Minnesota House of Representatives
Health Finance and Policy Committee
Re: HF 1828 Athletic Training Bill
February 28, 2022

Dear Committee Members:

The Minnesota Chapter of the American Physical Therapy Association (APTA MN) wishes to comment on HF 1828, a bill that expands the populations of individuals that would have 30 days of direct access to the services of an athletic trainer, without physician referral and without supervision.

Framed as an access bill, HF 1828 fails to recognize that athletic trainers (ATs) are not sufficiently trained to screen and diagnose all populations. Current language limits the AT to the treatment of athletes who have athletic injuries. Both terms are defined in statute and they describe the current scope of AT practice.

APTA MN believes that should MATA seek to expand the population of patients as they suggest, there should be a commensurate change in the level of supervision, some limits on the settings or populations, and a reconsideration of the role of the protocol as a form of supervision.

The Minnesota Athletic Trainers' Association (MATA) seeks to include in their scope of practice "physically active individuals" but the bill offers no definition of the term nor any prohibitions that would exclude specialized populations of individuals who are physically active. Examples of those populations would be those who have neurological conditions such as cerebral palsy, stroke, and Parkinson's disease as well as cardiopulmonary conditions. Instead they are asking to be able to treat anyone for any condition without clear boundaries. A good question to ask is whether or not there are any "nonorthopedic conditions" that should be excluded.

HF 1828 describes the definition of athletic training as being determined by the individual "athletic trainer's education." That may sound logical, but scope of practice is determined by entry-level knowledge and skills for everyone licensed under the practice act. Scope of practice should not be determined or expanded for a single AT by what that individual has been taught without any criteria or standard. Outside of AT academic programs, which are accredited, licensed ATs are being taught invasive procedures like joint injections and suturing by individual physicians. These procedures are not within the standards of AT education and should be prohibited under the scope of AT practice. MATA also asserts that accredited programs include at least two years of clinical training, which appears to be misleading. Didactic training is not the same as clinical training.

APTA MN asserts that while AT training has advanced over the years, the majority of clinical training remains on the athletic field and in the training rooms. Student ATs are exposed to other populations of patients, but the clinical training is highly variable, observational in nature and does not require the student to examine, evaluate, diagnose, and create and execute individualized care plans.

Medicare does not consider athletic trainers to be qualified providers for rehab services to the patient population of aging adults and those who have physical and cognitive disabilities.

The Minnesota Department of Health does not collect workforce data on athletic trainers so there is disagreement over the number of athletic trainers who are working in the clinical setting who have post-baccalaureate degrees. While many ATs have advanced degrees, they are not typically in athletic training. Instead they are in areas such as business and education, and some are physical therapists who chose to advance their education and earn a doctorate in physical therapy. The U.S. Bureau of Labor Statistics reports that the typical entry-level education for ATs is a bachelor's degree. (https://www.bls.gov/ooh/healthcare/athletic-trainers.htm)

Currently a protocol form is used as supervision in all settings with the exception of when the AT is working in an outpatient Physical Therapy clinic, in which case the physical therapist must provide direct supervision of the AT when treating athletes who have athletic injuries. In that case, the PT evaluates the patient, diagnoses and creates the care plan under which the AT provides treatments. HF 1828 would allow the protocol form to suffice as supervision in all other settings. The protocol is a list of interventions that the "primary physician" agrees the AT can provide but does not provide anything near direct supervision as with the PT supervision. In fact, that physician is not necessarily the patient's physician and the AT does not need to be employed by that physician. A good question to ask is why, in the PT setting, the AT must have direct supervision, but if an AT set up an independent practice or worked in another setting, there is no provision for direct supervision whatsoever.

The protocol form was designed for on the field or in the athletic training room, when a physician is not necessarily present. Given the decision-making and treatment that is provided in that setting, the protocol makes sense. The allowance of 30 days of treatment without referral allowed the AT to manage athletes' condition initially but was not designed for any other settings or other populations wherein the decision-making and treatment interventions are significantly different. Patients in today's clinical settings represent complex populations who have many co-morbidities and who take multiple medications further complicating the clinical picture. APTA MN believes that supervision beyond the protocol form should be required for athletic trainers.

Related to supervision, HF 1828 requires the AT to perform athletic training "under the direction of, on the prescription of, or in collaboration with a primary physician." None of those terms are defined nor appropriately assigned to any specific clinical setting. It is also not clear whether the primary physician includes chiropractors and podiatrists who can refer to athletic trainers.

APTA MN has met over 30 times with MATA on this topic. We assert that should the scope of practice of the AT expand to the degree they are asking, there should be some prohibitions and limitations but MATA has been reluctant to discuss those options. APTA MN remains open to further discussion and hopes to schedule a meeting.

Please do not hesitate to contact APTA MN if you have questions regarding our comments.

Thank you,

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