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DESIGN AND IMPLEMENTATION OF A SPORTS MEDICINE CLINIC
WITH EMPHASIS ON THE HIGH SCHOOL STUDENT-ATHLETE

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Special Major

by
Christopher Allen Mumaw
March 1989

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Date



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Chapter 1

INTRODUCTION

The components which comprise a successful sports medicine clinic have yet to be clearly defined. The administrators of these facilities have numerous factors to consider when designing and operating such a medical organization. This paper will attempt to identify those aspects which need to be considered when creating a clinic with emphasis on high schools and the high school student-athlete. Those components were derived from the trial and error process experienced by the author as a member of a successful sports medicine facility. Over the course of several years, these components were identified and refined. Since not all ideas work in all situations, each component is dealt with as a separate entity. This allows the reader to select any or all of the sections which may be applicable to his or her individual situation and not be forced to accept these ideas as a "all or nothing" proposition.

Review of Literature

In 1980 there were a reported 275 "sport medicine treatment centers" (5) throughout the United States. By 1989 this figure climbed to 1,237 (4). These centers were classified by 26 different variables which included functions, 7, facilities, 7, services, 7, and staffing, 5. This variabil-

ity indicates that, even among currently operating clinics, the factors which constitute a sports medicine facility are debatable.

In 1982 Galsasko, et al, (1) viewed the work of a sports injury clinic based at the Student Health Center at a British university. The clinic was established primarily to treat students and staff of the University, but expanded to treat members of local clubs and athletes of the National Centre of Excellence.

The methods described included four 3 1/2 hour clinics throughout the week with adequate time allowed for discussion between the patient, doctor, and physiotherapist. Referrals occurred from coaches, general practitioners, Health Center physicians and self-referrals. Treatment provided at the Center consisted of physiotherapy, supportive measures (not clearly explained), and pharmacology. Patients requiring surgery were referred to the University Department of Orthopaedics. The remainder of the article was concerned with injury location, sport, and surgical procedure performed.

In 1985, Hossler (2) published his ideas on ways to employ an athletic trainer on the high school level. The primary focus was the different methods by which a high school could obtain the services of a qualified athletic trainer. Of the eight options suggested, seven placed a person on campus in one of several situations, i.e. full-time

trainer, teacher-trainer, part-time trainer, etc. The eighth option suggested the use of sports medicine centers. Hossler (2) described the "typical" sports medicine clinic staffed by orthopaedic surgeons, podiatrists, athletic trainers, physical therapist, nutritionist, and exercise physiologists. The article mentions rehabilitation of athletes but no specific programs or equipment. Hossler's (2) concept of a sports medicine center is one which "offers a broad spectrum of services" with few specifics.

Also in 1985, Nash (3) explored the way five different individuals set up sports medicine clinics. This article mentioned some of the "nuts and bolts" aspects of a clinic, i.e. staffing, locations, and equipment, but was mostly concerned with the financial aspect of a single individual or partnership creating an economically successful business. The financial subjects, such as incorporating, securing bank loans, and accountant's fees, were the prominent discussions.

In 1988, Weidner (6) attempted to identify the aspects of operation and approaches to care of sports medicine centers. This article was essentially a survey of currently operating sports medicine clinics. The data gathered pertained to classifications of sports medicine clinics, types of person seeking care, programs and services offered, general operation procedures, and staffing. The article offered a wide range of conclusions on these areas. These conclusions were based upon the response of 63 facilities.

According to this survey, the primary client is the adult recreational/ fitness enthusiast with the student-athlete second.

While these articles did provide some insight to the concept of sports medicine clinics, none provided the reader with specific details of what should be done to create a clinic with emphasis on the high school student-athlete. The clinics described in these articles were designed primarily for the general populace. Also, little information was given as to the author's reason why a specific idea should be considered. Nash (3) explained his position fairly well but, again, the focus was on the financial aspect of a clinic.

Statement of the Problem

With today's current trend of budget cut backs in the high school, funding for an athletic trainer becomes increasingly more difficult. The use of sports medicine clinics can be seen as a substitute. However, those individuals who desire to enter into this profession have had little information on the successful design of a sports medicine facility. It is hoped that this paper will provide some guidance into the area of sports medicine clinic design, especially as it pertains to the high school athlete. Their future should be just as bright as well-cared-for college and professional athletes and not dimmed because of inadequate sports medicine care.

Chapter 2

Procedure

An analysis of Community Orthopaedic Medical Group Inc., specifically, the sport medicine services offered to the local high schools as they pertain to the high school athlete, was conducted to determine the structure of their health care/sports medicine delivery system.

After this analysis, it was determined the following components held significant importance in the overall design and structure as related to their concept of a successful sports medicine clinic. These components included location, staffing, doctors/referrals/funding, facilities and equipment, school contracts and visitations, injury recording and support forms, event coverage, and marketing and special events. Each of these areas were explored individually to determine the specific qualities needed.

Chapter 3

Results

LOCATION

The location selected for a facility should be given careful consideration. The location within a large community can make a difference to its success. There are several factors which need to be addressed.

First, the facility should be located to have as much availability as possible to as many athletes as possible. This means the clinic should be "centrally" located, which does not necessarily mean in the geographical center of the community, but rather central to the greatest percentage of those using the facility. This can be done by pinpointing on a map who might be utilizing the clinic along with potential future growth.

Once the facility location has been narrowed, direct accessibility should be considered. The clinic should be easy to get to with good visibility from the street. It should not be set back off the street or hidden by other buildings. The best location would be on a main street within a few blocks from a major freeway or highway. This would provide maximum access and common, well-defined routes to the clinic.

A third factor which should be considered when finalizing the location would be current sports medicine clinics operating in the area. It would be beneficial to try to avoid

starting a clinic in an area which might have one or more similar facilities. Obviously, the least competition there is the better the chances of success. There is, after all, a limited community populace to draw from. One way to avoid "overlapping" areas of competition, i.e. one clinic drawing business from the already established clientele of another, is to try to use geographically natural boundaries. Establishing a facility in a community which has a separation from the next community by open land or just minimal community development, will help to establish solid boundaries in which to work and draw from. This will also help in the early stages of defining the target population rather than having the problem of trying to service too large an area with limited resources or personnel.

STAFFING

Selecting the appropriate personnel to staff the facility is of critical importance. The staff needs to be a group of well educated, experienced professionals with excellent human relation skills. A large percentage of the long term success for a clinic is based upon how well the staff interacts with the athletes who are seen in the clinic. Although an individual may receive the proper treatment and therapy and fully recover from his or her injury, if athletes continually leave unhappy with or did not like the staff, the clinic's public reputation will be poor.

A successful clinic will be one which uses a marriage of, both, certified athletic trainers and registered physical therapists effectively. Both professions, while having some overlap in knowledge and abilities, have individual specialties which should be identified and utilized.

The certified athletic trainer should be the core of a program which revolves around the care and treatment of athletes. A trainer's experience and education have taught him or her to effectively manage the prevention, care, and rehabilitation of injuries that occur to athletes versus the general populace. Experienced trainers will also develop sport psychology skills from dealing with the depression, anger, and frustration some athletes develop following an injury. Addressing the mental aspect of an injury can be just as important as treating the physical problem.

A second major function of the athletic trainer is developing lines of communication with the coaching staffs of the various high schools serviced. As with any sports medicine regimen, it is absolutely critical that there be good communication between the coaching staffs and the athletic trainer. It is here that mutual trust and respect are developed. Because the trainer at a sports medicine clinic does not see the coach and athlete at the practice field on a daily basis, the trainer needs to be assured that the coach and athlete are following the recommended treatment protocols for the athlete. The coach and athlete, in turn, must have a sense of

trust in the recommendations suggested by the trainer. This is accomplished by the trainer explaining, in detail, the problem or injury and why a particular treatment is recommended, and the coach and athlete understanding and agreeing to the recommended treatment. If the trainer fails to make the coach or athlete understand or if the coach and athlete will not comply with the treatment, there will be little chance of successfully developing the type of relationships needed.

The physical therapist also plays an important role within the sports medicine clinic. While a therapist's major function will be treating the general public, the therapist can be a vital back-up and support system for the athletic trainer. The trainer should know his limitations in regard to evaluation and rehabilitation. Should the trainer be faced with an injury that exceeds his expertise, he should utilize the therapist's experience and education. An example would be injuries which would be classified as neurological. In general, any injury which would require long-term, one-on-one therapy could be treated by the therapist as they may be equipped to successfully treat these types of problems.

When staffing a sports medicine clinic, the athletic trainer should not be given the status of a physical therapy aide. The athletic trainer should be looked upon as a medical professional and given the same professional respect as a physical therapist. Since both are vital to the success of a

sports medicine clinic, each should be recognized for the contributions they make.

DOCTORS/REFERRALS/FUNDING

In some fashion a doctor or group of doctors (preferably an orthopaedist) must be involved in the operation of the facility. In general, sports medicine clinics are one of two types: physician owned or physical therapist owned (also known as "privately owned"). Both can be successful. An important point to understand is that only a small portion of the revenue needed to be financially successful will be generated by the contracts with the high schools. This particular area will be covered in more detail in a later section. For now, it must be understood that the bulk of income generated must come from the treatments given by physical therapists on patients referred to the clinic by physicians. This is why doctors must be involved in some aspect. If the clinic is physician owned, there will be, obviously, little problem with having adequate numbers of patients for the physical therapist to treat. However, if the clinic is therapist or privately owned, the therapist is at the discretion of the local physicians for a referral base. It is best if working relationships are established between the therapist/owner and one or more physicians. This way, both needs are met. The therapist has a constant, reliable inflow of patients to

treat and the physician has a quality facility to refer patients for therapy.

A second reason for direct physician involvement with the clinic is the need for follow-up diagnosis and care of the athletes who come to the clinic following an injury. The staff must have a physician to whom they can refer athletes when needed. This is also a very important aspect to the program. The doctor(s) involved should be, as well as orthopaedic surgeons, reasonably familiar athletes and athletic injuries. The physician should understand the difference when treating an athlete versus the general public. The physicians should be aware that the athlete wants to return to competition as soon as possible. When possible (and sometimes it is not), the physician should try to be reasonably aggressive when treating an injured athlete. This is done, of course, with the athlete's health and safety put first and foremost.

The physicians should be willing to evaluate athletes informally in the clinic as the trainer might request. This helps to save a great deal of time in many cases, as all the trainer may need is a quick diagnosis or confirmation of his own evaluation of an injury. By doing this, the physician has saved the athlete and trainer time by not forcing the athlete to go through the conventional route of an office visit, which may require several days to pass. Athletes seldom have that kind of time to spare. The physician should also be

willing to staff an "open clinic" once or twice a week. An open clinic is a period of time when only high school or college athletes, not recreational, may come into the clinic, not the doctor's office, and be evaluated at no cost. This would not include x-rays or medication, however. It would be useful to have the open clinics sometime after school, mid-week and Saturday mornings during fall football. These types of free services, which take only 2-3 hours per week, are an invaluable tool in developing a solid reputation and trust in the community.

The administrators of the clinic, either the physician or therapist, must understand that the athletic training portion of the clinic will not be a direct financial contributor. There will be some money generated through the surgeries performed on the athletes who require a repair of an injury. There will also be a small amount of therapy performed by the therapy staff for which billing can occur. For the most part, rehabilitation on the athletes will be done by the trainer. This amount will usually be less than the salary of the training staff. So why have the program if it is a financial drain on the whole clinic? The answer is because over the course of time the community will see that the clinic's primary focus is to provide the area high school athletes with the care they need and deserve and that the financial aspect is a secondary consideration. Once this occurs, the recreational athlete and community in general will hear of this

reputation, through the athletes, coaches, and parents and will avail themselves of the physician's and clinic's services. These indirect referrals can be quite substantial over the course of time.

FACILITIES AND EQUIPMENT

Careful consideration should be given when looking at the facility design and equipment selected for use in the clinic. The eventual setup of the clinic will be influenced, of course, by the size of the facility and the amount of capital available for equipment purchase.

The facility size will depend on several variables. First is the size of the staff who will be working there. This includes support staff, such as billing and reception. Second, the size of the expected daily patient load will be a factor. The patients and staff should not feel crowded or confined. Third, there should be, if possible, an allowance for future growth. Being forced to relocate because the facility has become too small can be expensive and inconvenient. In general, the facility should be versatile to accommodate changing needs, easily accessible with adequate parking and large enough to allow freedom of movement for the staff and patients.

When the decision is made to open a clinic it should be understood that there are some pieces of equipment that, while not absolutely mandatory, are very useful to have. The

clinic will need to have the staples, such as treatment tables, whirlpools, ice machine, ultrasound unit, hydrocollator, stationary bikes, electric galvanic muscle stimulator, faradic muscle stimulator, and ankle weights. In addition to these standard items, there are some "big ticket" items to consider. A modern, well equipped facility of today should have some type of device for strength testing, such as a Cybox or Bio-Dex. This type of machine is necessary to quantify strength difference which would be an indicator for return to work or, in the case of athletes, return to competition. This makes the decision of whether or not an athlete (worker) can return to competition (work) an objective decision rather than subjective. The results from this kind of testing are reproducible which validates its use.

A second type of rehabilitation equipment to consider are weight machines, such as Nautilus or Eagle by Cybex. These machines are safer and much easier to use than free weights. Free weights, other than fixed plate dumbbells, should be avoided in a clinical setting. They are time consuming to set up, noisy, and a second person must be used as a spotter. The pin adjusted, chain or cable driven weight machines are far superior in this type of setting. Machines which should be considered first would be knee extension, leg curl, multi-hip, chest press, and rowing. These machines can

be easily incorporated into most rehabilitation programs for upper and lower extremity injuries.

Equipment should be selected on the basis of how many rehabilitation programs can the piece accommodate. The more specific the equipment the less it can be used.

SCHOOL CONTRACTS AND VISITATIONS

The major component to the athletic training program is the contract between the high schools and the clinic. This contract should describe all aspects of the services offered by the clinic to the schools and athletes. The basic services offered to all contracted schools should be, at no cost to the athlete, evaluation by an athletic trainer or registered physical therapist of any athletic injury and treatment of the injury for up to two weeks following the initial evaluation. Any injury which takes longer than two weeks goes beyond the minor to moderate range of injuries and should be referred to a physician, if not already done so, for consideration of a more formal physical therapy by a registered physical therapist. A written report will go back to the coaching staff, via the athlete, on the athletic trainer's impression of the injury and the recommended participation level with updates as needed. The athlete will also be given a program for home treatment as well as receiving treatment in the clinic. The athlete can be evaluated at any time by a physician during the open doctor's clinic, as previously de-

scribed. The athlete will receive a written report of the doctors's diagnosis and any further recommendations, such as x-rays.

At the completion of the fall athletic season and end of the school year a written, preferably computerized report should be given to the contracted schools. This would cover the who, when, and how of the injuries seen at the clinic for each school. This will be covered in more detail in the next section. The second part of the contract would be the school visitations. This part of the program is extremely critical to the overall success of the athletic training program for the clinic. It is here that the coaching staff of each sport gets to meet the individuals treating their athletes. It is here that some of the trust and confidence in the trainer is developed by the coaches.

The training staff should do an on-site visit of each contracted school no less than once each week. This can be designed so that the trainer arrives at each school at approximately the same time and day each week. This would allow the coaching staff to have available any athlete they would like to have evaluated. This would be useful for those athletes who may have difficulty in gaining transportation to the clinic. The trainer and coach can also use this time to discuss any concerns the coach may have about any athletes being seen at the clinic. The trainer will be able to better explain the recommended treatments and activity level to the

coach and receive feedback as to how well the athlete is progressing during practices. This type of communication is extremely vital in developing a working relationship. This importance was described previously in the Staffing section.

The visitations by the trainer also conveys a message to the coaches that the training staff cares about the coach's program by taking the time to come to him, as we all like the thought of personalized services.

One of the reasons the athletic training program cannot stand by itself financially is because of the cost of the program. If the price were enough to pay for itself, the school(s) would not be able to afford the program. School administrators will generally consider a fee of \$500.00 to \$1000.00 reasonable. Beyond this, however, securing the money can become difficult. Based on this amount, one can easily see the fee is a token amount which does not really offset the operating cost of the program. The fee can, however, be used to purchase supplies for the clinic such as adhesive tape, Ace wraps, and crutches to be used on the athletes as needed.

Should a school have difficulty in budgeting even this small amount, an alternative would be for the school to approach the school's booster club. Many times this group can pay all or part of the contract fee.

INJURY RECORDING AND SUPPORT FORMS

An integral part of injury prevention is recording and categorizing the injuries which do occur. By knowing when and how injuries happen, it is then possible to give this information back to the schools to help reduce the frequency and severity of injuries.

There are various computer programs on the market today for recording injury data. When choosing one of these programs, the program should include at least the following components: It should separate each sport from the other. Within each sport, the various positions should be indicated. The program should be able to name specific structures such as "medial collateral ligament" not just "knee". It should differentiate between the types of injuries, i.e., sprain, strain, contusion, etc. It should ask if the injury occurred in a practice or game, left or right side, the position played at time of injury, mechanism of the injury and the level of severity of the injury. Along with this, there should be the basic information of name, date of injury, date of evaluation and school. All of this information can be put onto a form which the trainer would complete upon initial evaluation. This would then be input into the computer at a more convenient time. An example of this form may be found on Figure 1. When analyzing the information the program should be able to generate reports which, both, combine all injuries and schools and separate each school, by each sport. This

way a particular coach can see what kind of injuries occurred to his team, by position, and also be able to compare his injury rate against the group as a whole.

Along with recording the injuries, the program should also record the daily treatments given to each individual injury. The program should allow the user to determine the types of modalities that the computer records. This would allow for the variability needed depending on what modalities a clinic may have. This information would be on the back side of the injury report form (Figure 1). Each time the athlete returned for a treatment this would be recorded (Figure 2).

As previously discussed, there are several other forms which may be used. These should be printed on NCR paper which gives multiple copies. The first form, (Figure 3), would be the coach's report form. This is taken back to the coach by the athlete. The copy is stapled to the injury report form. The second, (Figure 4), would be the physician's report form. This is the form used for the open physician's clinics. This would be a three-part form, with the original being stapled to the injury report form and the second and third being sent with the athlete for the parent and coach, respectively.

Figure 1. An example of a form used to record injury data.

COMPUTER INJURY REPORT FORM

Name: _____ School _____

Today's Date _____ Date of Injury _____

Sport Playing at Time of Injury _____ Grade _____

Health Insurance Company _____ Home Ph. _____

=====

FILL IN INFORMATION ABOVE THIS LINE ONLY

=====

Trainer will fill in information below

SPECIFIC STRUCTURE _____

SIDE: LEFT RIGHT MIDDLE BOTH N/A

INJURY TYPE _____ MECHANISM _____

ONSET: ACUTE CHRONIC

SEVERITY: 1 1+ 2 2+ 3

POSITION AT TIME OF INJURY: _____

PRACTICE GAME

Figure 2. An example of a form used to record treatments.

COMPUTER INJURY TREATMENT FORM

TREATMENT:

- | | | |
|----------------|---------------------|-----------------|
| 01 ICE BAG | 07 ANKLE PROGRAM | 13 HOME PROGRAM |
| 02 ICE MASSAGE | 08 KNEE PROGRAM | 14 CRUTCHES |
| 03 COLD W/P | 09 BACK PROGRAM | 15 CYBEX EVAL |
| 04 WARM W/P | 10 SHOULDER PROGRAM | 16 E.G.S. PP |
| 05 HOT PACK | 11 POOL THERAPY | 17 E.G.S. PN |
| 06 ULTRASOUND | 12 ICE MASS/U.S. | 18 DR.'S CLINIC |

DATE | _____

_____| _____

_____| _____

_____| _____

_____| _____

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_____| _____

_____| _____

_____| _____

_____| _____

_____| _____

_____| _____

_____| _____

_____| _____

_____| _____

Figure 3. An example of a coaches report form.

COACHES' REPORT FORM

NAME: _____ DATE _____

SPORT: _____ SCHOOL _____

ATHLETIC TRAINER'S IMPRESSION: _____

SEVERITY: 1 1+ 2 2+ 3

SWELLING: 1 1+ 2 2+ 3

EXTENT OF ACTIVITY RECOMMENDED:

_____ COMPLETE REST _____ LIGHT PARTICIPATION
_____ FULL PARTICIPATION _____ PARTICIPATION TO TOLERANCE
_____ RETURN FOR FOLLOW-UP _____ SHOULD SEE PHYSICIAN

HOME TREATMENTS RECOMMENDED:

_____ ICE PACK _____ TIMES/DAY FOR _____ MINUTES
_____ ICE MASSAGE _____ TIMES/DAY FOR _____ MINUTES
_____ CONTRAST BATHS: COLD WATER _____ MIN. THEN WARM WATER _____ MIN
_____ WARM BATHS _____ TIMES/DAY FOR _____ MINUTES
_____ CRUTCHES
_____ ELEVATION
_____ ACE WRAP

ADDITIONAL COMMENTS: _____

Figure 4. An example of a physician's report form.

PHYSICIAN'S REPORT FORM

PATIENT: _____ DATE _____

SCHOOL _____ SPORT _____

EXAMINING PHYSICIAN: _____

PHYSICAL FINDINGS: _____

DIAGNOSIS: _____

RECOMMENDATIONS: _____

RECOMMENDED ACTIVITY LEVEL:

_____ COMPLETE REST _____ FULL PARTICIPATION NON-CONTACT

_____ LIGHT NON-CONTACT _____ FULL PARTICIPATION

_____ PARTICIPATION TO TOLERANCE

_____ RETURN TO CLINIC FOR FOLLOW-UP TREATMENT

HOME TREATMENTS RECOMMENDED:

_____ ICE PACK _____ TIMES/DAY FOR _____ MINUTES

_____ ICE MASSAGE _____ TIMES/DAY FOR _____ MINUTES

_____ CONTRAST BATH: COLD WATER _____ MIN THEN WARM WATER _____ MIN.

_____ WARM BATH _____ TIMES/DAY FOR _____ MINUTES

_____ CRUTCHES _____ ACE WRAP _____ ELEVATION

_____ EXERCISE OR STRENGTHENING PROGRAM: _____

EVENT COVERAGE

Because the contracted schools will usually not have a trainer on staff, the athletic trainer(s) at the clinic can expect to be approached to cover various athletic contests. It is recommended that the trainer try to accommodate the schools as much as possible. By covering games, the trainer becomes even more important in the overall services offered to the schools. The clinic now has contact at virtually every level of athletic care. The trainer evaluates and treats the injuries, has one on one contact with the coaches on campus, assists in injury prevention programs by use of injury analysis on the computer, and finally is present when the reason for all of the above occurs, the games.

In as much as most athletic competition occurs after normal work hours and to eliminate the risk of litigation to the clinic, it is suggested that a small fee be charged for event coverage. The most frequently requested event coverage would, obviously, be football. A suggested fee schedule for this sport would be \$50.00 to \$60.00 for varsity football games, which would include pre-game taping, and \$35.00 to \$40.00 for junior varsity and freshman games, with no pre-game taping expected. The trainer covering these games (and any other events for that matter) would be on a straight contractual agreement with the school for whom he is covering the game. Since this is on the trainer's own time and he, not the clinic, is receiving a fee, the trainer alone holds

all responsibility for his actions.

The trainer may also expect to be required for event coverage in sports such as multiple team wrestling meets and league track and field meets. In general, when covering single event competitions involving multiple numbers of teams or contestants, a fee schedule may be developed based on the amount of time the trainer will be in attendance.

MARKETING AND SPECIAL EVENTS

With the level of competition currently found with sports medicine clinics, marketing the sports medicine clinic becomes somewhat necessary if growth and expansion is expected. The extent of marketing is, again, dependent upon the financial resources of the clinic. The concept of marketing the sports medicine clinic is meant to put the clinic's name in front of the people who might avail themselves of the clinic's services. It starts with choosing the name. Many currently operating clinics have chosen an acronym for a name or logo. This acronym is usually short, to the point, and easy to remember. This choice should be considered carefully as this will become the name most closely associated with the clinic and virtually impossible to change. Two examples of successful acronyms are "S.C.A.R." (Southern California Athletic Rehabilitation and Treatment) and "S.P.O.R.T." (Sport Physiology Orthopedic Rehabilitation and Treatment).

Once a name is chosen, a color scheme should be considered next. It is advisable to avoid color combinations associated with any schools in the area. Maintaining neutrality is a must.

The name which is finally chosen and the color scheme for the name should appear on everything that goes out to the athletic community and general public. Soon, by simple repetition of seeing the name or logo, the target audience will associate the name with the clinic and staff.

One of the easiest ways of promoting the clinic is to have printed an information brochure which describes the clinic, its services, and the type of professionals on staff. This can be distributed to the schools so the coaches better understand what services are offered.

A second brochure, which can be quite helpful to the parents, is a consent brochure. This would explain the basic services covered for the contracted schools. The brochure can be put together in a question and answer format such as: Q: "Can I bring my son or daughter into the clinic at any time?" A: "No. Students from contracted schools may come in only at the specified times." or Q: "Are x-rays included in the open physician clinic?" A: "No. Only an examination of the injury is included." This enables the parent to quickly read through the brochure and learn exactly what the program is about. There should also be a place on the brochure for the parent to sign to give consent for treatment by the

clinic's staff. These should be distributed prior to the start of any new athletic season to the respective coaching staffs who should give the consent brochure to each team member to take home. The signed consent may be collected by the coach and given as a team to the clinic to keep on file or the athlete may bring with him the signed consent on his first visit to the clinic.

Another promotional concept which may be utilized is to provide educational opportunities for the athletes, coaches, parent, and general public. One way of achieving this would be to publish a small newsletter two or three times a year. The newsletter could consist of four to six pages that would contain articles on current topics of concern and interest within athletics and sports medicine. The articles could be written by members of the clinic's staff or physicians. The topics could be varied to correspond with the seasonal sports throughout the school year. Articles relating to popular recreational sports, such as jogging, aerobics, or racquetball, could be included. The purpose of the newsletter would be to educate the reader as to the prevention of injuries and, when injuries do occur, what the reader can do to care for the injury.

Another method of education is to offer regularly scheduled free lectures at the clinic. These lectures would feature knowledgeable professionals in varied areas of interest. Examples of these areas could be nutrition for the

competing athlete, weight training, and the use of amino acids and steroids. An attempt should be made to uncover new areas of interest within the community in an effort to reach as many individuals as possible. Also, the speakers should be paid a small stipend for their time and expenses.

A related activity to the lectures would be for the clinic to sponsor seminars for the coaches in the area. A particular sport, such as baseball, would be chosen to be the topic. Respected coaches or player from a professional team or successful college programs would speak on their speciality, such as pitching or batting. There should also be a portion of the day reserved for injury prevention programs or other sports medicine concepts being used at these levels. These seminars could be done yearly, with different sports or sub-areas of a particular sport addressed each time.

A final idea of promoting the clinic is to take some of the fees paid from the contracted schools and purchase an item of equipment, such as a first aid/trainer's kit, water containers, or ice chest. The clinic's name or logo should be put on the item in some fashion, i.e. stenciled, painted, etc. This would be given to each school as a small "thank-you". The coaches and administrators of the schools will find this contribution demonstrates, both, generosity and care for the athletes.

Chapter 4

SUMMARY

As one can easily see from the previous discussion, the components which comprise a sports medicine clinic can be varied and complex in their relationship to each other. This paper attempted to identify the major aspects which need to be considered when designing such a facility. Each component could, if needed, be used independently of each other to accommodate individual differences and needs of the program organizers.

The emphasis of this paper was on providing the high school student athlete with consistent, dependable, high quality sports medicine care within a delivery system which would also be reasonable and possible to maintain over time for the provider. This particular format demonstrates that this is possible.

It is hoped that the contents of this project can prove beneficial to some reader in the future with a desire to make sports a safer and healthier environment for the high school student-athlete.

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