BEST PRACTICE GUIDELINES FOR ATHLETIC TRAINING DOCUMENTATION

August 2017

Disclaimer of Liability

The materials and information provided in the National Athletic Trainers' Association (NATA) "Best Practice Guidelines for Athletic Training Documentation" (the "Guidelines") are educational in nature, and the Guidelines are published as a resource for NATA members and is intended solely for personal use/reference in the manner described herein.

NATA has taken reasonable efforts to ensure that all materials included in the Guidelines are accurate and consistent with standards of good practice in the general athletic trainers' industry. As research and practice advance, however, standards may change. For this reason, it is recommended that NATA members evaluate the applicability of any materials included in the Guidelines in light of particular situations and changing standards.

By accessing these Guidelines, NATA members agree to use it appropriately and within applicable state laws regarding athletic training licensure and/or regulation.

In no event shall the National Athletic Trainers' Association, its directors, officers, or employees be held liable for any losses, injury, damages, or any other consequences resulting from, or arising in connection with, the use or reliance on any materials provided in or accessed via the Guidelines.

By accessing the Guidelines, all NATA members who make use of the Guidelines agree to indemnify, defend and hold harmless the National Athletic Trainers' Association, its directors, officers, or employees, from and against any and all losses, costs, expenses, claims, damages and liabilities related to or associated with the NATA member's use of the Guidelines, including but not limited to any and all losses, costs, expenses, claims, damages and liabilities arising from or related to the improper use of the Guidelines. By accessing the Guidelines, all NATA members who make use of the Guidelines agree to abide by applicable state laws, and NATA standards, rules and regulations regarding the lawful practice of athletic training.

Preface

The Board of Directors (BOD) of the National Athletic Trainers' Association (NATA) formed a work group charged with developing Best Practice Guidelines for Athletic Training Documentation.

The work group addressed the following areas: define all practical and appropriate documentation practices for the athletic trainer (AT); develop awareness of the advantages of appropriate documentation; identify proper methods to facilitate communication with relevant stakeholders (employers, administrators, and supervising physicians, and others); and define key terms as they pertain to documentation.

The work group was comprised of ATs with various levels of experience and from diverse athletic training settings, including, college/university, secondary school, clinical/industrial, and education/academic.

Work Group Members

Chair: Charlie Thompson, MS, ATC	College/University Athletic Trainers' Committee
Amanda Muscatell	NATA Staff Liaison
Patrick Buffum	NATA Staff Liaison
Bart Peterson, MSS, AT	Secondary School Athletic Trainers' Committee
Larry Cooper, MS, LAT, ATC	Secondary School Athletic Trainers' Committee
Chris Mathewson, MSS, ATC, CSCS	Secondary School Athletic Trainers' Committee, NATA Board of Directors
Stacey Ritter, MS, ATC	Secondary School Athletic Trainers' Committee
Michael Goldenberg, MS, ATC	NATA At Large Member
Elizabeth Neil, MS, LAT, ATC	NATA At Large Member
Terry DeZeeuw, MS, AT	College/University Athletic Trainers' Committee
Randy Cohen, AT, DPT	College/University Athletic Trainers' Committee
Sara Nottingham, EdD, ATC	Inter-Agency Terminology Workgroup
Andy Gepford, MA, LAT, ATC	Professional Education Committee
Jeff McKibbin, MEd, LAT, ATC	Governmental Affairs Committee
Marty Matney, MBA, LAT, ATC	Committee on Practice Advancement
Gretchen Schlabach, PhD, ATC	Professional Responsibility Committee
Jeff Konin, PhD, ATC, PT, FACSM, FNATA	Professional Responsibility Committee

Outline

Section I: Introduction

Athletic training has evolved quite rapidly over its relatively brief existence as a profession. Part of this evolution includes gaining recognition and enhanced credibility as a health care discipline and validating the role of the athletic trainer (AT) in the domain of medicine. As such, it is necessary to be held to the same standards as other medical professions as they pertain to documentation for the purposes of patient care, communication and ethical-legal requirements. Such necessity is supported by the 7th Edition of the Board of Certification (BOC) Practice Analysis, located in Domain 5- Health Care Administration and Professional Responsibility: "ATs require various criteria for documentation of patient care and treatment, depending on setting and state requirements. Using appropriate documentation, no matter the athletic training setting, permits meeting of state, professional and ethical standards of practice" (p. 6).[1]

Documenting the services of an AT has evolved over the years. Early records were mostly hand-written, sometimes by the patients themselves, and were rudimentary at best. Many services provided by the AT were left unrecorded altogether. With the wide variety of academic and clinical mentoring styles, experiential learning and formal education, many different views exist regarding what appropriate documentation should consist of. Questions such as what, how and when to document continue to persist, and the nuances of the variety of work-type settings unique to the profession of athletic training, create challenging and understandable inconsistencies. Standardization of contemporary documentation practices is essential for today's practicing AT regardless of one's employment setting. Furthermore, whether in written or electronic form, compliance to the accepted standards should be viewed as the gold standard.

The primary purposes of establishing guidelines for documentation are four- fold. First and foremost, it is an AT's professional responsibility to comply with medical industry standards and statutory regulations of record-keeping. Second, proper documentation serves to provide a complete, accurate and timely record of a patient's complete medical history. Third, proper recordkeeping will facilitate communication and help to ensure a consistent level of care among and within multiple care-givers across various settings. Lastly, incorporating best practices for documentation may serve to minimize the risk of malpractice for the AT and their employer in the event of litigation.

This document will serve to help the AT:

1. Understand the importance of medical documentation.
2. Recognize key terminology related to medical documentation.
3. Understand how specific state athletic training practice acts, federal laws, and associated rules and regulations guide medical documentation.
4. Understand considerations for electronic communication and medical documentation.
5. Recognize setting-specific variables with regard to medical documentation.
6. Develop a record retention system in conjunction with other stakeholders for the institution.

Section II: Importance of Medical Documentation

Documentation is a contemporaneous narrative detailing patient encounters and athletic training services provided for each and every medical situation ATs are engaged in. Accurate and up-to-date medical records facilitate better patient management and provide a precise narrative of services rendered if the clinician is required to recall events at a later date. At its core, documentation provides a record of an initial evaluation of a condition, all treatments and interventions related to the condition, an opportunity to indicate the status of the patient as it relates to their specific condition, and a written plan detailing goals and outcomes.

Communication between clinicians is imperative to managing the patient, allowing for collaboration and consultations, and providing a continuum of care. Communication with the patient can serve to educate them on their condition, the proposed treatment program, and the expected outcomes. Patient communication can also serve to facilitate understanding and expectations of short and long-term goals. There are a number of additional benefits of thorough documentation and record-keeping. The list includes, but is not limited to, compliance with guidelines for third party reimbursement; collecting data to assist with staffing, budgeting, inventory, and facility needs; assessing interventions for quality assurance purposes; facilitating concise and temporal communication between caregivers and stakeholders; and contributing information that may lead to practice-based evidence (research informed by clinical practice).

Inadequate documentation of the services and care provided by ATs may lead to less than desirable patient outcomes and pose a risk to oneself, one's employer(s) , one's patients, and potentially the profession as a whole. By establishing minimum guidelines and recommendations here, and implementing them into practice, ATs would be adhering to optimal measures of risk management.

In today's litigious society, it is more important than ever to have thorough records of an AT's services. Comprehensive documentation should provide a complete history of the patient care in the event that a lawsuit is filed involving the AT. Given the lengthy timeframe between when an alleged incident may have occurred and when a claim is made, having the ability to refer back to written notes best serves an AT in recollecting the facts of a case.

Section III: Relevant Terminology

Athletic Trainers

Athletic trainers (ATs) are health care professionals who render services or treatment, under the direction of or in collaboration with a physician, in accordance with their education and training, state statutes and rules and regulations. As a part of the health care team, patient care services provided by ATs include injury and illness prevention, wellness promotion and education, emergent care, examination and clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical conditions. Services provided by athletic trainers are further detailed in state practice acts, the Board of Certification (BOC) Practice Analysis,[1] and the Commission on Accreditation of Athletic Training Education (CAATE) Standards.[2] ATs should consult these resources for detailed information.

Patient Encounter

ATs should document any **patient encounter**. A **patient encounter** is defined here as any interaction with a patient when an athletic training service is provided or a communication occurs regarding their health status. Communication regarding a patient's status may include, but is not limited to, written, verbal, or electronic communication with any individual or entity.

ATs should be familiar with the definition of patient encounter if it is identified in one's state practice act and/or rules and regulations. In addition, there should be a clear understanding between the AT, the supervising physician, and the employer with regard to what is considered a patient encounter. This should be accomplished through written standing orders between the directing physician and the AT. Patient encounters may also be addressed in one's policy and procedure manual.

Informed Consent

Informed consent is the process of assuring that a patient is fully aware of all aspects associated with a treatment intervention to be rendered. There are many aspects inclusive of comprehensive and legal informed consent, all of which should be made clear prior to the administration of a patient encounter involving a direct or indirect intervention. At a minimum, information conveyed by the AT to the patient must include the following:

- The type of care/intervention to be rendered.
- The likely benefits and potential risks associated with the care/intervention.
- All available options as possible alternatives to the proposed care/intervention.

Furthermore, it is the responsibility of the AT to assure that the patient understands and agrees to the rendering of the proposed care/intervention. This is best obtained via written permission. The patient consenting to such care must do so voluntarily and be a competent adult who is not under any influential pressures to receive the care. Informed consent is not required to be obtained when an AT is rendering care in an emergency situation.

Change in Patient Status

Any unexpected changes or deviations from the expected result should be documented in the interim and include appropriate follow-up documentation. When an AT provides any service, evaluation, consultation, subjective and/or objective measurement of a status change, the specifics of the service provided or action taken, and the short/long-term plan would need to be documented.

However, if a consistent or routine athletic training service is provided without change in patient status, the AT and their employer can determine in a policy and procedure if daily or summary (i.e. weekly) documentation of that care can be considered adequate. If daily prophylactic taping or stretching is done by an AT, the employer

and AT can decide that a summary note written at a certain interval such as weekly or biweekly is appropriate.

Abbreviations

Abbreviations and acronyms are common in medical documentation. It is vital that use of abbreviations is minimized and when used they are utilized in a consistent manner to prevent errors and miscommunication. An individual program or facility should create a policy and procedure that has an "approved list" of abbreviations or acronyms and a list of "not to use" abbreviations and acronyms that are standardized for that facility. This list should be public record for any persons outside your facility to interpret the medical record. ATs may consider using resources by Parvaiz et al[3], Brunetti et al[4], and Konin et al[5] when developing policies on abbreviation use (links to articles in reference section).

Section IV: Rules and Regulations

State Practice Acts

ATs must be cognizant of the fact that laws related to documentation differ from state to state. Most states do not address documentation specifically in either their practice act or rules and regulations, however, there are some states, such as New Jersey, that have very specific regulations as it pertains to documentation and records.[6] It is important to recognize that when a state practice act and/or its associated rules and regulations specifically address documentation guidelines, such guidelines become the standard of care and subsequent legal expectation. To review your individual state practice act, refer to the BOC state regulation website.[7] This page provides the contact information for state regulatory agencies in states with current AT practice acts. Please contact the appropriate agency if you have questions about the practice of athletic training.

Absent specific reference to documentation requirements in one's state regulation, ATs should adhere to all other best practices for documentation as described here within.

Federal Laws

Regardless of individual state statutes that do or do not regulate documentation, each state is regulated by federal and state laws that have been developed to ensure that an individual's personal health and academic records remain confidential. Two of these laws are the federal Health Insurance Portability and Accountability Act (HIPAA) and Federal Education Rights and Privacy Act (FERPA). It is incumbent on each AT to discuss with their administrators, legal counsel and supervising physician how each of these laws affect their level of documentation and to whom and how they can release protected medical information. Established and agreed upon written policy and procedures regarding how an AT is expected to manage information protected under HIPAA and FERPA should be developed at the organizational level.

Legal Responsibility

It is the responsibility of the AT to keep the administration, employer, legal counsel and supervising physician aware of the current state practice act and rules and regulations

governing the practice of athletic training for the state in which one practices in. This includes awareness of any potential and/or recent changes that may apply. A policy regarding who needs to know what information, and what is necessary to communicate, should be created with input from each stakeholder to clearly delineate appropriate, as well as inappropriate sharing of information. ATs who practice across state lines should be cognizant of how this impacts one's allowance to perform all professional duties.

It is recommended that the AT or their supervisor consult with the employer's legal counsel for specific interpretation of the respective state laws and associated rules and regulations. In addition, it is incumbent on all ATs to know and follow their respective state practice act and associated rules and regulations. Ignorance of a state practice act or rules and regulations does not allow one to escape liability merely due to being unaware or unknowing of relevant information.

Section V: Electronic Medical Records & Communication

Technological advances over the years have allowed for the electronic charting of medical records. In 2009, the American Recovery and Reinvestment Act was signed into law which mandated that as of January 1, 2014, all public and private health care providers must have electronic health records in order to maintain their existing Medicaid and Medicare reimbursement levels.[8] Although ATs were not specifically named in this act, there are ATs who work in settings that are affected by this requirement.

Benefits of Electronic Medical Records

An electronic medical record (EMR) is a real-time, patient centered digital version of a patient's paper chart that is created and managed within a single health care facility. There are numerous EMR systems that a health care professional can choose from. Some are designed specifically for the AT, while others are intended for use by a variety of caregivers in an organization, such as hospitals, clinics and college health centers. In either case, there are many advantages to using EMRs. The following is a list of some of the advantages[8]:

1. Providing accurate, up to date, and complete information about patients at the point of care.
2. Enabling quick access to patient records for more coordinated and efficient care.
3. Securely sharing electronic information with patients and other clinicians.
4. Helping providers more effectively diagnose patients, reduce medical errors and provide safer care.
5. Improving patient and provider interaction and communication, as well as health care convenience.
6. Helping promote legible, complete documentation and accurate, streamlined coding and billing.
7. Enhancing privacy and security of patient data.

Documentation of Email Communication

Many medical professionals use email to communicate with their patients and other pertinent individuals when necessary. With regard to email communication, the AT should:

1. Check with their employer and state regulations regarding the policies and procedures for documenting email communication.
2. When communicating with a patient electronically, especially if there is medical information in the message, it is considered best practice to communicate through an EMR system, if this function is available. The communication is usually secure and with many systems, all the emails/messages are automatically populated into the patient's chart.
3. If unable to communicate through an EMR system, then it is recommended that the AT copy and paste the entire email, with the time stamp, into the EMR. Some EMR systems have regions within the chart where this type of correspondences can be posted.
4. If paper records are being kept, then the email should be printed and put into the patient's chart.
5. Once the email has been officially saved into the patient's record and the email system being used by the provider meets the required encryption and security standards, the email can be archived. Many health care professionals, however, will delete the correspondence, even if their system is secure. Since the correspondence constitutes a legal medical record, the extra written document should be disposed of properly, such as through a process of shredding.
6. If there are any concerns that the organization's technology does not meet the standard requirements, the email should be deleted.
7. Check with their information technology department to confirm that after an email is deleted, it is actually removed and not saved elsewhere in the system. This will help ensure patient privacy in case there is a breach of AT's email account or the organization's system.

When communicating by email with someone who is not the patient, such as a coach or family member, the AT must be careful as to what is included in the email message. This is dependent on the AT's employer and/or HIPAA[9] and FERPA guidelines. Emails sent to non-patient individuals have been documented in a variety of ways. Best practice would be to communicate with the non-patient individuals through an EMR system where the person logs into the secure system to view the message. The message will automatically become part of the patient's official record. A second method is to cut and paste the email into an EMR or print and file it, if keeping paper records. A third practice is to note in the EMR or paper chart, that the person has been contacted via email with level of activity that is marked in the chart. Be sure to always share records only with those who have proper written permission to do so with as agreed upon by the patient.

Text Messaging

Text messaging allows for streamlined communication and the ability to respond in an expedient manner. However, based on HIPAA guidelines a standard text message (or other forms of instant messaging) is not considered electronic protected health information (ePHI) because interception of transmission can happen by unauthorized

users.[9-10] Therefore, ATs need to be vigilant about the information being sent and received through this medium.

> *"Consumers increasingly want to communicate electronically with their providers through email or texting. The Security Rule requires that when you send ePHI to your patient, you send it through a secure method and that you have a reasonable belief that it will be delivered to the intended recipient. The Security Rule, however, does not apply to the patient. A patient may send health information to you using email or texting that is not secure. That health information becomes protected by the HIPAA Rules when you receive it."9*

Standardized text messaging has to be secured and encrypted to be HIPAA compliant. There are several companies, both paid and non-paid, that allow for protected text messaging. Discuss with your employer and comply with state laws regarding appropriate application and documentation of text messages sent and received.

When a health care provider receives a non-secure text from a patient or other health care provider/entity, it is the responsibility of the health care provider to contact (phone call, secure text or secure email) the sender to further discuss the situation. This contact should then be documented in the patient's chart. This text includes any information that states name, diagnoses, results, etc.

Social Media

Social media has become a source of HIPAA and FERPA violations (i.e. athlete takes a picture of treatments in the athletic training room) and possible ramifications for the athletic training staff. Essentially all individuals pictured need to sign a written consent allowing for the publication of that picture. ATs need to continuously communicate with student athletes, patients and coaches about abolishing the sharing of information from the athletic training facility. When there is a posting of text or a photo on social media, an AT should document the event and what discussion had taken place with the individual to take down or delete the posting and photo in question. In the end, the picture must be removed from social media. ATs should also be aware that spectators and others may videotape and take pictures of their own that may include what would otherwise be considered as protected health information. In such cases, it is not the responsibility of the AT to monitor these materials unless the images were captured in a location or under circumstances whereby the patient was under the care of the AT who should have assured confidentiality of the situation, such as providing care within the athletic training facility. It is important for the AT to know that images and video that others capture may serve to support or refute appropriate care provided by an AT in a public venue.

Section VI: Development of a Record Retention System

It is critical that all medical records are stored and maintained according to legal standards. The legal standard is determined by state law requirement, in addition to HIPAA and FERPA laws. It is important to know the standards that your facility is required to follow.

A policy and procedure on medical record storage and retention should be developed. Formal and documented training should be required for anyone who needs to access such records. These policies and procedures should include:

1. Who has access to medical records and what functions they are allowed to perform? This should include non-medical providers such as administrators and information technology personnel. All those who have access should be bound by confidentially agreements. Function or reasons for access can include the ability to create and review medical record for medical care; the ability to review medical record for limited purpose such as billing or record request; and, the ability to have access to medical record system for computer maintenance and security only.
2. The system by which medical records are secured.
3. A procedure for when medical records are requested and produced for patient or others when a legal request is made.
4. A determination of who is the custodian of the medical records.[11]
5. A notification plan if medical record security is breached
6. A determination for how long medical records are retained and where they well be retained.
7. A plan to determine how medical records are transferred, when applicable.[12]

Section VII: Setting-Specific Considerations

Complete documentation of all medical conditions has been discussed in previous sections, and the need for this documentation does not change from setting to setting. The AT must be aware that there are certain setting-specific pieces of medical information that should be included as a part of an individual's medical record. An example would be a parental consent for treatment of minor children. This is most prevalent in a secondary school setting, but is also an issue at the college/university setting, and in the clinical setting as well.
As a best practice, the AT must be acutely aware of those documentation needs specific to their setting and comply with all state regulations, established guidelines, and institutional requirements/expectations.

ATs in certain settings, i.e. college/university and secondary schools, can have encounters with their patients before an injury, illness or issue occurs. Injury and illness prevention along with wellness is a major aspect of the ATs' duties. An AT in these particular settings may see individual patients multiple times per day, and may provide assistance/care for non- medical reasons or for activities not related to a particular injury or illness. Maintenance intervention and services provided to optimize performance are activities provided by ATs in these particular settings and may create documentation dilemmas. ATs should work with their employer and collaborating

physicians to ensure these services are adequately documented and compliant with organizational policy and federal/state laws.

Section VIII: References

1. Board of Certification. Practice Analysis, 7th Edition (PA7). http://www.bocatc.org/athletic-trainers#practice-analysis
2. Commission on the Accreditation of Athletic Training Education. Standards for the Accreditation of Professional Athletic Training Programs. https://caate.net
3. Parvaiz MA, Subramanian A, Kendall NS. The use of abbreviations in medical records in a multidisciplinary world – an imminent disaster. *Commun Med.* 2008;5(1):25-33. https://www.ncbi.nlm.nih.gov/pubmed/19363877
4. Brunetti L, Santell JP, Hicks RW. The impact of abbreviations on patient safety. *The Joint Commission Journal on Quality and Patient Safety.* 2007;33(9):576-583. http://www.wapatientsafety.org/downloads/Brunetti_JCJQPS_2007.pdf
5. Konin JG, Frederick M, Kaltenborn J (Eds.). *Documentation for Athletic Training, 2nd Edition.* SLACK Inc. Publishers, Thorofare, NJ, copyright 2011.
6. New Jersey Administrative Code. Title 13, Chapter 35, Subchapter 10: Athletic Trainers. http://www.njconsumeraffairs.gov/regulations/Chapter-35-Subchapter-10-Athletic-Trainers.pdf
7. Board of Certification. State Regulation. http://www.bocatc.org/state-regulation
8. "What are the advantages of electronic health records" 4 Sep. 2014, https://www.healthit.gov/providers-professionals/faqs/what-are-advantages-electronic-health-records. Accessed 29 Jan. 2017.
9. Guide to Privacy and Security of Electronic health information. The office of the National Coordinator for Health Information Technology. https://www.healthit.gov/sites/default/files/pdf/privacy/privacy-and-security-guide-chapter-4.pdf. Department of Health and Human Services, USA. Chapter 4.Pg. 26-31.
10. Greene, Adam H. "HIPAA Compliance for Clinician Texting" Journal of AHIMA 83, no.4 (April 2012): 34- 36.
11. US Legal. Records Custodian Law and Legal Definition. https://definitions.uslegal.com/r/records-custodian/
12. Radiology Administrator's Compliance & Reimbursement Insider. August 2002. http://www.hcpro.com/content/42948.pdf