

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS

“SUNRISE” REGULATORY REQUEST QUESTIONNAIRE

Section A: Applicant Group Identification

This section of the questionnaire is designed to help identify the group seeking regulation and to determine if the applicant group adequately represents the occupation.

1. WHAT OCCUPATIONAL GROUP IS SEEKING REGULATION? IDENTIFY BY NAME, ADDRESS AND ASSOCIATIONAL AFFILIATION THE INDIVIDUALS WHO SHOULD BE CONTACTED WHEN COMMUNICATING WITH THIS GROUP REGARDING THIS APPLICATION.

Athletic trainers are seeking licensure. The California Athletic Trainers' Association (CATA) is the membership organization pursuing regulation for the athletic training profession in California. The primary points of contact for this effort are:

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2. LIST ALL TITLES CURRENTLY USED BY CALIFORNIA PRACTITIONERS OF THIS OCCUPATION. ESTIMATE THE TOTAL NUMBER OF PRACTITIONERS NOW IN CALIFORNIA AND THE NUMBER USING EACH TITLE.

Titles currently used by practitioners of athletic training in the State of California are Athletic Trainer and Certified Athletic Trainer. There are 3,326 Board of Certification, Inc. (BOC) - certified practitioners who would qualify for the proposed regulation using these titles (J). There are at least 151 individuals holding themselves out to be an athletic trainer in secondary schools without the requisite education and qualifications (X6). Included among the individuals who purport to practice athletic training in California secondary schools are administrators, custodians, teachers, coaches, etc.

3. IDENTIFY EACH OCCUPATIONAL ASSOCIATION OR SIMILAR ORGANIZATION REPRESENTING CURRENT PRACTITIONERS IN CALIFORNIA, AND ESTIMATE ITS MEMBERSHIP. FOR EACH, LIST THE NAME OF ANY ASSOCIATED NATIONAL GROUP.

The primary occupational association representing the current practitioners of athletic training in California is the California Athletic Trainers' Association with a membership of approximately 2,970 ([link](#)). Two other organizations representing California athletic trainers are the National Athletic Trainers' Association (NATA) and the Far West Athletic Trainers' Association (FWATA). The NATA represents members from all 50 states, the District of Columbia, Guam, and American Samoa and has over 42,000 members. FWATA is a regionally based sub-organization of the NATA and is comprised of athletic trainers in California, Nevada, and Hawaii and has a membership of nearly 3,430 ([link](#)). All three of these organizations are related to one another.

4. ESTIMATE THE PERCENTAGE OF PRACTITIONERS WHO SUPPORT THIS REQUEST FOR REGULATION. DOCUMENT THE SOURCE OF THIS ESTIMATE.

Based on a survey completed in September of 2011 (U1), 98% of practitioners support this request for regulation with a full understanding of costs associated with Licensure. Of the nearly 2,500 certified athletic trainers practicing in California at the time, 2,014 permitted the BOC to share their email addresses. A request to participate in this survey was sent to these athletic trainers. Seven had incorrect emails, so of the 2,007 individuals who received a survey, 760 certified athletic trainers (38%) responded, including 88 individuals who were not members of the CATA. Of the 760 respondents, 745 (98%) were in favor of regulation, while only 15 (2%) were opposed.

5. NAME THE APPLICANT GROUP REPRESENTING THE PRACTITIONERS IN THIS EFFORT TO SEEK REGULATION. HOW WAS THIS GROUP SELECTED TO REPRESENT PRACTITIONERS?

The applicant group is the California Athletic Trainers' Association (CATA). In existence for 35 years, the CATA is the only group that represents athletic trainers in the state of California. Over 87% of certified athletic trainers and some non-certified athletic trainers are represented in this membership. This is an incredibly high percentage of health care practitioners who choose to be members of their professional association. The high percentage of athletic trainers who are members of the CATA indicates the trust that the members and non-members have placed in the CATA leadership to represent them in this matter.

6. ARE ALL PRACTITIONER GROUPS LISTED IN RESPONSE TO QUESTION 2 REPRESENTED IN THE ORGANIZATION SEEKING REGULATION? IF NOT, WHY NOT?

The CATA is the only membership organization that represents athletic trainers in the state of California and has both certified and non-certified members.

Section B: Consumer Group Identification

This section of the questionnaire is designed to identify consumers who typically seek practitioner services and to identify non-applicant groups with an interest in the proposed regulation.

7. DO PRACTITIONERS TYPICALLY DEAL WITH A SPECIFIC CONSUMER POPULATION? ARE CLIENTS GENERALLY INDIVIDUALS OR ORGANIZATIONS? DOCUMENT.

According to the BOC, approximately 60% of certified athletic trainers in California work with athletes in an educational or specific professional setting. Over a third of clinically practicing athletic trainers in California (35%) work with in a non-traditional setting with physically active people or "non-athletes". This is consistent with the national average of over 36% of athletic trainers who work with "non-athletes" (M).

Athletic trainers serve a wide variety of consumers who have sustained injuries or have other medical conditions exacerbated by participation in physical activity. This includes individuals across the lifespan, from young adolescent athletes to adults injured on the job to geriatric individuals post joint replacement procedures. Athletic trainers are typically employed by organizations such as professional sports teams, colleges and universities, high schools, out-patient rehabilitation clinics, hospitals, industry/corporations, performing arts groups, physicians, the military, and health clubs. In the

course of their employment, athletic trainers serve individual consumers associated with these organizations and/or employers.

8. IDENTIFY ANY ADVOCACY GROUPS REPRESENTING CALIFORNIA CONSUMERS OF THIS SERVICE. LIST ALSO THE NAME OF APPLICABLE NATIONAL ADVOCACY GROUPS.

The following advocacy groups are supportive of the athletic training profession in California:

- Advocates for Injured Athletes
- Board of Certification, Inc.
- Brain Injury Association of California
- California Community College Athletic Association
- California Interscholastic Federation
- KEN Heart Foundation
- Kendrick Fincher Hydration Foundation
- Korey Stringer Institute
- Major League Baseball Players' Association
- Moms Team
- National Athletic Intercollegiate Association
- National Basketball Association - Players' Association
- National Center for Catastrophic Sports Injury Research
- National Football League Players' Association
- National Hockey League Players' Association
- Parent Heart Watch
- Safe Kids USA
- Sportsconcussions.org
- Sudden Arrhythmia Death Syndromes Foundation
- Taylor Hooton Foundation
- TBI Phoenix Fund

Additionally, there are hundreds of medical and other member organizations that represent employers of athletic trainers and other professional groups that collaborate with athletic trainers:

- American Academy of Orthopedic Surgeons
- American Academy of Pediatrics
- American Academy of Podiatric Sports Medicine
- American Association of Cheerleading Coaches and Administrators
- American Chiropractic Association's Council on Sports Injuries and Physical Fitness
- American College of Sports Medicine
- American Football Coaches Association
- American Medical Society for Sports Medicine
- American Medical Association, Orthopedic Section
- American Orthopaedic Society for Sports Medicine
- American Osteopathic Academy of Sports Medicine

Collegiate & Professional Sports Dietitians Association
Cook Children's Medical Center
ImPACT
National Academy of Neuropsychology
National Association of School Nurses
National Association of Secondary School Principals
National Athletic Trainers' Association
National Basketball Athletic Trainers Association
National Center for Sports Safety
National Cheer Safety Foundation
National Coalition for Promoting Physical Activity
National Collegiate Athletic Association
National Council of Youth Sports
National Interscholastic Athletic Administrators Association
National Sports Safety Organization
North American Booster Club Association
North American Society for Pediatric Exercise Medicine
Pop Warner Little Scholars
Professional Baseball Athletic Trainers Society
Professional Football Athletic Trainers Society
US Lacrosse
USA Football
United States Anti-Doping Agency
United States Olympic Committee
The West Coast Sports Medicine Foundation

In addition to the groups listed above, there are 290 organizations who have joined the Youth Sports Safety Alliance. These parent advocate groups, research institutions, professional associations, health care organizations, and youth sports leagues share a commitment to make America's sports programs safer for young adults including the prevention of catastrophic injuries and death in young athletes. All 290 of these organizations should be considered as advocacy groups representing California consumers ([link](#)).

9. IDENTIFY ANY CONSUMER POPULATIONS NOT NOW USING PRACTITIONER SERVICES LIKELY TO DO SO IF REGULATION IS APPROVED.

No additional consumer groups have been identified that will receive athletic training services due to this proposed regulation.

10. DOES THE APPLICANT GROUP INCLUDE CONSUMER ADVOCATE REPRESENTATION? IF SO, DOCUMENT. IF NOT, WHY NOT?

Yes, both the Commission on Accreditation of Athletic Training Education (CAATE) and the BOC, who share in a strategic alliance with the NATA (G1) and therefore indirectly

the CATA, have public members to ensure that the public's interests are served in the education and certification of athletic trainers (H1, I2, S2). In addition, the CATA has a strategic alliance with the consumer advocacy group Advocates for Injured Athletes ([link](#)).

The creation of an Athletic Training Licensing Committee under the California Board of Occupational Therapy would include public members to advocate for, and protect, the public's interests.

11. NAME ANY NON-APPLICANT GROUPS OPPOSED TO OR WITH AN INTEREST IN THE PROPOSED REGULATION. IF NONE, INDICATE EFFORTS MADE TO IDENTIFY THEM.

Non-applicant groups in favor of athletic training regulation are:

NCAA

NHL

San Francisco 49ers

AICCU (Association of Independent California Colleges and Universities)

NFHS (National Federation of State High School Associations)

CIF (California Interscholastic Federation)

CIF Commissioners:

- North Coast Section
- San Francisco Section
- Central Coast Section
- Central Section
- Southern Section
- Los Angeles Section
- San Diego Section

Los Angeles Unified School District

AMSSM (American Medical Society for Sports Medicine)

AOSSM (American Orthopaedic Society for Sports Medicine)

COPA (California Osteopathic Physicians Association)

COA (California Orthopaedic Association)

NATA (National Athletic Trainers' Association)

FWATA (Far West Athletic Trainers' Association)

CATA (California Athletic Trainers' Association)

CCCATA (California Community College Athletic Trainers' Association)

CAATE (Commission on Accreditation of Athletic Training Education)

BOC (Board of Certification, Inc.)

University of California, San Francisco (UCSF) Orthotic and Prosthetic Center

Play Safe (non-profit outreach program of UCSF Orthopaedics)

Providence Health and Systems

Barton Health System

Onsite Innovations (occupational healthcare service provider)

Beta Healthcare Group (healthcare/hospital liability insurance/risk management company)
DonJoy Global Inc. (brace manufacturer)
Breg Inc. (brace manufacturer)
San Diego State University
Cal Baptist University
Chapman University
University of the Pacific
USC (University of Southern California)
Southern California Intercollegiate Athletic Conference
Eric Paredes Save a Life Foundation
Advocates for Injured Athletes
College Athlete's Players Association

The California Board of Occupational Therapy is in favor of athletic training licensure and placement under their board. We are still working with them to refine the language.

The California Medical Board and the California Chiropractors Association have expressed interest in the regulation of athletic training and have not expressed concerns.

The Occupational Therapy Association of California and the California Academy of Physicians Assistants have no opposition to the licensure of athletic trainers but has concerns about the language (oppose unless amended).

The only non-applicant groups who have expressed opposition to the regulation of athletic training are the California Physical Therapy Association and the California Nurses Association.

Section C: Sunrise Criteria

This part of the questionnaire is intended to provide a uniform method for obtaining information regarding the merits of a request for governmental regulation of an occupation. The information you provide will be used to rate arguments in favor of imposing new regulations (such as educational standards, experience requirements, or examinations) to assure occupational competence.

Part C1 – Sunrise Criteria and Questions

The following questions have been designed to allow presentation of data in support of application for regulation. Provide concise and accurate information in the form indicated in the *Instructions* portion of this questionnaire.

**I. UNREGULATED PRACTICE OF THIS OCCUPATION WILL HARM OR
ENDANGER THE PUBLIC HEALTH SAFETY AND WELFARE**

**12. IS THERE OR HAS THERE BEEN SIGNIFICANT PUBLIC DEMAND FOR A
REGULATORY STANDARD? DOCUMENT. IF NOT, WHAT IS THE BASIS FOR
THIS APPLICATION?**

Yes, due to the alarming rise in injuries and lack of qualified athletic trainers present, there has been significant documented public demand for regulation of the athletic training profession in California. This support has been documented in a variety of ways:

- The public has sent thousands of letters in support of athletic training regulation.
- California news outlets including TV, radio, and newspapers have generated over 25 articles and interviews regarding the need for athletic training regulation in California in the first 10 months of 2017 alone (T). This includes a front-page article in the San Francisco Chronicle that summarizes the need for this regulation ([link](#)).
- The California non-profit advocacy groups Eric Paredes Save a Life Foundation, Advocates for Injured Athletes, College Athlete's Players Association are strongly in favor of the regulation of athletic training and representatives have testified in hearings expressing such support.
- In the last 2.5 years, the CATA has received 93 complaints from the public regarding actions by both certified and non-certified individuals practicing athletic training (V). This includes harm to the public with patients asking the association to initiate disciplinary action against athletic trainers. Of note, the CATA has no authority to investigate or otherwise act on such information.
- The BOC has documented cases and reports of athletic trainers practicing incompetently or unethically in California. Since 2014, the BOC has closed close to 1,831 cases nationally, including 178 disciplinary cases against athletic trainers with a California address. The causes of disciplinary action in the California cases range from recertification violations and practicing without a license in other states to sexual misconduct/criminal convictions (O3). Currently there are 9 athletic trainers residing in California who have had their BOC certification suspended, but there is no way the BOC can determine if they are still practicing in California (O3). Of note, the BOC has limited ability to investigate complaints against certified practitioners and no statutory authority to limit practice of offenders. In addition, the BOC has no authority to investigate or discipline non-certified individuals posing as athletic trainers.
- Participation in the national membership organization (NATA) is voluntary. Although it actively pursues complaints of unethical behavior by members, its sanctions are limited to suspension or revocation of membership. These sanctions have occurred in California but they do not impact the ability of members to continue to practice athletic training ([link](#)). In cases of egregious violations, it is the policy of NATA to forward the information to the state licensing agency, which of course does not exist in California.

- Inquiries to the NATA, the BOC, and the CATA from athletic trainers, employers, and regulators regarding the licensure status of practitioners in California indicate that there is a need for regulatory measures for athletic trainers in California.

Just as the state of California regulates the level of education and defines and sets minimal standards of practice for physical therapists, paramedics, emergency medical technicians, occupational therapists, and speech therapists, it is necessary to regulate athletic trainers. This application is also based on the accepted premise that evaluation, rehabilitation and prevention of injuries related to physical activity takes a required level of education and training to perform competently and safely. Athletic training is listed by the American Medical Association (AMA), Health Resources Services Administration (HRSA), the Department of Health and Human Services (HHS), and Centers for Medicare and Medicaid Services (CMS) (A1, AP1, [link](#)) as an allied health profession along with physical therapy, occupational therapy, and speech therapy. As noted in Question #11, numerous California and national physician associations, who also share the goal of protecting the safety and welfare of its members and the public, support athletic training licensure.

The state of California demands strict standards for medical professionals. This reduces the chance of incompetent persons making difficult and life-threatening decisions. Athletic training is the last allied health profession to be regulated by California, thus increasing the likelihood that unqualified, unethical or sanctioned individuals may be currently practicing athletic training and jeopardizing the safety and welfare of the public who seek services from an athletic trainer.

13. WHAT IS THE NATURE AND SEVERITY OF THE HARM? DOCUMENT THE PHYSICAL, SOCIAL, INTELLECTUAL, FINANCIAL OR OTHER CONSEQUENCES TO THE CONSUMER RESULTING FROM INCOMPETENT PRACTICE.

Athletic trainers evaluate and manage injuries sustained by physically active individuals such as concussions, joint dislocations, and fractures. They also work with athletes and other patients who are diabetic, asthmatic, or have cardiac issues or other underlying chronic health conditions in which the patient may suffer acute, life threatening episodes during participation in physical activity. The harms, unfortunately, have become too obviously evident. Often athletic trainers are the only health care personnel present at the time of injury or event. If they are not properly trained and qualified, or act incompetently, the consequences can be as severe as loss of limb, paralysis, permanent mental impairment or even death. The social, intellectual and financial implications to the individual, family and community can be substantial.

Harm to Young Athletes and the Public

- Nationally from 2008 - 2010, 372 young athletes died, including 41 in California, as a result of their participation in sports. These deaths were due to injuries and

illnesses that included: mild traumatic brain injury, severe heat illness, exertional sickling, sport-induced asthma, or sudden cardiac arrest – all during or immediately following sporting activity (AR).

- The public including young athletes are at risk from unqualified and non-certified individuals holding themselves out as athletic trainers. According to recent California Interscholastic Federation data, over 151 such individuals are currently practicing in California secondary schools on unknowing young athletes (X6). This includes giving medical advice to parents who incorrectly assume that the “athletic trainer” their school has hired is qualified to give such advice. Hundreds of thousands of student athletes come in contact with these individuals and unfortunately, albeit predictably, there are hundreds of documented cases of harm resulting to athletes under the care of these unqualified individuals (U2).
- The financial consequences for individuals who have had injuries or conditions unrecognized or mismanaged by unqualified practitioners can be significant. This can be very costly when surgical intervention is involved, especially when a minor intervention at an early time would avoid a more involved surgery later. For example, an isolated Anterior Cruciate Ligament (ACL) tear (which is somewhat common among physically active people across the age spectrum) reconstructive surgery performed at the University of California, San Francisco (CPT 29882) costs on average \$4,635. If this injury goes unrecognized by an unqualified individual acting as an athletic trainer and the athlete returns to sport and suffers another injury to the knee because of the lack of an ACL and tears their meniscus, the athlete would then need an additional meniscus repair. The cost for both an ACL reconstruction (CPT 29882) and a Meniscus Repair (CPT 29882) results in a total average cost of \$7,959 for an average increase cost of \$3,324 that could have been avoided (Z). Often times, appropriate early treatment can even help avoid an expensive surgical intervention altogether as may be the case for severe ankle sprains, stress fractures of the foot or ankle, or distal radius fractures just to name a few.
- Other financial consequences for individuals who have had injuries or conditions unmanaged or mismanaged by unqualified practitioners are more difficult to quantify. What is the total cost of a lifetime of medical and supportive care to a 16 year-old that ends up as a quadriplegic as the result of a bad decision by an incompetent provider at \$72,000/year ([link](#)).
- How do you put a price on the mental anguish to family and friends of a 17-year-old who was cleared to play by an unqualified provider too soon after sustaining a concussion, and then sustains a second blow to the head resulting in death or permanent cognitive disability? What are the costs to the health care system of a young athlete who suffered heat illness and was not treated appropriately on the field, and then spent weeks in the intensive care unit before dying?
- To contrast, how much financial cost and emotional suffering was saved by a certified athletic trainer standing her ground and insisting that a 17-year old lacrosse player in San Diego not be moved from the field but rather be spine boarded and sent to the hospital via ambulance? In this case, the athletic trainer suspected a cervical spine injury, even though all around her, including a physician, felt that there was nothing wrong with his spine. This athlete had in

fact suffered a C1-C2 comminuted cervical spine fracture that would likely have resulted in death if he had been allowed to stand and walk off the field ([link](#)).

- Research includes the consequences of mismanaged concussions by allowing athletes to return to play too soon. The emotional and social toll to these players, their children, spouses and other family and friends is incalculable. There is also a physical toll that results in intellectual disabilities, premature dementia and/or severe depression leading to suicide, among other effects. (AQ2).
- There are other examples of significant consequences as a result of incompetent practitioners (AJ2). According to the US Department of Labor Division of Practitioner Data Banks, a voluntary repository of malpractice claims in 2000-2014 indicated that there were cases of athletic trainers successfully sued for “failure to diagnose” or “failure/delay in hospital admission” that resulted in “significant permanent injury” or “major temporary injury”. We know of several other cases that are still working their way through the court system.
- In addition to malpractice claims there are documented cases of sexual misconduct by practitioners, including rape, child abuse and inappropriate sexual contact with patients which will be described in Question #14. These cases often result in irreparable emotional distress to their victims that may also lead to severe depression requiring ongoing costly therapy. This is compounded by the emotional and/or financial damage these incidents have on the victim’s families and friends.
- Incredibly, consumers are denied choice in providers as some employers are firing or not hiring athletic trainers due to liability concerns over the legal gray area unlicensed athletic trainers currently work under in California.

Athletic trainers are responsible for making a myriad of medical decisions, including life or death decisions regarding acute injuries and conditions in the course of their duties. As they are often the only health care provider present in the crucial minutes that will make the difference between survival or a tragic outcome, they must use sound clinical decision making skills and the entirety of their knowledge and training. They also make regular decisions regarding return to activity, referral and treatment. If an athletic trainer who reduces a dislocated shoulder improperly can cause nerve damage and paralysis to that arm. This combination of life threatening injuries, complex decision making requirements that must be made in an instant and the potential for death or long term consequences (hospitalization, ongoing medical treatments, counseling/therapy, prosthetics/wheel chairs or other devices, etc.) make both the nature and severity of physical, social, emotional, intellectual and financial harm due to incompetent practice very high.

A combination of the lack of mandatory reporting, the fact that civil settlements are often sealed, and insurance companies not reporting claims information on specific cases make quantifying harm difficult. However, there is no doubt that it is substantial, potentially millions of dollars per incident.

Harm to Employers of Athletic Trainers

Organizations and individuals who hire athletic trainers are often hamstrung because California is the only state not to regulate athletic trainers:

- California has increased the role and responsibility that schools and organizations have for managing concussions. As the law is currently written, athletic trainers are barred from specific components of concussion management, including supervision of “return to activity protocols,” even though athletic trainers are typically the most available and most qualified individuals to do so (C1). The sole reason for this egregious and dangerous situation is because athletic trainers are not licensed in California.
- In some institutions in California, athletic trainers are barred from looking at, or entering into, patient electronic medical records because of their non-licensed status, which obviously compromises the care they, and other members of the healthcare team, provide.
- Licensure of healthcare professions like athletic training is imperative to provide clarity on the limits of the responsibilities that can be delegated to them. Without a clearly delineated scope of practice and the surety of state law that is part of licensure, the businesses and educational institutions that hire athletic trainers are at risk of increased liability.
- Athletic trainers in many settings are required to travel as part of their job. An increasing number of states require athletic trainers to be licensed in their home state when they travel to care for their athletes/performers in another state (B6). The unintended consequence of being the only state in which the licensure of athletic trainers is not required, is that California athletic trainers cannot meet this standard. This places employers in the untenable situation of choosing between compromising the care of their athletes/performers by having to contract out to a local athletic trainer, who does not know the individuals they are treating, or increase their liability by sending their unlicensed athletic trainer to practice in a state requiring licensure.

Harm to Athletic Trainers

- Without a state defined scope of practice created by licensure, the legal grey area that surrounds the employment of athletic trainers increases the athletic trainer’s personal liability. The lack of licensure also impedes the ability of athletic trainers to fully provide the care that they are qualified to provide.
- Athletic trainers in addition to their employers are at increased risk for liability when traveling with their team across state lines due to the unlicensed status of the profession in California. An increasing number of states require athletic trainers to be licensed in their home state when they travel to care for their athletes/performers in another state (B6).
- There is an increasing recognition and concern on the part of employers about the unlicensed status of athletic trainers. In some instances, solely because of these concerns, employers have had to fire or demote athletic trainers. The financial impact of this on the athletic trainer in a state like California is particularly significant.

- There are 14 accredited athletic training education programs in California including 7 California State Universities ([link](#)). The lack of licensure undercuts taxpayer education because anyone can call themselves an athletic trainer which takes jobs away from graduates in these programs.

14. HOW LIKELY IS IT THAT HARM WILL OCCUR? CITE CASES OR INSTANCES OF CONSUMER INJURY. IF NONE, HOW IS HARM CURRENTLY AVOIDED?

There is a forbidding consequence when we fail to regulate a profession like athletic training. All states that regulate athletic training are mandated to report their disciplinary actions and malpractice settlements. Without a regulatory board in California there is no mechanism for consumers and employers to ensure athlete trainers coming in from other states to practice have not been sanctioned and more importantly there is no mechanism for California consumers to report harm.

The survey referenced in the answer to Question #4 asked whether the respondents knew of instances of harm as the result of improper care due to both certified athletic trainers and unqualified individuals acting as athletic trainers. Of the 760 respondents, there were reports of 400 instances of harm. Of those that provided details, there were 20 discrete instances of harm due to improper care by a certified athletic trainer. Excluding care provided by other health care professions, there were over 60 other cases of harm as the result of improper care provided by unqualified individuals acting as athletic trainers (U2).

In 2015 the CATA began offering anonymous reporting of harm on the association website. The CATA has received 93 complaints from the public regarding actions by both certified and non-certified individuals practicing athletic training. This includes harm to the public with patients asking the association to initiate disciplinary action against athletic trainers (V).

Due to the nature of the injuries and conditions that athletic trainers are responsible for managing, there is a very real potential of harm. According to the US Department of Labor Division of Practitioner Data Banks (AJ1), a reporting repository for sanctions made by state boards, there were 590 reports of sanctions to athletic trainers between 2000 and 2014. Some of these sanctions were for conduct including incompetent practice/harm, practicing beyond the scope of practice and sexual misconduct. However because this is a voluntary database it likely underestimates sanctions and harm. The BOC reported over 1,800 violations of professional practice standards since 2014 with 178 in California including sexually based offenses (O3).

There are also instances of harm that resulted in lawsuits and malpractice claims against athletic trainers. The US Department of Labor Division of Practitioner Data Banks has a list of voluntary reports of malpractice payment claims against athletic trainers. There are 11 reports between 2000 and 2015 for reasons including improper technique, delay in care, failure to diagnose, and failure to recognize a complication

(AJ). However as this is a voluntary database, it likely underestimates claims. We also identified at least 5 other cases that were filed, settled, or reached a verdict in 2011 alone (E). These cases involved 3 deaths and the sequelae of a back injury and concussions. We also noted another case in 2011 of a death of a collegiate athlete resulting in the firing of a collegiate athletic trainer, although no lawsuit has been filed to date. Two additional athletic trainers were fired after being arrested on sexual crime charges.

Looking farther back, two attached memorandum from law firms identify a combined 20 other cases involving harm as the result of actions taken by athletic trainers (Analysis of Potential Harm - Hughes Luce (AH3), Athletic Trainers Legal Duties - Thorpe, Reed & Armstrong) (AU). While cases as far back as 1982 are noted, as well as cases related to the unavailability of athletic trainers, in the decade between 1992 and 2002, over 20 cases of athletic trainer caused harm were reported. This information also underestimates the issue of harm as some cases are not reported publically and some cases get resolved prior to a lawsuit being filed.

Most telling however is that despite 49 states and the District of Columbia having regulation for athletic training, no athletic training board has ever been sunset.

15. WHAT PROVISIONS OF THE PROPOSED REGULATION WOULD PRECLUDE CONSUMER INJURY?

Licensure will protect California consumers and athletic trainers. There are a number of specific provisions that will also preclude consumer injury from occurring. It would establish education and certification requirements for the practice of athletic training both for initial licenses and continued competence for license renewal. It would enact a state defined scope of practice and create a mechanism for disciplining incompetent practitioners.

The establishment of licensure for athletic trainers will expand consumer protection by allowing athletic trainers who are the most available health care professional to manage concussions including supervision of "return to activity protocols". As discussed earlier athletic trainers are barred from providing care for concussions solely because state statute requires licensure (AD). It will also allow athletic trainers to access medical records that some institutions do not allow because of the unlicensed status in California. This will improve patient care and safety.

The educational system for athletic training has been standardized and accredited by a national accreditation agency, the Commission on Accreditation of Athletic Training Education (CAATE) (S1). CAATE is nationally accredited by the Counsel for Higher Education Accrediting (CHEA) which sets educational standards for health care professionals such as physical therapists, physicians assistants, pharmacists, podiatrists, chiropractors, and optometrists (W, AB14). All states currently regulating athletic training utilize the BOC certification examination-which is based on CAATE

educational competencies. The proposed regulation will require this standard as well. The establishment of educational standards for athletic training practitioners will ensure that those making decisions required of athletic trainers have the requisite preparation and training to do so competently.

The proposed regulation would also require individuals to hold a national certification offered by the BOC. The BOC is currently the only entity that offers athletic training certification. The BOC is nationally accredited by the National Commission of Certifying Agencies (NCCA), which sets standards for excellence for certification programs and accredits other medical professionals including nurse practitioners, occupational therapists, physician assistants, optometrists, and respiratory therapists (AL2). The processes to attain certification and determination of certification standards are thoroughly described in detail in the BOC Candidate Handbook (K5-34).

Nationally, BOC certification is considered the benchmark for qualified athletic training practice, but without regulation it is not a requirement in California. The proposed regulation would ensure that only those who have demonstrated sufficient knowledge and skill to have attained BOC certification will be able to practice athletic training. Those who are unqualified, i.e. uneducated, uncertified and/or disciplined will be barred from doing so. This will protect young athletes who currently are being unknowingly exposed to harm caused by unqualified individuals posing as athletic trainers in California.

Currently, athletic trainers in California do not have a state defined guide for their practice. Enacting a state defined scope of practice will clarify what services athletic trainers may and may not provide. This will ensure that athletic trainers do not provide services outside of their training and education, which will limit the risk of public harm. It also protects athletic trainers and their employers from unnecessarily increased liability. Creation of a scope of practice will also remove the legal grey area that surrounds the employment of athletic trainers, thereby decreasing the liability to athletic trainers and those that employ them.

Again, there is no mechanism for the public to file complaints against illegal, incompetent, or unethical behaviors and have them investigated and if appropriate have sanctions levied. The proposed legislation would establish an Athletic Training Licensing Committee under the California Board of Occupational Therapy whereby the public would have the ability to file a complaint. The committee would also have the ability to investigate these complaints and have the power to levy appropriate sanctions for those found guilty. The committee would be able to address those individuals who are practicing athletic training without a license.

II. EXISTING PROTECTIONS AVAILABLE TO THE CONSUMER ARE INSUFFICIENT

16. TO WHAT EXTENT DO CONSUMERS CURRENTLY CONTROL THEIR EXPOSURE TO RISK? HOW DO CLIENTS LOCATE AND SELECT PRACTITIONERS?

The overwhelming majority of consumers who access athletic training services have no choice in what provider they utilize and therefore cannot mitigate risk.

Institutions hire athletic trainers to provide services for their constituents or clients. For example, college and high school athletic programs hire athletic trainers to provide medical services for their student-athletes. The same scenario exists in professional sports, the military, industrial settings, hospital systems, and performing arts arenas such as Disneyland providing services to its cast members. These student-athletes, employees, and performers have to utilize the athletic trainers provided by that institution. These individuals and their parents rely on the employers and institution to provide qualified practitioners and without licensure there is no mechanism to ensure that this is done.

According to CIF data, there are over 151 uncertified individuals holding themselves out as athletic trainers and providing care to young athletes (X6). In this situation most, if not all parents, athletes, and coaches are unaware that their practitioner is unqualified and are therefore not afforded the ability to control their risk.

In many settings, including middle and high schools, the athletic trainer may be the only health care professional on site. In these situations, there would be no other individual present to make a judgment about whether the athletic trainer is practicing competently. This is different from hospitals, clinics and even physicians' offices where multiple health care professionals may be employed and where professional behavior and judgment may be observed. Furthermore, unqualified individuals in the high school setting are much less likely to have the physician oversight that is required of certified athletic trainers. Physicians are not willing to oversee an uncertified individual.

Only in very limited instances can the public select an athletic training practitioner. If a rehabilitation clinic employs an athletic trainer to provide rehabilitation services to outpatient clients, the public may (if insurance allows) choose their own clinic and potentially their specific provider. However, the number of rehabilitation clinics who employ athletic trainers versus the number of rehabilitation clinics without athletic trainers is very small. The number of patients seen by these practitioners on a daily basis is typically significantly less than those in the other settings. Even in these settings, insurance dictates which clinics may be utilized, leaving consumers without a choice in provider.

17. ARE CLIENTS FREQUENTLY REFERRED TO PRACTITIONERS FOR SERVICES? GIVE EXAMPLES OF REFERRAL PATTERNS.

Clients typically access athletic training practitioners directly. For example, an injured athlete, soldier, police officer or assembly line worker will be directed by a supervisor or “self-refer” to the institution’s athletic trainer for services such as injury prevention, evaluation, treatment, or rehabilitation. In cases of acute injury, the athletic trainer responds to the patient when notified of the injury. These are not referrals in the traditional sense, as no other health care professional is involved. This differs from “direct access” as athletic trainers are required to work under the direction of a physician and will collaborate with them on patient care.

Other health care practitioners may refer patients to athletic trainers for services. Physicians and physical therapists refer their patients to athletic trainers for rehabilitation programs and/or return to activity progression.

18. ARE CLIENTS FREQUENTLY REFERRED ELSEWHERE BY PRACTITIONERS? GIVE EXAMPLES OF REFERRAL PATTERNS.

Athletic training is not a stand-alone profession as certified athletic trainers work under the direction of and in collaboration with physicians. Practice is predicated upon a formalized relationship with a physician and athletic trainers work under guidelines established by their physician. Athletic trainers utilize professional decision-making authority within the parameters provided by the physician.

Certified athletic trainers work as a part of a health care team. They commonly refer to other health care professionals, reflecting best practices. Most referrals are made to the directing physician or to a patient’s primary care physician. Referrals are also made to other physicians and health care providers in appropriate specialties. Examples of these specialists include, but are not limited to, physical therapists, chiropractors, dentists, occupational therapists, nutritionists, psychologists and podiatrists. Currently these standards are not mandated and noncertified individuals in particular would not follow these guidelines. The proposed legislation would require that any injury or condition presenting outside of an athletic trainer’s education or preparation must be referred to a physician or appropriate specialist.

19. WHAT SOURCES EXIST TO INFORM CONSUMERS OF THE RISK INHERENT IN INCOMPETENT PRACTICE AND OF WHAT PRACTITIONER BEHAVIORS CONSTITUTE COMPETENT PERFORMANCE?

Unfortunately, as the media has highlighted in numerous stories (T), California is the only state that does not have an athletic training regulatory agency which would allow the public access information regarding incompetent practitioners.

20. WHAT ADMINISTRATIVE OR LEGAL REMEDIES ARE CURRENTLY AVAILABLE TO REDRESS CONSUMER INJURY AND ABUSE IN THIS FIELD?

Currently, there are no significant administrative remedies to redress consumer injury in the state of California. Neither the CATA or the NATA, as professional advocacy organizations, have the ability to investigate or sanction incompetent practice. While the BOC may open an "investigation", it has limited investigative power, cannot subpoena testimony, and has no statutory authority to discipline incompetent practitioners in California. Civil litigation would likely be the only option to address consumer injury or abuse.

21. ARE THE CURRENTLY AVAILABLE REMEDIES INSUFFICIENT OR INEFFECTIVE? IF SO, EXPLAIN WHY.

The current remedies in California are ineffective. In other states, issues of competence are typically addressed by the BOC only after discipline has been handed out by state licensing boards. Due to the lack of a state athletic training licensing board, these protections do not apply to California consumers.

The BOC may open an "investigation" but it has limited investigative power, cannot subpoena testimony, and has no statutory authority to discipline incompetent practitioners in California. Regardless of the outcome of any investigation by the BOC, the results would not impact Californians because certification is not currently mandatory to practice athletic training in the state. Additionally, non-certified individuals are not subject to any discipline/sanctions and are freely able to practice in California.

The remedy of civil litigation against an individual or institution is too late if a consumer suffers a life-altering injury or dies. Also, it would not prevent an individual from practicing in the state subsequent to a verdict of negligence. It is also only available to those with the means to hire a lawyer and take a financial risk to file a lawsuit.

III. NO ALTERNATIVES TO REGULATION WILL ADEQUATELY PROTECT THE PUBLIC

22. EXPLAIN WHY MARKETPLACE FACTORS WILL NOT BE AS EFFECTIVE AS GOVERNMENTAL REGULATION IN ENSURING PUBLIC WELFARE. DOCUMENT SPECIFIC INSTANCES IN WHICH MARKET CONTROLS HAVE BROKEN DOWN OR PROVEN INEFFECTIVE IN ASSURING CONSUMER PROTECTION.

Athletic trainers are not stand-alone health care professionals and therefore do not own their own facilities and the general public typically cannot exercise choice when accessing athletic training services. As a result, the consumer access to athletic trainers and athletic training services is typically determined by the employer or educational institution and is not made by individual choice. When a high school or

college athlete is injured on the field, they are evaluated and treated by the athletic trainer that has been hired by the school. If employees at the Gallo bottling plant or Disneyland sustain an injury, the treatment and rehabilitation is provided by the company's athletic trainer.

There are unqualified individuals currently practicing in California because marketplace factors are ineffective in ensuring public safety. Without government regulation, job descriptions for athletic trainers in educational settings are inconsistent. This allows employers to hire anyone, even those without the proper education and certification, as an athletic trainer. In the California community college setting there are at least 2 people practicing as athletic trainers who are not certified and have not completed an accredited athletic training education program. There are at least 151 individuals practicing as athletic trainers at California high schools and are not certified and are therefore unqualified (X6). The reasonable assumption by athletes, parents, and coaches is that the athletic trainer provided by the school is qualified even though this may not be the case. This puts consumers at risk as they unknowingly heed the medical advice and recommendations from unqualified "athletic trainers".

As previously described in Question #14 there are a substantial number of reports of harm to the public because marketplace factors are ineffective. Due to the lack of a board and the reporting mechanism that is provided with government oversight, reports of harm to the public is more anecdotal, and therefore underreported.

Cases exist where athletic trainers from other states have had their licenses revoked and came to California because they were able to continue practicing despite disciplinary action they faced (O). This is also likely underestimated. It is difficult to track individuals who lose their license in another state and come to California to practice because there is no regulatory board to validate credentials of individuals applying for licenses.

The ineffectiveness of the marketplace to protect the public is further validated by the fact that every other state and the District of Columbia regulate the athletic training profession.

23. ARE THERE OTHER STATES IN WHICH THIS OCCUPATION IS REGULATED? IF SO, IDENTIFY THE STATES AND INDICATE THE MANNER IN WHICH CONSUMER PROTECTION IS ENSURED IN THOSE STATES. PROVIDE, AS AN APPENDIX, COPIES OF THE REGULATORY PROVISIONS FROM THESE STATES.

Forty-nine other states and the District of Columbia currently have statutory regulation of the athletic training profession ensuring consumer protection ([link](#)). In 44 states this regulation is termed licensure. In five states their statutes have all the characteristics of licensure including title protection, scope of practice and a regulatory board/agency with investigation/disciplinary powers but is called registration or certification. West Virginia

has registration which includes title protection and investigation/discipline but no scope of practice.

24. WHAT MEANS OTHER THAN GOVERNMENTAL REGULATION HAVE BEEN EMPLOYED IN CALIFORNIA TO ENSURE CONSUMER HEALTH AND SAFETY. SHOW WHY THE FOLLOWING WOULD BE INADEQUATE:

Various voluntary organizations such as the California Community College Athletic Association, the BOC, CATA, and the NATA have developed codes of ethics, standards of practice guidelines, etc., but they are ineffective due to their voluntary nature and the fact that there is no mandate that employers recognize them or their decisions. The lack of investigative and enforcement power coupled with the absence of statutory recognition of BOC certification, leaves the public with no protection. As described previously, individuals that have had their license in another state or BOC certification revoked have practiced in California due to the fact that there is no statutory regulation to prohibit this from occurring.

- a. **code of ethics** – Voluntary membership with NATA, maximum penalty expulsion from member organization (Y1-3). Violation/discipline would still mean the individual would be able to practice in California.
- b. **codes of practice enforced by professional associations** – Embedded in the BOC Standards of Practice (N1-3). Violation/discipline would still mean the individual would be able to practice in California.
- c. **dispute-resolution mechanisms such as mediation or arbitration** – No dispute-resolution mechanism known.
- d. **recourse to current applicable law** – There is no current law regarding the practice of athletic training in California.
- e. **regulation of those who employ or supervise practitioners** – There is no employer regulation in California that would ensure consumer health and safety. There is no current mandate that athletic trainers must work under the direction or in collaboration with a physician or health care provider.
- f. **other measures attempted** – No other measures attempted.

25. IF A “GRANDFATHER” CLAUSE (IN WHICH CURRENT PRACTITIONERS ARE EXEMPTED FROM COMPLIANCE WITH PROPOSED ENTRY STANDARDS) HAS BEEN INCLUDED IN THE REGULATION PROPOSED BY THE APPLICANT GROUP, HOW IS THAT CLAUSE JUSTIFIED? WHAT SAFEGUARDS WILL BE PROVIDED CONSUMERS REGARDING THIS GROUP?

A grandfather clause was added to the legislation as a compromise with the California Federation of Teachers. The exemption was narrowly constructed so that it includes only a small group of individuals. It would not confer licensure but would allow those who have been working for 20 consecutive years to call themselves an athletic trainer and practice for 3 years after the onset of regulation, and then expire. This will allow those who have been practicing in California time to meet the requirements for licensure

if they so choose. Public safety will be protected as they will not be granted the title of Licensed Athletic Trainer. These individuals will also be subjected to all other components of the licensure measure as would a fully licensed athletic trainer including scope of practice, continuing education, discipline, and physician direction.

IV. REGULATION WILL MITIGATE EXISTING PROBLEMS

26. WHAT SPECIFIC BENEFITS WILL THE PUBLIC REALIZE IF THIS OCCUPATION IS REGULATED? INDICATE CLEARLY HOW THE PROPOSED REGULATION WILL CORRECT OR PRECLUDE CONSUMER INJURY. DO THESE BENEFITS GO BEYOND FREEDOM FROM HARM? IF SO, IN WHAT WAY?

The licensure of athletic trainers will significantly decrease risk of harm to the public.

- A state defined scope of practice will protect public safety by ensuring that athletic trainers only work within the confines of their education and training. It also requires that licensed athletic trainers are rendering treatment under the direction of or in collaboration with a physician, surgeon, or osteopathic physician or surgeon which also protects the public. Currently this athletic trainer physician relationship is not required.
- Protecting the title of athletic training will provide assurance that only those qualified to provide athletic training services are calling themselves athletic trainers. Most importantly, this bill will require licensees to have gone through a rigorous educational and certification process to prove competence before practicing as an athletic trainer in California. Furthermore, it will define who can apply for a license and disqualifies individuals who have been convicted of a felony or other crime that substantially relates to the functions or duties of an athletic trainer.
- Enforcement is the linchpin of the proposed regulation. This regulatory bill will create the Athletic Training Licensing Committee to investigate complaints about athletic trainers such as unprofessional conduct, violation of the licensing chapter, and impose suspensions, revocations, or probationary conditions. Without investigation and enforcement, the other provisions of regulation are rendered void as the status quo will still be in effect. As a total package the proposed regulation would ensure that only those that are sufficiently trained and demonstrated competence would be able to make the medical decisions required of athletic trainers.
- Licensure would also decrease harm by allowing athletic trainers, the health care provider most highly trained and available to manage concussions to supervise return-to-play protocols and other components of concussion management. Current statute requires that only licensed healthcare providers trained in the management of concussions be involved in concussion intervention precluding the athletic trainer.

Although decreased harm is the paramount reason for, and effect of regulation, it is not the only benefit that will be realized with implementation of the proposed regulation. Employers of athletic trainers and athletic trainers will benefit from the proposed regulation for a number of reasons:

- Employers of athletic trainers will benefit from having a state defined scope of practice. Currently they have little guidance on hiring and the scope of practice of athletic trainers and because of this California athletic trainers are practicing in a legal grey area.
- Employers of healthcare facilities will benefit from having clear legal protection necessary to allow athletic trainers to interact with other health care professionals and view/enter information into medical records. This will increase patient safety and quality of care and decrease their liability.
- Companies have become interested in hiring athletic trainers due to the potential for significant savings in health care dollars and worker's productivity ([link](#)). The CATA has had numerous inquiries from employers who are interested in hiring athletic trainers but are hesitant due to the lack of regulation in the state. In health care settings such as hospital systems and rehabilitation clinics, athletic trainers are often the only professionals that are not licensed. This lack of certainty creates an increased risk in the employers' liability.
- Employers of athletic trainers in collegiate and professional sports and performing arts, who send their employees to travel outside of the state will decrease their liability. The Assembly Committee on Arts examined this issue and found that 14 states do not accept BOC certification or title protection for athletic trainers traveling into their states with their teams or organizations. Included in these states are Hawaii, Arizona, Utah, Alaska, Texas, Massachusetts, Virginia and Arkansas (B6). In June 2017, Georgia joined that list when they passed a bill requiring out of state athletic trainers to be licensed in their home state when traveling to Georgia (AG1-2). The passage of licensure will decrease the risk of liability for these employers.
- Athletic trainers will benefit from licensure because individuals are being demoted or are losing jobs due to a lack of state defined scope of practice and licensure.
- Certified athletic trainers, many of whom are educated in tax-payer funded institutions in California, will no longer lose job opportunities to unqualified individuals.

We believe that there would also be benefit to California businesses, and government agencies and programs with athletic training licensure. Savings for state and local governments as well as industry, are more common in other states as they are more likely to employ athletic trainers. This is due, at least in part, to the unregulated status of the athletic training profession in California.

- A Sports Medicine Department on a large UC campus created a program for delivering part-time athletic training services to 20 local high schools. A majority of these schools are receiving athletic training/sports medicine care for the first

time. This program is staffed by 15 athletic trainers who are supported by 9 primary care sports medicine and orthopedic physicians. The impact and reach of the program is evident in the number of athletes this program has serviced. Collectively during the 2015-16 athletic season, the athletic trainers evaluated 3,239 injured athletes and performed over 10,110 athletic training room clinic procedures (AW1-2). Many of these athletic training evaluations and treatment procedures may have otherwise been seen in local hospitals and clinics, impacting health care premiums and the medical system.

- Local and state governmental entities, via Medi-Cal and other insurance costs, can see budgetary savings as a result of employing athletic trainers. Team Heal, a program founded by Dr. Clarence Shields, M.D. of the Kerlan-Jobe Clinic, provides athletic trainers to a few Los Angeles city high schools. Approximately 80.8% of the students at these schools are eligible to receive free or reduced fee lunches and the number of these students that are on Medi-Cal should be similar (AI1-2). In 2015-2016 there were 4,917 treatments for 676 injuries and in 2016-17 there were 3,722 treatments for 621 injuries. Given the high percentage of these students that are covered by Medi-Cal, many of these injuries and treatments would have ended up costing that system.
- Similar savings can be seen with public safety academies and departments. California does not have many, if any athletic trainers working for police or fire departments, likely based in part due to the regulatory status of the profession. The Department of Justice and cities and departments (as well as the military) throughout the country have athletic trainers taking care of the medical needs of their recruits, officers, firefighters and agents. Savings to the worker's compensation system can be in the hundreds of thousands of dollars in direct treatment savings to local municipalities. This also does not take into account cost savings of decreased utilization of other specialties and decreased lost time (AO).
- Regulation of the athletic training profession may make employers in settings such as industry/manufacturing more likely to hire athletic trainers, which can result in large savings in the worker's compensation, Medi-Cal and private health care systems. A national provider of athletic training services to industrial corporations reports that a larger manufacturing client (3,000 employees) in California saved \$7 million dollars annually in worker's compensation costs by hiring 5 athletic trainers. They state that this is fairly typical for their clients and that their clients who use athletic trainers in a preventive role see an even higher savings. A Las Vegas performing arts company with 90 performers realized a savings of over \$700,000 in workman's compensation costs by employing athletic trainers. These savings do not take into account additional savings due to decreased lost work time or increased worker productivity. As noted previously many employers have been hesitant to hire athletic trainers, or have even fired/demoted athletic trainers due to lack of licensure.

27. WHICH CONSUMERS OF PRACTITIONER SERVICES ARE MOST IN NEED OF PROTECTION? WHICH REQUIRE LEAST PROTECTION? WHICH CONSUMERS WILL BENEFIT MOST AND LEAST FROM REGULATION?

Due to the nature of the medical decisions made by athletic trainers on a regular basis, all consumers of athletic training services are in need of protection from uneducated, unqualified, and incompetent providers. Most consumers are required to see the specific athletic training practitioner provided by the institution without consultation from the consumer and they do not have the ability to research and choose their own provider.

The most vulnerable consumers are the high school and college athletes, as athletic trainers in those settings are required to make more potentially life-altering decisions. In the high school setting, athletic trainers typically are the only health care professional and students are less likely to question an adult in a position of authority. These students have less knowledge with which to develop questions to determine appropriateness of care and parents are not typically present as they are when their child visits the pediatrician. There are also more documented unqualified practitioners in the high school setting than in other settings (X6). This affects hundreds of thousands of young athletes. Regulation will ensure that the most vulnerable Californians are being treated by qualified, competent and ethical practitioners.

Additionally, statute regarding management of concussion in secondary schools mandates that only licensed health care providers, trained in the management of concussions determine the status of a high school athlete suspected of sustaining a concussion (C1). This lack of licensure prevents athletic trainers, the health care provider most available and qualified to manage these injuries including direct supervision of physical activity and sport progressions from doing so.

While still seeing benefits and protection from licensure, consumers who access athletic training services in a rehabilitation setting are least likely to significantly benefit from regulation because other health care professionals are present.

28. PROVIDE EVIDENCE OF “NET” BENEFIT WHEN THE FOLLOWING POSSIBLE EFFECTS OF REGULATION ARE CONSIDERED:

Due to the risk to the public from incompetent practice, up to and including death, there is a significant “net benefit” to the regulation of athletic training no matter which of the following issues, individually or collectively, are considered.

- a. RESTRICTION OF OPPORTUNITY TO PRACTICE – Only unqualified individuals will be barred from practicing. Due to the potential serious health and financial consequences due to incompetent practice, the risk of such practice far outweighs any restriction of practice opportunities. Many people wish to become physical therapists, chiropractors, occupational therapists, respiratory therapists

etc., but due to the potential consequences of a mistake, the state regulates those professions. While similar to these professions, athletic trainers often need to make quick decisions under pressure and in emergency situations, the need to mandate a minimum level of competence is even greater. The minimum qualifications under the proposed legislation are the same as the rest of the country. Most of the individuals currently practicing athletic training already meet or exceed the standards proposed by this bill.

Implementing licensure will therefore provide a net benefit to the public, employers, and athletic trainers because of decreased harm.

- b. RESTRICTED SUPPLY OF PRACTITIONERS – This is not an issue. There are nearly 350 accredited programs throughout the country, including 14 in California. In 2016, 3,878 individuals completed an accredited program and were certified as athletic trainers nationally (Q). In the past four years an average of 215 Californians were certified as athletic trainers. This number has been consistently growing and in 2016, 255 Californians became certified (P). Historically the supply of athletic trainers has kept pace with available jobs, both nationally and in California. Based upon an informal survey of other state athletic training associations, we know of no other states where the supply of athletic trainers was negatively impacted due to licensure.

Implementing licensure will therefore provide a net benefit to the public, employers, and athletic trainers because there are plenty of providers available to meet demand.

- c. INCREASED COSTS OF SERVICE TO CONSUMER – No effect anticipated. Consumers do not pay directly for services and in most cases, the employment of an athletic trainer saves the employer money in reduced insurance, workman's compensation, lost work/school days and other related costs.

Implementing licensure will therefore provide a net benefit to the public, employers, and athletic trainers because there will be no increased cost to the consumer.

- d. INCREASED GOVERNMENTAL INTERVENTION IN THE MARKETPLACE – The athletic training profession is not inherently part of a traditional free-market system. It does not typically compete with other professions in the health care arena and as such, this government intervention will not impact the health care marketplace.

Implementing licensure will therefore provide a net benefit to the public, employers, and athletic trainers because athletic trainers are not part of the traditional free market system.

V. PRACTITIONERS OPERATE INDEPENDENTLY, MAKING DECISIONS OF CONSEQUENCE

29. TO WHAT EXTENT DO INDIVIDUAL PRACTITIONERS MAKE PROFESSIONAL JUDGMENTS OF CONSEQUENCE? WHAT ARE THESE JUDGMENTS? HOW FREQUENTLY DO THEY OCCUR? WHAT ARE THE CONSEQUENCES? DOCUMENT.

Athletic trainers are health care providers and as a result, they must make medical decisions during the course of each workday. They always work under the direction of or in collaboration with a physician, but may not be directly supervised by a physician at all times. Athletic trainers evaluate injuries and determine the patient's disposition, respond to emergencies and make decisions regarding the management of an injury, make decisions regarding the course of rehabilitation and must modify programs based on patient response on a daily basis.

Athletic trainers also make immediate decisions regarding serious conditions such as concussion, spinal cord injury, heat illness and sudden cardiac arrest, without the intervention or advice of other health care providers. In all of these instances, an incorrect decision could lead to a catastrophic or fatal outcome for the patient. Athletic trainers also work with individuals who have co-morbidities such as sickle cell trait, asthma, diabetes and epilepsy, in which timely interventions may be required in response to an acute attack. In addition to injury or illness, athletic trainers are educated to recognize and intervene with psychological issues that may affect the wellbeing of the individual. Examples include: disordered eating, chronic fatigue syndromes, performance enhancing drug dependence, and nutrition concerns. By being able to judge the warning signs associated with these psychological issues, illnesses and injuries can be prevented.

Due to the nature of the injuries and illnesses that athletic trainers are faced with, consequences can be severe. Incorrect actions can lead to loss of limb, decreased cognitive function, long-term disability, and loss of life. Harm and consequences were previously described in detail in Questions #13 and #14 (O3, U2, V, X6, AJ, AR).

30. TO WHAT EXTENT DO PRACTITIONERS WORK INDEPENDENTLY (AS OPPOSED TO WORKING UNDER THE AUSPICES OF AN ORGANIZATION, AN EMPLOYER OR A SUPERVISOR)?

Athletic trainers do not typically own their own businesses, but are employed by educational institutions, professional sports and performing arts groups, the armed forces, police/fire departments, manufacturing/industry and health care facilities; some of which may be shielded from liability in cases of athletic trainer wrong doing. While athletic trainers always work under the direction of a physician, they may not be directly supervised by a physician at all times. In most instances, the athletic trainer's direct supervisor is a non-health care provider such as an athletic director, general manager,

etc. As a result of these factors, athletic trainers must regularly utilize independent professional judgment based on their training and education.

Conflicts arise when coaches or other non-medical authority figures attempt to override the professional medical judgment of an athletic trainer, usually in furtherance of the team's/organization's performance rather than the condition of an individual athlete. In California, the lack of a professional license and government oversight diminishes the athletic trainer's ability to insist that medical decisions take precedence.

31. TO WHAT EXTENT DO DECISIONS MADE BY THE PRACTITIONER REQUIRE A HIGH DEGREE OF SKILL OR KNOWLEDGE TO AVOID HARM?

Certified athletic trainers always work under the direction of or in collaboration with a physician, but may not be directly supervised by a physician at all times and routinely make medical decisions that require a significant amount of education and training. From injury evaluation to acute management, from follow-up treatment to return-to-activity decisions, professional judgment and discernment are required to prevent harm.

Further supporting the fact that athletic trainers make decisions requiring a high degree of skill or knowledge to avoid harm are the educational standards for an athletic trainer. The current minimum entry point into the profession of athletic training is the baccalaureate degree in athletic training from an accredited program. Based on externally validated role delineation studies, it was recently determined that the minimum professional degree level needs to be a master's degree for athletic training education. This is despite the fact that more than 70 percent of currently practicing athletic trainers have at least a master's degree.

Upon completion of a CAATE-accredited athletic training education program, students become eligible for national certification by successfully completing the BOC examination (K5). Basic science such as anatomy, physiology, chemistry and physics are the essential underpinnings of athletic training education, as they are for most health care professions. Athletic trainers must understand all systems of the body and their normal and pathological functions. Included in athletic training education is specific and extensive didactic instruction and clinical training in the following clinical competencies: Risk Management and Injury Prevention, Orthopedic Clinical Assessment and Diagnosis, Medical Conditions and Disabilities, Acute Care of Injuries and Illness, Therapeutic Modalities/Conditioning Rehabilitative Exercises, Psychosocial Intervention and Referral, Nutritional Aspects of Injuries and Illness, Health care Administration, and Professional Development (L). Within each of these broad categories are numerous specific competencies which athletic trainers are held accountable for in their educational programs and ultimately for their certification examination (D 9-34). These skills and knowledge are based on the practice analysis that ascertains what athletic trainers routinely do during the course of their jobs (L).

Athletic trainers make evidenced based medical decisions many times daily. According to the U.S. Department of Labor, athletic trainers are classified as “learned professionals.” In the Code of Regulations under FLSA Section 213 exemption provision, athletic trainers have advanced and specialized knowledge through academic instruction which puts the athletic training profession in the same classification as professions of law, medicine, theology, accounting, actuarial computation, engineering, and architecture (AS3, [link](#)). Most of which require state licensure and codes of professional ethics to practice.

Even the American Physical Therapy Association, who traditionally opposes regulation of the athletic training profession, for questionable purposes, agreed in a legally binding statement that “athletic trainers are health care professionals authorized to provide interventions within their scope of practice...” and that “the scopes of practice of the two professions overlap to some extent.” (AF)

VI. FUNCTIONS AND TASKS OF THE OCCUPATION ARE CLEARLY DEFINED

32. DOES THE PROPOSED REGULATORY SCHEME DEFINE A SCOPE OF ACTIVITY WHICH REQUIRES LICENSURE, OR MERELY PREVENT THE USE OF A DESIGNATED JOB TITLE OR OCCUPATIONAL DESCRIPTION WITHOUT A LICENSE?

Yes, the proposed regulatory scheme provides for a scope of practice, along with title protection and enforcement/disciplinary capabilities.

33. DESCRIBE THE IMPORTANT FUNCTIONS, TASKS AND DUTIES PERFORMED BY PRACTITIONERS. IDENTIFY THE SERVICES AND/OR PRODUCTS PROVIDED.

Athletic trainers are unique in that they are the only profession to provide a continuum of care to their patients. This seamless provision of care encompasses everything from the active prevention of injuries to the evaluation, treatment and management of all stages of the injury recovery process. This is illustrated in the most recent Athletic Training Practice Analysis, 7th Edition (L) which identifies the following areas as being those tasks and duties performed by practitioners:

- Injury and Illness Prevention and Wellness Promotion
- Examination, Assessment, and Diagnosis
- Immediate and Emergency Care
- Therapeutic Intervention
- Health Care Administration and Professional Responsibility

Injury and Illness Prevention and Wellness Promotion

A key aspect of the athletic trainer's education and training is in the area of prevention and risk management. The athletic trainer is the front-line professional charged with this duty. Many individuals come to activity in less than ideal condition. They may suffer from disorders such as sickle-cell trait, diabetes, asthma, or have other conditions predisposing them to injury or illness. Pre-participation screenings are critical to identifying risks and putting prevention plans into action. Additional prevention and risk management strategies undertaken by the athletic trainer range from on-site reviews for hazards, monitoring environmental conditions and educating participants on nutrition and performance enhancing drugs to monitoring for overtraining, maintenance of clinical and treatment areas, and development of emergency action plans.

Examination, Assessment, and Diagnosis

An athletic trainer may be asked to perform in one or more distinct evaluation areas: 1) the pre-participation examination which assists in determining the readiness of an individual to participate in physical activities, 2) an on-field evaluation for acute conditions that had occurred during activity using the primary and secondary survey models, 3) a clinical evaluation, often occurring in a clinical or athletic training facility and 4) the ongoing evaluation of progress of an injury or illness assisting the athletic trainer in advancing or modifying current care and making return to play decisions. Through the use of a sequential evaluation process and with the understanding of the injury pathology and any comorbidities of the affected individual, the athletic trainer provides a clinical diagnosis, determines appropriate immediate care, and establishes short and long term goals for the affected individual.

Immediate and Emergency Care

The profession of athletic training is unique in that the athletic trainer may be present at the time of an injury or emergency. This requires the clinician be prepared and proficient in all aspects of emergency care. Preparation includes writing, rehearsing and executing emergency action plans for every venue for which the athletic trainer is responsible. The athletic trainer must demonstrate excellent communication skills, both verbal and/or written, in order to transfer vital assessment information to the health care provider, parent, supervisors and others that are involved in the health care of the individual. The recognition of signs and symptoms of life-threatening conditions is the cornerstone of effective management of emergencies. Athletic trainers have a vast knowledge of medical conditions that can quickly become emergencies and because the athletic trainer is often on-site, they are the primary health care professional able to intervene. There are times that injuries require care that warrant referrals. It is the athletic trainer who recognizes these conditions and selects the most effective and safest method to transport the individual to the appropriate health care professional.

Therapeutic Intervention

Following injury, the athletic trainer serves as the clinician who designs, administers and executes a plan of care. Included within this plan of care is the implementation of appropriate techniques, procedures, practices and methods that are designed to provide the patient with optimal outcomes. Acting under the direction of or in

collaboration with a physician and within the scope of practice acts and/or BOC Standards of Professional Practice, the athletic trainer provides a plan of care that is realized through the evaluation of the patient. Protection from additional injury and appropriate steps toward optimal recovery are included in the athletic trainers plan and execution of care. Effective and clear communication to the patient and appropriate individuals concerned with the patient's care is critical to achieving full return to activity. Treatment objectives are outlined using short and long-term goals. These goals are achieved using appropriate treatment/rehabilitation methods available to the athletic trainer. Selection of various treatment/rehabilitation modes is based on sound rationale, appropriate standards of health care, reliable clinical judgment and when available, evidence based medicine.

Healthcare Administration and Professional Responsibility

Athletic trainers are charged with critical responsibilities including: (1) injury/illness prevention and wellness protection, (2) clinical evaluation and diagnosis, (3) immediate and emergency care, and (4) treatment and rehabilitation. However, in order to properly implement any type of comprehensive athletic training services, an organization must demonstrate and support an appropriate level of organizational and professional health and well-being. Together, organizational and professional health and well-being is defined as an organization's or professional association's ability to function effectively, to cope adequately, to change appropriately, and to grow from within. It is also the process by which the athletic trainer empowers patients and employees in the improvement of their health-related physical, mental and social wellbeing as well as physical and professional well-being of the institution and/or organization.

Whether providing athletic training services at a youth soccer tournament, a hospital rehabilitation clinic, a physicians' office, industrial workplace, or a high school or University the athletic trainer relies on these practices, standards, and guidelines. Maintenance of records and accurate documentation is mandatory for communication, risk management, and determining best practices. Emergency action plans with consideration for staffing, coordination of resources, liability, and equipment reduce the risk to the individual and organization. When organizing a health care team or making referrals related to injuries, illness and unhealthy lifestyle behaviors, the athletic trainer must be knowledgeable of their scope of practice and the state statutes that regulate their profession and the health professionals with whom they work. Additionally the athletic trainer engages in ongoing professional education to ensure the care provided by the organization and health care professionals adheres to best practices. For organizations and professions to maintain financial health, the athletic trainer must demonstrate the ability to utilize basic internal business skills including strategic planning, human resource management, budgeting, and facility design. They must be able to apply external business skills, such as marketing and public relations to support organizational sustainability, growth, and development.

34. IS THERE A CONSENSUS ON WHAT ACTIVITIES CONSTITUTE COMPETENT PRACTICE OF THE OCCUPATION? IF SO, STATE AND DOCUMENT. IF NOT, WHAT IS THE BASIS FOR ASSESSING COMPETENCE?

Yes, one that has been vetted and is sensible for the provider and valuable to the consumer. This consensus is defined and supported in the complementary documents of the NATA/CAATE Educational Competencies (D) and the BOC Practice Analysis (L). They provide the agreement of the educational underpinnings of the profession with the activities that constitute competent practice at entry level. A description of the rigorous development process of these documents can be found in the answers to Questions #43 through #45 and demonstrate how consensus was reached. Consensus is further defined and disseminated through NATA Position and Consensus Statements ([link](#)), athletic training textbooks, NATA Ethics Guidelines (Y), the NATA Guide to Athletic Training Services (F), and BOC Standards of Professional Practice (N). These documents define the characteristics of competent practice of the profession. The activities that constitute competent practice continue to evolve as science and research advances dictate and are reflected in regular updates of these documents.

35. ARE INDICATORS OF COMPETENT PRACTICE LISTED IN RESPONSE TO QUESTION 34 MEASURABLE BY OBJECTIVE STANDARDS SUCH AS PEER REVIEW? GIVE EXAMPLES.

All of the documents listed in question 34 have been validated by peer review, often repeated peer review as well as by accreditation by other external agencies such as the NCCA (AL2). One example is the drafting of updated Educational Competencies for Athletic Training (D). This review is undertaken by the Professional Education Council of the NATA under the guidance of CAATE. The American Academy of Family Physicians (AAFP), The American Academy of Pediatrics (AAP), the American Orthopaedic Society for Sports Medicine (AOSSM), and the NATA cooperate to sponsor the CAATE (S1) and to collaboratively develop these Educational Competencies.

The Practice Analysis (L) is the blueprint for the BOC certification examination and is validated by a broad, stratified random sample of practicing athletic trainers. Additionally, the validation of the examination results via the psychometric data described in the answer to question 49, further demonstrates the measurable nature of the competence indicators.

36. SPECIFY ACTIVITIES OR PRACTICES THAT WOULD SUGGEST THAT A PRACTITIONER IS INCOMPETENT. TO WHAT EXTENT IS PUBLIC HARM CAUSED BY PERSONAL FACTORS SUCH AS DISHONESTY? DOCUMENT.

A practitioner demonstrates incompetence by not adhering to the latest clinical standards and evidence based practice, exercising poor judgment, over- or under-treating, failing to adhere to the NATA code of ethics and failing to act ethically (Y, N). Some specific examples include returning a concussed athlete to participation prior to

resolution, not recognizing the severity of a potential spinal cord injury, applying therapeutic ultrasound to an open growth plate in an adolescent patient, and misdiagnosing a spleen injury as a rib contusion (AJ2). In addition, athletic trainers are required to collaborate with physicians. Unqualified and noncertified individuals practicing as athletic trainers have no such requirement or means of oversight.

In California, because there is no licensing board or committee, there is no accurate or systemic way for the public to report evidence of harm against athletic trainers or those posing as athletic trainers. In the last two years, the CATA has fielded 93 complaints broken down as follows (V):

- Non-BOC certified person employed/volunteering as an Athletic Trainer – 58
- Unsupervised athletic training students – 17
- Harm to Patient – 7
- Licensed health-care professional claiming to be an Athletic Trainer – 9
- Other – 2 (violation of patient privacy via social media, administering an over the counter drug to an injured high school athlete)

The Board of Certification also tracks complaints and disciplinary actions, but they are unable to investigate or enforce. Over the past 3 years the BOC has had 178 disciplinary cases against athletic trainers residing in California for a variety of causes ranging from recertification violations to alcohol related incidences or other convictions. Currently there are 9 athletic trainers residing in California who have had their BOC certification suspended, but there is no way the BOC can determine if they are practicing in California or not (O3). In all of these cases, the BOC has no standing in California statute to provide any remedy or ramifications. Harm may also extend beyond complaints received as there is no widely known or formal mechanism for filing complaints and no ability to investigate.

There is proof of harm in other states, including suspended or revoked licenses, suspended or revoked certifications and lawsuits against practicing athletic trainers. The public in those states, however, have recourse to a board or committee with investigative and true disciplinary power.

Personal factors are just one of the reasons that a practitioner could cause public harm. Examples such as falsifying continuing education requirements, substance abuse, or sexual contact with a patient can cause harm and often reveal dishonesty and personal issues. As described previously, the lack of a reporting agency makes the extent that personal factors rather than incompetence contributing to harm difficult to determine.

For organizations and professions to maintain financial health, the athletic trainer must demonstrate the ability to utilize basic internal business skills including strategic planning, human resource management, budgeting, and facility design. They must be able to apply external business skills, such as marketing and public relations to support organizational sustainability, growth, and development.

**VII. THE OCCUPATION IS CLEARLY DISTINGUISHABLE FROM OTHER
OCCUPATIONS THAT ARE ALREADY REGULATED**

37. WHAT SIMILAR OCCUPATIONS HAVE BEEN REGULATED IN CALIFORNIA?

While athletic training is a profession with a unique set of skills and requisite knowledge, some of these skills are shared with other allied health professions licensed in California. Included among these professions are physical therapy, occupational therapy, physician assistant, chiropractic medicine, speech therapy, respiratory therapy, EMT and paramedic.

**38. DESCRIBE FUNCTIONS PERFORMED BY PRACTITIONERS THAT DIFFER
FORM THOSE PERFORMED BY OCCUPATIONS LISTED IN QUESTION 37.**

While there are some areas of overlap between athletic training and other health care professions, there are also vast differences.

Athletic training is distinct from other professions in that athletic trainers are the only health care professionals that provide a continuum of care. As discussed previously, this is validated by numerous governmental agencies and private organizations. Athletic trainers are present before an injury, at the time of injury, and throughout the treatment and rehabilitation process including return to play/activity decision-making. They are not only trained in prevention, evaluation and treatment of injuries, they act as de facto case managers, providing and coordinating care among a variety of other health care professionals. Athletic trainers are a very necessary part of a collaborative health care delivery system. Examples of differences and overlap between athletic training and these professions are delineated below:

Physical Therapy: While physical therapists provide physical medicine services (rehabilitation) like athletic trainers, physical therapists are not trained in injury prevention, acute injury management, or return to play/activity.

Occupational Therapy: While occupational therapists provide ergonomic assessment (before an injury) like athletic trainers, occupational therapists are not trained in evaluation, acute management, or manual therapy.

Physician Assistant: While physician assistants provide basic medical services (treatment) like athletic trainers, physician assistants are not trained in the same treatment or rehabilitation techniques and often do not provide acute injury management.

Chiropractic Medicine: While chiropractors evaluate and treat injuries and conditions in patients they are not trained in the same treatment or rehabilitation techniques or acute injury management.

Speech Therapy: While speech therapists treat and rehabilitate injuries and conditions, these injuries are typically different than those seen by athletic trainers. They are also not trained in injury prevention, acute care, and return to play/activity decisions.

Respiratory Therapy: While respiratory therapists treat and rehabilitate injuries and conditions, these injuries are typically different than those seen by athletic trainers. They are also not trained in injury prevention, acute care, and return to play/activity decisions.

Paramedics and EMT: While paramedics and EMTs provide emergency care (at time of injury) like athletic trainers, they are not trained to prevent injuries or to provide non-acute treatment, rehabilitation, or make return to play decisions.

Medical Assistant: While medical assistants perform back office medical history, vitals, medical records, referral coordination and proper referral like athletic trainers, medical assistants are not trained in injury evaluation, injury prevention, acute management, treatment modalities or manual therapy, nutrition and emergency care.

39. INDICATE THE RELATIONSHIPS AMONG THE GROUPS LISTED IN RESPONSE TO QUESTION 37 AND PRACTITIONERS. CAN PRACTITIONERS BE CONSIDERED A BRANCH OF CURRENTLY REGULATED OCCUPATIONS?

All of the listed professions in Question #37 have a specific skill set and are stand-alone health care professions. Each of them requires licensure except athletic training, even though athletic training also requires an education at an accredited professional school and the passing of a national examination just like the other regulated professions. Athletic training is not considered a branch of any of the listed professions with which it has overlap. As described throughout this document, athletic training is a unique profession that has a specific validated role delineation, specific professional educational programs that lead to a degree in athletic training, and a single national examination.

The Department of Labor (Standard Occupational Classification Code (SOC Code) 29-9091) (AV6) and the United States military have professional categories for each of the professions discussed in this section. Athletic trainers are assigned National Provider Identifier (NPI) numbers like other health care professionals. The taxonomy code for athletic trainers is 2255A2300X (AM1). There are specific CPT insurance billing codes for athletic training evaluation and re-evaluation (97005 and 97006) (AA1-4). While these codes are in the physical medicine section, along with treatment codes that can be used by any provider, athletic trainers, physical therapists, and occupational therapists have exclusive use of their own evaluation codes. Obviously there is some overlap between these allied health care professions but the areas of overlap are limited. The exclusive use of evaluation and re-evaluation codes point to the significant differences between the professions. The attached legal settlement between the APTA and NATA also highlights some of the areas of overlap and differences (AF).

The U.S. Department of Labor classifies nationally-certified athletic trainers as “learned professionals” for purposes of the Fair Labor Standards Act exemption (FLSA, 29 U.S.C. § 213) (AT, [link](#)) along with regulated professions including medicine, law, and accounting. See *generally* 29 C.F.R. §541.301 (AS3). There is also legal precedent supporting the classification of athletic trainers as learned professionals who are state-certified. See *Owsley v. San Antonio Independent Sch. Dist.*, 187 F.3d 521 (5th Cir. 1999) (holding athletic trainers certified by the state qualified as learned professionals based on their possession of a specialized advanced degree) (AN1-4); see also *Villegas v. El Paso Ind. Sch. Dist.*, 481 F. Supp. 2d 729 (W.D. Tex. 2006) (holding plaintiffs-athletic trainers met the requisite salary and duty requirements to qualify for the FLSA’s learned professional exemption, and the fact that the trainers were not supervised by a physician at practice emphasized that the trainers exercise great professional discretion) (AX2-6).

The DOL’s FLSA exemption rules state that athletic trainers who have successfully completed four academic years of pre-professional and professional study in a specialized accredited curriculum and who are nationally certified generally meet the duties requirements for the learned professional exemption. 29 C.F.R. §541.301(e)(8) (AS3). In defining the rules and regulations for certified athletic trainers, the DOL notes that these requirements include courses in specialized fields such as “athletic training, health, physical education or exercise training,” and, in particular, six specific subjects: “Human Anatomy, Human Physiology, Biometrics, Exercise Physiology, Athletic Training and Health/Nutrition.” 69 F.R. 22152 (2004) (AC35). Candidates must also participate in extensive clinical programs under the supervision of NATA-licensed trainers, in which a minimum of 25 percent of clinical hours are obtained “on location, at a practice or game, in one of many eligible sports such as football, soccer, wrestling, basketball or gymnastics.” *Id.* (AC35).

The Department of Labor’s classification of certified athletic trainers as learned professionals is significant because it affirms that athletic trainers have “advanced knowledge . . . in a field of science or learning . . . customarily acquired by prolonged course of specialized knowledge through academic instruction.” See 29 C.F.R. § 541.301(a)–(d) (AS1-3). The classification further indicates that certified athletic trainers are not mere “low-skilled workers,” rather they are on par with other highly regulated, traditional professions including law and medicine. See § 541.301(c) (AS1). The certification requirement indicates that there are some “athletic trainers” who are uncertified and thus considered lower-skilled as defined by the DOL; it logically follows that certification is required to indicate knowledge and skill level to differentiate those athletic trainers who received advanced training, possess superior knowledge, and regularly engage in autonomous decision-making for the health and safety of individuals, from those “athletic trainers” which do not possess the skills and knowledge of learned professionals and may be under-qualified to make the same medical and physiological decisions for athletes.

40. WHAT IMPACT WILL THE REQUESTED REGULATION HAVE UPON THE AUTHORITY AND SCOPES OF PRACTICE OF CURRENTLY REGULATED GROUPS?

No currently regulated professions will be impacted with the requested regulation. The proposed language specifically states the following:

***2697.14.** This chapter does not limit, impair, or otherwise apply to the practice of any person licensed and regulated under any other chapter of Division 2 (commencing with Section 500).*

Additionally, existing statute also prohibits such a requirement:

***BPC 850.** No healing arts licensing board or examining committee under the Department of Consumer Affairs shall by regulation require an applicant for licensure or certification to be a member of, to be certified by, to be eligible to be certified or registered by, or otherwise meet the standards of a specified private voluntary association or professional society except as provided for in this article.*

No health care provider, working under their scope of practice and using their title, will be required to get licensed as an athletic trainer, or would fall under any other provision of the proposed bill. Even if someone is dual credentialed (e.g. PT and AT), they would not be required to get an additional license unless they wished to practice in the scope of an athletic trainer that is not under the scope of practice of their current license.

41. ARE THERE UNREGULATED OCCUPATIONS PERFORMING SERVICES SIMILAR TO THOSE OF THE GROUP TO BE REGULATED? IF SO, IDENTIFY.

There are currently no other unregulated professions that are providing services similar to those of athletic trainers. Due to the similarity in the names of the professions, there is occasionally some confusion in public perception between personal trainers (who are not health care providers) and athletic trainers. It is worth noting again that California is the only state in the nation that does not regulate the profession of athletic training.

42. DESCRIBE THE SIMILARITIES AND DIFFERENCES BETWEEN PRACTITIONERS AND THE GROUPS IDENTIFIED IN QUESTION 41.

There are no groups identified in Question #41.

VIII. THE OCCUPATION REQUIRES POSSESSION OF KNOWLEDGES, SKILLS AND ABILITIES THAT ARE BOTH TEACHABLE AND TESTABLE

43. IS THERE A GENERALLY ACCEPTED CORE SET OF KNOWLEDGES, SKILLS AND ABILITIES WITHOUT WHICH A PRACTITIONER MAY CAUSE PUBLIC HARM? DESCRIBE AND DOCUMENT.

Yes, as described previously, there are two documents that define the knowledge and skills required to perform the activities of an athletic trainer.

The Athletic Training Educational Competencies (D) defines the knowledge and skills that must be taught to athletic training students. Additionally, the CAATE publishes Standards for the Accreditation of Professional Athletic Training Programs which describes the minimum standards for accredited education programs (R3-17). The CAATE is recognized as an accrediting agency by the Council of Higher Education (CHEA) (W).

The BOC conducts and publishes a Practice Analysis that defines the duties and roles of an athletic trainer. This document is the blueprint of the certification examination (L8). It is reviewed, revised and subsequently validated by a broad, stratified random sample of practicing athletic trainers. This ongoing process is just one requirement for maintaining the BOC's accreditation by the National Commission for Certifying Agencies (AL2).

44. WHAT METHODS ARE CURRENTLY USED TO DEFINE THE REQUISITE KNOWLEDGES, SKILLS AND ABILITIES? WHO IS RESPONSIBLE FOR DEFINING THESE KNOWLEDGES, SKILLS AND ABILITIES?

For the current edition the Professional Education Council (PEC) of the NATA was charged with creating the 5th edition of the Educational Competencies. The PEC developed and executed a systematic plan to draft the Competencies and to solicit and integrate feedback from multiple sources as the draft was revised. First, the PEC orchestrated an initial open call for feedback on the 4th edition of the Competencies. Next, groups of subject-matter experts, including practicing athletic trainers, educators, and administrators, were identified. In addition to the feedback on the 4th edition, these subject-matter experts considered today's health care system, current best practice in athletic training, and their own expertise in creating an initial draft of the 5th edition. Many conversations ensued and subsequent drafts were submitted. Following revision for form and consistency of language, a draft of the Competencies was again posted for open feedback. This valuable feedback was considered in its entirety by the PEC, and final revisions were made. The advice, cooperation, and feedback from the BOC and the CAATE were utilized throughout this process.

This process has transitioned to the CAATE and they are currently in the middle of developing the next set of standards.

The BOC and the certification program establish that individuals have the knowledge and skills necessary to perform tasks critical for the safe and competent practice as an

entry-level Athletic Trainer. The BOC Practice Analysis (PA) identifies essential knowledge and skills for the athletic training profession and serves as a blueprint for examination development (L). The PA validates importance, criticality and relevance to practice for both broad content areas and tasks. The PA is significant for content validity because it ensures that the domains of athletic training covered on the BOC examination reflect the range of practice settings throughout the US.

In general, a PA is one of the commonly accepted psychometric methodologies used to identify and prioritize the critical tasks of a job or profession and the essential competencies an individual should possess to perform the required functions satisfactorily. For certification purposes, a PA is used to establish a defined set of domains, tasks and associated knowledge and/or skills necessary to carry out the responsibilities of the job to the standards required for certification.

The PA, 7th Edition was published in 2015 (L). In 2014, the BOC began the process of reviewing the test blueprint for the BOC Athletic Trainer Exam. The BOC worked with Castle Worldwide, Inc., a certification and licensure design, development, and administrative service company, to ensure that its certification exams meet guidelines and standards for examination development. A number of steps were taken for the analysis of the practice requirements for newly certified athletic trainers. First, feedback was obtained from the existing BOC examination item writers, examination development personnel, and a review of feedback from candidates and other persons to identify task areas on the existing athletic trainer test content outline that were problematic. A panel of subject matter experts (SMEs) was then assembled. The panel reviewed the existing material and feedback and developed a list of athletic trainer activities that was incorporated into a survey sent to a randomly selected sample of athletic trainers, and the data was collected and analyzed. A 17-member panel of subject matter experts was assembled to develop an outline of the areas of practice required for competent performance as an athletic trainer. With the assistance of Castle Worldwide and BOC staff, this group developed a survey based on the expert's analysis. The survey was sent to a representative sample of 5,000 certified athletic trainers and the response rate was 18%, which is similar to other role practice analysis surveys. The data from this survey was collected and analyzed by Castle Worldwide staff and then utilized to describe the tasks and domains necessary for competent practice of certified athletic trainers. A more complete description of the processes utilized by the BOC can be found (L67-91).

45. ARE THESE KNOWLEDGES, SKILLS AND ABILITIES TESTABLE? IS THE WORK OF THE GROUP SUFFICIENTLY DEFINED THAT COMPETENCE COULD BE EVALUATED BY SOME STANDARD (SUCH AS RATINGS OF EDUCATION, EXPERIENCE OR EXAM PERFORMANCE)?

Yes, the skills and abilities are defined and published to the public so that competence can be evaluated. BOC's examination tests knowledge and the Practice Analysis is the blueprint for the BOC examination. Program directors of accredited programs are

required to indicate that the students that complete their programs and subsequently sit for the BOC examination are competent in the skills and abilities as defined by the Athletic Training Educational Competencies document (D9-34).

46. LIST INSTITUTIONS AND PROGRAM TITLES OFFERING ACCREDITED AND NON-ACCREDITED PREPARATORY PROGRAMS IN CALIFORNIA. ESTIMATE THE ANNUAL NUMBER OF GRADUATES FROM EACH. IF NO SUCH PREPARATORY PROGRAMS EXIST WITHIN CALIFORNIA, LIST PROGRAMS FOUND ELSEWHERE.

The following colleges and universities are all accredited by CAATE, the Commission on Accreditation of Athletic Training Education:

Azusa Pacific University
California Baptist University
California State University - Sacramento
California State University - Long Beach
California State University - Fullerton
California State University – Fresno
California State University - Northridge
Chapman University
Concordia University - Irvine
Point Loma Nazarene University
San Diego State University
San Jose State University
University of La Verne
University of the Pacific

Last year 191 students graduated from these programs (P).

In addition to the 14 colleges in California listed above, there are nearly 335 colleges and universities that offer CAATE accredited athletic training education programs across the nation with an unverified number of graduates. Estimates would be over 3,000 graduates per year ([link](#)).

47. APART FROM THE PROGRAMS LISTED IN QUESTION 46, INDICATE VARIOUS METHODS OF ACQUIRING REQUISITE KNOWLEDGE, SKILL AND ABILITY. EXAMPLES MAY INCLUDE APPRENTICESHIPS, INTERNSHIPS, ON-THE-JOB TRAINING, INDIVIDUAL STUDY, ETC.

If an individual is a certified Canadian Athletic Therapist or a certified member of the Athletic Rehabilitation Therapy Ireland and holds a bachelor's degree, they qualify to sit for the BOC examination. The BOC receives very few applications via this route.

Prior to January 1, 2004, candidates could qualify for the BOC examination by completing an "internship" route. This included completion of at least a bachelor's degree, completion of specific coursework and 1,500 hours working/learning under the supervision of a BOC certified athletic trainer. This route to certification ended on December 31, 2003.

48. ESTIMATE THE PERCENTAGE OF CURRENT PRACTITIONERS TRAINED BY EACH OF THE ROUTES DESCRIBED IN QUESTIONS 46-47.

Neither the BOC, CAATE nor CATA are able to determine the percentage of current California practitioners trained by each of the routes described in questions 46 and 47. However, it is estimated that approximately 85% of athletic trainers in California graduated from an accredited athletic training education program. No matter the training route, all practitioners who would be licensed by the proposed regulation are certified by the BOC and all license candidates moving forward will have graduated from an accredited athletic training education program except for the small number applying from Canadian and Irish degree programs.

49. DOES ANY EXAMINATION OR OTHER MEASURE CURRENTLY EXIST TO TEST FOR FUNCTIONAL COMPETENCE? IF SO, INDICATE HOW AND BY WHOM EACH WAS CONSTRUCTED AND BY WHOM IT IS CURRENTLY ADMINISTERED. IF NOT, INDICATE SEARCH EFFORTS TO LOCATE SUCH MEASURES.

Yes, athletic training is recognized as a health care profession and the purpose of the BOC examination is to assess candidates' knowledge in the five domains of athletic training as defined by the current BOC Practice Analysis (L). All items and examination forms are written to meet specifications outlined in the Practice Analysis and subsequent performance standards for the certification examination. The BOC examination is a computer based examination that is currently administered by Castle Worldwide.

Questions for the certification exam are prepared by a committee made up of BOC Certified Athletic Trainers. Each question is validated by a panel of independent judges in item writing groups, referenced to current resources from the literature on or related to athletic training and repeatedly edited by athletic trainers for clarity and content. Questions satisfy the exam specifications of the current BOC Practice Analysis.

Questions are developed to assess the candidate's knowledge on subject matter from the five domains of athletic training. Each question is also subjected to editing for grammar and technical adequacy by experts from the BOC's testing agency. Thus, content experts write the questions and validate their appropriateness for the exam, and experts in testing review the questions to ensure that the questions perform as intended.

50. DESCRIBE THE FORMAT AND CONTENT OF EACH EXAMINATION LISTED IN QUESTION 49. DESCRIBE THE SECTIONS OF EACH EXAMINATION. WHAT COMPETENCIES IS EACH DESIGNED TO MEASURE? HOW DO THESE RELATE TO THE KNOWLEDGES, SKILLS AND ABILITIES LISTED IN QUESTION 43?

The BOC certification examination is given electronically at specific testing sites throughout the country at various times of the year. It contains a combination of 175 scored and un-scored (experimental) items including:

- Stand-alone multiple-choice questions
- Stand-alone alternative items (drag-and-drop, text based simulation, multi-select, hot spot, etc.)
- Focused testlets
 - A 5-item focused testlet consists of a scenario followed by 5 key/critical questions related to that scenario
 - Each focused testlet may include multiple-choice questions and/or any of the previously described alternative item types

Candidates will not know which questions are experimental (unscored).

Following login, candidates are presented with an entry screen in to the examination. Candidates can select to view a demo or enter the examination. When candidates have completed the examination, they will submit it for scoring.

Candidates have the ability to move forward or back throughout the entire examination.

Candidates have a total of 4 hours to complete the examination.

<u>PA Domains for Examination Questions</u>	<u>% of Questions on Exam</u>
Injury and Illness Prevention and Wellness Promotion	19.8%
Examination, Assessment and Diagnosis	24.3%
Immediate and Emergency Care	15.5%
Therapeutic Intervention	27.4%
Healthcare Administration and Professional Responsibility	13%

(BOC Exam Candidate Handbook Appendix K)

51. IF MORE THAN ONE EXAMINATION IS LISTED ABOVE, WHICH STANDARD DO YOU INTEND TO SUPPORT? WHY? IF NONE OF THE ABOVE, WHY NOT, AND WHAT DO YOU PROPOSE AS AN ALTERNATIVE?

No other examinations are listed in question #50 because no other examinations are available. There are no alternatives. This is consistent with the other similar medical

professions discussed in previous questions where there is one national examination recognized by the state.

IX. ECONOMIC IMPACT OF REGULATION IS JUSTIFIED

52. HOW MANY PEOPLE ARE EXPOSED ANNUALLY TO THIS OCCUPATION? WILL REGULATION OF THE OCCUPATION AFFECT THIS FIGURE? IF SO, IN WHAT WAY?

Due to the variety of settings in which athletic trainers work, the number of people exposed to athletic trainers is vast and integral to the way our communities function.

Currently, the athletic training profession is growing nationally. The United States Department of Labor, Bureau of Labor Statistics states in the 2016-17 edition of the Occupational Outlook Handbook: "Employment of athletic trainers is projected to grow 21 percent from 2014 to 2024, much faster than the average for all occupations. As people become more aware of sports-related injuries at a young age, demand for athletic trainers is expected to increase" (AV1-2). US News and World Report also called Athletic Training "one of the 50 best careers of 2011" and "should have strong growth over the next decade" ([link](#)). This growth, however, is not attributed to the regulation of the profession, but rather to the quality, cost effective nature of the care provided by athletic trainers and the value placed on their services.

All collegiate athletes are exposed to athletic trainers annually, as are all professional and Olympic level athletes. Over half of all 850,000 California high school athletes and their parents are exposed to athletic trainers annually. An undetermined number of patients are treated in clinics and hospitals by athletic trainers annually. Athletic trainers also provide services to an undetermined number of soldiers/sailors, performing artists, public safety officers and industrial employees. Based on this, the overall number of California consumers exposed to athletic training is likely over a million annually.

53. WHAT IS THE CURRENT COST OF THE SERVICE PROVIDED? ESTIMATE THE AMOUNT OF MONEY SPENT ANNUALLY IN CALIFORNIA FOR THE SERVICES OF THIS GROUP. HOW WILL REGULATION AFFECT THESE COSTS? PROVIDE DOCUMENTATION FOR YOUR ANSWERS.

There are almost no direct costs to consumers for specific services provided by athletic trainers. Athletic training is unique in the health care arena in that athletic trainers do not typically bill for services. As a result, the cost of athletic training services is the fixed costs of athletic trainer salaries. Per the California Economic Development Department (EDD) (AE) and NATA Salary Survey (AK1-2), the average salary of an athletic trainer in California is approximately \$52,000. With approximately 3,200 athletic trainers in the state, the total cost of employment is \$166 million.

As indicated above the profession is growing nationally and while regulation may also increase the attractiveness of the employment environment in California, likely providing more opportunities in industrial and public safety sectors, the growth will be relatively small. The resultant match of the steady increase of supply noted in the answer to Questions #52 and #56, with slightly increased demand of employment opportunities for practitioners, should keep salary growth to a minimum.

No matter the cost of providing athletic training services, it is worth noting that these costs are counteracted by cost savings to consumers, industrial employers, schools/colleges, and the government. As described in the answer to Question #26, hiring athletic trainers to provide evaluative, treatment and rehabilitative services to their employees can save companies, as well as city and state governments, millions of dollars in worker's compensation costs annually. It can save high schools and colleges thousands in insurance premiums and the government thousands of dollars of Medi-Cal costs.

54. OUTLINE THE MAJOR GOVERNMENTAL ACTIVITIES YOU BELIEVE WILL BE NECESSARY TO APPROPRIATELY REGULATE PRACTITIONERS. EXAMPLES MAY INCLUDE SUCH PROGRAM ELEMENTS AS: QUALIFICATIONS EVALUATION, EXAMINATION DEVELOPMENT OR ADMINISTRATION, ENFORCEMENT, SCHOOL ACCREDITATION, ETC.

The Occupational Therapy Board will house the Athletic Training Licensing Committee. The athletic training committee's primary responsibility will be qualification review for issuing licenses and renewals, as well as investigation and enforcement. CAATE would be in charge of accrediting educational programs and the BOC would be in charge of the examination and continuing education as they currently do. All costs will be borne by the licensees.

There is precedent in California statute for delegating these responsibilities to private entities for similar health care professions. Delegation of accreditation of educational institutions and certification to private entities is referenced in occupational therapy ([link](#)), physical therapy ([link](#)) and respiratory therapy ([link](#)) statutes. The delegation of certification responsibilities is referenced in recreation therapy ([link](#)) and respiratory therapy ([link](#)) statutes. Delegation of educational accreditation is referenced in the physical therapy assistant statute ([link](#)).

55. PROVIDE A COST ANALYSIS SUPPORTING REGULATORY SERVICES TO THIS OCCUPATION. INCLUDE COSTS TO PROVIDE ADEQUATE REGULATORY FUNCTIONS DURING THE FIRST THREE YEARS FOLLOWING IMPLEMENTATION OF THIS REGULATION. ASSURE THAT AT LEAST THE FOLLOWING HAVE BEEN INCLUDED:

A. COSTS OF PROGRAM ADMINISTRATION, INCLUDING STAFFING

B. COSTS OF DEVELOPING AND/OR ADMINISTERING EXAMINATIONS
C. COSTS OF EFFECTIVE ENFORCEMENT PROGRAMS

Historically new boards, bureaus, and commissions do an excellent job of offsetting their costs through a fiscal policy long-established by the Legislature and Department of Consumer Affairs. The bill provides that all start-up costs will be paid for by the CATA. The legislation also provides that ATs will be regulated by the Board of Occupational Therapy and will share all costs of licensure administration and discipline. The CATA is actively working with the DCA and Board of Occupational Therapy to determine specific costs of administering the Athletic Training Committee.

56. HOW MANY PRACTITIONERS ARE LIKELY TO APPLY EACH YEAR FOR CERTIFICATION IF THIS REGULATION IS ADOPTED? IF SMALL NUMBERS WILL APPLY, HOW ARE COSTS JUSTIFIED?

We conservatively anticipate at least 2,600 of the 3,500 certified athletic trainers in California to become licensed in the first year. This includes 80% of those certified athletic trainers whose primary employment entails clinical practice and will therefore be required to become licensed to continue their practice. We further anticipate that a number of certified athletic trainers whose primary work setting does not require licensure will become licensed to continue to use their credential and allow them to work clinically part-time. However, we were unable to confirm exact numbers and therefore did not include them in the 2,600 number. This is consistent with other recently regulated states such as Michigan, Colorado and Maryland, in which the number of licenses issued in the first year was between 70 and 80 percent of certified athletic trainers.

In subsequent years, we anticipate the number of new licensees to start around 220 athletic trainers per year and increase steadily. According to the BOC, last year 191 students graduated from California Athletic Training Education programs (P). As indicated in Question #52, the US Department of Labor anticipates a 21% growth of the profession between 2014 and 2024 (AV1-2).

While not a large number when compared to some professions, it is still substantial and is larger than some other regulated professions. We also believe that the potential for, and severity of harm to consumers is so significant, that it more than justifies the number of potential licenses. Additionally, based on the survey referenced in Question #4, athletic training practitioners are overwhelmingly in favor of regulating themselves and absorbing the licensing fees (U1).

57. DOES ADOPTION OF THE REQUESTED REGULATION REPRESENT THE MOST COST-EFFECTIVE FORM OF REGULATION? INDICATE ALTERNATIVES CONSIDERED AND COSTS ASSOCIATED WITH EACH.

Licensure is the only appropriate and most cost-effective form of regulation because it is the only solution to the problems occurring in California as a result of a lack of regulation of athletic trainers. While the absolute costs of certification and title protection are obviously lower than licensure, the net benefits of these options to public protection, employers of athletic trainers, and athletic trainers themselves is significantly lower and in some casts non-existent. It should also be noted that there is no cost to the General Fund or taxpayers for athletic training Licensure.

- Only licensure creates statutory guidelines that prevent unqualified individuals from acting as an athletic trainer providing healthcare to young athletes.
 - Title protection does not prevent individuals from providing healthcare that they are not qualified to perform which can lead to serious consequences including improper treatment, permanent disability or death.
- Only licensure creates a board to investigate and if necessary discipline or otherwise sanction individuals who have committed harm to the public.
 - Title protection will not create a board to investigate harm and the Board of Certification, Inc. has no jurisdiction in California.
- Only licensure would ensure that athletic trainers work under the direction of or in collaboration with a physician.
 - Although most certified athletic trainers work under the direction of or in collaboration with a physician there is currently no statutory mandate to ensure compliance and physicians are not likely to oversee non-certified / unqualified individuals.
- Only licensure would allow athletic trainers, the healthcare provider most highly trained and available to manage concussions to supervise return-to-play protocols and other components of concussion management.
 - Current statute requires that only licensed healthcare providers trained in the management of concussions be involved in concussion intervention (AD). Title protection would not allow athletic trainers to be involved in these activities.
- Only licensure gives other licensed healthcare providers the clear legal protection necessary to interact with athletic trainers allowing safe, quality care.
 - Some institutions are barring athletic trainers from viewing or entering information into the medical records of their patients solely because of the lack of licensure.

- Only licensure provides the scope of practice necessary to remove the legal grey area that athletic trainers work under in California that increases liability to athletic trainers and their employers.
 - Title protection provides no scope of practice.
- Only licensure provides the regulatory framework required of California athletic trainers travelling to some other states to practice in accordance with their state law.
 - California is the only state that does not regulate the profession of athletic training. The Assembly Committee on Arts recognized that 14 states do not accept BOC certification or title protection for athletic trainers travelling into their states with their teams or organizations. Included in these states are Hawaii, Arizona, Utah, Alaska, Texas, Massachusetts, Virginia and Arkansas (B6). In June 2017, Georgia joined that list by passing a bill requiring out of state athletic trainers to be licensed in their home state when traveling to Georgia (AG1-2).

In summary, licensure of athletic trainers is the sole remedy to concerns and harm. Title protection only mandates the non-use of a title, it does not specify a scope of practice, work qualifications and practice standards. Title protection is not sufficient to protect the public, employers of athletic trainers and athletic trainers. Additionally, as the cost of this proposed regulation will be borne by the practitioners through licensing fees, the burden of the cost of this regulation will not fall to the state's General Fund or to the taxpayers. The bill's language ensures that the income will be sufficient to cover expenses and is therefore very cost effective to the state.

Part C2 – Rating on Sunrise Criteria

Assign each Criterion a numeric rating of 0–5 in the space provided. The rating should be supported by the answers provided to the questions in *Part C1*. Scale descriptions are intended to give examples of characteristics indicative of ratings.

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5
(Little Need for Regulation) LOW HIGH (Great Need for Regulation)

I. UNREGULATED PRACTICE OF THIS OCCUPATION WILL HARM OR ENDANGER THE PUBLIC HEALTH SAFETY AND WELFARE 5

low: Regulation sought only by practitioners. Evidence of harm lacking or remote. Most effects secondary or tertiary. Little evidence that regulation would correct inequities.

high: Significant public demand. Patterns of repeated and severe harm, caused directly by incompetent practice. Suggested regulatory pattern deals effectively with inequity. Elements of protection from fraudulent activity and deceptive practice are included.

II. EXISTING PROTECTIONS AVAILABLE TO THE CONSUMER ARE INSUFFICIENT 5

low: Other regulated groups control access to practitioners. Existing remedies are in place and effective. Clients are generally groups or organizations with adequate resources to seek protection.

high: Individual clients access practitioners directly. Current remedies are ineffective or nonexistent.

III. NO ALTERNATIVES TO REGULATION WILL ADEQUATELY PROTECT THE PUBLIC 5

low: No alternatives considered. Practice unregulated in most other states. Current system for handling abuses adequate.

high: Exhaustive search of alternatives finds them lacking. Practice regulated elsewhere. Current system ineffective or nonexistent.

IV. REGULATION WILL MITIGATE EXISTING PROBLEMS

5

low: Little or no evidence of public benefit from regulation. Case not demonstrated that regulation precludes harm. Net benefit does not indicate need for regulation.

high: Little or no doubt that regulation will ensure consumer protection. Greatest protection provided to those who are least able to protect themselves. Regulation likely to eliminate currently existing problems.

V. PRACTITIONERS OPERATE INDEPENDENTLY, MAKING DECISIONS OF CONSEQUENCE

5

low: Practitioners operate under the supervision of another regulated profession or under the auspices of an organization which may be held responsible for services provided. Decisions made by practitioners are of little consequence.

high: Practitioners have little or no supervision. Decisions made by practitioners are of consequence, directly affecting important consumer concerns.

VI. FUNCTIONS AND TASKS OF THE OCCUPATION ARE CLEARLY DEFINED

5

low: Definition of competent practice unclear or very subjective. Consensus does not exist regarding appropriate functions and measures of competence.

high: Important occupational functions are clearly defined, with quantifiable measures of successful practice. High degree of agreement regarding appropriate functions and measures of competence.

VII. THE OCCUPATION IS CLEARLY DISTINGUISHABLE FROM OTHER OCCUPATIONS THAT ARE ALREADY REGULATED

5

low: High degree of overlap with currently regulated occupations. Little information given regarding the relationships among similar occupations.

high: Important occupational functions clearly different from those of currently regulated occupations. Similar non-regulated groups do not perform critical functions included in this occupation's practice.

VIII. THE OCCUPATION REQUIRES POSSESSION OF KNOWLEDGES, SKILLS AND ABILITIES THAT ARE BOTH TEACHABLE AND TESTABLE

5

low: Required knowledge undefined. Preparatory programs limited in scope and availability. Low degree of required knowledge or training. Current standard sufficient to measure competence without regulation. Required skill subjectively determined; not teachable and/or not testable.

high: Required knowledges clearly defined. Measures of competence both objective and testable. Incompetent practice defined by lack of knowledge, skill or ability. No current standard effectively used to protect public interest.

IX. ECONOMIC IMPACT OF REGULATION IS JUSTIFIED

5

low: Economic impact not fully considered. Dollar and staffing cost estimates inaccurate or poorly done.

high: Full analysis of all costs indicate net benefit of regulation is in the public interest.