PREFACE

The purpose of the Commission on Accreditation of Athletic Training Education (CAATE) is to develop, maintain, and promote appropriate minimum education standards of quality for athletic training programs. CAATE is sponsored by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Orthopaedic Society for Sports Medicine, and the National Athletic Trainers’ Association (NATA).

The Standards and Guidelines for the Accreditation of Post-Professional Athletic Training Residency Programs (Standards) are to be used for the development, evaluation, analysis, and maintenance of post-professional athletic training residency programs. Via comprehensive and annual review processes, CAATE is responsible for the evaluation of a program’s compliance with the Standards. The Standards provide minimum academic requirements; institutions/entities are encouraged to develop sound innovative educational approaches that substantially exceed these Standards. The Standards document also contains a glossary of terms used throughout the process; the definition provided in the glossary must be applied as stated.

Post-Professional Athletic Training Residency Programs are formal educational programs that offer structured curricula, including didactic and clinical components, to educate Athletic Trainers. They are designed to build upon and expand the Athletic Trainer’s knowledge and experience acquired during professional (entry-level) education.

Residency program accreditation is designed to evaluate the post-professional athletic training educational program being offered and is not meant to imply that an Athletic Trainer must participate in an accredited residency to obtain the requisite knowledge and skills necessary for practice in a focused area of clinical practice. The standards allow each post-professional athletic training residency program to be creative and innovative with its program design and the methodologies used to enable Athletic Training residents to achieve program goals and acquire defined competencies.

The accreditation process conducted by the Commission on Accreditation of Athletic Training Education (CAATE) is voluntary and may be pursued by institutions and programs that sponsor a structured educational experience. The process gives applicant programs the opportunity to demonstrate compliance with the approved standards. While the process is voluntary, it provides programs an external validation of their educational offering. Additionally, the process offers prospective athletic training learners a mechanism by which they can judge the quality of the educational experience offered by the program or institution. Programs that successfully demonstrate compliance are accredited...
by the CAATE. A list of accredited programs is published and available to the public.

**Post-Professional Athletic Training Residency Mission**
The mission of a post-professional residency advances preparation of an athletic training practitioner through a planned program of clinical and didactic education in a specialized area utilizing an evidence-based approach to enhance patient care.

**Post-Professional Athletic Training Residency Competencies**
A Post-Professional Athletic Training Residency (PP-ATR) must prepare athletic trainers for advanced clinical practice that will enhance the quality of patient care, optimize patient outcomes, and improve patients’ health-related quality of life through the utilization of evidence-based practice concepts. To realize these objectives, a PP-ATR must ensure that students attain specific “competencies” that relate to professional behaviors.

The Institute of Medicine (IOM) has identified five core competencies for all healthcare providers, regardless of discipline\(^2\), and similar concepts are represented in six competencies defined by the Accreditation Council for Graduate Medical Education (ACGME)\(^3\) and the American Board of Medical Specialties (ABMS)\(^4\) for all graduate medical education, regardless of specialty. PP-ATR competencies are consistent with those specified by IOM and ACGME/ABMS, and they are consistent with seven foundational behaviors of professional practice identified by the NATA.\(^1\) The six core competencies that a PP-ATR must be designed to address include: 1) patient-centered care, 2) interdisciplinary collaboration, 3) evidence-based practice, 4) quality improvement, 5) use of healthcare informatics, and 6) professionalism.

Descriptions of the six core competencies are provided:

1) **Patient-Centered Care**
Patient-centered care is characterized by efforts to clearly inform, educate, and communicate with patients in a compassionate manner. Shared decision-making and management are emphasized, as well as continuous advocacy of injury and disease prevention measures and promotion of a healthy lifestyle.

Competency in patient-centered care relates to the athletic trainer’s ability to serve as an advocate for a patient’s best interests, to educate the patient about health-related concerns and intervention options, to recognize any conflict of interest that could adversely affect the patient’s health, and to facilitate collaboration among the patient, physician, family, and other members of the patient’s social network or healthcare system to develop an effective treatment plan that includes agreed-upon implementation steps, short-term goals and long-term goals.
2) **Interdisciplinary Collaboration**
Cooperation among clinicians who provide care for a patient is far more important than professional prerogatives and roles. Different health professions often perform a subset of overlapping functions, but separate scopes of practice, governance structures, and standards maintained by licensing agencies for the different health professions present obstacles to the delivery of optimum patient care by an interdisciplinary team.

Competency in interdisciplinary collaboration relates to the athletic trainer’s ability to interact with other health professionals in a manner that optimizes the quality of care provided to individual patients.

3) **Evidence-Based Practice**
Evidence-based practice is the integration of best research evidence with clinical expertise and patient values and circumstances to make decisions about the care of individual patients.

Competency in evidence-based practice relates to the athletic trainer’s ability to integrate the best available research evidence with clinical expertise and consideration of patient values and circumstances to optimize patient outcomes.

4) **Quality Improvement**
Healthcare organizations are increasingly adopting quality assessment methods that originated in the industrial manufacturing sector to minimize waste, decrease errors, increase efficiency, and improve quality of care. Competency in quality improvement relates to the athletic trainer’s recognition of the need for constant self-evaluation and life-long learning, and it includes the ability to identify a quality improvement objective, specify changes that are expected to produce an improvement, and quantitatively confirm that an improvement resulted from implementation of the change (e.g., improved patient outcomes from administration of a specific intervention or utilization of a specific protocol).

5) **Use of Healthcare Informatics**
Clinicians must increasingly use information technology to manage clinical data and access the most recent evidence pertaining to optimum patient care.

Competency in the use of healthcare informatics relates to the athletic trainer’s ability to:
1) search, retrieve, and utilize information derived from online databases and/or internal databases for clinical decision support, 2) properly protect the security of personal health information in a manner that is consistent with legal and ethical considerations for use of such data, including control of data access, utilization of patient identity coding, de-identification of aggregated data, and encryption of electronically transmitted data, 3) guide patients to online sources of reliable health-related information, 4) utilize word processing, presentation, and data analysis software, and 5) communicate through email, text messaging, listservs,
and emerging modes of interactive electronic information transfer.

6) **Professionalism**

Professionalism relates to personal qualities of honesty, reliability, accountability, patience, modesty, and self-control. It is exhibited through ethical behavior, a respectful demeanor toward all persons, compassion, a willingness to serve others, sensitivity to the concerns of diverse patient populations, a conscientious approach to performance of duties, a commitment to continuing education, contributions to the body of knowledge in the discipline, appropriate dress, and maintenance of a healthy lifestyle.

Competency in professionalism relates to the athletic trainer’s adherence to the CAATE Code of Ethics and the Board of Certification Standards of Practice, and includes intrinsic motivation to continuously exhibit the manifestations of professionalism in all aspects of clinical practice and personal conduct.
Standard 1: Qualifications of the Resident (The resident will be an athletic trainer committed to attaining specialized clinical competence beyond entry-level practice.)

Requirements:
1.1 Residency applicant qualifications will be evaluated through an established, formal procedure that includes an assessment of the applicant’s ability to achieve the educational goals and objectives established for the program.
1.2 The resident must be appropriately credentialed to practice athletic training in the state of the residency.

Standard 2: Obligations of the Program to the Resident (The athletic training residency program will provide an exemplary environment conducive to resident learning.)

Requirements:
2.1 Programs must be a minimum of twelve consecutive months with a continuous full-time practice commitment.

2.2 The residency program director (RPD) must ensure that neither the educational outcomes of the program nor the welfare of the resident or the welfare of patients are compromised by excessive reliance on residents to fulfill service obligations. Providing residents with a sound academic and clinical education must be planned and balanced with concerns for patient safety and resident well-being. Programs must comply with the current duty hour standards of the residency program, not to exceed the duty hour standards of the Accreditation Council for Graduate Medical Education (ACGME). www.acgme.org

2.3 The RPD must provide residents who are accepted into the program with a letter outlining their acceptance to the program. Information on the terms and conditions of the appointment must also be provided in a manner consistent with that provided to athletic trainers within the organization conducting the residency. Acceptance by residents of these terms and conditions must be documented prior to the beginning of the residency.

2.4 The residency program must provide a sufficient complement of associated clinical staff to ensure appropriate support and preceptor guidance to all residents.

2.5 The residency program must provide residents an area in which to work, access to appropriate technology, access to extramural educational
opportunities related to the specialized residency experience, and sufficient financial support to fulfill the responsibilities of the program.

2.6 Policies concerning professional, family, and sick leave and the effect such leaves would have on the resident’s ability to complete the residency program must be defined, published, and readily available.

2.7 Program admission and retention policies, and minimum completion requirements must be clearly defined, published and readily available to prospective and enrolled athletic training residents.

2.8 Upon completion of the program, each resident will receive a certificate of residency from the CAATE. These certificates are requested by the RPD from the CAATE. A certificate must not be issued to anyone who does not complete the program’s requirements.

2.9 The RPD must ensure the program’s compliance with the provisions of the current version of the CAATE Post-Professional Athletic Training Residency Standards and Guidelines.

2.10 The RPD and preceptors must provide the resident with planned and documented feedback related to performance.

2.11 All health care professionals associated with the residency must be appropriately credentialed to practice in the state of the residency and practice within the code of conduct for their profession.

**Standard 3: Obligations of the Resident to the Program** (The resident will be committed to attaining the program’s educational goals and objectives and will support the organization’s mission and values.)

**Requirements:**

3.1 Residents’ primary professional commitment must be a full-time obligation to the residency program.

3.2 Residents must be committed to the values and mission of the organization conducting the residency program.

3.3 Residents must be committed to completing the educational goals and objectives established for the program.

3.4 Residents must seek constructive verbal and documented feedback that directs their learning.

3.5 Residents must be committed to making active use of the constructive feedback provided by the RPD and residency program preceptors.
Standard 4: Requirements for the Design and Conduct of the Residency Program (The resident’s didactic and clinical experiences will be designed, conducted, and evaluated.)

Requirements:

4.1 Program Design. The RPD and, when applicable, program preceptors will collaborate to design the residency program. The program will document its mission, purpose (the type of practice for which the residents are to be prepared); its educational goals (broad, sweeping statements of abilities); educational objectives (observable, measurable statements of resident performance, the sum of which ensure achievement of the educational goal) for each educational goal; plan to meet the objectives; and related outcomes (evidence that the objectives are being met). The resulting design must include the following components:

A. Providing defined, planned and mentored education and training in a focused area of clinical practice within the scope of athletic training. The practice site offering the residency shall provide an exemplary clinical practice environment and mentored athletic training experience.
   • The residency program director must mentor the preceptors as they interact with the resident.
   • Document that the clinical practice environment involves a defined and planned experience within a focused area of athletic training practice.
   • Document that the preceptors provide clinical expertise within the focused area.
   • Document that the resident had consummate clinical experiences within the focused area.
   • The majority of the clinical experience must be completed within the focused area, and at least 20% of the time must occur with the preceptors in a one-on-one basis within that focused area.

B. Providing defined, and planned didactic education experiences in a focused area
   • Document the planned and ongoing educational opportunities (minimum requirement of five hours per week) that the resident must complete throughout the residency.
   • These may include case reviews, didactic classroom instruction, journal club, problem solving sessions, clinical rounds, in-services, seminars, workshops, etc.).
C. Instilling principles of evidence-based practice to include reading and interpreting available patient oriented evidence and integrating into clinical practice.
   • Identify, assimilate and review research within the focused area and disseminate that demonstration of change has occurred within the scope of current practice or demonstration of validation of current clinical practice.

D. Instilling principles of evidence based practice to include the measurement of patient oriented evidence to determine the effectiveness of athletic training interventions
   • Actively engaged in patient oriented outcomes as part of systematic data collection and ongoing assessments within the focused area and disseminate the information that has been compiled.

4.1.1 Preceptors will create a description of their learning experience and a list of activities to be performed by residents in the learning experience that demonstrates adequate opportunity to learn the educational goals and objectives assigned to the learning experience.

4.1.2 The program will create an outcome-based approach to evaluation of resident attainment of the program’s educational goals and objectives, resident self-assessment of their performance, and resident evaluation of preceptor performance and of the program. The strategy will be employed uniformly by all preceptors and include a preceptor evaluation of the resident, a resident self assessment, a preceptor self assessment, and a resident evaluation of the preceptor.

4.1.3 Each competency must be incorporated within both the didactic and clinical aspect of the residency program and assessment of each competency must be performed. The six core competencies that a PP- ATR must be designed to address include: 1) patient-centered care, 2) interdisciplinary collaboration, 3) evidence-based practice, 4) quality improvement, 5) use of healthcare informatics, and 6) professionalism.

4.2 Program Delivery. The program’s design must be implemented fully, with ongoing attention to fulfillment of both preceptor and resident roles and responsibilities. In delivering the program the following must occur and be documented:
   a. The RPD and, when applicable, preceptors will conduct essential orientation activities. Residents will be oriented to the program to include its purpose, the applicable accreditation regulations and standards, designated learning experiences, and the evaluation
strategy. When necessary, the RPD will orient staff to the residency program. Preceptors will orient residents to their learning experiences, including reviewing and providing written copies of the learning experience educational goals and objectives, associated learning activities, and evaluation strategies.

b. The RPD and, when applicable, preceptors will customize the training program for the resident based upon an assessment of the resident’s entering knowledge, skills, attitudes, and abilities and the resident’s interests.

c. The RPD and preceptors will provide the resident with documented feedback on their program objective-based performance through completion of the program’s plan for assessment. Overall progress toward achievement of the program’s outcomes, through performance of the program’s educational goals and objectives, will be assessed at least quarterly, and any necessary adjustments to residents’ customized plans, including remedial action(s), will be documented and implemented.

4.3 Program Evaluation and Improvement. Program evaluation and improvement activities will be directed at enhancing achievement of the program’s identified outcomes. The RPD will evaluate potential preceptors based on their desire to teach and their aptitude for teaching (as differentiated from formal didactic instruction) and provide preceptors with opportunities to enhance their teaching skills. Further, the RPD will devise and implement a plan for assessing and improving the quality of preceptor instruction including, but not limited to, consideration of the residents’ documented evaluations of preceptor performance. At least annually, the RPD and, when applicable, preceptors will consider overall program changes based on evaluations, observations, and other information.

4.4 Tracking of Graduates: The RPD should evaluate whether the residency produces the type of practitioner described in the program’s purpose statement. The RPD must document how the outcomes assessment information is utilized to develop the program. (Information tracked may include initial employment, changes in employment, employer evaluations, etc.)

Standard 5: Qualifications of the Residency Program Director (RPD) and Preceptors (The RPD and preceptors will be professionally and educationally qualified clinicians who are committed to providing effective training of residents.)

Requirements of the residency program director:
5.1 The RPD must be an athletic trainer and appropriately credentialed to
practice athletic training in the state of the residency and should have a minimum of five years of athletic training practice experience with demonstrated mastery of the knowledge, skills, attitudes, and abilities expected of one who has completed a residency.

5.2 The RPD must have documented evidence of his/her own ability to teach effectively in the clinical practice environment (e.g., through student and/or resident evaluations). The RPD serves as leaders of programs, responsible not only for precepting residents, but also for the evaluation and development of all other preceptors in their programs.

5.3 Each residency program must have a single RPD who must be an athletic trainer from a practice site involved in the program or from a sponsoring organization.

5.4 A single RPD must be designated for multiple-site residencies or for a residency offered by a sponsoring organization in cooperation with one or more practice sites. The responsibilities of the RPD must be defined clearly, including lines of accountability for the residency and to the residency training site. Further, the designation of this individual to be RPD must be agreed to in writing by responsible representatives of each participating organization.

5.5 The RPD must have demonstrated their ability to direct and manage an athletic training residency such as previous involvement as a preceptor in an accredited athletic training residency program, management experience, or previous clinical instruction or supervision experience.

5.6 The RPD must have a sustained record of contribution and commitment to athletic training practice that may be characterized by the following:
   a. Documented record of improvements in and contributions to athletic training practice.
   b. Formal recognition by peers or supervisors as a model practitioner.
   c. An ongoing record of continued contribution to the total body of knowledge in athletic training through publications in professional journals and/or presentations at professional meetings.
   d. Serves as a reviewer of manuscripts submitted for publication.
   e. Demonstrated leadership in advancing the profession of athletic training through active service in professional organizations and activities at the local, state, and national levels.
   f. Demonstrated effectiveness in teaching (e.g., through student and/or resident evaluations, teaching awards).

Requirements of preceptors: (The RPD should document criteria for clinicians to be preceptors. The following requirements may be supplemented with other criteria.)
5.7 Preceptors must be an appropriately credentialed health care provider.
   - Preceptors who are athletic trainers, physical therapists, physicians assistants and similarly qualified practitioners must have a minimum of five years of practical experience beyond the entry level certification, appropriately credentialed to practice in the state of residency, and must demonstrate expected mastery of the knowledge, skills, attitudes, and abilities.
   - Preceptors who are physicians must have completed their residency programs.

5.8 Preceptors must have training and experience in their formal area of practice for which they serve as preceptors, must maintain continuity-of-practice in that area, and must be practicing in that area at the time residents are being trained.

5.9 Preceptors must have a record of contribution and commitment to their specified area of practice that may be characterized by the following:
   a. Documented record of improvements in and contributions to their focused area of practice.
   b. Formal recognition by peers or supervisors as a model practitioner.
   c. An ongoing record of continued contribution to the total body of knowledge in their specified area of practice through publications in professional journals and/or presentations at professional meetings.
   d. Serves as a reviewer of manuscripts submitted for publication.
   e. Demonstrated leadership in advancing their profession through active service in professional organizations and activities at the local, state, and national levels.
   f. Demonstrated effectiveness in teaching (e.g., through student and/or resident evaluations, teaching awards).

5.10 Preceptors must demonstrate the capability for effective teaching that includes mastery of teaching clinical problem solving. Further, preceptors must demonstrate abilities to provide program outcome-based feedback and evaluation of resident performance. Preceptors must continue to pursue refinement of their teaching skills.

**Standard 6: Minimum Requirements of the Sponsoring Organization**

**Conducting the Residency Program** (The organization conducting the residency will meet accreditation standards, regulatory requirements, and other nationally applicable standards and will have sufficient resources to achieve the purposes of the program.)

**Requirements:**

6.1 As appropriate, residency programs must be conducted only in practice settings that have sought and accepted outside appraisal of facilities and
patient care practices. The external appraisal must be conducted by a recognized organization appropriate to the practice setting.

6.2 Residency programs must be conducted only in those practice settings where management and professional staff have committed to seek excellence in patient care, demonstrated substantial compliance with professionally developed and nationally applied practice and operational standards, and have sufficient resources to achieve the educational goals and objectives selected for the residency program.

6.3 Two or more practice sites, or a sponsoring organization (e.g., colleges/universities, health system) working in cooperation with one or more practice sites, may provide an athletic training residency.
   a. Athletic training residencies are dependent on the availability of a sufficient patient population base and professional practice experience to satisfy the requirements of the residency program.
   b. Sponsoring organizations must maintain authority and responsibility for the quality of their residency programs.
   c. A mechanism must be established that designates and empowers an individual to be responsible for directing the residency program and for achieving consensus regarding the evaluation and ranking of applicants for the residency.
   d. Sponsoring organizations and practice sites must have contractual arrangement(s) or signed agreement(s) that define clearly the responsibilities for all aspects of the residency program.
   e. Each of the practice sites that provide residency training must meet the requirements set forth in Requirement 6.2.
Glossary

**Competency.** Professional behavior that involves the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice. ²

**Focused area of clinical practice within the scope of athletic training:** An area of clinical practice that can be clearly denoted as being advanced in depth of knowledge and skills. The purpose of this focused depth is to develop specialists in sub-disciplines within athletic training. Areas of focused practice depth should be developed around the focused patient population (e.g., pediatrics) or body system (e.g., orthopedics/musculoskeletal). Areas of focused clinical practice should NOT be developed based upon practice setting (e.g., secondary school, hospital, industrial). Programs are encouraged to examine the residency models of specialization in peer health professions such as medicine, pharmacy, and physical therapy when determining an appropriate focused area of clinical practice. Programs bare the burden of establishing why their chosen focused area of clinical practice is appropriate to advance the residents depth of knowledge and skills in a specialized area of athletic training practice.

**Guideline:** Requirements that are so important that their absence must be justified. Denoted by the verb “should.”

**Multiple-site residency.** A residency site structure in which multiple organizations/practice sites are involved in the residency program. In a multiple-site residency, a sponsoring organization must be identified to assume ultimate responsibility for coordinating and administering the program.

**Must:** Verb used to indicate that something is required, compelled, mandatory or shall be done without fail. It connotes an absolute requirement. A Standard.

**Preceptor.** An expert clinician who provides practical experience and training to an athletic training resident. Preceptors responsibilities include development of a resident’s practice competency, therefore it is critical that learning experiences be mentored by preceptors who model clinical practice skills and provide regular criteria-based feedback. It is permissible to use practitioners in addition to athletic trainers (e.g., physicians, physician assistants, and nurse practitioners) as preceptors.

**Residency program director.** The athletic trainer responsible for direction, conduct, and oversight of the residency program.

**Single-site residency.** A residency site structure in which the practice site assumes total responsibility for the residency program. In a single-site residency, the majority of the resident’s training program occurs at the site; however, the resident may spend assigned time in short elective learning experiences off-site.

**Should.** A term used to designate requirements that are so important that their
absence must be justified. A program is at risk if it is not in compliance with a "should". A guideline.

**Sponsoring organization.** The organization assuming ultimate responsibility for the coordination and administration of the residency program. The sponsoring organization is charged with ensuring that the resident experiences are educationally sound and are conducted in a quality practice environment. The sponsoring organization is also responsible for submitting the accreditation application and ensuring periodic evaluations are conducted. If several organizations share responsibility for the financial and management aspects of the residency the organizations must mutually designate one organization as the sponsoring organization.

**Standard:** Mandatory components of the program. Denoted by the verb “**must**” and “**shall.**”

*modified from the ASHP Accreditation Materials (www.ashp.org), ARC-PA Accreditation Materials, and APTA Accreditation Materials.*
REFERENCES


5. American Society of Health-System Pharmacists Accreditation Materials (www.ashp.org)
