BEST PRACTICES IN THE IMPLEMENTATION AND STRUCTURE OF MEDICAL CARE FOR COLLEGE ATHLETES

National Athletic Trainers' Association

Introduction

Sports, which have been part of the American culture since the 1800s, play an integral part to our educational system.[1] Athletic participation fosters personal development in areas such as self-discipline, teamwork, leadership and sportsmanship. There are more than 7.6 million individuals participating in youth sports with an estimated 1.4 million injuries per year.[2] Based on concern about musculoskeletal injuries, concussions and catastrophic injuries, collegiate sports medicine departments should be continuously evaluating their services.[2] Previously published reports highlight areas of concern for the collegiate athletic trainer and team physician. Some of those concerns were described in the *Chronicle of Higher Education.* This publication reported that 11 head football athletic trainers or directors of sports medicine reported directly to a football coach; and more than 50% of major college football athletic trainers felt pressure to medically clear student athletes.[3] In a 2019 survey conducted by the National Athletic Trainers' Association (NATA), 19% of collegiate athletic trainers reported coaches having played a student athlete who was not medically cleared for participation.[4]

Overview

Collegiate institutions have a responsibility to their student athletes to provide a safe environment where the diagnosis, management and return-to-play determinations following injury and/or illness are the responsibility of the institution's primary athletic health care providers.[2] In addition to good patient care, holding institution's athletic health care providers responsible for student athletes' health is a sound risk management practice. Previous publications, such as the NATA's Inter-Association Consensus Statement on Best Practices for Sports Medicine Management for Secondary Schools and Colleges and the NCAA Independent Medical Care legislation, provide guidance on best practices for sports medicine services. There are wide variations in how different collegiate sports medicine programs may be set up, ranging from an organization's structure, setting, staffing, resources and budget.[2]

In August 2019, a group of health care professionals and athletic administrators met at the NATA headquarters to discuss and provide further guidance for appropriate medical care within the collegiate setting. The outcome of this meeting was the development of the following document that describes an Appropriate System of Medical Care that may be implemented within any organizational setting and resource structure. Three main elements are critical to an Appropriate System of Medical Care:

1. Patient-centered care
2. Medical evaluation and supervision
3. Autonomous medical decision-making

Patient-Centered Care

Patient-centered care is respectful of, and responsive to, the preferences, needs and values of an individual patient, ensuring that patient values guide all clinical decisions. Patient-centered care is characterized by efforts to clearly inform, educate and communicate with patients in a compassionate manner. Shared decision-making and management between patient and clinician, continuous advocacy of injury and disease prevention measures and the promotion of a healthy lifestyle are all emphasized.[5]

The patient should have a clear understanding of their medical condition. Health care professionals need to provide an opportunity to understand the patient's goals when developing a patient's management plan and making return-to-play decisions.

As health care providers, athletic trainers and team physicians have a responsibility to inform and educate student athletes, coaches and administrators on the importance of patient-centered care and shared decision making. Institutions must foster a culture that advocates for patient-centered care across its respective sports teams. This can be measured through patient outcomes, student athlete satisfaction surveys, AT service metrics, peer evaluation, self-evaluation and/or student athlete exit interviews.

Medical Evaluation and Supervision

Medical evaluation and supervision best practices state medical care must be evaluated by appropriate health care professionals, such as team physicians and athletic trainers.[2,4] Non-health care professionals may not have the knowledge or understanding of medical care and protocols to effectively evaluate health care professionals about the quality of their health care delivery. Additionally, physicians and athletic trainers should have input with respective human resource departments on developing specific job descriptions for athletic trainers and other health care professionals within the sports medicine umbrella.

The administrative oversight and evaluation of health care professionals may be performed or administered by any supervisor who is experienced and skilled in health care assessment. Responsibilities in these areas that are important to providing quality health care within the collegiate environment include reliability, accountability and adherence to administrative policies. Health care professionals must be able to listen and communicate effectively, both orally and written, to their patients, coaches and administrators. That communication is critical to optimizing patient care. The requirements to fulfill their responsibilities should be consistent with organizational operational philosophy and financial resources. Those health care professionals who have a responsibility for supervising medical staff members need to be provided with the authority to:

1. Hold staff accountable
2. Provide timely and appropriate feedback
3. Achieve department goals
4. Provide training and development of medical staff and the department where applicable

Employment decisions (i.e., hiring, firing, promotions or salary adjustments) of health care professionals should be made in consultation with the supervising health care professional. Health care professionals may not be disciplined by coaches or non-supervisory administrators for medical decisions. Supervisor(s) should work with their respective human resources departments when medical decisions are not made in the best interest of the student athlete, particularly if influenced by prioritizing team success.

Autonomous Medical Decision-Making

Institutions are responsible for promoting and sustaining a culture of unchallengeable medical autonomy on all medical decisions within their athletic departments. Coaches and administrators should

be informed that health care professionals have final authority with respect to all medical decisions, which include, but are not limited to, return-to-play, activity accommodations, injury and/or illness management plans and referral processes. Coaches and/or administrators should never insert themselves into situations where they act as the decision-maker in these situations. Specific examples include, but are not limited to, directing injury/illness management options directly to the student athlete, instructing student athletes on medical referrals, coercing student athletes into activities they are not comfortable with or creating an environment in which student athletes do not seek care.

Coaches should have the ability to be part of the medical process. It is appropriate for coaches to ask questions in areas including, but not limited to, extent of injury or illness, management process of injury or illness, referral process, return-to-play and why an injury or illness may not be recovering as anticipated. Coaches or administrators who have suggestions in the medical care of student athlete(s) should communicate these suggestions and seek approval with the institution's health care professionals and the patient. Primary health care professionals have a responsibility to create an environment that is receptive to open communication from coaches and administrators who seek conversation in this area. Changes in student athlete management processes ultimately should be based on evidence-based medicine and patient's goals. The purpose of evidence-based medicine is to provide health care professionals, patients and those close to them with up-to-date and scientifically proven information on the various medical options that may be available to them.[6]

Institutions shall have standards in place to effectively evaluate unchallengeable medical autonomy. The institution's CEO or designee should certify that prioritizing the unchallengeable medical autonomy of primary athletic health care professionals has been communicated to all athletic department staff. Coaches and administrators should sign a document acknowledging they understand and agree to the unchallengeable medical autonomy of the health care team. The administration should value annual feedback across the student athlete population, such as, but not limited to, surveys or the student athlete exit interview process. Information may be sought from the institutions health care professionals regarding coaches' support in this area and made part of a coach's annual performance review. Institutions must have, and communicate, an established process by which anyone can report failure to comply with unchallengeable medical autonomy guidelines. The institution shall create a safe space for reporting if there is a violation claim.

As part of the work done by the group in August 2019, best practices and checklists (Appendix A) were developed for each of the three main areas of the Appropriate System of Medical Care. The next section of this report lists Appropriate System of Medical Care Best Practices These best practices are divided by the following key stakeholders who are most important to implementation of an Appropriate System of Medical Care: 1) institutions/CEOs; 2) athletics administration and coaches; and 3) health care providers.

Appropriate System of Medical Care Best Practices

The role of the Institution/CEO:

- Institutions shall establish "an administrative structure that provides independent medical care and affirms the unchallengeable autonomous authority of primary athletic health care providers (team physicians and athletic trainers) to determine medical management and return-to-play decisions..."[2,4,7,8, 12]
- Institutions have the responsibility to create, promote, and sustain a culture of unchallengeable medical autonomy on all medical decisions within their athletic departments.[2,4,7,8, 12]
- The Institution's CEO (or designee) is responsible for prioritizing and verifying that the concept of unchallengeable medical authority as the guiding tenant for athletic health care decision making.[2,4,8, 12]
- Standards shall be developed to assess the departments/institutions adherence to unchallengeable medical authority and patient centered care.[2,4,8, 12]
- Institutions shall create a mechanism to report violations of the medical autonomy decision making process and provide a safe space (whistleblower protection) for those reporting such violations.[2,9,10, 12]
- Institutions have the responsibility to ensure that the evaluation of the quality of health care providers is completed by an appropriately qualified/credentialed health care professional.[2,4,8, 12]

The role of athletics administration and coaches:

- Coaches and athletics administrators should be educated routinely about the importance of health care professionals having unchallengeable medical authority with respect to all medical decisions affecting student-athletes (patients). Annual verification of the education and understanding of the concept should be maintained in the office of the Athletics Health Care Administrator (or their designee.[2,7, 12]
- Coaches and/or athletics administrators shall have the ability to ask questions and discuss patient care management plans with health care professionals.[2,11]
- Coaches and/or athletics administrators cannot be permitted to impose their perspective on health care issues directly to the patient. Specifically, items like directing treatment, referral of student-athletes for patient care, coercing student-athletes into activity that may be detrimental to their well-being, and fostering an environment where student-athletes do not seek care, are a few examples for concern.[2,7,8, 12]

The role of health care professionals:

- Health care professionals shall work to create an environment that is receptive and open to communication from coaches and administrators concerning student-athlete's (patient's) health, management plan, and return-to-play decisions.[2,11, 12]
- Evidence-based decision making, in combination with the patient's goals should be considered when developing and/or modifying the student-athlete's treatment, management, and return-to-play plans.[2,6, 12]
- Health care providers have a responsibility to inform and educate student-athletes, coaches and administrators on patient-centered care.[2.7]
- A variety of assessment tools should be developed for multiple entities to implement to provide input and evaluation for the institutions health care professionals. Examples include (but are not limited to):[2]
    - Student-Athlete satisfaction surveys
    - Documented/measureable patient outcomes reports
    - Injury surveillance documentation
    - Exit interview with patients

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APPENDIX A
CHECKLIST

This appendix contains a checklist to assist key stakeholders (i.e., institutions/CEOs, athletics administration, coaches and health care providers) with the implementation of the recommended best practices.

Patient-Centered Care:

1. Institutions should advocate for and create a culture that prioritizes patient-centered care across its respective sports teams.
2. Patient-centered care:
    a. Includes being respectful of, and responsive to, the preferences, needs and values of the individual patient.
    b. Includes informing and educating patients on their injury/illness with shared decision-making between the patient and health care team.
    c. Involves communication by health care professionals, coaches and administrators in a compassionate and respectful manner.
    d. Allows health care providers to consider opportunities to understand their patient's goals when developing a management plan and making return-to-play decisions.
3. Health care providers have the responsibility to inform and educate student athletes, coaches and administrators on best practices and evidence-based decisions in managing patient care.
4. Institutions should have a process in place to evaluate patient-centered care across their sports teams. Examples include, but are not limited to, patient-reported outcomes, student athlete surveys and/or student athlete exit interviews.

Medical Evaluation and Supervision:

1. Medical care must be supervised and evaluated by appropriately qualified health care providers, such as team physicians and/or athletic trainers.
2. Administrative responsibilities may be evaluated by professionals with experience in this area. Examples of health care administrative responsibilities include, but are not limited to, reliability, accountability, adherence to policies, listening and effective communication, organized, task prioritization, work efficiency, ability to meet deadlines, perform duties consistent with organizational operational philosophy and financial resources.
3. Health care professionals with a responsibility in supervising staff members should be provided with the authority to hold staff accountable, provide timely and appropriate feedback, achieve department goals, provide professional training and development of staff and progress their department.
4. Decisions on hiring, firing, promotions or salary adjustments of health care professionals should be made in consultation with the supervising medical professional.
5. Physicians and athletic trainers should have input with respective human resource departments on developing specific job descriptions for athletic trainers and other health care professionals within the sports medicine umbrella.
6. Health care professionals may not be disciplined by coaches or administrators for medical decisions.

7. Supervisor(s) may work with their respective human resources departments when medical decisions are not made in the best interest of the student athlete.

Medical Autonomy Decision-Making Best Practices:

1. Institutions are responsible for promoting and sustaining a culture of unchallengeable medical autonomy on all medical decisions within their athletic departments.
2. Coaches and administrators should be informed that health care professionals have final authority with respect to all medical decisions.
3. Coaches and/or administrators should never interject themselves into situations where they act as the decision-maker, such as directing treatment to student athletes, referring student athletes for physician care, coercing student athletes into activity against their will and/or creating an environment in which student athletes do not seek care.
4. The institution's health care professionals should create an environment that is receptive to open communication from coaches and administrators who seek conversation regarding a student athlete's health, management plan and return-to-play decisions.
5. Coaches should have the ability to ask questions about items such as, but not limited to, injury/illness, prescribed management plan(s), referral process, return-to-play and/or why an injury is not recovering as anticipated.
6. Coaches and administrators should have the ability to discuss changes in student athlete(s) management plans with health care professionals.
7. Any changes to a student athlete's management plan should be approved by an institution's health care professional based on best practice and evidence-based medicine as well as the patient's goals.
8. Institutions should have standards in place to effectively measure unchallengeable medical autonomy.
9. An institution's CEO or designee certifies that prioritizing the unchallengeable medical autonomy of primary health care professionals has been communicated to all athletic department staff.
10. Coaches and administrators should sign a document acknowledging they understand and agree to the unchallengeable medical autonomy of the institution's health care professionals.
11. Administration should value annual feedback across the student athlete population, through items such as, but are not limited to, surveys or the student athlete exit interview process.
12. Information should be sought from an institution's health care professionals regarding coaches' support of unchallengeable medical autonomy.
13. Institutions should have, and communicate, an established process by which anyone can report failure to comply with unchallengeable medical autonomy guidelines.
14. Institutions need to create a safe space for reporting a claim of unchallengeable medical autonomy violation.

APPENDIX B
MEETING OF THE MINDS

The Meeting of the Minds was held on August 15 – 16, 2019 in Carrollton, TX at the National Athletic Trainers' Association Home Office.

Chair

Murphy Grant, MS, ATC, CES, PES
Senior Associate Athletic Director/Athletics Health Care Administrator
Wake Forest University

Invited speakers and participants

Brant Berkstresser, MS, ATC, LAT
Associate Director of Athletics for Student-Athlete Health and Performance
Harvard University

Carolyn Campbell-McGovern
Deputy Executive Director
Ivy League

Jamie DeRollo, DAT, MBA, ATC
Instructor - PE/Athletic Trainer
Modesto Junior College

Forrest Karr
Director of Athletics / Adjunct Professor–Labor and Employment Law
Northern Michigan University

Russ Richardson, EdD, ATC
Director of Student-Athlete Health and Wellness
NAIA

Mark Stoessner, MA, ATC
Associate Director of Athletics - Medical Services (Strength & Conditioning Coordinator, Men's Basketball, Soccer)
Grand Valley State University

Tim Weston, Med, ATC
Head Athletic Trainer
Colby College

Attendees via phone

Tory Lindley, MA, ATC
Senior Associate A.D. for Health, Safety and Performance

Northwestern University

Charlie Thompson, MS, ATC
Head Athletic Trainer
Princeton University

Staff

Tamesha Logan, MBA
Director, Marketing and Communications
National Athletic Trainers' Association

Todd Christman
Senior Marketing & Communications Coordinator
National Athletic Trainers' Association

Anita James, CMP
Director, Knowledge Initiatives
National Athletic Trainers' Association