**When a House is not a Home**

**Key Points**

- Many academic and clinical programs in the college/university setting are organized in ways not conducive for advancing the profession.

- Athletic Training Educational Programs must affiliate with other allied health programs in the college/university setting in order to improve professional respect and financial compensation for athletic trainers.

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Like adolescent youth graduating high school transitioning from home to college life or a new first job, athletic training has evolved and experienced significant growing pains the past several years. For many decades the athletic department served the profession well, providing a backdrop and organizational structure for countless athletic trainers (AT) to enjoy successful careers. But just as time marches on, and life moves forward, so do the situations and the homes where adolescent youth reside. Athletic Training itself is at the brink of one of these life changing milestones—events taking place in the world that require leadership and policy changes in order to prepare the profession for a brave new and unknown world of national health care initiatives and technological developments. Unfortunately, remaining at home in the athletic department house will prove stifling to the profession. The purpose of this article is to discuss how some athletic training programs, and the ATs who work within them can advance the profession by working to change the organizational structures and bureaucratic configurations where their programs are housed. For it is the location of a program in the larger organizational structure that will inform and prepare AT for the future and advance the profession. In other words, athletic training programs, both academic and clinical-service must be willing to affiliate with allied health peers such as Physical Therapy and Occupational Therapy in order to improve professional respect, working conditions, and financial compensation.

Now is the time to revisit the NATA Board decision made in May 2004 that stated changing the name of the profession could be divisive for the membership and damaging to its fiscal health[1]. The policy decision made in May 2004 has not produced significant results, and therefore, should be reexamined as national health care is implemented.

Historically, athletic training educational programs in college and universities were

staffed by athletic trainers with dual roles whereby they taught courses and provided clinical services. The model worked quite well for many years. Today, however, there are at least three negative ramifications for athletic trainers working in settings whereby the athletic department is their home. First, budgets and the funding mechanisms for athletic trainers and AT programs in athletic departments are usually allocated, and not generated. Much like parents who give their children an allowance, athletic trainers working in athletic training programs housed in athletics are often at the mercy of administrators and their allocations. This delivery model is contrary to nearly every other health care profession working in nearly every other setting.

Secondly, a perception issue impacts clinical practice in the athletic department setting. Athletic trainers in these settings are perceived as peers to coaches and support personnel. While they are indeed peers in the context of carrying out the mission of providing athletic participation opportunities, the general public may not easily distinguish the AT from other roles that ultimately unfold on the sidelines of a sporting event or the daily operations of athletics, which are otherwise contrary to the typical day in a healthcare setting.

Thirdly, this daily isolation from other healthcare professionals not only dilutes perceptions and diminishes professional respect it effectively places athletic trainers in these settings on islands which diminishes the teamed approach to healthcare that our profession espouses as noted in the 4th edition of the NATA competencies[2]. This lessens the understanding of the profession by peer health professions and inhibits the professional growth that can occur in clinical settings when different health professions interact and share ideas in patient care.

As health care in the United States continues to evolve, so too must athletic training. The new paradigm serves as a starting point for greater recognition, remuneration, and respect.

**Evolving Away from Athletics**

The challenge athletic trainers continually face as a profession is convincing the public that the athletic trainer's primary duty is more than filling water coolers or waiting anxiously for an injury to occur. Many people have spent decades working to promote the fact that athletic trainers are well-educated, highly-trained, and qualified professionals. Nearly every state has regulatory standards and efforts to gain recognition by the Center for Medicare and Medicaid Services (CMS) for more universal reimbursement are examples of progress.

Unfortunately, the athletic trainer's status within athletic departments is many times just another face in a sea of support personnel such as equipment managers and team statisticians. In some settings, the athletic trainer is hired, fired, evaluated, and promoted almost entirely by mechanisms unrelated to medicine. Examples of athletic trainers being hired (and fired) as new coaching staffs are evaluated on wins and losses is not surprising in the world of athletics. Recent events such as those at Texas Tech University in which the head football coach allegedly instructed the athletic trainer to escort a concussed athlete into a dark equipment shed as punishment for breaking team rules serves as an example[3].

When the athletic trainer reports directly to the team physician, and not the head coach, a fundamental aspect of the AT being recognized as a well-educated, highly trained, and qualified healthcare profession is advanced. This relationship also ensures appropriate oversight, delivery of quality health care, and safety for athletes. Without clearly defined structures and reporting lines, decisions made solely on the basis of what is medically appropriate are less likely and may negatively impact the health and well-being of patients and athletes. Unfortunately, the situation such as one that occurred during the Texas Tech University football season are not isolated. In many institutions, these and other issues have perpetuated the long

hour/low pay phenomena which significantly is part of the respect dynamics that continue to hold the profession hostage.

Several studies have discovered that that AT is one of the lowest paying jobs for individuals with college degrees.[4] In some cases reporting lines mean that ATs essentially get treated and paid like, if not less than, assistant coaches. Conversely, a recent ESPN.com story reported that the annual salaries of strength and conditioning coaches at some of the BCS schools exceed six figures[5] while there is no evidence that athletic trainers at the same institutions even approaching six figure salaries.

One method suggested for improving the athletic department model of athletic training is called an independent clinical services unit[6]. The benefits of such a department include increased efficiency, staff development, increased resources, and collaboration. In a model like this, where the Athletic Trainers have more of an independent voice and are more clearly recognized as health care providers, more favorable working conditions, life balance, and increasing salaries are much more realistic possibilities. It also positions the entity for increased revenue opportunities. While important, these benefits pale in comparison to the potential facilitation of partnering. By housing athletic trainers in health centers and placing them under the leadership of medical professionals bonds can be created to instill a multi disciplinary climate thereby enhancing delivery of care. No longer does the athletic trainer have to serve the "jack of all trades" role. Further, it enhances not only delivery of service but education. By working in a multidisciplinary setting with health care professionals as peers rather than coaches, a professional allied health culture is created.

There is precedence for outsourcing services in the collegiate setting[7] and given the economic challenges facing many institutions of higher education and athletic departments it

is reasonable to anticipate that this trend may well continue if ATs don't chart their own paths. Furthermore, a change to utilization of an independent entity would seemingly open the door to providing coverage to not only collegiate student-athletes but also club sport athletes, intramural participants, and the general student body. Interestingly, some institutions already provide such services independently.[8,9]

Partnering is a term that has been identified as one of five core competencies for healthcare providers in the 21st century. It is the ability to join with patients, other providers, and communities for effective care of patients with chronic conditions. Partnering includes the ability to work in teams and collaborate with other providers, as well as being able to care for the patient across time, in different settings, from different disciplines, and for different diseases.

Partnering itself is not a significant paradigm shift from the traditional model of athletic training in part because the gatekeeper role skill set ingrained in the profession remains intact. However, what is different is the ways in which students will prepare for health care partnering opportunities. In other words, a more focused and intentional effort must take place in terms of structural alignment for the profession.

On the one hand, ATs are in select company when treating musculoskeletal conditions. On the other hand, many of the foremost chronic conditions (diabetes, heart disease) are related to physical activity or lack thereof, which is also an area of expertise. The bottom line is connecting patients to the people that can assist them most effectively in the shortest amount of time.

**Rethinking Traditional Academic Alignments**

In 1996 the Education Reform Task Force made eighteen recommendations. One of

those suggested that Athletic Training Education Programs (ATEP's) should be located in schools of health professions.[1] Another postulated that "The National Athletic Trainers Association (NATA) should encourage the development of multi-disciplinary education programs that coordinate athletic training with teaching, nursing, physical therapy, occupational therapy, or other appropriate baccalaureate level professions."[1] In the interim, some of those professions have obviously evolved beyond the bachelor's level for entry-level education. However, fourteen years later, the academic home of athletic training continues to be problematic. Although Commission on Accreditation of Athletic Training Education (CAATE) does not make public specific data, a random perusal of program web sites will reveal that many are still housed elsewhere. In many cases they are housed elsewhere even when a school/college of health professions exists at the institution. To be better positioned for many of the forthcoming changes brought on by health care reform as well as appropriate professional recognition and respect, ensuring all athletic training education programs are aligned with other allied health programs and not health and physical education must be a priority. This realignment may be ultimately more critical than degree level choice for entry-level athletic training education.

Aligning all educational programs exclusively with allied health programs and away from health and physical education will do much to improve status, mutual respect, perception, and program operations. Generally speaking, one's status is typically judged by the company one keeps. A reflection on our "home" and the misconceptions about our profession reveals that many are directly related to our perceived (and largely actual) peer groups. For instance, who are we most often confused with? We are most often confused with personal trainers. So much so that our national organization has seen fit to create a handout comparing between the two

professions. Of course, where are most personal trainers likely to get their training (if they have any)? Very likely this training will occur in Physical Education and Health departments. Further, the origins of coaching are also largely in these departments. Thus, if the general public believes we are similar or "the same as" then they are likely to assume that our credentialing and training is also similar. If the general public cannot distinguish the titles, how can we possibly expect they will identify that athletic trainers must have bachelor's degrees, pass national certification exams, and receive credentialing from their state of residence.

Much of the NATA legislative and public relations efforts have been designed to have us perceived equally with PT, Nursing and other disciplines. If we want to be perceived as peers to medical and health professions programs then we need to live with them. In order to live with them, many of our colleagues will have to initiate a physical move away from Health and Physical Education to associations with colleagues such as nurses and physical therapists. Program operations are also intricately intertwined with structural alignments. Funding of Medical and Health Science programs tends to be stronger than funding of Education related programs. These programs tend to be more active and successful when it comes to grant funding and navigating other potential revenue streams. Is it logical to expect budgetary support for larger ticket items when colleagues are purchasing items such as cones, balls, and stopwatches?

This call for change is consistent with the ongoing call throughout the education reform process of the 1990's and 2000's to be more congruent with other allied health professions. In fact, 1990 brought with it a major milestone when the profession was officially recognized by the American Medical Association (AMA),[10] perhaps one of the greatest impetuses for the movement toward accreditation as the sole means of athletic trainer preparation, that is, to be viewed as an "equal player."

More recently, the 2007 shift from Commission on Accreditation of Allied Health Education Programs (CAAHEP) to Commission on Accreditation of Athletic Training Education (CAATE) demonstrates that Athletic Training has attained the same organizational level as physical therapy (Commission on Accreditation of Physical Therapy Education) and similar professions. This is important for many of the reasons already mentioned. In addition, the new accrediting body focuses specifically on athletic training, rather than applying a broad accreditation template to a wide array of programs.

Above all, preparing for the future requires thinking differently about the now. If we want to be perceived as peers to medical and allied health care providers then we need to position ourselves to work more closely with them. To ensure this structural arrangements must emerge that position athletic trainers both functionally and physically with their peers. This process must begin at a grassroots level. Athletic trainers must start by embracing their status as healthcare providers. Then, they need to begin talking to both academic and athletic administrators about the benefits of an arrangement change. This will require data on injuries and "value." Athletes will ultimately receive better care because of the presence of more individuals that can specialize in their condition and a "one stop shop" approach whereby multiple health providers could see them during a single visit. A spine center in Appleton, Wisconsin has implemented such a model whereby patients can see physical therapists, neurosurgeons, orthopedic spine surgeons, physiatrists, and chiropractors without ever leaving the building[11].

**Planning for Change**

The athletic trainer might ask, "How do I do this?" " How is it that I implement change in my setting? Actually, in times of tight budgets and decreasing percentages of budgets being

allocated for higher education at public institutions there is no better time than the present. It starts with drafting a proposal to be passed on to higher level administration. The proposal should focus on three elements: 1) value, 2) efficiency, and 3) enhanced care. Value is actually fairly easy to demonstrate. Athletic trainers are fairly proficient at maintaining data on treatments, exercise, rehabilitation. Fairly simply math allows one to demonstrate value. Simply call a few insurance carriers to determine what is "reasonably and customary" reimbursement for a given treatment (ultrasound, unit of exercise, etc.). Multiply these figures by the number of treatments administered in a year and the dollars add up quickly.

Next, efficiency is achieved with the athletic trainer being housed among other professionals. Patients are triaged and referred to the professional best equipped to provide care. Athletic trainers are positioned to provide their expertise to not only intercollegiate athletes but also the general student population. Meanwhile, physicians, nurse practitioners, physician's assistants, and nurses can apply their expertise to systemic conditions. This process ensures the third point, enhanced care. Further, expertise can also be more effectively applied within athletic training staffs. Instead of each staff member having to address every condition, "experts" in lower extremity, upper extremity, rehabilitation, can be fostered within athletic training staffs. In some health centers this approach might ultimately facilitate revenue generation in addition to the already established cost savings.

Athletic training has made significant strides the past twenty years, and the potential for the next 20 years is bright. But in order to take advantages of opportunities emerging from healthcare reform and the evolution of healthcare in general being properly positioned is critical. This starts with working among peers on a daily basis and fostering the professional respect afforded to other healthcare professions. And although many of these issues are larger than any

one person or committee, AT cannot collectively get there from here without an enhanced focus, a renewed sense of optimism and willingness to change the status quo. Taking these steps and others will require time, effort, a need to strive for consensus, and careful monitoring of issues spawned by and related to healthcare reform, reimbursement, and others. Ultimately, not everyone will agree in all cases. But, waiting to ask the question "how do we change?" will only put us further behind. In order to move up we first have to move out.

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[2] NATA. NATA Educational Competencies. 4th ed. 2006.

[3]New York Times, Pete Thamel, November 24, 2010

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[6]Laursen RM. *A Patient-Centered Model for Delivery of Athletic Training Services.* Athletic Therapy Today. 2010;15: 1-3.

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[10]American Medical Association. *2010-11 Health Careers Directory.*

[11]www.neurospinewi.com

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