Physician Direction – They Really Don't Need the Directions, We Do!

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Objectives

- Participants will be able to identify the need for Physician Direction in their Practice.
- Participants will contrast between the Team Physician and a Directing Physician
- Participants will identify essential components of Physician Direction.
- Participants will begin the process of collaboration with their directing physician, school, and clinical administration in developing appropriate documents.

Disclosures

- I am the Chair of the NATA Secondary School Committee
- I am the District 7 Chair on the NATA Foundation Board o Directors
- I a member of the Arizona State Board of Athletic Training
- Nothing here should be confused with a policy or procedure of the Az Board of Athletic Training

Definition

Physician Direction: The Athletic Trainer renders service or treatment under the direction of, or in collaboration with a physician, in accordance with their training and the state's statutes, rules and regulations

Definition

Team Physician: The Team Physician MAY work with the school and the athletic trainer providing practice and/or game day health care. The Team Physician and the directing physician may or may not be the same.

Az Statutes

32-4103. Board; powers and duties; direction of athletic trainers; continuing education requirements; civil immunity

...

B. The board shall adopt rules to prescribe the direction of athletic trainers by a licensed physician, including recommendations, guidelines and instructions as to standard protocols to be followed in the general, day-to-day activities in which athletic trainers engage. These rules shall require that post-athletic injury or athletic illness treatment direction be provided by the person's treating physician or, if applicable, by the team physician for the institution or organization that employs the athletic trainer. If appropriate, athletic trainers may also seek direction as to the treatment of an athletic injury or athletic illness from any health care provider who is involved in that person's treatment and who is not licensed pursuant to this chapter but who is licensed pursuant to this title.

Az Rules

R4-49-405. Direction of a Licensed Physician A licensee shall render service or treatment under the direction of a physician licensed under A.R.S. Title 32, Chapter 13 or 17, as follows:

1. The licensee shall have standard, written protocols for common athletic training activities approved by the physician.
2. The licensee shall have post-injury treatment guidelines that comply with A.R.S. § 32-4103(B) approved by the physician.

Historical Note New Section made by final rulemaking at 8 A.A.R. 4389, effective November 25, 2002 (Supp. 02-3).

What constitutes "Physician Direction"?

Prehosp Emerg Care. 2009 Apr-Jun;13(2):185-92. doi: 10.1080/10903120802706120. Physician medical direction and clinical performance at an established emergency medical services system. Munk MD1, White SD, Perry ML, Platt TE, Hardan MS, Stoy WA.

METHODS:
Over one year, changes to the service's clinical infrastructure were made: Policies were revised, paramedic scopes of practice were adjusted, evidence based clinical protocols were developed, and skills maintenance and education programs were implemented. Credentialing, physician chart auditing, clinical remediation, and online medical command/hospital notification systems were introduced.

RESULTS:
Following these interventions, we report associated improvements to key indicators: Chart reviews revealed significant improvements in clinical quality. A comparison of pre and post intervention audited charts reveals a decrease in cases requiring remediation (11% to 5%, odds ratio [OR] 0.43 [95% confidence interval (CI) 0.20-0.85], p = 0.01). The proportion of charts rated as clinically acceptable rose from 48% to 84% (OR 6 [95% CI 3.9-9.1], p < 0.001). The proportion of misplaced endotracheal tubes fell (3.8% baseline to 0.6%, OR 0.16 [95% CI 0.004 1.06], (exact) p = 0.05), corresponding to improved adherence to an airway placement policy mandating use of airway confirmation devices and securing devices (0.7% compliance to 98%, OR 714 [95% CI 64-29,334], (exact) p < 0.001). Intravenous catheter insertion in unstable cases increased from 67% of cases to 92% (OR 1.31 [95% CI 1.09-1.71], p = 0.004). EMS administration of aspirin to patients with suspected ischemic chest pain improved from 2% to 77% (OR 178 [95% CI 35-1,604], p < 0.001).

CONCLUSIONS:
We suggest that implementation of a physician medical direction is associated with improved clinical indicators and overall quality of care at an established EMS system.

Tucson Unified School District
Interscholastics Department

Exertional Heat Illness Policy & Procedures

Policy Area: Environmental Safety	**Subject:** Exertional Heat Illness
Title of Policy: Exertional Heat illness	**Number:**
Effective Date: (Date policy is to be implemented)	**Page Number:**
Approved Date: (Date when policy was approved)	**Approved By:** (This area may contain a routing list of individuals who must review and approve)
Revision Date: (Date of most recent revision)	

1. Purpose of policy:

Exertional heat illness includes exercise-associated muscle cramps, heat syncope, heat exhaustion, and exertional heat stroke (EHS). Current best practice guidelines suggest that the risk of exertional heat injuries can be minimized with heat acclimatization and diligent attention to monitoring individuals participating in activities that place them at a higher risk for these types of injuries.[1] In the event an athlete sustains a heat illness, immediate and proper treatment is needed.

National governing bodies, such as the National Federations of High School Associations, National Collegiate Athletic Association (NCAA) and numerous state athletic/activity associations, have published guidelines for the prevention, monitoring and treatment of exertional heat illnesses. In addition, national authorities such as the National Athletic Trainers' Association and the Korey Stringer Institute have published research to support best practices in this area. The development of the organization's heat acclimatization guidelines will be based on the current best practice documents.

[1] Casa DJ, Demartini JK, Bergeron MF, et al. National Athletic Trainers' Association Position Statement: Exertional Heat Illnesses. *Journal of Athletic Training*. 2015;50(9):986-1000.

Sample Standing Operating Procedures
2014-2015

The following are general treatment Standing Operating Procedures (SOP) for injuries/illnesses as seen by the following Licensed Athletic Trainer(s) for School:

NAME: **State Licensure #:**

These general treatment orders are as outlined by the American Orthopedic Society for Sports Medicine:

1. Evaluate and initiate first aid care for all injuries to all student-athletes.
2. Carry out an appropriate rehabilitation program to increase range of motion, strength, and agility using those indicated modalities.
3. Clear the student-athlete to return to full or partial activities as the student-athlete progresses. If a student-athlete sees a physician the student-athlete will secure appropriate medical clearance before they can return to participation. The student-athlete must meet the following criterion to be able to safely return to participation.
   a. 90% strength, full pain-free range of motion, & normal gait pattern (if applicable).
4. HEAD: An appropriate healthcare professional trained in the evaluation and management of concussions must evaluate all cases of a suspected concussion, including but not limited to unconsciousness and/or memory loss. All student-athletes with a suspected concussion must follow the Concussion Management Plan for School before they return to participation. Student-athletes may compete a 5 Phase Return to Participation program with the Licensed Athletic Trainer(s) if designated by the licensed healthcare professional trained in the evaluation and management of concussions. The School Medical Director allocates the Licensed Athletic Trainers to determine if a concussion is suspected. If no concussion is suspected, the School Medial Director designates the Licensed Athletic Trainers the responsibility to return an athlete to participation.
5. NECK: A physician must evaluate brachial plexus injuries with motor weakness.
6. UPPER EXTREMITY: Suspected fractures and dislocations are to be immobilized and referred to a physician for immediate evaluation.
7. ABDOMEN: Evaluate, treat and refer to a physician as indicated.
8. CHEST: Evaluate and treat to rule out a Sudden Cardiac Arrest event and refer to a physician as indicated.
9. PELVIS/BACK: Evaluate, treat and refer to a physician as indicated.
10. LOWER EXTREMITIES: Suspected fractures and dislocations are to be immobilized and referred to a physician for immediate evaluation.
11. General Physician Referral: In addition to the specific cases previously mentioned, the Licensed Athletic Trainer(s) shall communicate their assessment and management of those non-referred cases in a prompt manner to the Team Physician or Physician designated by parent/guardian.
12. Licensed Athletic Trainer(s) will communicate with Team Physician on a weekly basis regarding athletes, injuries, rehabilitation, and return-to-participation status.
13. Please refer to the *Standard Procedures for Injury and Illness for Licensed Athletic Trainer(s)* document for further information.

______________________, MD ______________ Date ________
Medical Director Signature Medical License #

Source:
NATA SS Team Physician Contract Guidelines
https://www.nata.org/sites/default/files/ss_team_physician_contract_guidelines.pdf

&

https://www.nata.org/professional-interests/job-settings/secondary-school/resources

PASS – PROGRAM ASSESSMENT FOR SAFETY IN SPORT

Standard 9.6
Does the organization have a policy on decision-making authority of all QMP and coaches that includes the roles and responsibilities of each in determining participation status of athletic activity for any health reason?

Standard 12.2
Does the organization have a designated team physician (MD or DO) under agreement that establishes the relationship and services provided?

What needs to be in a Physician Order?

These general treatment orders are as outlined by the American Orthopedic Society for Sports Medicine:

1. Evaluate and initiate first aid care for all injuries to all student-athletes.
2. Carry out an appropriate rehabilitation program to increase range of motion, strength, and agility using those indicated modalities. (parameters, time, indications to advance…)
3. Clear the student-athlete to return to full or partial activities as the student-athlete progresses. If a student-athlete sees a physician the student-athlete will secure appropriate medical clearance before they can return to participation. The student-athlete must meet the following criterion to be able to safely return to participation:
   a. 90% strength, full pain-free range of motion, & normal gait pattern (if applicable).

Can AT overrule PCP or ER/Urgent Care notes?
Can Supervising Physician overrule PCP or ER/Urgent Care notes?

4. HEAD: An appropriate healthcare professional trained in the evaluation and management of concussions must evaluate all cases of a suspected concussion, including but not limited to unconsciousness and/or memory loss. All student-athletes with a suspected concussion must follow the Concussion Management Plan for School before they return to participation. Student-athletes may compete a 5 Phase Return to Participation program with the Licensed Athletic Trainer(s) if designated by the licensed healthcare professional trained in the evaluation and management of concussions. The School Medical Director allocates the Licensed Athletic Trainers to determine if a concussion is suspected. If no concussion is suspected, the School Media Director designates the Licensed Athletic Trainers the responsibility to return an athlete to participation.

Can AT progress injured athlete through phases without consulting physician?
Can AT clear injured athlete after completion of phases without consulting physician?

Arizona SB 1521

15-341-A-24 states:
A PUPIL MAY RETURN TO PLAY ON THE SAME DAY IF A HEALTH CARE PROVIDER RULES OUT A SUSPECTED CONCUSSION AT THE TIME THE PUPIL IS REMOVED FROM PLAY. ON A SUBSEQUENT DAY, THE PUPIL MAY RETURN TO PLAY IF THE PUPIL HAS BEEN EVALUATED BY AND RECEIVED WRITTEN CLEARANCE TO RESUME PARTICIPATION IN ATHLETIC ACTIVITY FROM A HEALTH CARE PROVIDER WHO HAS BEEN TRAINED IN THE EVALUATION AND MANAGEMENT OF CONCUSSIONS AND HEAD INJURIES. A HEALTH CARE PROVIDER INCLUDES:

A PHYSICIAN WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17
AN ATHLETIC TRAINER WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 41
A NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15
A PHYSICIAN ASSISTANT WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 25.

What needs to be in a Physician Order?

5. NECK: A physician must evaluate brachial plexus injuries with motor weakness.
6. UPPER EXTREMITY: Suspected fractures and dislocations are to be immobilized and referred to a physician for immediate evaluation.
7. ABDOMEN: Evaluate, treat and refer to a physician as indicated.
8. CHEST: Evaluate and treat to rule out a Sudden Cardiac Arrest event and refer to a physician as indicated.
9. PELVIS/BACK: Evaluate, treat and refer to a physician as indicated.
10. LOWER EXTREMITIES: Suspected fractures and dislocations are to be immobilized and referred to a physician for immediate evaluation.

What needs to be in a Physician Order?

11. General Physician Referral: In addition to the specific cases previously mentioned, the Licensed Athletic Trainer(s) shall communicate their assessment and management of those non-referred cases in a prompt manner to the Team Physician or Physician designated by parent/guardian. (epilepsy, anaphylaxis, diabetes, asthma, …)
12. Licensed Athletic Trainer(s) will communicate with Team Physician on a weekly basis regarding athletes, injuries, rehabilitation, and return-to-participation status.
13. Please refer to the Standard Procedures for Injury and Illness for Licensed Athletic Trainer(s) document for further information.

In Summary

- Required by law – If you don't have written physician direction you will LOSE .
- Resources are available to help.
- Don't include just the what, but the why, the how, and the when.
- Most likely won't be one page – and shouldn't be.
  - If it is, is it really "direction"?

Thank you

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