
Independent Medical Care Legislation

A briefing document submitted by:

The Committee on Competitive Safeguards and Medical Aspects of Sports

NCAA Sport Science Institute

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EXECUTIVE SUMMARY

What is the purpose of the briefing document?

The briefing document explains the origins, rationale and key components of existing independent medical care legislation. It also discusses the potential impact of the legislation on athletics health care delivery at member schools.

Who should read this document?

This briefing document is intended for all individuals with responsibility to comply with the legislation.

What is Independent Medical Care and why is it important?

Independent medical care refers to an environment in which primary athletics health care providers, defined as the team physician and athletic trainer, make medical decisions for student-athletes free of pressure or influence from non-medical factors. This approach empowers team physicians and athletic trainers to have final decision-making authority regarding the diagnosis, management and return-to-play determinations for student-athlete care without influence exerted by non-medical professionals, such as a coach or director of athletics.

What are the legislative requirements?

The independent medical care legislation includes two primary requirements:

Administrative Structure: The legislation requires an administrative structure that provides for the “unchallengeable autonomous authority” of primary athletics health care providers (defined as the team physicians and athletic trainers) to have final decision-making authority for the diagnosis, management and return-to-play determinations for student-athlete care.

Athletics Health Care Administrator: The legislation also requires the designation of an “athletics health care administrator” to oversee a school’s athletic health care administration and delivery. While primary athletics health care providers will retain unchallengeable autonomous authority to determine medical management and return-to-play decisions, the athletics health care administrator will play an administrative role serving as the primary point of contact to assure schools are compliant with NCAA health and safety legislation and interassociation recommendations.

What considerations are there for implementation?

To implement the legislation, schools must provide an administrative structure that ensures there is no interference with medical decision-making, and specifically ensures that “no coach serve as the sole supervisor for any medical provider, nor have sole hiring, retention and dismissal authority over the provider” and that schools designate an “athletics health care administrator.”

What are the necessary action steps arising from this legislation?

1. Evaluate the structures and policies of all administrative units with responsibility for delivery of athletic health care.
2. Identify “gaps” that might undermine the ability of primary athletics health care providers (i.e., athletic trainers and team physicians) to make independent decisions regarding the medical management and return to play decisions of student-athletes. This evaluation may include, but is not limited to:
 - a. organization charts, including reporting and supervisory relationships.
 - b. performance evaluation protocols.
 - c. personnel management policies, including hiring and firing responsibilities.
3. Create and implement solutions to address existing gaps.
4. Designate an athletics health care administrator.
5. Convene a meeting of sports medicine personnel, including athletic trainers and team physicians, with the athletics health care administrator to determine roles and responsibilities.
6. Submit contact information for the athletics health care administrator to the NCAA membership database.

INDEPENDENT MEDICAL CARE: A BRIEFING DOCUMENT

Purpose

The primary purpose of this document is to explain the origins and rationale for Division I (Constitution 3.2.4.17), Division II (Constitution 3.3.4.17) and Division III (Constitution 3.2.4.19) independent medical care legislation, and to clarify the main components of the legislation.

The secondary purpose is to discuss the potential impact of the legislation on both the structure and process of athletics health care delivery in Divisions II and III member institutions.

Who Should Read This?

This paper is intended primarily for those with responsibility to comply with the legislation.

Stakeholders include:

- Presidents and Chancellors
- Directors of Athletics
- Senior Woman Administrators
- Head Coaches
- Primary Athletics Health Care Providers (i.e., athletic trainers and team physicians)
- Other Medical Providers (e.g., psychologists, dieticians, medical specialists)
- Compliance Staff
- Faculty Athletic Representatives
- Student-Athletes

What is Independent Medical Care and Why Is It Important?

Independent medical care occurs in an environment in which medical professionals make reasoned and appropriate decisions for the medical management of patients, free of complication, pressure or influence from non-medical factors. In such an environment, medical providers are more capable of practicing “patient-centered care,” which refers to care that is solely focused on the needs of the patient, and which is the gold standard of medical care. Patient-centered care delivered to student-athletes in an athletic environment has been called “athlete-centered medicine.”¹ Consequently, independent medical care is important to member institutions because it facilitates the delivery of athlete-centered medicine, which maximizes the opportunity for quality medical care, and by extension, student-athlete health and well-being.

Independent medical care is also important because in recent years, the public has grown more aware of, and more concerned with, conflicts of interest in the medical decisions made for student-athletes. Conflict arises when influence is exerted by non-medical professionals (e.g., coach, athletics directors) on the medical decisions of primary athletics health care providers.

This conflict is enhanced when those non-medical personnel have supervisory authority over medical personnel, and use that authority to either influence medical decision-making, or to punish for unpopular medical decisions.

For example, the Chronicle of Higher Education² published the results of a survey of team physicians and athletic trainers, which demonstrated that nearly half of athletic trainers polled reported being pressured by a coach to return a concussed athlete to participation prematurely. In 2014, the Journal of Athletic Training published interassociation consensus recommendations on best practices for sports medicine management, which called for institutions to establish a clear line of unchallengeable authority for team physicians and athletic trainers.¹ A subsequent 2015 survey³ documented higher levels of pressure from coaches on athletic trainers and team physicians when athletics health care departments were directly supervised by the athletics department. At the same time, some have called for a reconsideration of the organizational and administrative structure of athletic health care units and their relationship to athletics departments.³⁻⁵

History of Independent Medical Care Policy and Legislation

The NCAA and its partner sports medicine organizations formerly established their commitment to principles of independent medical care in the 2014 document, [Inter-association Consensus: Independent Medical Care for College Student-Athletes Guidelines](#), which was the product of the first Safety in College Football Summit held in January of 2014.⁶ That document was recently reviewed during the Second Safety in College Football Summit (February 2016), and an updated and endorsed interassociation document is expected for public distribution in the fall of 2016 or early 2017.

At the 2016 NCAA convention in San Antonio, the five NCAA Division I conferences with autonomy passed Proposal 2015-15 (independent medical care), which reflected the interassociation guidelines referenced in the previous paragraph. Division I Constitution 3.2.4.17 (independent medical care) became effective for the Division I conferences with autonomy on August 1, 2016. In October 2016, all member schools in the 27 non-autonomy Division I conferences opted in to the legislation. At its June 2016 meeting, the Committee on Competitive Safeguards and Medical Aspects of Sports (CSMAS) recommended sponsorship of similar independent medical care legislation to both Divisions II and III and at the 2017 NCAA Convention, independent medical care legislation was passed, effect August 2017, for Divisions II (Constitution 3.3.4.17) and III (Constitution 3.2.4.19).

Existing Division I legislation (Constitution 13.11.3.7.4 and 13.11.3.8.2) and Division II legislation (Constitution 17.01.2) gives unchallengeable authority to the sports medicine staff to cancel or modify voluntary summer conditioning for health and safety reasons. But that legislation does not address the day-to-day medical management of student-athletes. Additional Divisions I (Constitution 3.2.4.16) II (Constitution 3.3.4.17) and III legislation (Constitution 3.2.4.18) mandates the designation of a team physician, who “shall be authorized to oversee the medical services for injuries and illnesses incidental to a student-athlete's participation in

intercollegiate athletics,” but this legislation contains no other provisions in support of independent medical care.

Independent Medical Care Legislative Requirements

Independent Medical Care Legislation

An active member institution shall establish an administrative structure that provides independent medical care and affirms the unchallengeable autonomous authority of primary athletics health care providers (team physicians and athletic trainers) to determine medical management and return-to-play decisions related to student-athletes.

An active institution shall designate an athletics health care administrator to oversee the institution's athletic health care administration and delivery.

The primary focus of the legislation is on two related but distinct issues: 1) an administrative structure conducive to independent medical care; and 2) the designation of an athletics health care administrator.

Administrative Structure

The legislation requires an administrative structure that both provides for independent medical care and “affirms the unchallengeable autonomous authority of the ‘primary athletics health care providers,’” which is defined as the team physician and athletic trainer. This designation reflects the central role the physician and athletic trainer play as the foundation of health care delivery for college athletes.

This role reflects the training and credentialing of physicians and athletic trainers, as well as their duty to the daily management of student-athlete

health and safety. Such responsibility must be coupled with clear authority for the diagnosis, management and return-to-play determinations for student-athlete care. There are other members of the sports medicine team (e.g., strength and conditioning coach, dietician, psychologist) who work with the primary athletics health care providers in an integrative and consultative manner. However, the primary athletics health care providers should ultimately be empowered to make final decision-making to both ensure appropriate medical controls and to avoid confusion.

The legislation is silent as to the specific nature or characteristics of the administrative structure. Implementation considerations will be discussed below.

Athletics Health Care Administrator

The legislation also requires the designation of an “athletics health care administrator.” Per the legislation, this individual will “oversee the institution’s athletic health care administration and delivery.” As the legislation has no budgetary impact, compliance with the legislation would not require the creation of a new position. Designation of an existing employee of the institution is acceptable.

The athletics health care administrator position is, as the name implies, administrative in nature. It is intended that this position become the primary point of contact for communication and dissemination of health and safety legislation, educational material and interassociation guidelines and best practices. The designation of such a position will, for the first time, provide a primary point of contact within a member school to work directly with the NCAA Sport Science Institute. This also means that the athletics health care administrator will have some responsibility for helping to ensure that the administrative structure allows for the delivery of independent medical care.

A real-world analogy for this position is that of a medical office manager who works in a physician's office. The typical medical office manager has administrative and clinical knowledge, skills in business and administration and clinical management. The medical office manager is also responsible for the operations of the medical practice. Importantly, medical office managers are not dictating the care delivered by the physician. Instead, they are ensuring that the care is being delivered in an organizational environment that reflects relevant laws, rules and regulations. This analogy is not meant to suggest a standard set of responsibilities for the athletics health administrator, but instead; to clarify how that role integrates with existing health care operations.

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It is also important to note that the athletics health care administrator position lies outside of the normal medical hierarchy required for the lawful delivery of medical care. Physicians sit atop of that hierarchy, and a team physician/medical director is ultimately responsible for the care being delivered at all member institutions. As noted above, existing legislation in all three divisions requires the designation of a team physician who “shall be authorized to oversee the medical services for injuries and illnesses incidental to a student-athlete's participation in intercollegiate athletics” (NCAA Constitution [3.2.4.16](#) (Division I), [Constitution 3.3.4.17](#) (Division II), [Constitution 3.2.4.18](#) (Division III)). Team physician authority is the linchpin for independent medical care of student-athletes (cite [Interassociation Consensus: Independent Medical Care for College Student-Athlete Guidelines](#)).

In this way, the athletics health care administrator is a necessary complement to the team physician. Where the team physician has responsibility for providing medical services, the athletics health care administrator will have responsibility for administration and delivery of those medical services. One position doesn't necessarily answer to the other as they have separate but related responsibilities to the whole of athletics health care services.

Considerations for Legislative Implementation

To implement this legislation, schools must ensure that primary athletics health care providers have unchallengeable autonomous authority to determine medical management and return-to-play decisions of student-athletes. This means that the institutions must ensure that there is no interference with medical decision-making from coaches or other members of the athletics staff.

Administrative Structure

Member institutions would have flexibility to determine the best strategies for “establishing an administrative structure that provides independent medical care and affirms the unchallengeable autonomous authority of primary athletics health care providers.”

The only explicit requirement, as stated in the proposal rationale, is that “no coach serve as the sole supervisor for any medical provider, nor have sole hiring, retention and dismissal authority over the provider.” In other words, the coach must be completely de-coupled from medical decision-making, and primary athletics health care providers must be in an environment in which making such decisions are free of any threat from coaches. This may pose a challenge for some schools with athletics directors who also serve as coaches, and to whom a primary athletics health care provider solely reports. Effective solutions to this challenge may focus on the development of shared supervisory relationships for athletics health care providers, or on the creation of appeal or oversight mechanisms, external to the athletics department, for the evaluation of the merits of negative employment decisions against athletics health care providers.

Additional considerations can be found in the [Inter-association Consensus: Independent Medical Care for College Student-Athlete Guidelines](#). For example, schools may evaluate their administrative structure to ensure that an athletic trainer’s professional qualifications and performance evaluations, especially performance in the delivery of care and medical decision-making, are not primarily or solely judged by administrative personnel without health care knowledge or expertise. Ensuring such an arrangement may imply that lines of supervisory authority should reflect both administrative and medical responsibilities, and that where medical responsibilities exist, team physicians play the central role.

Athletics Health Care Administrator

The legislation does not specify who must or can be designated as the athletics health care administrator. As stated above, the legislation has no budgetary impact, so member schools may choose to designate an existing employee. Appropriate professionals to serve in this role include physicians, athletic trainers, other health care professionals with administrative backgrounds or administrative personnel who have experience managing health care matters.

Importantly, the designation of the athletic health care administrator must be made in a manner that respects the stated administrative requirements structure.

For example, athletic trainers deliver health care under the direction of a licensed physician. However, an athletic trainer could serve as the athletics health care administrator, which is an administrative position. While primary athletics health care providers, under the ultimate direction of the team physician, will retain unchallengeable autonomous authority to determine medical management and return-to-play decisions, the athletics health care administrator will assume an administrative role in the delivery of athletics health care. This administrative role may include assuring that schools are compliant with all pertinent NCAA health and safety legislation and with interassociation consensus statements and education that impact student-athlete health and safety.

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