Vision Quest #7 Summary Notes from May 3, 2010

(Final draft June 10, 2010)

Final VQ Meeting, Face-to-Face, 8:30am-4pm, June 21, 2010
Breakfast 7:30-8:30am
Non-working lunch 11:30am-12:15pm
Philadelphia Marriot Downtown, Room 302-306

Welcome

President Marje Albohm provided an introduction of the goals for the Webinar. She requested that the Vision Quest team start coming to consensus on the "most important questions" that must be addressed by the athletic training profession and the four stakeholder groups. She requested that the VQ team frame the specific context of those questions, and be prepared to make concrete decisions at the June 21, 2010, meeting in Philadelphia. The context should also answer: "Why is this issue one of the most important questions to the future of athletic training? To whom is it most important?"

Ed O'Neil provided a framework for the group: how should the athletic training profession respond to the changes in healthcare, both now and in the future? He reminded the team that it had previously found the AT scope of practice generally sound. However, the scope of practice will need to evolve over time as changes in science and practice patterns change. He suggested that the practices models would need to continue to evolve with the health care system.

Question 1: Discussion on Scope of Practice and Terminology

Turocy provided an overview of CAATE's position. CAATE believes that the AT scope of practice is currently broad enough to embrace the future. She suggested that how the scope is taught is the issue to consider. The AT education leaders must immediately adopt changes in terminology and language used to describe AT courses. Course titles must evolve from including "athletes" and "athletic injuries" to terminology that is more reflective of other health care professionals and general medical education. Those course titles focus on patients and types of injuries and illnesses. She noted that if ATs want to be more widely accepted in health care, they must use similar language. Fandel, representing the BOC, agreed that the language must evolve. Koehneke, speaking for the BOC, noted that the state practice acts must also evolve but could only do so after education course titles had changed. Thornton noted that practice terminology must also change. Specifically, the term practice or game "coverage" should be changed to "providing health care services" or something similar. Thornton noted that providing "coverage" does not adequately portray AT services as health care services.

O'Neil noted that almost all health care professions struggle with state licensure, title protection and definitions. One notable exception is physician assistants, whose scope of practice is anything a physician delegates to them.

Starkey and Detwiler noted that the AT profession will want to maintain its identity and alignment with serving physically active people. Gibson agreed that the future for ATs is with physically active people and that alignment should be strengthened as a specialty of ATs. Additionally, the AT's natural and learned ability of working in teams and goal setting are strong, somewhat unique skills. And finally, the skills and education of U.S. ATs can and should be exported internationally.

The question was called and consensus was reached. The AT scope of practice is basically sound but language needs to be updated by CAATE, BOC, ATEP programs and state practice acts.

Question 2: Should the professional degree (i.e. entry level) be a baccalaureate or master's degree or both?

Brown, chair of the Executive Committee for Education, provided a thorough overview on the complexity of the degree issue. One continuing issue is that many AT programs are not housed in allied health or medical schools; many are still in education departments. Generally, the skills and material taught do not require a large subset of foundational knowledge; this typically means a degree is more of a "technician" degree. Additionally, the selective admissions process for ATs doesn't help the students or profession, and there is an overabundance of education programs (ATEPs). There is a professional expectation that ATs can work and are valuable to the employer on day-one, which is an anomaly in health care. AT supervision is narrowly defined. Cost of the degree is another factor. And finally, the profession puts an emphasis on process rather than product, which doesn't meet the needs of the employer market. She encourages the profession to explore expanding its knowledge base.

O'Neil agreed on the complexity of the education issue. He encouraged the VQ team to be aspirational but grounded in reality; the team needs to determine what the profession should move toward over the next decade. There are no quick fixes to this problem but changes can be achieved by unity of vision, commitment by all groups and slow steady pressure. The philosophies of individual colleges and universities will vary, but change can be achieved over time. State licensing requirements do not have to follow a parallel route to achieve a change from bachelor's to master's degree.

Discussion continued on how changes to education would affect the profession. Gibson noted that there are a finite number of jobs in professional, college and high school athletics. For the profession to thrive, it needs to expand to emerging settings and, especially, those in health care that pay higher salaries. He noted that the profession needs to focus on improving itself rather than comparing itself to other professions. Dieringer noted that ATs moved into emerging settings prior to NATA's marketing efforts, and that the traditional and emerging settings are not mutually exclusive. The profession can thrive in both concurrently. Several people commented that PTs are moving into the college setting but it may be because they want to bill for the services provided.

The question was called and the consensus was to narrow the question further at the June meeting. The VQ team will decide then on recommendation(s) related to degree level and whether two levels or options could co-exist and benefit the profession.

Question 3: How will athletic trainers fit into the future health care system?
O'Neil explained that the traditional health care system is changing but there is no consistent, high-level strategy or policy from public or private insurers. A second major influencer is that the affluent Boomer population seeks help in maintaining fitness and health. Many of these wellness services will be paid out-of-pocket/cash. A third major influencer is that the public and private insurers are seeking to improve wellness and physical activity to reduce chronic diseases. These wellness services will likely be delivered via community-based services in homes, schools and outpatient clinics and may be cash based.

How health care is delivered and financed will evolve fairly rapidly because of recent federal legislation. O'Neil noted that accountable care (or organized care) is a new, important focus in health care reform legislation. Hospitals, provider groups and home health providers will also be part of accountable care organizations. ATs can benefit from this shift in health care delivery. Comparatively lower-cost providers will likely flourish as part of accountable care financial models. New initiatives in comparative effectiveness research may determine that increased use of reasonably priced services provided by highly skilled, cross-trained professionals can provide the same or better quality outcomes at a reduced cost. The health care system will likely evolve from fee-for-service to bundled single-payment per episode of care. A team approach will be emphasized with bundled payments.

On outcomes research, O'Neil said that the AT profession needs to partner with faculty that work on comparative effectiveness studies. These studies may demonstrate that ATs have the availability to provide services, have flexibility in their skills and other areas. The VQ team must plan to equip the next generation with a core set of technical and professional skills that can be adapted and upgraded over the course of their careers.

The question was called and the VQ team reached consensus. VQ will determine concrete goals, tactics, activities, and milestones at the June meeting. The VQ team will determine solutions to issues and devise a high level plan for the AT stakeholder groups. O'Neil cautioned against making binary decisions; in some cases multiple paths should be pursued to achieve the most favorable result.

Question 4: Consensus was reached that the "three model" approach to reimbursement and practice will be incorporated into Vision Quest.

- Cash-fee and/or direct-fee for service,
- Reimbursement from third-party payers (the current organized system of reimbursement and care);
- Salary plus stipend based.

Question 5: That a voluntary moratorium on accrediting new academic programs is encouraged.

- Consensus was reached that the stakeholder groups will support a voluntary moratorium on accrediting new academic programs. This concept will be incorporated into Vision Quest and future plans

Question 6: VQ must determine and develop specific research agendas for clinical treatments, evidence-based practice, comparative effectiveness of AT services, patient outcomes and business issues for the profession. Examples are included here only for reference.

- What level and type of research is needed to prove to insurance companies, CMS and patients/consumers that we can provide great outcomes at a good ROI?
- What are the most important clinical issues we should address to demonstrate positive outcomes and improve patient care?
- What business and demographic research to influence policy makers.
- How can the stakeholder groups work together to achieve these goals?

Respectfully submitted,
Cate Brennan Lisak, VQ staff liaison

Past resources are located here: http://www.nata.org/members1/committees/VisionQuest/index.cfm

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Also on this call: Judy Pulice, Nick Campbell, Patty Ellis