trainers' Account in the existing Physical Therapy Fund.

34) Defines the terms "athletic trainer," "Board," and "Commission".

35) Provides that the provisions of this bill related to title protection, the structure of the Committee, the scope of practice, and physician and surgeon direction of the AT shall become operative on July 1, 2014, as specified.

36) Makes findings and declarations relative to the need to regulate the profession of athletic training.

EXISTING LAW provides for the regulation of various professions and vocations, including those of an athlete agent.

FISCAL EFFECT: Unknown

COMMENTS:

1) Purpose of this bill. This bill would create the Athletic Training Practice Act to license and regulate ATs through a Committee created under the Physical Therapy Board. The Committee would have powers similar to other licensing boards under the Department of Consumer Affairs to promulgate regulations, approve training and educational programs, investigate applicants and issue licenses, and order disciplinary measures up to and including license suspension. The Act would become operational on July 1, 2014 and sunset on January 1, 2019 unless dissolved or extended before that date. Opponents question the need for full licensure rather than simple title protection, and also contend that the scope of practice is overly broad and that the Committee should not be located under the Board. This bill is sponsored by the California Athletic Trainers' Association (CATA).

2) Author's statement. According to the author:

> "Athletic trainers and other individuals are currently practicing athletic training – a health care profession – in an unregulated manner. Athletic training is recognized by the American Medical Association as an allied health care profession that is in the same category as physical therapy and occupational therapy. Currently 48 other states regulate athletic training due to the inherent risk of individuals practicing healthcare without oversight. Individuals have come to California from other jurisdictions after losing their license or certification and practice in the state. In some cases, individuals who have no training, instruction, or experience in athletic training (or any other health or medical profession) are practicing as athletic trainers. They are employed by schools, businesses and healthcare facilities. In some cases, individuals such as janitors, coaches, shipping and receiving clerks and others have been given the title Athletic Trainer and the responsibility for doing things such as evaluating and managing concussions, spinal cord injuries, shoulder dislocations, and knee injuries. This lack of oversight has caused harm to the public in California and in other states.
>
> "Furthermore, the lack of oversight of athletic trainers is a consumer protection problem. The athletes with whom these unqualified individuals work, and the employers who hire them, have no way of knowing that these individuals are not qualified to be athletic trainers. The public has no way to determine if someone practicing athletic training is qualified. The public has no way to file a complaint, or ask for a practitioner to be investigated and/or sanctioned for incompetence, unethical practice, etc. This creates a

huge regulatory gap in the healthcare system....

"Additionally, athletic trainers are typically the most available, and also the most qualified, health care providers to evaluate symptoms of a head injury suffered at a school practice or competition to determine if the athlete has a concussion. However, current law bars athletic trainers from managing concussions simply because they are not licensed."

3) The practice of athletic training. ATs are physical medicine and rehabilitation specialists who generally work in institutional settings under the direction of a physician. In practice, they are often the first healthcare providers on the scene when injuries occur (particularly at sporting events), and must be able to recognize, evaluate and assess injuries and provide immediate care when needed. ATs operate with substantial independence and professional decision-making authority, as a physician need not be onsite with the AT, or even to individually know or work with the AT's clientele.

   The Act generally describes the practice of athletic training as including the professional treatment of a patient for risk management and injury or illness prevention, as well as the clinical evaluation and assessment, immediate care and treatment, organizational health and well-being, and rehabilitation and reconditioning of a patient from an injury or illness sustained or exacerbated while participating in physical activity.

   ATs are considered "health care professionals" by the American Medical Association, which states that "athletic training encompasses the prevention, diagnosis and intervention of emergency, acute, and chronic medical conditions involving impairment, functional limitations, and disabilities." ATs are distinct from "personal trainers", who are generally thought of as individuals who prescribe, monitor and modify individual exercise programs in a fitness or sports setting. Athletic training and physical therapy are also specific and different professions, although there are some areas of overlap.

   ATs are usually employed by organizations such as professional sports teams, colleges and universities, high schools, outpatient rehabilitation clinics, hospitals, industry/corporations, performing arts groups, physicians, the military and health clubs. Roughly 44% of certified ATs work with athletes in educational or professional sports setting, with nearly 19% working in health care facilities, and over 10% working in industry, public safety and the military. The sponsor reports that large employers use ATs in part because of their utility in reducing employee injuries and worker's compensation costs.

4) Current state of regulation for athletic trainers. The educational system for athletic training has been standardized and accredited by a national accreditation agency, CAATE. According to the author, all 48 states currently regulating athletic training utilize the BOC certification examination, which is based on CAATE educational principles. BOC is the only entity that currently provides athletic training certification, which means that it would be the sole provider of the certification exam required by this bill. Certification is not mandatory to practice athletic training in California, and non-certified individuals are not subject to regulatory discipline.

   Despite its widespread adoption, BOC has a limited ability to investigate complaints against certified ATs because they have no subpoena power and limited staff with no authority in

California. Its sole disciplinary power is the suspension or revocation of the national certification which is not recognized in California and thus poses no barrier to an individual's continued practice.

According to the author, athletic trainers are already licensed and regulated in the vast majority of states: "...although 48 states in the nation license athletic trainers and 30 of those states have sunset processes for their licensure acts, no athletic training board has ever been discontinued, demonstrating that there is a continuing need for licensing in those states because of the investigative and regulatory oversight they provide."

The sponsor notes that there are 47 states that regulate athletic trainers, 39 of which provide licensure. The remaining 8 states have elements of licensure, although different terminology is used. Only Alaska and Hawaii do not regulate athletic trainers in any form, although they have legislation pending.

There are 16 accredited athletic training programs in California. In 2010, 182 Californians were became certified ATs.

Currently, there are approximately 2,500 certified ATs practicing in California who would qualify for licensure as ATs under the Act. The sponsor of this bill, CATA, represents approximately 2,300 ATs in California.

5) Evidence of substandard practice. One rationale for licensure is that an oversight body like the Committee can remove bad actors from practice by suspending or revoking the license that may be a precondition for employment. Licensure also makes it difficult for unqualified individuals to hold themselves out professionally as ATs.

According to the author, "[a] survey of 760 certified athletic trainers for the Sunrise report found more than 60 cases of harm as the result of improper care provided by non-certified 'athletic trainers.' According to the U.S. Department of Labor Division of Practitioner Data Banks, a voluntary reporting repository for sanctions made by state boards, there were 469 reports of sanctions to athletic trainers – both certified and uncertified – from 2000 to 2010. These sanctions were based upon misconduct including incompetent practice/harm, practicing beyond the scope of practice, and sexual misconduct. The BOC reported over 2,700 violations [nationwide] of professional practice standards in five years (2005-10) with nearly 300 violations in California, including three sexual offenses. In a 2011 case, a collegiate athlete died because of negligence of a collegiate athletic trainer, although no lawsuit has been filed to date. Two additional athletic trainers were fired after being arrested on sexual abuse charges."

The sponsor reports that it is aware of at least 150 individuals practicing as athletic trainers without certification in California high schools, and seven individuals working in California community colleges who are similarly unqualified.

The standardized training required for licensure and the disciplinary oversight provided by the Committee are intended to address these problems.

6) Proposed California licensure requirements. In order to be eligible for licensure, applicants must have a professional degree from an accredited institution, pass the national written

certification exam, possess an emergency cardiac care certification, and pay the application fee. Individuals without a professional degree would be required to complete at least 1500 hours of clinical experience instead. Biannual license renewal will be subject to continuing education requirements, as determined by the Committee.

The Act requires ATs to refer a patient to the appropriate health care provider when the treatment of an injury, illness or condition falls outside of the AT's scope of practice. The Act also requires ATs to render treatment only under the written or verbal direction of a physician and surgeon. Exemption from licensure will apply to ATs licensed in another state or country operating temporarily in California due to a sporting event, students participating in educational activities under the supervision of a licensed AT, and active members of the military.

7) Questions for the Committee. This bill currently establishes the Committee as the responsible regulatory entity for ATs, and locates it within the existing Physical Therapy Board. The location of the Committee may prove to be problematic, given the apparent overlap between the professions and the opposition from some quarters of the physical therapy profession. According to the sponsor, the reason for colocation is simply administrative convenience and avoidance of the cost of creating a new board. Nevertheless, the Committee may wish to consider whether or not the licensing body for ATs should be located under the board of a more closely allied profession, such as the Medical Board of California, or if its mission would be better served as an independent board fully supported by licensing fees.

One critically important question is how the scope of practice broadly set out in this bill compares with and overlaps other professions. The California Physical Therapy Association (CPTA) argues that this bill effectively permits ATs to engage in diagnosis (physical therapists require a physician's diagnosis) and grants a broader scope of practice than physical therapists enjoy, which may or may not be merited by their differing educational requirements. Given the importance of consistency in setting scope of practice relative to training and education, the Committee may wish to inquire of the author and sponsor as to exactly how the scope and educational requirements for ATs proposed by this bill compare with those of related professions, such as physical therapists, and whether or not the scope indicated by this bill is clear, consistent and fair.

This bill also contains a confusing passage declaring that the practice of athletic training does not include the "practice of physical therapy, the practice of medicine, the practice of osteopathic medicine, the practice of chiropractic medicine, the practice of nursing, or medical diagnosis or treatment." (BPC 2697.22(b)) Given the practical overlap that exists between athletic training and physical therapy, for example, this language read literally could be construed to restrict athletic training only to those practices that do not fall within the other cited professions – which presumably would be minimal. This suggests that the language was intended to communicate the semantic point that the same practices may be described differently by different professions. The Committee may wish to inquire of the author as to the necessity of that language.

One alternative to licensure that has been proposed in previous legislation is certification and title protection, where AT's continue with certification without a regulatory board, but use of the title of "athletic trainer" is reserved by law only for qualified individuals. While this

approach would be simpler, less expensive, and likely less controversial, the sponsor argues that the overall level of consumer protection would be lower as well because there would be no mechanism for investigating or disciplining unqualified, incompetent or unethical practitioners. The Committee may wish to inquire of the author as to the relative merits of a title act approach versus the practice act approach taken by this bill.

Finally, the Committee may wish to consider whether or not a cap on licensing fees should be made explicit in this bill, as it is with many other regulated professions, which provides a legislative check against excessive licensing fees.

8) Technical amendments. There are two technical corrections that the author may wish to consider.

Section 2697.8(f) of the bill related to the sunset date of the Committee contains a reference to the now-defunct Joint Sunset Review Committee. Given that the committee no longer operates, and the sunset review process is now handled jointly by the Senate Business, Professions and Economic Development Committee and the Assembly Business, Professions and Consumer Protection Committee, that reference should be deleted.

Page 4, lines 8-12: on line 8, strike the word "The"; strike lines 9-12, inclusive.

Section 2697.20(b)(2) contains a typographical error.

Page 6, line 13: after a "certification body approved by", delete "te" and insert "the"

9) Arguments in support. According to the sponsor, "Athletic training is a profession that is regulated by 48 states, recognized by multiple governmental and healthcare agencies as a specific healthcare profession and which has a single nationally accredited education and certification process. As there is no defined scope of practice of athletic training in the state, the status quo is an expansive scope of practice and the ability of individuals to practice without any preparation. Further, the public has no ability to register complaints nor can the state investigate and sanction unsafe or unethical providers. AB 864 will for the first time provide a defined scope for this frontline medical profession that is consistent with the extensive education, training and certification of athletic trainers and ensure physician oversight. It will provide assurance of minimum standards of competence of practitioners and will allow those that are practicing illegally, unsafely or unethically to be sanctioned."

The American Medical Society for Sports Medicine (AMSSM) writes,

> "AMSSM has long recognized the value and role of athletic trainers within a Sports Medicine care team... Athletic trainers play an essential role as the front line healthcare professional for a well-functioning, multi-disciplinary Sports Medicine care team. Athletic trainers interact on a daily basis with the athletes for whom they are caring, are well trained in acute injury and illness evaluation and management, facilitate care from other clinicians when needed, and work closely with team physicians to provide comprehensive care for athletes.
>
> "[AB 864] will provide state-specific regulation to the practice of athletic training. This protects the public by ensuring that those individuals who call themselves "athletic

trainers" have the proper educational credentials and are adhering to accepted professional and ethical practice standards. AMSSM is concerned that a failure by the state of California to license athletic trainers when licensure exists in 48 other states will promote a situation where 'athletic trainers' in California provide substandard care for athletes. For instance, athletic trainers from other states who have lost their certification or license may come to California to practice.

"[AB 864] is a cost-neutral bill that will provide a defined scope of practice to the profession of athletic training in the state of California. It will provide the public with the certainty that athletic trainers who are practicing in their communities have the requisite skills and educational background to function safely, and it would allow the people of California the means to report and investigate athletic trainers who are practicing in an unsafe manner."

10) Arguments in opposition. According to the California Nurses Association, 'There are already qualified healing arts practitioners currently licensed by the state who can perform athletic training services, and thus there is no need to create a new licensing category for athletic trainers. These existing practitioners, like nurses, physical therapists, and others already retain the education, and clinical training and experience to provide these services in a way that is safe for athletes. Further, we have very strong concerns with the proposed scope of practice outlined in the bill which is very broad and would endow athletic trainers with the practice authority to treat, clinically evaluate, assess, rehabilitate, and recondition 'patients'."

CPTA opposes the bill on multiple grounds, namely: 1) there is insufficient evidence of a problem caused by a lack of regulations, and that title protection alone would be an appropriate middle ground; 2) the scope of practice of athletic trainers as defined in the bill is "overly broad, unsafe and inconsistent with the education and training of athletic trainers", particularly in comparison to physical therapists who have more stringent educational requirements yet a narrower scope of practice; 3) the bill unwisely outsources the certification of ATs to a for–profit company located in another state; 4) the Board is not an appropriate place to house the Committee because the Board would lack disciplinary authority over ATs while taking on unwanted financial responsibilities; and 5) physical therapists should be exempted from the licensure requirements because of the higher level of required education and training.

According to CPTA, the Joint Legislative Sunset Review Committee analyzed the issue of licensure for athletic trainers during its 2005 sunset review hearings, and found that "At this time, there appears to be insufficient justification to license athletic trainers. However, some sort of state recognition of athletic trainers may be appropriate."

The California Federation of Teachers opposes the bill unless amended to permit individuals who have been practicing as ATs for more than 15 years to continue to use the title "athletic trainer" indefinitely.

11) Previous legislation.

SB 1273 (Lowenthal) of 2012 was very similar to AB 864. SB 1273 failed passage in the Senate Business and Professions Committee.

AB 374 (Hayashi) of 2011 in its most recent version would have extended title protection to ATs. AB 374 was amended in the Assembly Appropriations Committee to address an unrelated issue.

AB 1647 (Hayashi) of 2010 would have extended title protection to ATs. AB 1647 was vetoed by the Governor.

SB 284 (Lowenthal) of 2007 would have provided for registration of ATs. SB 284 was vetoed by the Governor.

SB 1397 (Lowenthal) of 2006 would have provided for registration of ATs. SB 1397 was vetoed by the Governor.

AB 614 (Lowenthal) of 2003 would have required the Department of Consumer Affairs to review the need for licensing of ATs. AB 614 was held in the Senate Business and Professions Committee.

AB 2789 (Lowenthal) of 2002 would have required the Department of Consumer Affairs to review the need for licensing of ATs and undertake an occupational analysis. AB 2789 was held on the Assembly Appropriations Committee Suspense file.

REGISTERED SUPPORT / OPPOSITION:

Support

California Athletic Trainers' Association (sponsor)
American Medical Society for Sports Medicine
Advocates for Injured Athletes
California Community College Athletic Trainers' Association
1378 private individuals

Opposition

California Federation of Teachers
California Nurses Association
California Physical Therapy Association
Independent Physical Therapists of California
Mount St. Mary's College
Occupational Therapy Association of California
398 private individuals

Analysis Prepared by: Hank Dempsey / B.,P. & C.P. / (916) 319-3301

Date of Hearing: May 15, 2013

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Mike Gatto, Chair

AB 864 (Skinner) – As Amended: April 29, 2013

Policy Committee: Business, Professions and Consumer Protection

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY

This bill establishes the Athletic Training Practice Act (Act) to license and regulate athletic trainers (ATs) through the creation of an Athletic Trainer Licensing Committee (Committee) under the Physical Therapy Board of California (Board), to commence on July 1, 2014 and expire on January 1, 2019. Defines AT scope of practice, authorizes the Committee to develop regulations based on specified criteria, and requires ATs to practice under the direction of a physician and surgeon licensed by the Medical Board of California or an osteopathic physician and surgeon licensed by the Osteopathic Medical Board (OMB).

FISCAL EFFECT

Initial costs of at least $500,000 to establish the committee, develop regulations, and begin evaluating applicants. Annual costs of approximately $200,000 to $400,000, depending on the number of applicants and licensees. Funding would eventually be supported by fees; however the source of start-up funds is not clear.

COMMENTS

1) Rationale. The AT licensure created by this bill gives the Committee powers similar to other licensing boards under the Department of Consumer Affairs to promulgate regulations, approve training and educational programs, investigate applicants and issue licenses, and order disciplinary measures up to and including license suspension. This bill is sponsored by the California Athletic Trainers' Association (CATA).

   According to the author, athletic training is recognized by the American Medical Association as an allied health care profession similar to physical therapy and occupational therapy ATs practice today without regulation. Forty-eight other states regulate ATs because of the inherent risk in practicing without oversight.

2) Concerns. This bill is opposed by organizations representing nurses, physical therapists, occupational therapists, and teachers as well as numerous individuals. Primary concerns focus on the existence of already qualified healing arts practitioners and the proposed scope of practice, viewed by opponents as very broad.

3) Previous legislation. Numerous bills have been introduced in the last 10 years to provide licensure, title protection, or registration for ATs. One bill would have required a state review of the need for licensure. About half of these bills died in various committees and

about half were vetoed. Most recently, SB 1273 (Lowenthal) of 2012, which was very similar to this bill, failed passage in the Senate Business and Professions Committee.

Analysis Prepared by: Debra Roth / APPR. / (916) 319-2081

ATHLETIC TRAINING SERVICES

An Overview of Skills and Services Performed by Certified Athletic Trainers

National Athletic Trainers' Association
January, 2010

AT SERVICES PROJECT TEAM

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TABLE OF CONTENTS

Introduction

Athletic trainers are health care professionals who collaborate with physicians to optimize patient and client activity and participation in athletics, work and life. The practice of athletic training encompasses the prevention, examination and diagnosis, treatment, and rehabilitation of emergent, acute, subacute, and chronic neuromusculoskeletal conditions and certain medical conditions in order to minimize subsequent impairments, functional limitations, disability, and societal limitations.

The Athletic Training Scope of Practice is defined within two professional publications: the *Athletic Training Educational Competencies (Competencies)* published by the National Athletic Trainers' Association (NATA) and the *Role Delineation Study (RDS)* conducted and published by the Board of Certification, Inc. (BOC). Eligibility for the BOC exam is contingent upon completion of a program accredited by the Commission on Accreditation of Athletic Training Education (CAATE) that must instruct the *Competencies* within the curriculum. Passage of the certifying examination is a requirement for licensure in most states.

Athletic trainers' work settings can include high schools, colleges, universities, professional sports teams, hospitals, rehabilitation clinics, physicians' offices, corporate and industrial institutions, the military, and the performing arts. Regardless of their practice setting, athletic trainers practice athletic training (or provide athletic training services) according to their education and state practice act.

While the core documents (the *Competencies* and the *RDS*) define the minimal professional preparation necessary for entry into the practice of athletic training, other variables such as individual state practice acts and their implementing regulations must also be considered. Also, athletic trainers participate in continuing education as part of professional practice requirements. This continuing education may result in the achievement of additional qualifications and enhanced skill sets.

This *Athletic Training Services* document was created to provide a clear and concise description of the qualifications and skills of athletic trainers, as well as their role in the delivery of quality health care. The clinical tasks routinely performed by athletic trainers are organized according to the five domain areas established by the *RDS.*

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

Because this document represents a synthesis of the 4th edition of the *Athletic Training Educational Competencies* and the 6th edition of the *Role Delineation Study*, brief overviews of these two publications are provided in Appendix A and B, respectively. Both the *Competencies* and the *RDS* are generally revised every five years to ensure that they reflect the most current science and evidence-based clinical practice guidelines. Consequently, this Athletic Training Services document will also be updated regularly to reflect the current clinical practice guidelines presented in the *Competencies* or *RDS.*

Athletic trainers are also expected to practice ethically and professionally, regardless of their position, work setting, or patient/client population. Published as part of the *Competencies*, the Foundational Behaviors provide a framework for the affective behaviors that athletic trainers should display when entering the profession. The BOC Standards of Professional Practice also provide an outline for the professional expectations of athletic trainers. The Foundational Behaviors and the BOC Professional Standards of Practice are included in Appendix C and D, respectively.

This document addresses the competencies of entry-level athletic training as practiced by a graduate of an accredited athletic training education program. Post-professional education and training, as well as continuing education, may prepare individuals to perform services, modalities, functions or procedures beyond the professional education. Those individual qualifications must be considered on a case-by-case basis.

Injury/Illness Prevention and Wellness Protection

Athletic trainers are educated and trained in injury and illness prevention strategies that focus on optimizing health to improve an individual's quality of life. Athletic trainers are the only health care professionals whose expertise in prevention ranges from minor sprains to catastrophic head and neck injuries, and from minor illnesses to exertional heat syndrome. Nutrition and wellness also play an integral role in the athletic trainers' work in preventing injury and illness. Athletic trainers recognize when consultation with other health care providers is necessary and refer accordingly.

This list indentifies examples of skills that athletic trainers routinely use for injury and illness prevention.

1. Assess patients or clients to screen for potential injuries/illnesses or risk factors that would increase their risk of injury/illness. These screening procedures may include, but are not limited to:
   - pre-participation physical exams
   - musculoskeletal flexibility assessment
   - muscular strength and endurance assessment
   - cardiovascular fitness assessment
   - postural and ergonomic assessment
   - body composition assessment
2. Design and implement conditioning programs (flexibility, strength, cardiovascular fitness) to reduce the risk of injury and illness.
3. Design and implement emergency action plans to ensure medical personnel are prepared in an emergency situation.
4. Obtain and interpret environmental (e.g., ambient temperature, relative humidity, heat index, lightning) and patient/client data (e.g., hydration status) to make appropriate recommendations for patient or client safety and the continuance or suspension of activity.
5. Educate patients or clients, coaches, and parents on the importance of acclimatization and fluid and electrolyte balance in the prevention of heat illness.

6. Inspect facilities to ensure they are free of hazards, are sanitary, and that equipment is maintained properly.

7. Select, apply, evaluate, and modify prophylactic and protective equipment and other custom devices for patients/clients to minimize the risk of injury or re-injury.

8. Educate and advise patients and clients regarding the nutritional aspects of physical activity. Proper nutrition can enhance performance, prevent injury and illness, and assist patients or clients in maintaining a healthy lifestyle, and the athletic trainer is often the first point of contact for active patients/clients with nutritional questions. With regard to nutrition, athletic trainers:
    - Educate patients or clients about dietary needs related to the amount and type of activity being performed
    - Effectively explain the difference in the role of carbohydrates, proteins, fats, minerals, vitamins, fluids, electrolytes in the diet of an active individual
    - Refer patients or clients to appropriate medical professional for assessment or evaluation of nutritional needs
    - Identify and explain illnesses attributed to poor nutrition and advise patients/clients accordingly or refer to another medical professional
    - Educate patients or clients regarding nutrition habits prior to, during, and after physical activity
    - Educate patients or clients regarding ergogenic aids and other performance enhancing substances, and also understand FDA regulation of dietary products
    - Educate patients or clients regarding weight loss/gain, weight control methods, and strategies for performance enhancement
    - Communicate risks regarding substance abuse (social or performance enhancing) or improper dietary habits

Clinical Evaluation and Diagnosis

Athletic trainers are educated and trained to examine patients/clients who have acute, subacute, or chronic musculoskeletal disorders and medical conditions and to arrive at a differential diagnosis regarding suspected pathologies. Based on this assessment, athletic trainers determine the impairments, functional limitations and the disabilities that result from these injuries and illnesses. Effective examination requires a thorough understanding of musculoskeletal and systemic anatomy, and the physiological response to injury and illness. Examination is an ongoing process focused on meeting the changing needs of the patient/client. Athletic trainers recognize when consultation with other health care providers is necessary and refer accordingly.

This list identifies examples of skills that athletic trainers routinely use when examining patients or clients with orthopedic and medical conditions and illnesses.

1. Perform a comprehensive examination of the patient/client with an orthopedic injury or medical condition that includes:

    - Obtaining a thorough medical history, including an assessment of underlying systemic disease and consideration of its potential contributions to the current disorder. This history includes obtaining a description of the current disorder, prior injuries and comorbidities that may influence the current condition, pertinent family history, and a detailed investigation of potential causative factors and resulting disabilities.

    - Conducting a physical examination, including (as relevant) observation of the patient/client performing functional tasks (such as walking, reaching, running, throwing); observation and palpation for any detectable changes; joint and muscle function assessment; review of systems; stress testing; joint play; assessments for neurological and vascular abnormalities; and special tests designed to detect selective tissue or organ involvement.

    - Arriving at a differential diagnosis (including those conditions that cannot be ruled out based on the exam), determining functional deficits and understanding the impact of the condition on the patient/client's life.

- Recognizing the role of medications in the management of orthopedic injuries and medical illnesses.
- Identifying disordered eating and nutritional disorders and intervene and refer accordingly

3. Create a treatment plan based on the findings of the initial examination, subsequent examinations and the needs of the patient or client that assists with functional recovery.

4. Communicate the nature of the examination and resulting treatment plan to the patient or client and other involved health care personnel, while respecting the privacy of the patient/client.

Immediate and Emergency Care

Athletic trainers are educated and trained to provide standard immediate and emergency care procedures to patients and clients. Athletic trainers also recognize when consultation with other health care providers is necessary and refer accordingly.

This list identifies examples of skills that athletic trainers routinely use when providing immediate and emergency care.

1. Perform an initial assessment of the patient or client to determine his/her level of consciousness and the severity of the condition.

2. Implement appropriate emergency injury and illness management strategies following a pre-established emergency action plan (e.g., CPR, AED, splinting, use of spine board, control of bleeding, control of body temperature, use of epinephrine for anaphylaxis)

3. Perform a secondary assessment and employ the appropriate management strategies for non-life-threatening injuries or illnesses including, but not limited to:
   - Open and closed wounds (using universal precautions)
   - Head trauma
   - Environmental illness
   - Seizure
   - Acute asthma attack
   - Different types of shock
   - Thoracic, respiratory, and internal organ injury or illness
   - Acute musculoskeletal injuries
   - Spinal cord and peripheral nerve injuries
   - Diabetic emergency
   - Toxic drug overdose
   - Allergic, thermal, and chemical reactions of the skin

4. Formulate a differential diagnosis based on the results of the initial and/or secondary assessment(s).

5. Communicate the nature of the injury or illness and the resulting treatment plan to the patient/client and other involved health care personnel, respecting the privacy of the patient/client.

Treatment and Rehabilitation

Athletic trainers are educated and trained to assess the status of a patient's or client's post-operative, chronic, acute and subacute musculoskeletal injuries, illnesses and/or conditions to determine impairments, functional limitations and disability. Based on this assessment, athletic trainers determine the appropriate treatment goals and therapeutic interventions to reduce the extent of a patient's or client's disability. Athletic trainers modify the treatment plans based on continual/regular assessment of the patient/client, and discharge the patient/client once treatment goals are met or the patient's or client's condition is no longer improving. Athletic trainers recognize when consultation with other health care providers is necessary and refer accordingly.

This list identifies examples of skills that athletic trainers routinely use when providing rehabilitation services.

1. Select, apply and evaluate the effectiveness of therapeutic interventions using best evidence to guide those decisions. Interventions used by athletic trainers include:

    - Manual therapy (e.g., massage, joint mobilization, proprioceptive techniques, muscle energy techniques)
    - Techniques to restore joint range of motion and muscle extensibility
    - Exercises to improve strength, endurance, speed and power
    - Proprioceptive activities to improve balance, neuromuscular control and coordination
    - Agility training
    - Exercises to improve cardiorespiratory fitness
    - Sports specific and/or functional exercises
    - Modalities
        - Thermal agents (e.g., hot pack, cold pack, etc.)
        - Electrical stimulation
        - Therapeutic ultrasound
        - Mechanical agents (e.g., traction)
        - Therapeutic laser
        - Biofeedback

2. Recommend, fit and apply braces, splints and assistive devices to facilitate the patient/client's recovery.

3. Assess the patient's or client's functional status, interpret the results and determine the patient's or client's ability to return to his or her desired activity.

    - Activity-specific skill assessment

    - Ergonomics

    - Work hardening/work conditioning

4. Recognize the role of medications in the recovery process.

5. Provide patient or client education necessary to facilitate recovery. This includes instruction in self-treatment and education about the condition and its expected course.

Organizational and Professional Health and Well-Being

Athletic trainers possess the skills necessary to develop, administer and manage a healthcare facility and associated venues that provide healthcare services. Athletic trainers have the skill set to utilize human, physical, and fiscal resources to provide efficient and effective healthcare services.

This list identifies examples of administrative skills that athletic trainers routinely use in the delivery of athletic training services.

1. Use best evidence and the needs of the patient/client to guide their practice.

2. Ensure compliance with state and federal law and accrediting agencies' policies related to the delivery of healthcare:

    - Appropriately use protected information, documentation and patient education in conformance with the Health Insurance Portability and Accountability Act (HIPAA) and Federal Education Rights Privacy Act (FERPA)

    - Document and practice appropriate infection controls, equipment safety, environmental hazards safety and facility maintenance as mandated by the Occupational Safety and Health Administration (OSHA)

    - Administer programs appropriately per the accrediting agencies for healthcare facilities (e.g., Joint Commission on Accreditation of Healthcare Organizations [JCAHO], Accreditation Association for Ambulatory Health Care [AAAHC])

3. Utilize standard coding and reimbursement practices (ICD-9 and CPT codes) for documentation and billing.

4. Maintain medical records that meet legal and regulatory standards, including complete and accurate documentation, accepted abbreviations and correct medical terminology.

5. Abide by federal, state, and local regulations for the proper storage, transportation, dispensing (administering where appropriate), and documentation of commonly used medications.

6. Develop and implement policies and procedures related to employment, fiscal management and operations of a healthcare facility, including:

    - Human resource policy and employee handbook to guide the operation of athletic training services within a healthcare facility, and in conformance with state and federal employment law

    - Emergency action plans (EAP)

    - Risk management plans

    - Operational and capital budgets

    - Programs compliant with federal statutes and regulations (e.g., Title IX, Civil Rights Act, ADA and the Buckley Amendment, Medicare, CMS)

APPENDIX A
Overview of the NATA Athletic Training Educational Competencies

The Athletic Training Educational Competencies (*Competencies*), which are published by the National Athletic Trainers Association (NATA), identify the minimum knowledge and skills that athletic training students are required to master during their educational preparation in Commission on Accreditation of Athletic Training Education (CAATE) accredited Athletic Training Education Programs (ATEPs). The breadth and depth of the *Competencies* are designed to exceed that of the *RDS*, while still containing all of the knowledge and skills identified by the *RDS*. The knowledge (cognitive competencies), skills (psychomotor competencies), and application (clinical proficiencies) statements contained with the *Competencies* are organized across 12 content areas:

(1) Risk Management and Injury Prevention
(2) Pathology of Injuries and Illnesses
(3) Orthopedic Clinical Examination and Diagnosis
(4) General Medical Conditions and Disabilities
(5) Acute Care of Injuries and Illnesses
(6) Therapeutic Modalities
(7) Conditioning and Rehabilitative Exercise
(8) Pharmacology
(9) Psychosocial Intervention and Referral
(10) Nutritional Aspects of Injuries and Illnesses
(11) Health Care Administration
(12) Professional Development and Responsibilities.

It should be noted that the *Competencies* are not the only things an athletic training student must learn. To fully understand and apply the athletic training knowledge and skills, students must possess a comprehensive basic and applied science background. Additional coursework may include, but is not limited to, chemistry, biology, physics, physiology, psychology, and statistics. Also, students must complete extensive, structured and supervised clinical education rotations working with patients and clients in an athletic training clinical setting. These experiences provide students with the valuable opportunity to apply their knowledge and skills, while also developing vital clinical decision-making skills.

The *Competencies*, in concert with the revised *RDS*, are critically reviewed and revised every five years to ensure that they reflect the most current science and evidence-based practice guidelines.
(*Athletic Training Educational Competencies, 4th Edition. Dallas, TX: National Athletic Trainers' Association; 2006*)

APPENDIX B

Overview of the BOC Role Delineation Study (RDS)

The Role Delineation Study (*RDS*), which is conducted and published by the Board of Certification, Inc. (BOC), defines the minimum knowledge and skills necessary for the practice of Athletic Training and serves as the blueprint for developing the BOC Athletic Trainer Certification Examination. This document contains knowledge, skills and task statements organized across five domains. The five domains of the *RDS* are described below.

I	Injury/illness prevention and wellness protection	Educating participants and managing risk for safe performance and function.
II	Clinical evaluation and diagnosis	Implementing standard evaluation techniques and formulating a clinical impression for the determination of a course of action.
III	Immediate and emergency care	Employing standard care procedures and communicating outcomes for efficient and appropriate care of the injured.
IV	Treatment and rehabilitation	Reconditioning participants for optimal performance and function.
V	Organizational and professional health and well-being	Understanding and adhering to approved organizational and professional practices and guidelines to ensure individual and organizational well-being.

Role Delineation Study. 6th ed. Omaha, NE: Board of Certification; 2009.

The BOC generally conducts a new role delineation study every five years in order to ensure the content validity of the BOC Certification Examination (i.e., to ensure that the exam continues to reflect the athletic training tasks that are performed throughout the various clinical practice settings). The BOC, through the certification examination as well as continuing education requirements, works "to protect the public by identifying individuals who are competent to practice the profession of athletic training." (*Role Delineation Study. 6th ed. Omaha, NE: Board of Certification; 2009:1)*

APPENDIX C

Foundational Behaviors of Professional Practice

These basic behaviors permeate every aspect of professional practice, and should be incorporated into instruction in every part of the educational program. The behaviors in this section comprise the application of the common values of the athletic training profession.

Primacy of the Patient/Client

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

Teamed Approach to Practice

- Recognize the unique skills and abilities of other health care professionals
- Understand the scope of practice of other health care professionals
- Understand and execute duties within the identified scope of practice for athletic trainers
- Include the patient/client (and family, where appropriate) in the decision making process
- Demonstrate the ability to work with others in effecting positive patient/client outcomes

Legal Practice

- Practice athletic training in a legally competent manner
- Recognize the need to document compliance with the laws that govern athletic training
- Understand the consequences of violating the laws that govern athletic training

Ethical Practice

- Understand and comply with the NATA's *Code of Ethics* and the BOC's *Standards of Practice*
- Understand the consequences of violating the NATA's *Code of Ethics* and BOC's *Standards of Practice*
- Understand and 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
- Understand 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, patient/clients, other health care professionals, and others as necessary

Cultural Competence

- Understand the cultural differences of patients' or client's attitudes and behaviors toward health care
- Demonstrate knowledge, attitudes, behaviors, and skills necessary to achieve optimal health outcomes for diverse patient/client populations.
- Demonstrate knowledge, attitudes, behaviors, and skills necessary to 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

Reference:
National Athletic Trainers' Association (2006) Athletic Training Educational Competencies (4th ed.), Dallas, TX

APPENDIX D

BOC Standards of Professional Practice

Implemented January 1, 2006

Introduction

The mission of the Board of Certification Inc. (BOC) is to certify Athletic Trainers and to identify, for the public, quality healthcare professionals through a system of certification, adjudication, standards of practice and continuing competency programs. The BOC has been responsible for the certification of Athletic Trainers since 1969. Upon its inception, the BOC was a division of the professional membership organization the National Athletic Trainers' Association. However, in 1989, the BOC became an independent non-profit corporation.

Accordingly, the BOC provides a certification program for the entry-level Athletic Trainer that confers the ATC® credential and establishes requirements for maintaining status as a Certified Athletic Trainer (to be referred to as "Athletic Trainer" from this point forward). A nine member Board of Directors governs the BOC. There are six Athletic Trainer Directors, one Physician Director, one Public Director and one Corporate/Educational Director.

The BOC is the only accredited certification program for Athletic Trainers 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 National Organization for Competency Assurance.

The *BOC Standards of Professional Practice* consists of two sections:

I. Practice Standards
II. Code of Professional Responsibility

I. Practice Standards

Preamble

The Practice Standards (Standards) establish essential practice expectations for all Athletic Trainers. Compliance with the Standards is mandatory.

The Standards are intended to:

- assist the public in understanding what to expect from an Athletic Trainer
- assist the Athletic Trainer in evaluating the quality of patient care
- assist the Athletic Trainer in understanding the duties and obligations imposed by virtue of holding the ATC® credential

The Standards are NOT intended to:

- prescribe services
- provide step-by-step procedures
- ensure specific patient outcomes

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 Standards at all times.

Standard 1: Direction
The Athletic Trainer renders service or treatment under the direction of a physician.

Standard 2: Prevention
The Athletic Trainer understands and uses preventive measures to ensure the highest quality of care for every patient.

Standard 3: Immediate Care
The Athletic Trainer provides standard immediate care procedures used in emergency situations, independent of setting.

Standard 4: Clinical Evaluation and Diagnosis
Prior to treatment, the Athletic Trainer assesses the patient's level of function. The patient's input is considered an integral part of the initial assessment. The Athletic Trainer follows standardized clinical practice in the area of diagnostic reasoning and medical decision making.

Standard 5: Treatment, Rehabilitation and Reconditioning
In development of a treatment program, the Athletic Trainer determines appropriate treatment, rehabilitation and/or reconditioning strategies. Treatment 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. Assessment measures to determine effectiveness of the program are incorporated into the program.

Standard 6: Program Discontinuation
The Athletic Trainer, with collaboration of the physician, recommends discontinuation of the athletic training service when the patient has received optimal benefit of the program. The Athletic Trainer, at the time of discontinuation, notes the final assessment of the patient's status.

Standard 7: Organization and Administration
All services are documented in writing by the Athletic Trainer and are part of the patient's permanent records. The Athletic Trainer accepts responsibility for recording details of the patient's health status.

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 Responsibility

The Athletic Trainer or applicant:

1.1 Renders quality patient care regardless of the patient's race, religion, age, sex, nationality, disability, social/economic status or any other characteristic protected by law

1.2 Protects the patient from harm, acts always in the patient's best interests and is an advocate for the patient's welfare

1.3 Takes appropriate action to protect patients from Athletic Trainers, other healthcare providers or athletic training students who are incompetent, impaired or engaged in illegal or unethical practice

1.4 Maintains the confidentiality of patient information in accordance with applicable law

1.5 Communicates clearly and truthfully with patients and other persons involved in the patient's program, including, but not limited to, appropriate discussion of assessment results, program plans and progress

1.6 Respects and safeguards his or her relationship of trust and confidence with the patient and does not exploit his or her relationship with the patient for personal or financial gain

1.7 Exercises reasonable care, skill and judgment in all professional work

Code 2: Competency

The Athletic Trainer or applicant:

2.1 Engages in lifelong, professional and continuing educational activities

2.2 Participates in continuous quality improvement activities

2.3 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 Knows and complies with applicable local, state and/or federal rules, requirements, regulations and/or laws related to the practice of athletic training

3.3 Collaborates and cooperates with other healthcare providers involved in a patient's care

3.4 Respects the expertise and responsibility of all healthcare providers involved in a patient's care

3.5 Reports any suspected or known violation of a rule, requirement, regulation or law by him/herself and/or by another Athletic Trainer that is related to the practice of athletic training, public health, patient care or education

3.6 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, public health, patient care or education

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, without proper authority, possess, use, copy, access, distribute or discuss certification exams, score reports, answer sheets, certificates, certificant or applicant files, documents or other materials

3.9 Is candid, responsible and truthful in making any statement to the BOC, and in making any statement in connection with athletic training to the public

3.10 Complies with all confidentiality and disclosure requirements of the BOC

3.11 Does not take any 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 of a child or patient; actual or threatened use of a weapon of violence; the prohibited sale or distribution of controlled substance, or its possession with the intent to distribute; or the use of the position of an Athletic Trainer to improperly influence the outcome or score of an athletic contest or event or in connection with any gambling activity

3.12 Cooperates with BOC investigations into alleged illegal or unethical activities; this includes but is not limited to, providing factual and non-misleading information and responding to requests for information in a timely fashion

3.13 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 rights and well being of research subjects

4.3 Conducts research activities with the goal of improving practice, education and public policy relative to the health needs of diverse populations, the health workforce, the organization and administration of health systems and healthcare delivery

Code 5: Social Responsibility

The Athletic Trainer or applicant:

5.1 Uses professional skills and knowledge to positively impact the community

Code 6: Business Practices

The Athletic Trainer or applicant:

6.1 Refrains from deceptive or fraudulent business practices

6.2 Maintains adequate and customary professional liability insurance

For information or to order copies of this document, please contact:

Department of State Legislative and Regulatory Affairs
National Athletic Trainers' Association
2952 Stemmons Freeway, #200
Dallas, Texas 75247
214-637-6282
www.nata.org

Professional [entry-level]

Overview

The purpose of the Commission on Accreditation of Athletic Training Education (CAATE) is to develop, maintain, and promote appropriate minimum education standards for quality for professional (entry-level) athletic training programs. CAATE is sponsored by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Orthopaedic Society for Sports Medicine, and the National Athletic Trainers' Association (NATA).

The *Standards for the Academic Accreditation of Professional Athletic Training Programs (Standards)* are used to prepare entry-level athletic trainers. Each institution is responsible for demonstrating compliance with these *Standards* to obtain and maintain recognition as a CAATE-accredited professional athletic training program. A list of accredited programs is published and available to the public.

These *Standards* are to be used for the development, evaluation, analysis, and maintenance of athletic training programs. Via comprehensive and annual review processes, CAATE is responsible for the evaluation of a program's compliance with the *Standards.* The Standards provide minimum academic requirements; institutions are encouraged to develop sound innovative educational approaches that substantially exceed these *Standards.* The *Standards* also contain a glossary of terms used throughout the process; the definition provided in the glossary must be applied as stated.

Description of the Professional

Athletic Trainers are healthcare professionals who collaborate with physicians to optimize activity and participation of patients and clients. Athletic training encompasses the prevention, diagnosis and intervention of emergency, acute and chronic medical conditions involving impairment, functional limitations and disabilities. Athletic Training is recognized by the American Medical Association (AMA) as a healthcare profession.

The athletic trainer's professional preparation is based on the development of the current knowledge, skills, and abilities, as determined by the Commission (currently the 5th Edition of the NATA Athletic Training Education Competencies). The knowledge and skills identified in the Competencies consist of 8 Content Areas:

- 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
- Professional Development and Responsibility

Post-Professional Degree Programs

POST-PROFESSIONAL ATHLETIC TRAINING EDUCATION OVERVIEW

An individual enters the profession of athletic training via passing the Board of Certification (BOC) athletic training credentialing exam after graduating from a CAATE accredited professional education program that prepares them to be a competent and proficient healthcare provider. Individuals may choose to pursue further advanced education and training at the post-professional level after they have become a credentialed athletic training professional. A variety of post-professional athletic training educational programs currently exist to support the professional development of athletic trainers. The Commission accredits post-professional graduate athletic training programs (degree programs) and post-professional residency programs (certificate of completion). Post-professional graduate degree programs and residency programs are designed to prepare athletic trainers for advanced clinical practice, and research and scholarship, in order to enhance the quality of patient care, optimize patient outcomes, and improve patients' health-related quality of life.

POST-PROFESSIONAL GRADUATE DEGREE PROGRAMS

A "Post-Professional" Athletic Training Graduate Degree Program differs from a "Professional" (i.e., Entry-Level) Athletic Training Program in purpose, design, and content. The mission of a Post-Professional Athletic Training Graduate Degree Program is to expand the depth and breadth of the applied, experiential, and propositional knowledge and skills of athletic trainers, expand the athletic training body of knowledge, and to disseminate new knowledge in the discipline. Post-professional graduate education in athletic training is characterized by advanced systematic study and experience—advanced in knowledge, understanding, scholarly competence, inquiry, and discovery.

Provided below are links to two essential documents describing the Commission on Accreditation of Athletic Training Education (CAATE) accreditation of post-professional athletic training graduate degree programs. Below are links to two essential documents. The first document is entitled, Pursuing and Maintaining Accreditation of Post-Professional Athletic Training Graduate Degree Programs. Its purpose is to provide step-by-step instructions to post-professional athletic training graduate degree programs that wish to pursue or maintain accreditation. The second document defines the CAATE's Post-Professional Athletic Training Graduate Degree Program Standards and Guidelines, hereafter referred to as the Standards and Guidelines. Its purpose is to explicitly define the requirements to achieve and maintain CAATE accreditation of post-professional athletic training graduate degree programs. By requesting accreditation, the sponsoring institution of the graduate degree program agrees to be assessed against the Standards and Guidelines. The sponsoring institution of an accredited graduate degree program must comply with these Standards and Guidelines and use them to examine, improve and report on its program's growth and achievement.

Search

State/Territory: California

Program Type

Degree Type

Pages (1 of 1): « 1 »

INSTITUTION	STATE	TYPE	PROGRAM STATUS	DEGREE	PROGRAM DIRECTOR	DETAILS
AZUSA PACIFIC UNIVERSITY	CA	Professional	Active - progress report due	Bachelor	Christopher Schmidt	More
CALIFORNIA BAPTIST UNIVERSITY	CA	Professional	Active - in good standing	Masters	Nicole MacDonald	More
CALIFORNIA STATE UNIVERSITY - FRESNO	CA	Professional	Active - in good standing	Bachelor	Scott Sailor	More
CALIFORNIA STATE UNIVERSITY - FULLERTON	CA	Professional	Active - in good standing	Bachelor	Robert Kersey	More
CALIFORNIA STATE UNIVERSITY - LONG BEACH	CA	Professional	Active - progress report due	Bachelor	Keith Freesemann	More
CALIFORNIA STATE UNIVERSITY - NORTHRIDGE	CA	Professional	Active - in good standing	Bachelor	Shane Stecyk	More
CALIFORNIA STATE UNIVERSITY - SACRAMENTO	CA	Professional	Active - in good standing	Bachelor	Doris Flores	More
CHAPMAN UNIVERSITY	CA	Professional	Active - in good standing	Bachelor	Jason Bennett	More
CONCORDIA UNIVERSITY - IRVINE	CA	Professional	Active - progress report due	Bachelor	Jennifer Rizzo	More
LOYOLA MARYMOUNT UNIVERSITY	CA	Professional	Not admitting students	Bachelor	Sarah Strand	More
POINT LOMA NAZARENE UNIVERSITY	CA	Professional	Active - progress report due	Bachelor	Jeff Sullivan	More
SAN DIEGO STATE UNIVERSITY	CA	Professional	Active - progress report due	Bachelor	Lea Thomann	More
SAN JOSE STATE UNIVERSITY	CA	Professional	Active - progress report due	Bachelor	KyungMo Han	More
UNIVERSITY OF LAVERNE	CA	Professional	Active - in good standing	Bachelor	Paul Alvarez	More
UNIVERSITY OF THE PACIFIC	CA	Professional	Active - progress report due	Bachelor	Christopher Ludwig	More

Pages (1 of 1): « 1 »

Search

State/Territory: Oregon

Program Type

Degree Type

Pages (1 of 1): « 1 »

INSTITUTION	STATE	TYPE	PROGRAM STATUS	DEGREE	PROGRAM DIRECTOR	DETAILS
GEORGE FOX UNIVERSITY	OR	Professional	Active - in good standing	Bachelor	Dana Bates	More
LINFIELD COLLEGE	OR	Professional	Active - in good standing	Bachelor	Laura Kenow	More
OREGON STATE UNIVERSITY	OR	Professional	Active - in good standing	Bachelor	Kimberly Hannigan	More
UNIVERSITY OF OREGON	OR	Post Professional	Active - in good standing	Masters	Sierra Dawson	More

Pages (1 of 1): « 1 »

Search

State/Territory Nevada

Program Type

Degree Type

Pages (1 of 1): « 1 »

INSTITUTION	STATE	TYPE	PROGRAM STATUS	DEGREE	PROGRAM DIRECTOR	DETAILS
UNIVERSITY OF NEVADA - LAS VEGAS	NV	Professional	Active - in good standing	Bachelor	Tedd Girouard	More

Pages (1 of 1): « 1 »

Search

State/Territory Arizona

Program Type

Degree Type

Pages (1 of 1): « 1 »

INSTITUTION	STATE	TYPE	PROGRAM STATUS	DEGREE	PROGRAM DIRECTOR	DETAILS
A.T. STILL UNIVERSITY	AZ	Post Professional	Active - in good standing	Masters	Tamara McLeod	More
GRAND CANYON UNIVERSITY	AZ	Professional	Active - progress report due	Bachelor	Donna Gerakos	More
NORTHERN ARIZONA UNIVERSITY	AZ	Professional	Active - progress report due	Bachelor	Debbie Craig	More

Pages (1 of 1): « 1 »

Athletic Training Education Competencies

5th Edition

Table of Contents

Preface

The 5th edition of the Athletic Training Education Competencies (Competencies) provides educational program personnel and others with the knowledge, skills, and clinical abilities to be mastered by students enrolled in professional athletic training education programs. Mastery of these Competencies provides the entry-level athletic trainer with the capacity to provide athletic training services to clients and patients of varying ages, lifestyles, and needs.

The Commission on Accreditation of Athletic Training Education (CAATE) requires that the Competencies be instructed and evaluated in each accredited professional athletic training education program. The Competencies serve as a companion document to the accreditation standards, which identify the requirements to acquire and maintain accreditation, published by CAATE.

The Professional Education Council (PEC) of the NATA was charged with creating the 5th edition of the Competencies. The PEC developed and executed a systematic plan to draft the Competencies and to solicit and integrate feedback from multiple sources as the draft was revised. First, the PEC orchestrated an initial open call for feedback on the 4th edition of the Competencies. Next, groups of subject-matter experts, including practicing athletic trainers, educators, and administrators, were identified. In addition to the feedback on the 4th edition, these subject-matter experts considered today's healthcare system, current best practice in athletic training, and their own expertise in creating an initial draft of the 5th edition. Many conversations ensued and subsequent drafts were submitted. Following revision for form and consistency of language, a draft of the Competencies was again posted for open feedback. This valuable feedback was considered in its entirety by the PEC, and final revisions were made.

We thank the members of the PEC for their untiring efforts in revising this document to reflect the changing needs of athletic training education. The advice, cooperation, and feedback from the Board of Certification and the CAATE have also been instrumental in this process. Finally, the diligent and perceptive feedback that was received from stakeholders during the public comment periods was instrumental in creating a document that ensures that entry-level athletic trainers are prepared to work in a changing healthcare system. Together we are improving healthcare by improving the education of athletic trainers.

— NATA Executive Committee for Education, December 2010

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/diagnosis and medical conditions/disabilities content areas were combined to form the **Clinical Examination and Diagnosis (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 cognitive 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 oropharyngeal 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.

5th Edition Competencies – Project Team Members

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Marsha Grant-Ford, PhD, ATC; **Luzita Vela**, PhD, ATC; **Alice Wilcoxson**, PhD, ATC, PT

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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 examination 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 ability to conduct a research project is not an expectation of professional education. This section focuses 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 employing 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 quality 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 cardiovascular 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 dangerous 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 workplace organizations in order to properly advise clients/patients about possible disqualification and other consequences.

Clinical Examination and Diagnosis (CE)

Athletic trainers must possess strong clinical examination skills in order to accurately diagnosis 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 clinical-reasoning skills throughout the physical examination process in order to assimilate data, select the appropriate assessment tests, and formulate a differential diagnosis.

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 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. Consideration 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 diagnosis 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 diagnosis for common illness/disease and orthopedic injuries/conditions.

CE-18. Incorporate the concept of differential diagnosis 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 included 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 individuals 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 psychological 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 function is an understanding of risk management, healthcare delivery mechanisms, insurance, reimbursement, 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 Occupational Safety and Health Administration (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-participation 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 competence 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 reorganized 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/patient 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 Foundational 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 instructing 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. Incorporate 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 & Diagnosis / 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 interpretation of findings in order to formulate a differential diagnosis and/or diagnosis, 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 diagnosis and/or diagnosis. 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, diagnosis, 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 management 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, insurers, colleagues, administrators, and parents or family members while using appropriate terminology and complying with statues that regulate privacy of medical records. This includes using a comprehensive patient-file management system (including diagnostic and procedural codes) for appropriate chart documentation, risk management, outcomes, and billing.