Rising medical costs and the aging baby boomer generation have brought issues to the forefront of the national healthcare discussion, such as effectiveness of therapeutic interventions and patient access to care. To help bring relief to an already over-burdened healthcare system, policy makers have begun to highlight the need to identify medical interventions that are both effective and cost-efficient and the health professionals who can best provide those interventions to the general public. The recently passed American Reinvestment and Recovery Act (ARRA) allocates hundreds of millions of dollars to specifically address these needs. The athletic training profession could benefit from these initiatives if properly positioned; however, these policy initiatives often appear to be abstract ideas that have no immediate impact on how and where athletic trainers practice, and consequently, few pay attention. Therefore, the purpose of this report is to review the health-related initiatives of the ARRA as they relate to athletic training and to offer strategies for seizing these emerging opportunities.

Opportunity Through A Changing Healthcare System

Congress passed the ARRA in 2009, which addressed a number of national needs in an effort to stimulate the depressed American economy. Of this billion-dollar investment, $300 million was given to the Agency for Health Research and Quality (AHRQ) to fund grants and projects specifically related to comparative effectiveness research (CER). The primary goal of CER is to better inform patients, providers, and other healthcare stakeholders, through scientific evidence, about the most effective treatments and interventions for specific health conditions. From a research perspective, CER compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures related to preventing, diagnosing, treating, or monitoring health conditions. This may shift the focus of healthcare research from studies that are conducted in controlled laboratory settings (i.e., efficacy studies) to studies that take place in real-world clinical settings (i.e., effectiveness studies). This shift should lead to better evidence-based decisions about utilization of specific treatments and interventions.

CER may appear to be a novel idea, but its basic concepts (e.g., effectiveness and cost-efficiency of medical interventions) and goals (e.g., making more informed, evidence-based clinical decisions) are not very different from those of clinical outcomes assessment (COA). A review of CER methodology reveals that it is a form of clinical outcomes research. This is important to recognize, because recent efforts to incorporate COA into athletic training practice may have serendipitously provided our profession with a jump-start for pursuit of opportunities presented by healthcare change.

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Take Action and Seize Opportunity

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Taking Action

The direct path to CER funding, expanded clinical practice opportunities, and recognition from professional peers in the healthcare community is through
the routine assessment of clinical outcomes in athletic training practice. Engagement in COA is a no-lose situation for our profession. The successful integration of COA into athletic training practice will position us to take advantage of CER initiatives and will establish evidence related to the effectiveness and cost-efficiency of athletic training services. In an era of rising medical costs and increasing concerns about access to care, this type of information will be invaluable for employment security and expansion of clinical practice opportunities in the future.

Despite the many benefits of COA to the athletic training profession, and numerous appeals to clinicians and researchers to become involved in the collection and analysis of clinical outcomes data,3-6 there appears to be an underwhelming response from our profession. For example, recently acquired evidence suggests that approximately 70% of practicing athletic trainers in the high school, college, clinic, and industrial settings do not routinely assess clinical outcomes (Snyder et al. 2010, unpublished data), and that only a few research reports related to clinical outcomes in athletic training have been published in recent years. So we ask, “Why the apathy?”

**Addressing Threats**

From our experience, there are self-imposed obstacles that limit the ability of the athletic training profession to seize the potential opportunities afforded by the ARRA. Lack of availability of time and the necessary research infrastructure to engage in COA are important factors. If these obstacles are not addressed, our chances for realization of opportunities presented by healthcare change may be lost.

A frequent clinician objection to participation in COA research is not having the time to gather the necessary data. This issue is compounded by the fact that clinicians do not need outcomes information to establish an injury diagnosis, making the relationship between immediate patient care decisions and long-term outcomes appear to have low value. We suspect that every clinician faces time constraints that are imposed by personal, professional, and social obligations. Yet, most clinicians typically manage to get things done by prioritizing responsibilities from the most important and urgent to least important. Is the limited commitment to collection of clinical outcomes data in athletic training an issue of time or a perception of minimal value?

Clearly, persuading people to value something is difficult. Our argument for prioritization of engagement with COA would be strengthened by evidence that demonstrates its benefits to athletic trainers. Unfortunately, we can’t provide concrete examples. Relatively few athletic trainers collect outcomes data, and the collective volume of COA data is not large enough to impact clinical practice; however, we can identify several professional issues that have adversely affected athletic trainers for decades, and that may be directly or indirectly addressed through COA: burnout, job security, and treatment effectiveness.

Let’s consider the issue of burnout. For years, athletic trainers have cited long work days, extended work weeks, and unfavorable work hours (e.g., early mornings, late nights, and weekends) as detrimental to quality of life. Traditionally, athletic trainers have been expected to be available at almost any time. There is a common expectation among coaches that injured athletes should receive multiple treatments per day as a game approaches. This creates a huge time demand for athletic trainers and makes their work schedules dependent on the availability of the injured athletes. These time demands and suboptimal schedules undoubtedly contribute to professional burn-out (loss of passion for involvement in the profession), which ultimately leads many athletic trainers to seek an alternative career.

The notion that intensive treatments should be administered to ensure that injured players will be ready for a game contributes to a culture of practice that endorses the “more treatment is better” approach, without knowing whether the expenditure of time and effort provides any real benefit. COA research could provide evidence to resolve the issue of whether or not faster return-to-play is achieved when athletes receive multiple daily treatments. It is possible that three treatments per week produce the same outcome as 10 or more. Imagine the impact that this knowledge could have on the lives of athletic trainers, whose work schedules could be lightened by the removal of unnecessary treatment sessions.

Although the athletic training profession has a substantial number of trained researchers, most of them are dedicated to the study of biomechanical and physiological phenomena related to sports injuries, and relatively few possess the necessary expertise to perform COA research. Consequently, the profession has few individuals who can lead COA and CER research efforts. Furthermore, COA and CER investigations study treat-