Minutes  
Alabama Board of Athletic Trainers  
Alabama State Board of Medical Examiners  
Advisory Council  
July 1, 2021  
Microsoft Teams Virtual Meeting

**ABAT Members Present**  
R. T. Floyd  
Chris King  
Kyle Southall

**ABME Members Present**  
Beverly Jordan, M.D.  
Eric Law, M.D.  
James Robinson, M.D.

**Members Absent**

**Others Present**  
William Perkins (ABME)  
Matt Hart (ABME)  
Leah Taylor (ABAT)

Chris King, acting as the meeting’s facilitator, declared a quorum present and called the meeting to order at 5:32 p.m. He welcomed everyone and thanked them for their attendance at this inaugural meeting of the newly formed Advisory Council of the Alabama Board of Medical Examiners and Alabama Board of Athletic Trainers. Following his remarks, William Perkins gave welcoming remarks on behalf of the ABME.

Mr. King then addressed the need to elect a chairperson for the group and called for nominations. *A motion was made by R.T. Floyd to nominate Chris King as Chairman of the Advisory Council. Dr. Beverly Jordan provided the second to the motion and moved to close the nominations. The motion passed with a roll-call vote of five in favor and one abstention by Chris King.*

Chris King reported that Matt Hart had been working on draft rules (Attachment 1) and requested that he lead the Council through the them. Mr. Hart explained that he was presenting a broad draft of rules which would create stronger relationships between supervisory physicians and athletic trainers for future expansion as well as establish a set of standard and expanded protocols for various areas of practice. Discussion followed with many thoughts and ideas exchanged on the topics of supervisory physician registration and minimum requirements, minimum physician presence, and quality assurance. A great deal of emphasis was placed on having an emergency action plan in place as soon as possible but within 30 days of a new collaborative agreement between a supervisory physician and athletic trainer. Other topics
discussed included the concept of a “covering” physician, the ratio of athletic trainers to supervisory physician, the need to change a supervisory physician, the need of more than one supervisory physician based upon AT’s different areas of practice, and having the same physician across different venues. Mr. Hart will update the draft document based upon the feedback and guidance given during the discussions.

Mr. King then presented the “2021 Licensed Athletic Trainer Protocol” (Attachment 2) for discussion. He stated that it was prepared based upon the latest practice analysis prepared by the BOC, which is updated about every 5 years. This general protocol would replace the one which has been in place since being approved by ABME on May 4, 1994. Discussion followed. Kyle Southall made a motion that the Advisory Committee accept the 2021 Licensed Athletic Trainer Protocol document as written and presented for recommendation to each Board for approval. Dr. James Robinson seconded the motion, and it passed unanimously.

The discussions then moved to the various protocols which will be needed now that new practice settings are recognized by the updates to the law. The new practice settings will include clinical areas, secondary schools, collegiate/professional leagues, and industrial/occupational areas.

Chairman King called for any other business. There being none, the next meeting date was discussed. It was decided to delay setting the date and location until later. Further meeting information will be announced once more information is available regarding the completion of updates to the draft rules.

Dr. Robinson moved and Dr. Law seconded that the meeting be adjourned. The motion carried unanimously. The meeting adjourned at 7:15 p.m.

Respectfully submitted,

________________________________________
Chris King, Chairman
ATTACHMENT 1
540-x-__-.01 Definitions.

The following definitions will apply to these rules:

(1) ADVISORY COUNCIL. The Advisory Council of the State Board of Medical Examiners and the Alabama Board of Athletic Trainers, established pursuant to Code of Alabama 1975, as amended, § 34-40-3.2.

(2) ATHLETIC TRAINER. A person who is licensed by the State Board of Athletic Trainers as an athletic trainer in Alabama.

(3) BOARD OF ATHLETIC TRAINERS. The Alabama Board of Athletic Trainers established pursuant to Code of Alabama 1975, as amended, § 34-40-3.

(4) BOARD OF MEDICAL EXAMINERS. The State Board of Medical Examiners established pursuant to Code of Alabama 1975, as amended, § 34-24-53.

(5) PHYSICIAN SUPERVISION. A formal relationship between an athletic trainer and a licensed physician under which the athletic trainer is authorized to practice as evidenced by a written protocol approved by the State Board of Medical Examiners. Physician supervision requires that there shall at all times be a direct, continuing, and close supervisory relationship between the athletic trainer and the physician to whom that athletic trainer is registered. The term does not require direct on-site supervision of the athletic trainer; however, supervision does include the professional oversight and direction required by these rules and by the written guidelines established by the Board of Athletic Trainers and the Board of Medical Examiners.

(6) QUALITY ASSURANCE. Documented evaluation of the practice of the athletic trainer against defined quality outcome measures, using a selected, meaningful sample of patient records which will identify areas needing improvement, set performance goals, and assess progress towards meeting established goals, with a summary of findings, conclusions, and, if indicated, recommendations for change. The supervising physician’s signature on the patient record does not constitute quality improvement monitoring. (I do not know how we can do this in most AT settings.)

(7) PROTOCOL. A document approved by the Board of Athletic Trainers and the Board of Medical Examiners establishing the permissible functions and activities that an athletic trainer may perform under the supervision of a physician.

(8) SUPERVISING PHYSICIAN. A physician licensed by the Medical Licensure Commission of Alabama who agrees in writing to supervise one or more athletic trainers.
pursuant to the rules, regulations, and protocols established by the Board of Medical Examiners and Board of Athletic Trainers.

540-X-__-.02 Advisory Council

(1) The purpose of the Advisory Council is for enabling a mechanism for the exchange of information between the Board of Medical Examiners and Board of Athletic Trainers on matters related to the physician supervision of athletic trainers.

(2) The Advisory Council shall consist of the following:

(a) Three (3) physicians appointed by the Board of Medical Examiners. For the initial term, one member shall be appointed to a term concluding on July 1, 2022, one member shall be appointed to a term concluding on July 1, 2023, and one member shall be appointed to a term concluding on July 1, 2024. Thereafter, each appointee shall serve a term of three (3) years.

(b) Three (3) athletic trainers appointed by the Board of Athletic Trainers. For the initial term, one member shall be appointed to a term concluding on July 1, 2022, one member shall be appointed to a term concluding on July 1, 2023, and one member shall be appointed to a term concluding on July 1, 2024. Thereafter, each appointee shall serve a term of three (3) years.

(3) Members of the Advisory Council shall be eligible for reappointment. Should a vacancy occur on the Advisory Council, a successor shall be appointed by the original appointing authority to serve the unexpired term.

(4) The Advisory Council shall select one of its members to serve as chairperson for a term of one year. The office of chair shall alternate between a physician member and an athletic trainer member of the council. (duties of the chair?)

(5) Meetings of the Advisory Council shall be considered official functions of the Board of Athletic Trainers and Board of Medical Examiners. Any member of the Board of Athletic Trainers or Board Medical Examiners attending or participating in a meeting of the Advisory Council shall be entitled to their regular compensation as board members, pursuant to 34-40-3 and 34-24-54, respectively. Any member of the Advisory Council who is not a member of the Board of Athletic Trainers or Board of Medical Examiners shall receive per diem at a rate of one hundred dollars ($100) per day or any portion thereof that the Advisory Council member is attending an official meeting or function of the Advisory Council. All members of the Advisory Council shall receive reimbursement for subsistence and travel in accordance with state law as provided for state employees. Compensation of the members of the Advisory Council shall be paid by the appointing authority.

(6) The Advisory Council may exercise the following functions and responsibilities:
(a) Recommend model practice protocols to be used by athletic trainers;
(b) Review and/or recommend additions, deletions, or amendments to existing model practice protocols;
(c) Recommend rules establishing the ratio of physicians to athletic trainers;
(d) Recommend rules governing the ability to designate an alternate supervising physician when the supervising physician is temporarily unavailable;
(e) Review and/or recommend changes to the current rules and regulations governing the physician-athletic trainer relationship; and
(f) Serve in an advisory role regarding issues related to required education, renewal, and other matters concerning the physician-athletic trainer relationship.

(7) Notwithstanding any other provision of this Chapter, the Advisory Council shall serve in an advisory capacity only and any recommendation made by the Council shall be subject to approval by both the Board of Athletic Trainers and the Board of Medical Examiners.

540-X-.03 Protocols

(1) There shall be a model practice protocol for each of the following areas of practice for athletic trainers:

(a) Hospital/Physician Clinic Athletic Trainers;
(b) Secondary Education Schools Athletic Trainers;
(c) Post-Secondary Collegiate/Professional League Athletic Trainers; and
(d) Industrial/Institutional Athletic Trainers.

(2) In developing and evaluating model practice protocols, the Advisory Council shall consider the level of education, training, and experience required to safely perform the duties/procedures, the risks associated with the duties/procedures, the effectiveness and necessity of the duties/procedures, and the likelihood of positive patient outcomes.

(3) A physician and an athletic trainer may submit to the Advisory Council requests to deviate from their approved model practice protocol(s). The Advisory Council may review and evaluate these requests and make a recommendation to the Board of Athletic Trainers and Board of Medical Examiners. The Advisory Council may not grant deviations from protocols, but may only make a non-binding recommendation to the Board of Athletic Trainers and Board of Medical Examiners. Both the Board of Athletic Trainers and the Board of Medical Examiners must approve any request to deviate from the model practice protocol.

(4) Protocols deviating from the standard protocols shall be submitted to the Advisory Council for review and recommendation for approval or denial. When evaluating
whether to recommend the approval or denial of a non-standard protocol, the Advisory Council shall consider certain factors, including, but not limited to:

(a) The supervising physician’s and athletic trainer(s)’s education, training, experience, and specialty;

(b) The supervising physician’s and athletic trainer(s)’s disciplinary history and any licensure restrictions;

(c) FDA approved usages and recommendations;

(d) Whether a proposed protocol is within the current standard of care for treatment of the disease or condition specified in the protocol, including usages known as “off-label,” and whether the use is supported by evidence-based research;

(e) Whether the proposed protocol creates an undue risk of harm to patients; and

(f) The routine scope of practice and services provided by the collaborating physician and the athletic trainer(s).

After consideration of the factors listed herein, the Advisory Council may make a non-binding recommendation of approval or denial of a non-standard protocol in whole or in part.

540-X---.04 Limitations on the Physician Supervision of Athletic Trainers

(1) A physician shall not supervise athletic trainers exceeding four full time equivalent positions (one hundred sixty (160) hours) per week. “One full time equivalent” (FTE) is herein described as an athletic trainer collectively working forty hours a week, excluding time on call.

(2) A physician shall maintain independent medical judgment related to the practice of medicine at all times, irrespective of employment structure or business model.

(3) A physician shall complete quarterly quality assurance with each athletic trainer. Documentation of any quality assurance review required by this chapter shall be maintained by the supervising physician for _____.

ADDITIONAL QUESTIONS/TBD

-Any specific advanced training, qualifications, or CMEs required of ATs to be able to work in physician registration?
- Requirements of physicians to work with ATs (years of experience, Board certified, specialty limitations, specific CMEs)?

- Minimum physician presence requirements?

- Voluntary and Involuntary termination procedures?
2021 LICENSED ATHLETIC TRAINER PROTOCOL

I. Injury and Illness Prevention and Wellness Promotion

Promoting healthy lifestyle behaviors with effective education and communication to enhance wellness and minimize the risk of injury and illness.

A. Identify risk factors by administering assessment, pre-participation examination and other screening instruments, and reviewing individual and group history and injury surveillance data.
B. Implement plans to aid in risk reduction using currently accepted and applicable guidelines.
C. Educate individuals and stakeholders about the appropriate use of personal equipment.
D. Minimize the risk of injury and illness by monitoring and implementing plans to comply with regulatory requirements and standard-operating procedures for physical environments and equipment.
E. Facilitate individual and group safety by monitoring and responding to environmental conditions (e.g., weather, surfaces and client work setting).
F. Optimize wellness (e.g., social, emotional, spiritual, environmental, occupational, intellectual, physical) for individuals and groups.

II. Examination, Assessment and Diagnosis

Following an evidence-based model, the AT conducts examinations and assessments of injuries and illnesses to form relevant related diagnoses. Evidence-based clinical decision-making relies on clinical expertise that integrates athletic training knowledge and skills, clinical experience, current best evidence, clinical circumstances and patient and societal values. As part of the examination, assessment and diagnosis process, the AT utilizes clinical acumen to obtain a thorough patient history, problemsolve through confounding data, exclude and confirm varied presentations of injury and illness, and prioritize relevant examination, assessment and diagnostic techniques.

A. Obtain an individual's history through observation, interview and review of relevant records to assess injuries and illnesses and to identify comorbidities.
B. Perform a physical examination that includes diagnostic testing to formulate differential diagnoses.
C. Formulate a clinical diagnosis by interpreting history and the physical examination to determine the appropriate course of action.
D. Interpret signs and symptoms of injuries, illnesses or other conditions that require referral, utilizing medical history and physical examination to ensure appropriate care.
E. Educate patients and appropriate stakeholders about clinical findings, prognosis and plan of care to optimize outcomes and encourage compliance.

III. Immediate and Emergency Care

Integrating best practices in immediate and emergency care for optimal outcomes.

A. Establish Emergency Action Plans to guide appropriate and unified response to events and optimize outcomes.
B. Triage to determine if conditions, injuries or illnesses are life-threatening.
C. Implement appropriate emergency and immediate care procedures to reduce the risk of morbidity and mortality.
D. Implement referral strategies to facilitate the timely transfer of care.
IV. Therapeutic Intervention

Rehabilitating and reconditioning injuries, illnesses and general medical conditions with the goal of achieving optimal activity level based on core concepts (i.e., knowledge and skillsets fundamental to all aspects of therapeutic interventions) using the applications of therapeutic exercise, modality devices and manual techniques.

A. Optimize patient outcomes by developing, evaluating and updating the plan of care.
B. Educate patients and appropriate stakeholders using pertinent information to optimize treatment and rehabilitation outcomes.
C. Administer therapeutic exercises to patients using appropriate techniques and procedures to aid recovery to optimal function.
D. Administer therapeutic devices to patients using appropriate techniques and procedures to aid recovery to optimal function.
E. Administer manual techniques to patients using appropriate methods and procedures to aid recovery to optimal function.
F. Administer therapeutic interventions for general medical conditions to aid recovery to optimal function.
G. Determine patients' functional status using appropriate techniques and standards to return to optimal activity level.

V. Healthcare Administration and Professional Responsibility

Integrating best practices in policy construction and implementation, documentation and basic business practices to promote optimal patient care and employee well-being.

A. Evaluate organizational, personal and stakeholder outcomes.
B. Develop policies, procedures and strategies to address risks and organizational needs.
C. Practice within local, state and national regulations, guidelines, recommendations and professional standards.
D. Use established documentation procedures to ensure best practice.

REFERENCE

• Henderson, J. The 2015 Athletic Trainer Practice Analysis Study. Omaha, NE: Board of Certification; 2015. (Effective for April 2017 Exam and January 1, 2018 Continuing Education)