

# Room for Change

*Some colleges are trying a new model, aligning athletic training with campus health services instead of athletics*

Text **Darrin Scheid**

In a perfect world, athletic trainers in the college and university setting work no more than 45 hours per week, on average. They are treated like health care professionals, even by the most inexperienced assistant coaches and newly hired operations directors, and they make 20 percent more than the current national average.

It sounds like a fantasy – but this is the reality at Princeton, Boston University and Dartmouth. The University of North Carolina fits this description, and so does Division II Kutztown University in Pennsylvania.

What these schools and a handful of other institutions across the college landscape have in common is the way they handle the business of providing care for athletes. These schools don't have identical models, but one consistent theme is that athletic trainers report to the university's health care center and not the department of athletics. Charles Thompson, MS, ATC, Princeton's head athletic trainer, said once you have worked in this system, you wouldn't even think about going back.

"For the athlete, everything related to care is expeditious because we work so closely with other health care professionals on campus," Thompson said. "For the athletic trainers, we're treated in every respect as health care providers, from salary to how we're viewed by other medical professionals. And with coaches, I want coaches to understand why we're doing something. Ask questions, but don't question me. That's the way I look at it because we don't answer to a coach."

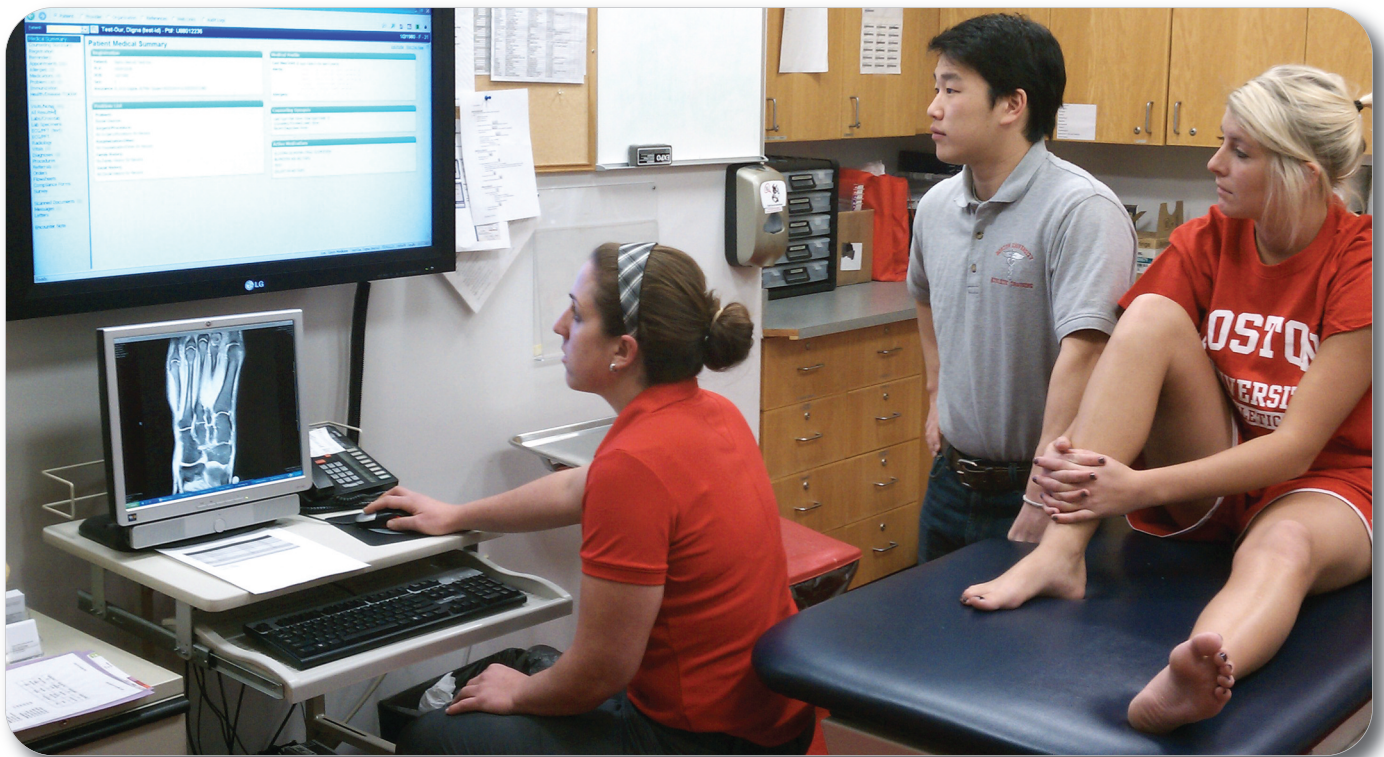


A Kutztown University football player receives medical attention from **Rennie Sacco**, MEd, ATC, the school's Coordinator of Sports Medicine.

At Princeton, the model works like this: University Health Services has an executive director that heads the operation and supervises a medical director and director for counseling services. Under the medical director is the director of athletic medicine, who is the team physi-

cian and Thompson's supervisor. Thompson has a staff of nine athletic trainers who oversee 38 sports at the Division I school.

Thompson said his staff members make at least \$50,000, and if they aren't enjoying life outside of work, it's not Princeton's fault. They



**Amanda Thoens, MA, ATC**, and athletic training education program students **Eric Hwang** and **Christine Kelly** study a foot evaluation in the Boston University athletic training room.

average 45 hours per week, and Thompson said these numbers aren't estimates because hours are documented just as they would be in a clinic. Coaches know that Princeton's athletic training room opens at 8 a.m., although somebody is usually there a quarter hour before that.

A plan for medical service is organized at the beginning of the year, and whether or not an athletic trainer attends a practice is based on the sport. At many colleges and universities, athletic trainers try to cover all practices. At Princeton, sports are categorized red, orange or yellow. Football and ice hockey are red, which means the team should not practice unless an athletic trainer is present. Basketball, baseball and softball fit under yellow, meaning practices should take place when an athletic trainer is at least available in the athletic training room. Tennis, swimming and squash are green, allowing those teams to practice without an athletic trainer as long as the coaches are versed in the emergency action plan for whatever facility they are using. All coaches are trained in First Aid and CPR.

"Basketball is an important sport here, but we don't sit and watch basketball practice every day," Thompson said. "If you're paying me by the hour, do you want me to sit on the basketball court and watch 15 kids run

around for two hours, or would you rather me be in the athletic training room treating patients? If something happens, coaches know what to do, and we're never far away. And a physician is here on campus."

Athlete medical records are stored in a database on campus and shared between the health center nurses, doctors and athletic trainers. If a women's lacrosse player gets a concussion, she can stay in the health center on campus overnight.

"I had some hamstring problems early in my career and recently had some ankle issues and a sports hernia operation, so I've spent a lot of time in the (athletic) training room," Princeton football player Andrew Kerr said. "If we talked about an injury and decide that I should see the doctor or get an X-Ray, I could come back down and have a diagnosis by that afternoon. The communication and how they work together makes it very efficient. It was pretty easy to be treated."

If it's so great, why aren't more people doing it?

Tradition is tough to break, said Renard Sacco, MEd, ATC, the Coordinator of Sports Medicine, at Kutztown. Sacco said there is usually a change in athletic administration that allows for college presidents and vice-presidents to shift their thinking, and that's

exactly what happened at this university in eastern Pennsylvania. It was nearly seven years ago that a change in athletic administration opened the door for discussion on how to better manage athlete health care.

The Sports Medicine Department was placed under KU's Health, Wellness and Counseling. Both Intercollegiate Athletics and Sports Medicine is under the Division of Student Services and Campus Life (Student Affairs). KU's athletic trainers are faculty (non-teaching), and starting pay and raises for them are determined the same way they are for all faculty. Sacco manages the university's sports medicine program, which today includes three additional full-time athletic trainers, who are responsible for the health care needs of more than 500 athletes in 22 sports.

"Athletic trainers, by and large, haven't had somebody in the athletic department to champion their cause," Sacco said. "A big percentage of athletic directors, are former coaches who don't have the same view or approach to athletic medicine as the athletic trainer or other medical professionals. That actually hurts athletic trainers moving forward, especially if they're trying to get their work environment better organized and more efficiently run."

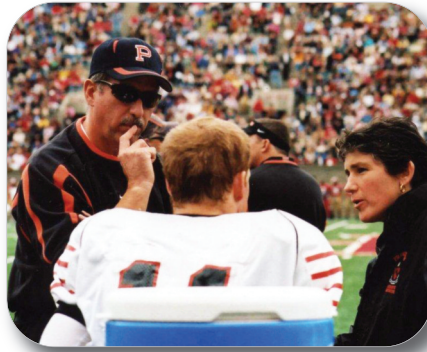


---

Sacco was able to use the new realignment at Kutztown to his advantage. The program added two faculty athletic trainers in the first three years since the move and recently completed a \$500K sports medicine facility move and renovation. Sacco was able to explain his facility needs to his supervisor, another medical professional who then appropriately championed their needs to the university vice president and so forth. What they ended up with is much-needed private exam space, additional staff offices and an improved medical records system. Although it was considered a small renovation and sorely needed for patient privacy, Sacco says it wouldn't have happened if the sports medicine department remained under the old model.

"I was not only able to explain our needs to a fellow health care professional, but it was somebody who understood that there are different specialized fields within health care," Sacco said.

Kutztown is much like Princeton when it comes to having an athletic trainer at practices. It's not necessary in every case. Additionally,



**Charles Thompson, MS, ATC, head athletic trainer at Princeton University, examines a football athlete with team physician Dr. Margot Putukian.**

their sports medicine department also has a written agreement, approved by management, with athletics regarding complete coverage of athletic activities, which includes not scheduling home games on Sundays.

"This departmental realignment was a natural fit for us because of our close working

relationship prior the move, and now it has allowed us to have a more reasonable work life," Sacco said.

But a mid-major in the Ivy League and a school in Division II are different than a Bowl Championship Subdivision school with big-time football such as North Carolina. The work model still succeeds, according to medical professionals at the university in Chapel Hill.

It has for a long time, too. UNC moved its sports medicine program away from the athletic department in the early 1970s as a result of a tragedy.

Bill Arnold, a junior guard on the football team, died of a heat-related illness suffered during a preseason practice on Sept. 6, 1971. He was running wind sprints on a hot, muggy day and had trouble finishing the exercise. He pushed through, collapsed and was taken first to the athletic training room and eventually to the local hospital emergency room.

UNC took a comprehensive look at athlete care in the weeks that followed Arnold's death. Changes included moving the sports medicine





**Rennie Sacco, MEd, ATC, Coordinator of Sports Medicine at Kutztown (Pa.) University, works with a track and field athlete along with athletic training student aid Erin Orth.**

program to student health services, an increase in staff and the creation of an Athletic Training Education Program, both at the undergraduate and graduate levels.

Dan Hooker, PhD, UNC's Associate Director of Sports Medicine, wasn't at North Carolina when the incident occurred but arrived in time to be involved with the changeover.

"The athletic training room was basically scapegoated," Hooker said. "The university administration said, 'We can do a better job of delivering care, and it's unacceptable for people to die participating in intercollegiate athletics. Figure out how to do it, let us know how much it's going to cost and we'll go from there.' What they came up with was putting it under university health services. This was the only one I knew of at the time that was structured this way. The university saw this as a crisis, not just at this level but in high schools and colleges everywhere with regard to understanding the needs of our athletic population."

Beginning with that tragedy, Hooker said UNC did much more than add some staff members and start an ATEP. Administrators wanted the school to be a leader in education and sports medicine research and expand this education to include physical therapy groups and medical professionals training to be team physicians. The university laid out plans to keep the athletic department from being isolated from the general student population, so the same health services available to Tar Heels athletes would be available to all students.

UNC recently added an athletic trainer whose sole responsibility is to care for the sports clubs on campus. The sports medicine budget

is funded by three departments; athletics, campus health and exercise and sports science.

"When I explain our model to a student or parent or recruit, it creates instinctive trust in those who might not know that my boss is a doctor and that the doctor's boss is the director of the hospital," said Scott Trulock, MS, ATC, LAT, UNC's head athletic trainer for football. "It's a powerful element. The danger of our model is that you can have a perception of complacency. If you don't work tirelessly to help the teams succeed, then you won't have trust of your coaches. It's a balancing act. You need to make the right medical decisions based on your skills and ability, but you need to do everything in your power to prevent injuries and get players back as soon as possible."

That balancing act becomes even more difficult because, in most cases, money to pay for the sports medicine staff comes from athletics. But athletics can't make the final decisions.

At Boston University, Mark Laursen, MS, ATC, said there was a short period of confusion at first when BU made the change. Laursen is the Director of Athletic Training Services and Clinical Associate Professor of Athletic Training and helped with the changeover about four years ago at the private Division I university.

Laursen said he and Sara Brown, MS, ATC, director of programs in athletic training, had discussed moving the sports medicine program away from athletics for years before it happened. When a longtime head athletic trainer retired, it opened the window to investigate the switch.

"I think the transition was relatively smooth," Laursen said. "We had good buy-in from the athletic director. He had concerns that we were able to address, and we made sure to do a good job of communicating exactly what we were doing. He has said publicly that he feels like our health care is better now. We just have more people around. We're able to make decisions based on what's best for athlete health care, not tradition."

The biggest shift from the old way of doing things is the quality of life for the athletic trainer.

NATA and the College/University Athletic Trainers Committee conducted a survey of athletic trainers in that setting and found a need for improvement nationwide. Published in the July 2010 *NATA News*, the survey showed that 47.8 percent of athletic trainers in Division I frequently miss family activities because of work; 11 percent said they always miss those events.

The results were similar across all NCAA divisions and slightly better in community colleges and in NAIA. Of the 807 survey respondents, 68.3% said they had considered leaving the profession because of poor salary, a heavy workload and lack of time for family and social events.

"I tell my staff flat out, you don't miss important family events to come in here and do something when we have other people capable of handling your shift," Laursen said. "We try to making it where nobody works six days in a row without a day off. Sometimes, it happens when we get busy. But we certainly don't have that situation you see at a lot of places where people are working 14 days in a row."

From an educator's perspective, seeing a sports medicine department operating in that fashion does wonders for the morale of students, Brown said. She has been a proponent of this model for years and investigated the operation at Princeton long before BU was ready to make the switch. Brown said one reason more colleges and universities don't follow suit is that it's a huge logistical task. Being a private school, she said, made it easier.

But the advantages go far beyond simply being able to make the final decision on an athlete's ability to play.

"It makes critical review easier," Brown said. "In the health care model, we are expected to look back at a patient and ask, 'Did we give this patient the best health care we should have?' The athletic director doesn't expect you to do that, but critical review is expected in health care. Also, students see their clinical instructors as health care providers."

And they see athletic trainers who aren't working from early morning to 10 p.m. every night.

It's documented, too. The athletic training staff at BU averaged 44 hours per week in 2008-09 and 45 hours per week in 2009-10. The staff stands at 18, including graduate students. The university is expanding its health care coverage to the ROTC program.

"This model sends the right message to students that you can do this job and also have hobbies and a family," she said. "We talk to our students all the time about how we made the change here. We also encourage them to compare us to other places and look at the advantages and disadvantages. It shows them that they can change their situation – maybe not shifting the model, but at least asking the question, 'How can we improve patient care here?'"