



Thank you to the Nebraska Department of Health and Human Services Technical Committee, the Nebraska State Athletic Trainers' Association, and other interested parties for allowing me to speak about the quality and extent of Athletic Training Education in support of the credential review for the Nebraska Statutes relating to the Athletic Training Practice Act.

My name is Micki Cuppett and I have been an athletic training and medical educator for more than 30 years and have created curricula for numerous athletic training programs. I served as faculty and the program director for Athletic Training at the University of Nebraska Omaha for several years prior to taking the same position at the University of South Florida. In fact, I had the opportunity to provide testimony the last time the Nebraska Athletic Training Statutes were revised back in 1998. I still have ties to Nebraska as both of my sons and their spouses live in Omaha and return to the area frequently. One of my sons is involved in high school coaching, so I have a particular interest in the quality of athletic training services in Nebraska.

During my tenure at the University of South Florida, I was instrumental in moving the AT program from the College of Education to the College of Medicine, where I taught alongside faculty from medicine, physical therapy, pharmacy, physicians assistant, and nursing. The curriculum of these programs had significant crossover and we often taught in each other's programs. Our students engaged in interprofessional education on a daily basis and began to recognize how their skills complimented one another.

I was also fortunate to have the opportunity to serve as a board member for our accrediting body for athletic training education, the Commission on Accreditation of Athletic Training Education (CAATE) and served as president of that organization. Following my tenure as president, I was hired by the CAATE to serve as their executive director, a position that I held for five years. Most recently I have my own consulting company with emphasis on accreditation and athletic training curriculum. I work with more than 20 programs across the country and have helped design the curriculum and assessment plans at many different institutions.

Today I will address the concerns of the opponents of the proposal put forth by the NSATA as it pertains to the educational content, quality and quantity.

The profession of athletic training has evolved as nearly 13,000 Athletic Trainers now work in industrial settings. In recognition of changing practice settings, athletic training education has also evolved. Especially if you consider the changes since the last time the Nebraska Athletic Training Statutes were revised in 1998. Four sets of educational standards have elevated AT education as a respected pathway for students interested in healthcare. These Standards were revised in 2001, 2005, 2012 and now 2020. Similar to other healthcare professions, AT students must complete pre-requisites in biology, chemistry, physics, psychology, human anatomy and physiology and foundational knowledge in statistics, research design, epidemiology,

pathophysiology, biomechanics and pathomechanics, exercise physiology, nutrition, pharmacology, public health, and health care delivery and payor systems. In addition, all graduates must be competent in the Core Competencies for Healthcare Professionals as defined by the Institute of Medicine back in 2001. The CAATE is recognized by the same agency, the Council on Higher Education Accreditation (CHEA) as the accreditors for other health professions. For example, CAPTE, ACOTE, ARC-PA, LCME, and ACCNE.

A change that has impacted both the education and practice of ATs is that most AT programs are now housed in the same academic unit as other healthcare professions. In the past, it was typical for AT programs to reside in departments of physical education and colleges of education. The CAATE now requires that programs be housed with similar health care professions that are subject to specialized programmatic accreditation. According to the CAATE, of the 364 accredited professional programs that completed the 2018-19 annual report, 265 (72.6%) indicated existing in an administrative structure with other healthcare programs. Of the 209 undergraduate programs, 138 (66.0%) are administratively housed with other healthcare programs, and of the 156 graduate programs, 127 (81.4%) are administratively housed with other healthcare programs. As programs continue to move to the graduate degree (by 2022) this number will approach 100%. Being housed with other healthcare professions has increased the opportunities for interprofessional education and has acculturated AT students into mainstream healthcare. Many AT programs are housed with PT and OT programs and share faculty, courses, and clinical sites.

The curriculum and patient clinical education experiences required for students in these programs has also evolved. The last time the Nebraska Statutes were revised, AT curricula mainly focused on musculoskeletal conditions in the active, healthy athlete. Today, AT education includes expanded patient populations in both the didactic and clinical education of the students and extensive education on non-musculoskeletal and comorbid conditions. Students must be competent in performing an exam to formulate a diagnosis and plan of care for patients with health conditions commonly seen in athletic training practice, including identifying comorbidities and patients with complex medical conditions. Students must be competent in recognizing conditions of the following systems:

- Cardiovascular
- Endocrine
- EENT
- GI
- GU
- Integumentary
- Mental Status
- Musculoskeletal
- Neurological
- Reproductive
- Respiratory

Students in AT programs are now expected to use the international classification of functioning, disability and health (ICF), are proficient in the use of meter-dosed inhalers, nebulizers,

epinephrine, bronchodilators, nitroglycerine, glucagon, and insulin. In addition, students must be competent in the administration of rescue medication such as naloxone, administration of oxygen and medications or other therapeutic agents by appropriate route of upon the order of a physician.

I am currently on faculty at five college/university athletic training programs where I teach courses largely pertaining to “medical” conditions seen in athletic training practice as well as pharmacology and administration of rescue medications as previously mentioned. The textbook I co-authored is used across the country and covers this material in depth. AT students learn this material and are trained and tested on these skills using task trainers and simulators consistent with other health professions.

Clinical education in Athletic Training has been expanded and adequately addresses a more diverse population across the lifespan. The Nebraska chapter of the APTA wrote in their last letter of opposition that “We do not believe they have adequate clinical experiences to treat the entire spectrum of people across the lifespan with a multitude of illnesses, diseases, injuries and co-morbidities.”

Even in the 2001 Standards for Accreditation of AT programs, programs were required to provide education and clinical experiences in medical conditions. The language was strengthened in 2005 and again in 2012. The 2012 Standards required that: *Students must gain clinical education experiences that address the **continuum of care** that would prepare a student to **function in a variety of settings** with patients engaged in a range of activities with conditions described in athletic training knowledge, skills and clinical abilities, Role Delineation Study/Practice Analysis and standards of practice delineated for an athletic trainer in the profession. Examples of clinical experiences must include, but should not be limited to: Individual and team sports; Sports requiring protective equipment (e.g., helmet and shoulder pads); Patients of different sexes; **Non-sport patient populations** (e.g., outpatient clinic, emergency room, primary care office, industrial, performing arts, military); A **variety of conditions other than orthopedics** (e.g., primary care, internal medicine, dermatology).*

Then in the 2020 Standards, Standard 17 explicitly states: *A program’s clinical education component is planned to include clinical practice opportunities with varied client/patient populations. Populations **MUST** include clients/patients:*

- *Throughout the lifespan (for example, pediatric, adult, elderly),*
- *Of different sexes,*
- *With different socioeconomic statuses,*
- *Of varying levels of activity and athletic ability (for example, competitive and (recreational, individual and team activities, high-and low-intensity activities), (*
- *Who participate in non-sport activities (for example, participants in military, industrial, occupational, leisure activities, performing arts).*

In addition, Standard 18 requires that *students gain experience with patients with a variety of health conditions commonly seen in athletic training practice.* Athletic trainers routinely practice in the areas of prevention and wellness, urgent and emergent care, primary care, orthopedics, rehabilitation, behavioral health, pediatrics, and performing and performance

enhancement. Within these areas of athletic training practice, the athletic training clinical experience provides students with opportunities to engage with patients with emergent, behavioral, musculoskeletal, neurological, endocrine, dermatological, cardiovascular, respiratory, gastrointestinal, genitourinary, otolaryngology, ophthalmological, dental, and environmental conditions. When specific opportunities are not possible programs use simulation or standardized patients to meet portions of this standard. *Students must have adequate patient/client interactions to prepare them for contemporary clinical practice with patients with a variety of health conditions commonly seen in athletic training practice.*

The entire purpose of this practice act modernization has been to focus on what we treat and non whom. Notice that the Standards do NOT say specific to athletes, but rather health conditions commonly seen in athletic training practice.

Some examples of non-athletic clinical sites include hospitals and physician practice settings, student health services, performing arts such as Cirque de Soleil, the Blue Man Group, and the Radio Music Hall Rockettes, and industry such as Toyota, Amazon, Frito Lay, NASA, Boeing, and WorkFit. In addition, clinical sites across the country include law enforcement and first responders, SWAT teams, and the Armed Forces. Through its Standards for Accreditation, the CAATE is requiring that all students obtain experience in those types of settings. The CAATE Standards require that all students complete a full-time immersion clinical education of no less than 4 continuous weeks. Throughout the 20 programs who are or have been my clients, students are completing their 4-8-week immersion in a non-sport setting. Using the immersion experience to complete a non-traditional, non-athlete experience provides an advantage as the students do not need to be on campus during this time so geographical restrictions are removed. The CAATE reports that the mean clinical education time for students in these immersive educational experiences across all programs is 35 hrs/week. If the minimum 4 weeks is completed (as required by the standards) that would be a mean of 175 contact hours with an expanded patient population.

The Standards allow for institutional autonomy such that the curricula and clinical education is not required to be identical across all AT programs. This allows for programs to use the strengths and clinical expertise within their geographical area. However, the onus is on the institution to show that ALL graduates of their program are competent in all of the knowledge skills and abilities defined by the Standards. For example, the AT programs within the State of Nebraska need to be creative in order to meet these Standards for non-athletic populations since they are currently restricted by the language in the State Statute. Their recourse might be to send students out-of-state to complete that portion of the requirements. Other options might be to provide some training of their students on standardized patients or through simulation. Regardless, Nebraska programs would need to provide documentation that students have met these criteria in order to remain compliant with the accreditation standards. A modernization of the Statute for ATs in the state may allow the AT programs in the state to provide those experiences within the state. In addition, Nebraska educational programs must ensure that their graduates are capable of working in states that may have less restrictive language in their practice acts. A modernization of the Statues would contribute greatly to that requirement.

Most programs are beginning to use a patient encounter system such as E-Value, or Typhon to track student experiences and are relying less on hours logged in a particular setting. Many have benchmarks of a certain number of procedures with actual patients or a certain number of patients with a particular condition. If the student has not reached that threshold within their required clinical rotations, then he/she will need to complete the procedures in a simulated setting. Programs also use Objected Structured Clinical Examinations (OSCEs) where students complete “mock” examinations and/or treatments of patients to demonstrate competence. Programs must be able to provide documentation to the CAATE that ALL students have met all of the accreditation standards (including sufficient clinical education with non-athletic populations, comorbidities and patients with complex medical conditions).

The Standards require that AT students *Practice in collaboration with other healthcare and wellness professionals (Standard 61)* and Standard 90 *Establish a working relationship with a directing or collaborating physician*. This standard is specific to preparing an athletic trainer to fulfill the BOC Standards of Professional Practice, specifically Standard 1, *the athletic trainer renders service or treatment under the direction of, or in collaboration with a physician in accordance with their training and the states statutes rules and regulations*.

And finally, to address the concern about the “rogue” AT providing care outside of their scope of practice.... AT students are taught throughout their programs to Practice in a manner that is congruent with the ethical standards of the profession(Standard 65), and Standard 66, *to practice health care in a manner that is compliant with the BOC Standards of Professional Practice and applicable institutional/organizational, local, state, and federal laws regulations, rules, and guidelines*. More information on the BOC Standards of Professional Practice will be/were provided in additional testimony today.

I hope that my comments today have helped to clarify the quality and quantity of the AT students’ education, especially concerning requirements for experience with non-athletic, non-orthopedic patients with co-morbid conditions. These requirements have been included in the Standards since 2001. The required professional knowledge has continuously been changed and reflected in each set of standards as the practice of athletic training has changed. Athletic Training education has evolved and now so should the Nebraska State Statues for Athletic Trainers reflect current practice and the needs of Nebraska patients.

Respectfully,

A handwritten signature in black ink, appearing to read "Micki Cuppett". The signature is fluid and cursive, with a large initial "M" and a stylized "C".

Micki Cuppett, EdD, LAT, ATC &