Contemporary Factors Influencing Employment in Athletic Therapy

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In today’s changing and competitive health care industry, the employment picture of athletic therapy is influenced by many variables: professional preparation of athletic therapists, a movement away from the contract/outreach athletic therapy model, trends toward managed care, and reimbursement issues, to name a few. As these dynamics evolve, employers and employees in the various athletic therapy settings need to position themselves to make the dynamics work in their favor.

Curriculum vs. Internship Debate

There is considerable debate as to which routes should lead to eligibility for athletic training certification. The debate is driven by two main questions:

1. Are there significant differences in the entry level preparation and readiness for the certification exam between athletic training curriculum and internship candidates?

2. Are the internship graduates competent to enter a work setting such as a sport rehabilitation clinic, having completed only the 7 domain-specific courses required by the internship route?

The NATA Education Task Force has been examining these and similar questions and will present their recommendations to the NATA Board of Directors this June. In a preliminary report designed to elicit feedback prior to the promulgation of final recommendations, the Task Force announced this past January its suggestion to eliminate internship programs by the year 2004.

If the internship route is to be phased out or modified substantially, this could significantly affect employment opportunities in athletic therapy. Athletic departments in colleges and universities would need to budget for additional funds to hire full-time or part-time personnel to meet the staffing levels previously provided by supervised interns. This would not be easy.

There would likely be an increase in part-time positions at first, including traditional part-time jobs or a medical “residency” model. Would entrepreneurs develop athletic therapy “temp” services to meet the demand? This has worked in other career areas but whether it would work in athletic therapy is unknown.

Even if these measures help meet the initial needs, the long-term effects may be more significant. Athletic therapy, particularly athletic training, is no longer a part-time profession. Those individuals who have completed the demanding professional preparation are unlikely to work part-time. They would probably further their education to develop additional skills and move in another direction.

Professional preparation program administrators in athletic training envision these changes as resulting in dramatic increases in full-time college and university clinical and instructional positions. Growth in accredited curricula would probably increase, with some internship programs being converted to curriculums.

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seems logical that more positions would require graduate degrees.

One implication would be the need for more entry level as well as advanced master’s degree opportunities. Would there be a move toward a 5- or 6-year entry level master’s degree in athletic training? Would innovative physical therapy professional preparation programs create clinical and curricular opportunities leading to eligibility for dual credentials?

Fiscal pessimists, on the other hand, argue that even if this job market were to develop, it would evolve only after many years and only as budgets allow. These individuals suggest that colleges and universities could turn to clinics for athletic health care, that is, using the contract/outreach athletic therapist to meet personnel needs. This model does have precedent in many high schools across the U.S. It is attractive to school administrators because they perceive it as cost-effective in terms of liability, fringe benefits, etc.

Presently, however, there is a trend in some regions of the country, the Northeast for example, of sport rehabilitation clinics moving away from outreach programs. Time will tell whether this trend gains momentum.

**Downsizing**

Over the last decade, private or hospital based sport rehabilitation clinics in this country have provided a primary source of athletic therapy to many high schools and a few colleges and universities. The practice of contracting with athletic therapists for their services has been cost-effective to fiscally strapped school departments. This has been the most attractive and fastest growing employment setting for new athletic training and physical therapy graduates.

Managers of rehabilitation clinics viewed the contracting for athletic therapy health care as a win-win situation for both parties. High schools were provided with cost-effective and quality athletic health care. And clinics were benefiting from the marketing opportunity to enhance patient (athlete) referrals to the clinic as well as from the public relations image of community involvement.

In reality, however, the flow of athletes being referred to the clinic has neither added to nor detracted from its revenue when salaries, equipment, and insurance are taken into consideration.

Given the movement toward managed care, and the fact that clinic revenue expectations have not been met, outreach programs may become even less attractive to clinic owners. Already in some regions, clinics are eliminating their outreach programs and focusing on the rehabilitation component.

This movement is exacerbated by a nationwide trend of several large sport rehabilitation companies purchasing local and regional sport rehabilitation facilities. Typically this is followed by the new owner hiring dual-credentialed individuals exclusively or eliminating the non-profitable elements of the operation—frequently the outreach program. Large firms with corporate offices many states away do not always demonstrate the social conscience and commitment to a community that a local company or facility is likely to possess.

If this trend continues, what are the implications for employment in athletic therapy? How will high schools continue to provide health care for their athletes? Will they revert back to placing the responsibility on the coach? Will school systems find some way to hire full-time athletic trainers? There are precedents for this in some large cities (e.g., Houston and Washington, D.C.) where school departments have limited resources.

Those close to the contract/outreach setting feel strongly that the communities with athletic trainers on that basis realize their importance to the education and co-curricular experiences of their children. It is suggested that those communities would find a way to hire the person if the clinic were no longer involved. For years, detractors of the contract/outreach trainer model have argued that the athletic trainer needs to be an integral part of the school system, not a part-time visitor. Whether full-time or combined with teaching or administrative duties, an athletic health care professional is a must for a quality high school athletic program.

For the immediate future, clinic/outreach employment opportunities are dependent on evolving changes in health care and fiscal issues. Even though this career option looks attractive to entry level athletic therapists and has proven significant in providing employment and quality health care to athletes, change seems imminent.