U.S. COUNCIL FOR ATHLETES' HEALTH

Summary Report of Findings

Presented to Husch Blackwell, LLC

Regarding

University of Minnesota

ATHLETIC MEDICINE & ATHLETIC PERFORMANCE

Independent Review Date: September 2018

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U.S. COUNCIL FOR ATHLETES' HEALTH

Summary Report of Findings

Athletic Medicine & Athletic Performance Independent Review

This report presents the results of a review the U.S. Council for Athletes' Health ("USCAH") conducted between June 2018 to September 2018 of various aspects of athletic medicine and athletic performance functions of the University of Minnesota's Athletic Department.

EXECUTIVE SUMMARY

This Executive Summary presents an overview of the outcome of the U.S. Council for Athletes' Health review of various issues regarding how the University of Minnesota's athletic medicine (athletic trainers and doctors) and athletic performance (strength and conditioning coaches) teams function and serve student athletes. Organized by addressing what will be referred to as *"Powerful Practices"* and *"Opportunities for Growth,"* this summary provides the opportunity to focus on the resources and responsibilities required in the provision of optimal health care, wellness and safety for the student athletes at the University of Minnesota.

Providing this optimal health care, wellness, and safety is an inclusive, not exclusive process where:

- every contribution and every contributor counts;
- all members of the athletic medicine and athletic performance teams are engaged and enabled to effect change;
- resources and responsibilities are collaborative and integrated; and where
- open conversations build the foundation of the strategy and alignment necessary to revitalize the program.

Only with complete collaboration and support from all institutional levels can the goal of providing student athletes optimal health care, wellness and safety be achieved.

An organization's ability to learn from and build upon its most effective and impactful practices is a key to continued growth and improvement. These practices serve as critical leverage points necessary to guide, support and ensure growth and improvement when providing optimal athlete health care and safety. In this Powerful Practices section, we highlight and demonstrate the Department of Athletics' commitment to build upon its most effective and impactful practices with the provision of student athlete health care, wellness and safety.

1. **Vision and Mission—*Unified Commitment to Optimal Health Care***

   - The Department of Athletics' singular goal is to provide optimal health care services for student athletes.
   - The Director of Athletics understands the importance of maintaining a positive health care culture where Independent Medical Care is the foundation of safety and wellness of student athletes.
   - All groups interviewed share the same expectations for best practices for student athlete health care and safety.
   - Comments from the Director of Athletics reflect his understanding of the elements of, and commitment to enhancing and providing, optimal health care and safety:
     - "We lack policies and procedures"
     - "We want to have best practices"
     - "We want to know where we need to get better"
     - "We want to be the best when it comes to student athlete health care and wellness"

2. **Culture—*Integration and Collaboration***

   - Cultural change has taken place, incredibly, in just over 18 months.
   - Collaboration and integration are evident and exist across all athletic programs and in all key departments that have a role in the provision of health care, safety and wellness to the student athletes.
   - We highlight that all groups who work with student athletes have asked for integration and collaboration for some time, demonstrating their recognition of the importance of these factors.
     - It is only under the current Department of Athletics administration that collaboration and integration have occurred.
     - This was clearly an area in our discussion with all groups where integration and collaboration under the previous administration and segments of the medical team were not supported.

3. **Department Communication—*Effective and Multi-Level Engagement***

   - The Director of Athletics has created a culture where open and informed dialogue is encouraged.
   - A structure of collegial communication has been implemented.
   - Continued support of transparent intra-department communication is paramount to success. This is of import to all stakeholders.

4. **Organization Structure—*Student Athlete Health and Performance***

   - The organizational structure the Department of Athletics has charted for the provision of optimal student athlete health care certainly supports the Independent Medical Care goal.
   - Under the direction of the current athletic administrative team, a formal and restructured approach to the provision of health care for the student athletes has placed the highest priority on the provision of Independent Medical Care.
     - The mandate comes from the Director of Athletics.
     - It is carried forward by the Associate Director of Athletics for Health and Performance, who oversees the newly structured Student Athlete Health and Performance Committee. The creation of the Associate Director of Athletics for Health and Performance position, and the current person in that position, bode well for the future of Independent Medical Care.
     - Using a newly created Student Athlete Health and Performance Committee model the Associate Director of Athletics for Health and Performance works directly with the head team physician and Director of Athletic Medicine from Athletic Performance, the Director of Athletic Performance, Sports Psychology and Sports Nutrition.
   - The restructuring of the health care services and the removal of department silos has brought a previously non-existent desire to collaborate and integrate.
   - Collaborative organization of responsibilities has allowed more opportunity for personnel in many areas to specifically address issues. Collaboration and communication between the Athletic Medicine team and the Athletic Performance team have developed.
   - Student athletes report experiencing a positive increase in collaboration and coordination of care.
   - Continued collaboration is needed as athletes rehabilitate from injured status to performing in their sport status.

Every organization can and must improve no matter what levels of athlete health care and safety it has achieved. During the review process, the USCAH Review Team identified areas where the organization has *Opportunities for Growth and Improvement.*

1. **Policies and Procedures—*Review, Revision, Development and Implementation***

    a. Develop and implement policies and procedures to guide the provision of health care to the student athletes.
    b. Consider a collaborative partnership with an external, independent organization to assist in the development of policies and procedures.
    c. Moving forward, support ongoing collaboration and integration in the creation of policies and procedures to sustain the improvement of health care for the student athletes.

2. **Independent Medical Care—*Development of a Ground-Up Program***

    a. To build upon the success of restructuring the Department of Athletics, the University should demonstrate its commitment to development of a ground-up independent medical care program through express Board support and appropriate resource allocation.
    b. The athletic department should consider a collaborative partnership with an external, independent organization to review the provision of optimal health care and safety for student athletes
    c. Ongoing commitment from all University levels to providing standardized health care to all athletic programs remains essential.

3. **Staff—*Certification, Evaluation and Assessment***

    a. Create policies and procedures to review and certify all athletic medicine staff and, as appropriate, athletic performance staff, including by creating an annual staff assessment/evaluation process for both teams.
        i. The credentialing and certification of all medical practitioners who provide health care services to the student athletes should be monitored and recorded by the Department of Athletics Athletic Medicine team.
    b. Create policies and procedures to review and confirm best practices in all procedures to be used by:
        i. Athlete Health and Performance Staff and
        ii. Outside medical personnel who work with student athletes.

4. **Education—*Development and Implementation***

    a. There is no formal process for education and compliance regarding student athlete health care, wellness and safety.
    b. A formal education process—E-Learning Modules, live training, required reading, etc.—should be implemented.
    c. This education process would introduce health, wellness and safety education for all athletic staff, coaches and student athletes.

d. This should be a high priority for the Department of Athletics.

5. Ongoing Review

a. Ongoing internal and external review and engagement will allow the University of Minnesota to identify any blind spots in the student athlete health care as the Department of Athletics continues to develop health care, safety and wellness policies and procedures to further the goal of providing optimal health care for all student athletes.

I. The Independence of the Investigation

a. Commencement of Review: The University of Minnesota Regents established a special, independent review of the student athlete health care services for the student athletes at the University of Minnesota to analyze:

i. All aspects of the student athlete health care delivery system

ii. Expressed concerns about various athletic medicine techniques and the University's general practices with respect to use of such techniques within the University's Athletic Medicine function. Included among the athletic medicine techniques under review are: Responsive Performance Reset ("activation" treatments); Omegawave device treatment; oxygen deprivation training techniques; Russian stimulation machines; "NO Explode" supplements and other student-athlete nutrition matters; and Toradol prescription rules and practices.

b. The United States Council for Athletes' Health

i. USCAH was contracted to provide services regarding the delivery of health care services to the student athletes at the University of Minnesota.

ii. USCAH is committed to partnering with organizations to ensure optimal health care and safety is provided for student athletes. In the complex world of athletic healthcare and risk management, USCAH is a trusted, independent partner with the experience and expertise to advise and consult with regarding healthcare delivery systems. With over forty years of experience in athletic healthcare, the USCAH Team provides an external, independent, unbiased and diverse, multidisciplinary approach to address all aspects of student athlete healthcare delivery including compliance, assessment, personnel, programming and more.

iii. USCAH Independent Investigators

1. Dr. James Borchers MD MPH
2. Dr. TC Perry EdD
3. Robert Sweeney AT MS

c. The Mandate of the Independent Investigation

i. USCAH, as an independent and unbiased organization, was directed to make such efforts as it determined necessary to find the facts and report findings on the topics specified below.

ii. In conducting the investigation and reaching our findings, we have not been influenced by anyone outside of our investigative team. The findings of the Independent Investigation are ours and ours alone.

II. Scope of and Primary Questions Posed for the Independent Investigation

a. ***Scope:*** Consistent with the requested scope of this review, USCAH organized all investigative efforts to understand the following issues:

i. ***Policies and procedures.*** Are the procedures and policies for the delivery of student athlete health care current and meeting the expected standards of care with respect to: independent medical care, general health care policies and procedures, safety and wellness, oversight, review and revision of policies and procedures, organizational structure of the health care personnel and the interaction and integration of the various branches of health care?

ii. ***Techniques and modalities.*** Does the health care provided to student athletes include practices that use questionable, inappropriate or abusive hands-on techniques and modalities that injure or harm student athletes, including but not limited to: Reflexive Performance Reset, Activation, Physically and Verbally Degrading/Abusive Punishment Workouts, Omegawave Technology, and Electrotherapeutic Modalities?

iii. ***Medication and outside medical services.*** What are the current medical review and documentation practices used to: monitor the distribution of over the counter medication and prescription drugs; the use of outside medical services and personnel, and the credentialing and certification of all medical practitioners who provide health care services to the student athletes?

iv. ***Student athlete needs and best practice standards.*** Are the organizational restructuring and changes to the administration of health care services over the past eighteen months better meeting the needs of the student athletes and are the changes meeting the expected standards of care for a Power Five Division 1 University?

b. ***Services Provided and Deliverables***

i. ***Document review.*** Receive and Review Requested Documents, Policies, and Procedures from University of Minnesota

ii. ***Interviews.*** Prepare, plan, and execute three, single day on-site interview sessions:

1. Interview Sessions

a. Interview Session 1—Athletic Performance and Athletic Medicine personnel: July 6, 2018

b. Interview Session 2— Team Physicians, Athletic Performance and Athlete Nutrition personnel: July 14, 2018

c. Interview Session 3—Student Athlete Focus Group, Head Coach Focus Group, Athletic Administration Leadership and Team Physicians: August 3, 2018

2. Four to six meetings were held each day with representatives from the following focus groups

   a. Student Athletes (6, representing 2 men's programs and 4 women's programs)

   b. Head Coaches (6, representing 3 men's programs and 3 women's programs)

   c. Athletic Medicine and Athletic Performance (9)

      i. Joi Thomas, Associate Athletic Director, Health and Performance
      ii. Jeff Winslow, Head of Athletic Trainer, Olympic Sports
      iii. Ronni Beatty-Kollasch, Assistant Director of Athletic Medicine
      iv. John Parenti, Director of Athletic Nutrition
      v. Sara Wiley, Director of Athletic Performance
      vi. Cal Dietz, Associate Director of Athletic Performance
      vii. Dr. Brad Nelson, MD Team Physician
      viii. Dr. Suzanne Hecht, MD Team Physician
      ix. Dr David Olson, MD Team Physician

   d. Athletic Administrators (3)

      i. Mark Coyle, Director of Athletics
      ii. Julie Manning, Executive Associate Athletics Director and Senior Woman Administrator
      iii. Emily Wendolek, Associate Athletic Trainer, Insurance Coordinator

3. Question categories posed to each focus group

   a. Organization Culture: Department specific roles and responsibilities, policies and procedures
   b. Student Athlete Hands-On Treatments

c. Student Athlete Injury Treatments, Tests, Assignment of Medical Practitioners
d. Student Athlete Nutrition
e. Student Athlete Injury Diagnosis, Education, Wellness, Body Composition and Safety
f. Student Athlete Medication Policies and Procedures

iii. ***Specific investigation directives:*** At each of the three on-site visits by the USCAH team, the following issues and concerns regarding health care delivery to student athletes at the University of Minnesota were investigated:

1. Treating student athletes with hands on techniques including Activation and Reflexive Performance Reset
2. Use of exercise as punishment for student athletes
3. Non-medical personnel interference with independent medical care of the student athletes
4. Policies and procedures regarding the following: use of Omegawave technology, application of electro therapeutic modalities, and chiropractic treatment
5. Student athlete nutrition prescription and advisement
6. Policies and procedures for nutritional and ergogenic supplementation for student athletes
7. Policies and procedures for body composition and biometric measurements for student athletes
8. Treatment and rehabilitation of injuries for student athletes
9. Coordination and communication of health and safety information for student athletes
10. Policies, procedures, regulation and oversight of student athlete training protocols
11. Review of athletic department prescription medication policies and procedures
12. Culture of collaboration and communication between University athletic medicine staff, athletic performance staff and student athletes

iv. ***Key terms and definitions***

1. Independent Medical Care: Allowing medical professionals to have unquestioned authority over medical decisions
2. Athletic Performance Team: Strength and Conditioning personnel
3. ATC: Athletic Trainer Certified
4. Athletic Medicine Services: Under former athletic administration the athletic trainers and graduate assistant trainers
5. Athletic Medicine Team: ATC—Athletic Trainer Certified and Team Physicians

6. Student Athlete Health and Performance Committee: Multi-disciplinary committee developed by the University of Minnesota in June of 2017 to address the health, safety, and sports performance of their student athletes
7. Reflexive Performance Reset (RPR): Manual muscle stimulation techniques designed to activate the muscles and improve performance
8. Activation: Similar to RPR, a muscular stimulation technique that analyzes and corrects muscular imbalance
9. Omega Wave: Biofeedback technology used to determine the readiness of physiological systems
10. Modalities: Any intervention—manual, electrical, or thermal—used in the therapeutic treatment of athletic injuries

v. Provide periodic updates

vi. Prepare and Submit Final Report of Findings

III. Key Factual Findings

We set forth here our key factual findings. In doing so, we discus information from witnesses, electronic and written documents and other sources that are relevant to our findings. Given our focus on systemic practices, we do not discuss all individualized information obtained by the Independent Investigation, unless illustrative of more general concepts or patterns. At the same time, all information material to our findings is discussed.

a. *Are the procedures and policies for the delivery of student athlete health care current and do they meet the expected standards of care for student athletes with respect to:*

i. Independent Medical Care

1. Without question, across all focus groups, Independent Medical Care is recognized as the standard of care that must be and is provided to and for the student athletes. The Athletic Medicine team members—athletic trainers and team physicians—clearly articulated they are provided the opportunity to perform independently and autonomously as they provide medical care for the student athletes.

2. Independent Medical Care was prevalent under the former athletic administrative team and the Athletic Medicine team. It is important to note that the former athletic administrative team before Athletic Director Mark Coyle's leadership reportedly had little or no interaction with the Athletic Medicine personnel (Athletic Trainers and Team Physicians) who took it upon themselves to ensure the provision of Independent Medical Care was available for the student athletes.

3. Under the direction of the current athletic administrative team, particularly Mark Coyle, Julie Manning, and Joi Thomas, a formal and restructured approach to the provision of health care for the student athletes has placed the highest priority on the provision of Independent Medical Care. The mandate comes from the Director of Athletics and is carried forward by the Associate Director of Athletics for Health and Performance, who oversees the newly structured Student Athlete Health and Performance Committee, consisting of representatives from Athletic Medicine, Athletic Performance, Sports Nutrition, Psychology, and Athletics Administration.

4. Interview Comments

Staff:

a. "We feel supported. More so now than the previous staff. They understand that athletic medicine trumps everyone else. No one will get in the way of providing proper coverage. We have not always had that support."
b. "Now there is a lot of collaboration. I have never felt pressured by a coach, athlete or medical professional. I don't know if others have had this happen—but I never had it happen to me in my time here."
c. "IMC is making sure medical personnel can make medical decisions without any intrusion—and thus exists here. There is no question the ATC make the decisions regarding student health. The Athletic Performance staff never question an ATC. Decisions are all made by medical personnel and no one else."
d. "The current administration has been fantastic with support especially with the Director of Athletics. He lets coaches know that the medical team has unquestionable final authority."
e. "The Dr. wins—everywhere I have been. This is how we will work."
f. "There are some staff that were hired by the head coaches in the past—three to five have been hired in the past five years. The first time this happened the medical staff were peeved this happened. May not have been the people we thought should be hired but they appear to be the right choice."
g. "Mark Coyle and the department very strongly support IMC. It also needs to be part of the performance review."
h. "Student Wellness is a big part of coach accountability."
i. "If a student athlete feels pressure from a coach etc. to compete, the Administration has provided structure—safety nets for student athletes."

Student Athletes:

a. "Previously the coaches had no trust with medical staff. Student athletes used to feel it was a power struggle where the ATC was pitted against the coach."
b. "We must be cleared to play—coaches don't get in the way."
c. "We don't participate unless cleared. Always in communication with head coach."

d. "As long as you are making progress, coaches follow the medical recommendations. The way the coaches make you feel—you would rather play hurt than put up with the conversations with the coach. 'Are you sure you are hurt?' Feels the pressure."
e. "There is a difference between playing hurt and being injured. Coaches don't cross that line."

ii. General health care policies and procedures

1. Historically, the policies and procedures for the administration of health care have been significantly lacking. There are very few written policies or procedures currently in place. Any policy or procedure that does exist was created out of necessity by athletic medicine to address a specific situation for the individual sports programs. The current athletics administration is committed to developing policies and procedures that are consistent with best practices for athletic health care.

2. Team physicians do have protocols/processes in place to ensure student athletes have access to physicians as needed. However, the protocols/procedures have not been formally reviewed or approved by the Department of Athletics. All stakeholders (athletic staff, coaches, and student athletes) interviewed expressed concern for improved transparency and communication regarding Athletic Medicine policies and procedures.

3. The creation of the Student Athlete Health and Performance Committee is very significant with respect to health care policies and procedures. This committee has already begun the task of creating policies and procedures to ensure student athletes receive optimal health care. The primary focus of the Committee is to develop proper policies and procedures to ensure the health and safety of the student athletes. Hand in hand with the development of policies and procedures is the creation of an oversight and continual review process.

4. The Committee's commitment moving forward must be to continually review, revise and adopt best practices to best serve the health care needs of the student athletes. Once the policies and procedures are approved, they must be universally applied across all athletic programs. The application of the policies and procedures must be evaluated and assessed on an annual basis.

5. The data collected indicates the athletic administration is committed to this goal. Overall, this commitment is significant and demonstrates a focus that did not exist under the previous athletic

administration. Without question this may be the single biggest area of concern where immediate action is needed. Rightfully so, it is fair to say the Director of Athletics has recognized this as the highest priority of the health care plan.

6. Interview Comments

Staff:

a. "(Laughter) We have no policies anywhere. We have formed a committee to get this done."
b. "Are there strength and conditioning policies? We follow national standards. We have a structured, individual common-sense approach."
c. "We have some policies--Sickle and concussion yes."
d. "Some policies are based on payments—student athlete is sent for knee evaluation and are trying to determine the payment process."
e. "We really need to have the policies created and then made available to student athletes."
f. "(Shrugs and laughs) I think there was a process but everything we did changed under the previous administration—no policies anywhere."
g. "Eating disorders—any policy? No, I don't think so."
h. "Any policy information available for parents and student athletes? No."

iii. Safety and wellness

1. Specifically, when it comes to this area we believe we need to mention and recognize that the coordination of Athletic Performance with Athletic Medicine is imperative. Fortunately, this coordination is already underway. This is a focused initiative to ensure health and safety is prioritized.

2. Formerly, too many members of the Athletic Performance team and the Athletic Medicine team were working in their individual silos where ideas and processes of integration and collaboration did not exist. Alignment of Athletic Performance and Athletic Medicine is the best method to ensure student athlete safety and wellness is guaranteed.

3. The restructured leadership model and integration and collaboration process is underway under the direction of the new administrative team.

    a. Alignment, sharing, integration, collaboration and effective communication have removed the previously existing department silos. With the removal of the department silos, the student athletes have already benefitted from the new team approach to health care, safety, wellness and rehabilitation.

b. The previous organization's chart had all athletic trainers reporting to a single Director of Athletic Medicine, with more limited leadership availability for questions, training and oversight; now, there are levels within the athletic medicine department, providing enhanced leadership. The new multi-layered reporting structure has removed the obsolete flat structure.

c. With all entities working together, the sharing of information is bringing positive results. Athletic Medicine, Athletic Performance, Athletic Nutrition and Sports Psychology work together to ensure all aspects of the student athlete's safety and wellness are considered.

iv. Oversight

1. The newly implemented, modern delivery system with a structure that emphasizes the care of the whole student athlete also provides better oversight. Under the former administration, this collaboration and alignment was not supported. With a new team approach that involves input from all the key players, the Athletic Medicine team has better overall knowledge of and continuity in the treatment and care of student athletes.

2. Still, in this new structure the ultimate and final decision regarding a student athlete's health care plan resides with the Athletic Medicine team. The current administrative staff has provided alignment that has been made clear from the top to all levels—the medical staff will operate independently, and the autonomous decisions of the medical staff are not challengeable.

3. Across the board, all interviewed groups indicated medical staff decisions are not questioned nor are they overturned.

v. Organizational structure of the health care personnel and the interaction and integration of the various branches of health care

1. The organizational structure of the health care personnel and the newly created and implemented organizational chart is an improvement over the previous administration's organizational chart. Improved health care is relative to the ability to provide alignment across all disciplines. This alignment exists through the implementation of the more modern structure.

2. The inclusion of Athletic Performance under the umbrella of the Associate Director of Athletics for Health and Performance role

ensures communication between Athletic Medicine and Athletic Performance systems. Further, the previous organization did not have designated nutrition or psychology arms; these added resources to the new Health and Performance structure ensure enhanced access to meet student athlete needs. Because the health care structure has been changed, the department of athletics can ensure they have improved and continue to improve health care.

3. The modern structure provides the opportunity to properly assess all policy and procedures and to determine the impact policies and procedures have with respect to the health care services provided to the student athletes.

4. There appears to be an adequate number of team physicians, with an identified head team physician who has oversight over all physicians who are involved with the program. It is fair to say that there is an opportunity for growth here with the implementation of an annual evaluation or assessment of the medical personnel, including the team physicians.

5. The newly created structure of integration and collaboration with the various branches of health care is a change that is positively impacting the student athletes.

6. There has been a concerted effort to create a culture of universal empowerment and, to date, it appears to be successful. This progressive movement must be sustained if they are going to continue down this path where the provision of optimal health care for the student athletes is the primary goal. The new structure ensures the overall process of care will be properly reviewed and assessed to provide ongoing sustained improvement and positive change.

7. Interview Comments

<u>Staff:</u>

a. "Currently working on creating Policy and Procedures manual. The new committee is committed to follow through. Still a very young committee."
b. "Will create policy, procedures and process and make sure it is sustainable."
c. "[Speaker loves] going to Committee meetings—they are all committed to the health and well-being of the student athletes. We have the best interests of student athletes as the number one priority."

vi. Summary conclusions

1. The Department of Athletics' singular goal is to provide optimal health care services for student athletes. The Director of Athletics understands the importance of maintaining a positive health care culture where Independent Medical Care is the foundation of safety and wellness of student athletes. Cultural change exists across all athletic programs and all key departments that have a role in the provision of health care to the student athletes.

2. The restructuring of the health care services and the removal of department silos has brought a previously unrecognized desire to collaborate and integrate.

3. Moving forward, opportunities for further collaboration and integration do exist and should be supported. Continued collaboration and integration will sustain the improvement of health care for the student athletes.

b. Does the health care provided to student athletes include practices that use questionable, inappropriate or abusive hands-on techniques and modalities that injure or harm student athletes, including but not limited to:

i. Reflexive Performance Reset, Activation, and massage therapy

1. Clearly, the primary items to address with Reflexive Performance Reset (RPR) are (a) the confirmation of its use as a technique for student athletes and (b) who implements it and how it is implemented.

2. As an initial matter, Athletic Performance staff may offer "hands on" techniques, including RPR, as long as such techniques are explained clearly, conducted properly, and with student athlete informed consent.

3. The Athletic Performance staff provides pre-technique instruction to student athletes regarding the benefits and the long-term goals of the use of this technique.

4. Reflexive Performance Reset is a technique that is made available to all student athletes across all programs.

5. The Athletic Performance staff introduces the Reflexive Performance Reset technique to student athletes who want this technique. It is a hands-on technique that often times can involve deep tissue and muscle massage to sensitive areas. The intent of

technique is to provide student athletes the opportunity to perform the technique themselves.

6. The common, standard practice is to treat RPR as a voluntary activity for student athletes. If student athletes don't want the therapy, they have the autonomy to decline the application of the technique. Similarly, coaches may also choose to not allow the technique to be provided to their student athletes.

7. RPR can be painful and uncomfortable. Changes in skin color to include redness, bruising, and swelling can be a normal byproduct of this technique. Student athletes should be informed of this prior to the technique being performed. Student athletes should be encouraged to report any side effects, as well as any inability to participate in their sport because of pain secondary to this technique to Athletic Medicine.

8. Activation is a technique similar in scope to Reflexive Performance Reset, having been derived from the same theoretical basis. Activation was developed by therapists to treat injuries and RPR has re-packaged Activation and moved the techniques into the Sports Performance sphere. For this reason, care should be taken to ensure that RPR is only used to assist with sports performance and not to treat injury. The use of RPR is becoming more popular in the sports performance realm and it can be used as a performance enhancing technique.

9. There is a consistent theme that RPR is something that is offered by the Athletic Performance staff to improve student athlete athletic performance or that the technique is used to treat injuries. There is confusion about the purposes of RPR—especially on the part of student athletes—as to why the technique is being performed. RPR should not be used to treat particular student-athlete injuries to avoid aggravating an existing problem unintentionally.

10. The current athletic administration has addressed the methods by which Reflexive Performance Reset is being used with student athletes. The administration has reviewed to whom and how the technique is provided as well as the impact the technique has on student athletes.

11. Additionally, the Department of Athletics should review the Athletic Performance staff commitment to teach the student athletes to be able to self-perform the technique. This review would determine if this technique should be made available to student athletes moving forward.

12. Indications are that all athletes in all programs have access to massage therapy.

13. Currently no policies or procedures exist within the athletic department around the use or implementation of these techniques.

14. The Department of Athletics should develop policies and procedures surrounding these techniques—RPR, Activation, and massage therapy. All personnel who perform them should be vetted, trained, and certified as appropriate. Policies and procedures should address student athlete informed consent and reporting of any side effects. Any technique intended to treat injury or other medical condition should be approved by appropriate medical staff. All treatments must be included in the health care record for each student athletes.

15. Interview Comments

Staff:

a. "From what I have seen, the Athletic Performance staff believes this to be a very important part of training. Some former staff members complain about these techniques."
b. "[She knows] of a student athlete complaining about the treatments, the pain, the crying. However, student athletes can opt out."
c. "If you have the certification you can provide the treatment. We do have the certified medical professional teach the rest of the staff what they have learned. For example—kinesio-tape isn't going to hurt anyone."
d. "Most times athletes are asking for it and athletes are instructed to learn how to do it themselves."
e. "Tried to make it an independent treatment. Not used in context of injuries—used not as an injury treatment but overall wellness or positional things like tight hip that would use this to assist with the overall wellness."
f. "I think that strength and conditioning started doing RPR, that we were getting some female athletes coming forward with significant bruising and had to do it as a team. What is the technique, why is it beneficial, and what do we know about it? Obviously, I am pretty sensitive about this because of Nassar situation. The other problem with the technique was that some of athletes were doing rehab with strength and conditioning instead of ATC so some questions about performance or rehab."

g. "This is where the structure of the program is important. The goal is to teach the student athlete how to do this on themselves."
h. "Athletes have not come to [him] to indicate they are being forced to do these things. Chiro and massage are sign up treatments and out in the open in the training room."

ii. Athletic Performance techniques and the use of exercise as punishment

1. All interview groups were asked about oxygen deprivation training techniques and the use of exercise as punishment. It appears a very limited number of programs used either technique.

2. The use of oxygen deprivation training techniques was discussed with all interview groups. Oxygen deprivation training is an accepted technique to be used in the training of Division I athletes. Training should be properly supervised using medical oversight for the planning. Also, appropriate equipment that is designed for safe oxygen deprivation training should be used. Student athletes, coaches and Athletic Medicine staff did not deem oxygen deprivation techniques to be punishment nor dangerous.

3. The interview data indicates there have been incidents where exercise has been used as punishment for student athletes. Again, all interview groups were asked about this topic. Overall, it appears there have been very few situations where physical or verbal punishment workouts have occurred. Indications are that the majority of physical workout punishment sessions took place as a result of team rule violations.

4. Regardless of the number of incidents of exercise punishment that have occurred, the practice must be ended immediately. Significant safety issues are always the concern when physical workouts are used as a form of punishment.

5. The Department of Athletics should make policy and education on oxygen deprivation training and exercise as punishment a priority. All coaches, student athletes, Athletic Performance staff, Sports Psychology staff, Sports Nutrition staff, Athletic Medicine staff and the Department of Athletics administrative staff should receive education.

6. Interview Comments

<u>Staff:</u>

a. "Yes, this will happen. The coaches trust him, and no one questions him in this setting. I am in charge of the workout punishment. Young ATC are not properly equipped to handle this."
b. "Never heard of athletes running until they puke etc."
c. "No reward to VB program so they don't do it."
d. "Have had kids not make the performance tests—so they go day to day until the meet the mark"
e. "NO coaches do this."
f. "Former coach did this."
g. "ATC had a coach request he/she bring in a team early to run conditioning for a drinking situation"
h. "Do you feel uncomfortable with the coach requests? Yes—with previous coach. Not now with current coaches."
i. "Done on occasion, very seldom. Did it one time last year—guys get in trouble, so they are physically accountable. Does not like to use conditioning as punishment—one time last year for 20 minutes."
j. "Had to run stairs at 6:00 with plates over their head for minor drinking. Run by strength coach but coach directed."

iii. Omegawave technology, and other performance-based technology

1. All groups interviewed indicated performance-based technology has become part of the overall training providing for the student athletes.

2. Omegawave technology does not appear to be a technique used with all of the student athletes. A small sample of the interviewed student athletes indicated they have used Omegawave technology. In each interview session, the use of this technology was discussed, and our conclusion is this technology is currently being used with one or two of the athletic programs.

3. Athletic Performance staff use Omegawave technology to measure brain wave patterns in an effort to help determine how to improve performance by adjusting workout intensity, regimens, etc.; they do not use such information for purposes of medical decisions and should not do so. It is acceptable to gather such information as long as it is used properly.

4. Policies and procedures for the use of performance-based technology should be created. The policy and procedures must ensure the technology is being used for sports performance and not for diagnostics. The policies and procedures should identify who should be granted access to the data gathered through the use of sports performance technology. Oversight with regards to

approval of technology, proper application of the technology and oversight of the technologies need to become the standard.

5. Interview Comments

   Staff:

   a. "I used Omegawave with female athlete with an eating disorder—had 20 pounds of weight on her at weigh-ins and discovered a heart issue."
   b. "Yes, I know it is used with hockey programs."
      "I don't have much on this—other programs use some technology—some programs use this. Not sure who uses it. [Her] understanding is that budget money is used by coaches to do this."

iv. Electrotherapeutic modalities

1. All interview groups indicated electrotherapeutic modalities are only used by medical staff. Student athletes who received electrotherapeutic treatments received the treatment only for medical injuries and all treatments took place in the training rooms. All treatments were performed by medical staff.

2. One interview group noted that Athletic Performance staff have used an automotive buffer to massage student athletes as a way of saving funds compared to similar devices designed for application to the human body. This practice creates risk of misuse and is not recommended.

3. Other than the buffer issue noted above, there is no indication electrotherapeutic modalities are performed on student athletes by non-medical personnel or used for reasons other than medical treatment.

4. It is clear the administration has made progress in this area to provide oversight. This remains an area where continued oversight is needed to ensure the overall safety and wellness of student athletes continues to be the number one priority.

5. Interview Comments

   Staff:

   a. "ATC makes decisions on modalities. One person orders the supplies, and another calibrates the machines."

b. "Ultrasound is part of clinic and only used by physicians or trainers."
c. "If you have the certification you can provide the treatment. We do have the certified medical professional teach the rest of the staff what they have learned. For example—kinesio-tape isn't going to hurt anyone."
d. "Use DEXA Scan but kept confidential—do not know what girls weigh."
e. "Use Zephyr to determine load for the week for the girls to help create the weekly practice schedule."
f. "How do you disseminate info from Zephyr, Catapult, DEXA? Info is shared with coaches. Wellness questionnaires can be shared with coaches. If DEXA is approved, it can be shared with medical staff but not coaches."
g. "Strength and Conditioning do not use stim units with student athletes."

v. Summary conclusions

1. It is only under the current Department of Athletics administration that collaboration and integration have occurred in this area. This was clearly an area in our discussion with all groups where integration and collaboration with the previous administration and medical team were not supported.

2. Indications support the conclusion that all treatment modalities are used only by trained medical staff, in the training rooms for the treatment of student athlete injuries. We do not have any information from the interview groups that would indicate modalities, especially electrotherapeutic modalities, are used in any other fashion.

3. Policy and procedure development should continue in this area.

c. Current Athletic Medicine procedures

i. The current medical review and documentation practices used to monitor the distribution of over the counter medication and prescription drugs

1. It is our assessment that the distribution of over the counter (OTC) medication only happens in the athletic training rooms. The athletic medicine staff is solely responsible for the distribution of over the counter medications. The coaching staffs are not involved in any capacity with the distribution of over the counter medication.

2. There do not appear to be any written policies or procedures regarding the distribution of over the counter medications. Nor does there appear to be any record or documentation of the over the counter medications dispensed to the student athletes.

3. An immediate priority of the Student Athlete Health and Performance Committee should be the creation of procedures and policies for the distribution of Over the Counter medications. The policies and procedures need to include a mandated record of the medications dispensed. Furthermore, there need to be policies and procedures regarding the types and quantities of over the counter medications that can be distributed by the Athletic Trainers.

4. With respect to prescription medications, all indications are that prescription medications are:

    a. Only obtained by student athletes who receive prescriptions for the medications.
    b. The prescriptions for the medications are from physicians, most often from student health physicians or family physicians.
    c. All prescriptions are filled by pharmacies. The University of Minnesota Department of Athletics does not have its own pharmacy or pharmacist. There is clear consensus that the only time that prescription medicine travels with a team it is under the supervision and in possession of the team physician.
    d. Under the previous athletic administration there were occasions where prescription medications were dispensed to student athletes by the athletic trainer. That practice no longer continues under this current administration.
    e. Moving forward, the current distribution process should continue—physician prescribed, pharmacist or pharmacy dispensed and picked up by the student athlete.
    f. Finally, policies and procedures are an immediate necessity.

5. Interview Comments

    Staff:

    a. "ATC allowed to distribute OTC and comes from locked cabinet in training room."
    b. "Not identified or listed in a record anywhere what is distributed to the student athlete."

c. "Meds always prescribed from a physician—must see physician to get the prescription."
d. "Student athletes hold on to their medications."
e. "Knows of an Adderall case and the student athlete asked coach to distribute."
f. "Have some policy for treatments but not for medication."
g. "Athletic trainers are not asked to distribute prescriptions."
h. "No real history observed that prescription drugs are available to student athlete."
i. "Students ask the trainers for items—a single dose of Tylenol for example. As an athletic trainer—I am very cautious."
j. "Do you document over the counter? No, we don't."
k. "There is a physician's bag of meds—usually used on the road. If student athlete needs something on the road in the middle of the night a physician can take from physician's bag."
l. "Since you don't have prescriptions how do kids keep or take their prescriptions. Student athletes must get them from team doctor—doc must call in prescription, coordinated through the athletic trainer."
m. "Oral Toradol—athlete receives Toradol from trainer at physician's request."
n. "As an athletic trainer I hope to hell this is not happening in our programs."
o. "In the past Toradol was available—4-5 years ago. To my knowledge this does not still happen."

ii. The use of outside medical services and personnel

1. Student athletes may always choose to seek advice from medical providers outside of the University's system. Program coaches can also select and or contact outside medical professionals to provide care and treatment to student athletes.

2. The involvement of outside medical staff, when initiated by University personnel of any kind, should be under the request and observation of the medical team rather than under the request and supervision of the coaching staff.

3. All outside medical personnel who will be utilized in the health care of the student athletes at the recommendation of University personnel must have appropriate background checks and regular performance evaluations.

4. Additionally, when medical specialists or medical practitioners from outside of the University medical team are utilized to provide

care for the student athletes, all interaction with those outside entities should be included in the official medical record of the student athlete at the University. There is no evidence, at present, to indicate the services provided by outside medical personnel for the student athletes are recorded or documented. This practice needs to change so the medical record for student athletes is accurate and complete.

5. Notably, the two groups within Athletic Medicine—the athletic training staff and the team physicians—currently use different medical review and documentation systems. Currently, the physicians are using Epic—an electronic health care tracking system used by most major health care organizations; the training staff is using Presagia—an injury tracking medical record system. It is strongly recommended that the Student Athlete Health and Performance Committee prioritize the implementation of a single medical single medical documentation record system, which will support complete and accessible records of outside, and internal, health care.

6. Interview Comments

Staff:

a. "Chiro and PT are contracted out. No background checks."
b. "Chiro and PT? It happens in the training room, contracts coming from department—nobody has oversight. Treatments for student athletes by chiro and PT are entered into SA record by UMN medical staff."
c. "Can you seek outside medical professionals? Just had that last semester—videoed her, sent it to the athletic trainer and asked if student athlete needed to see chiro."
d. "Is this becoming more consistent with the department? Yes, was the previous leadership an impediment to this--yes former leadership."
e. "Most of time, through the physicians. The athletic trainer makes the appointment and contacts the MD to let him/her know they will be seen in clinic. Track coach has a good relationship with MD to take care of eating disorders."
f. "Physicians are always involved. Head coaches are part of the discussion but the athletic trainer flows to team physicians regarding tests to be scheduled."
g. "How about individuals choosing their own doctors? We are able to steer the SA to the best person outside of the university."
h. "Team doctors might not be happy, but they understand."

i. "Do you have a referral directory? Yes, we do and the protocols to get them in immediately to see those docs."
j. "The student athletes know who the best doctors are."
k. "We try to have as much in house for institutional control."
l. "Family usually lets us know they want a second opinion."
m. "Do you have referral lists for docs to choose? If it is coming from a team physician, then they move forward with the 2nd opinion option."

iii. Oversight of those providing performance and medicine services

1. Currently, the University does not have a comprehensive system for documenting that Athletic Performance and Athletic Medicine staff have undergone appropriate background checks, training, and credentialing for the services that they provide to student athletes. Our review did not suggest that particular individuals were unqualified for their roles, but the University should be able to document their qualifications.

2. The Student Athlete Health and Performance Committee's work should include appropriate review, certification, credentialing, and monitoring processes for Athletic Performance staff, Athletic Performance techniques, and those providing Athletic Medicine care—including external providers—to support student athlete safety.

iv. Summary conclusions

1. Develop policies and procedures, and provide appropriate education, surrounding documentation for monitoring the distribution of all medications.

2. We recommend (a) creating policies and procedures to review, certify, and monitor all procedures to be used by outside medical personnel as well as (b) a process to credential and monitor care provided by outside medical staff to ensure the safety of student athletes is paramount.

3. The University should evaluate methods for further integrating all student athlete medical records to ensure comprehensive and accessible records.

4. The University should proceed with creating a formal method for documenting the review, certification, credentialing, and monitoring of all individuals providing Athletic Performance and Athletic Medicine services for student athletes.

d. Assessing the organizational restructuring and changes to the administration of health care services over the past eighteen months

i. Better meeting the needs of the student athlete

1. Under the previous Department of Athletics administration and the previous Athletic Medicine administration, the health care platform was antiquated structurally. In this platform, silos existed, and department personnel operated independent of one another without integration, collaboration, or communication. In the simple structure in place at that time—sports medicine and strength and conditioning did not interact. Unfortunately, the Student Athlete Health and Performance groups at that time—Athletic Medicine and Athletic Performance—were treated with indifference and in many cases completely ignored or purposely ignored by the former athletic administration team. From our investigation, it appears the resistance to collaboration and integration produced a terrible culture. Fortunately, the current administration has implemented a modern structure of collaboration and integration.

2. There is a current commitment from this administration to the priority of the health and safety of the student athletes. There is a genuine and implicit desire to provide an outstanding optimal health care structure, and to ensure providing optimal student athlete health care.

3. As an example demonstrating this commitment, the athletic training structure now assigns athletic trainers as mentors who have other athletic trainers, graduate assistant trainers and interns reporting to them. This collegial structure has created an in-house mentoring program.

4. By combining the four disciplines to work as one collaborative unit—Athletic Medicine, Athletic Performance, Sports Nutrition and Sports Psychology—the current Director of Athletics has modernized the entire health care platform. The creation of the Associate Director of Athletics for Health and Performance was an emphatic stroke that clearly has delivered a new message regarding culture. This position has a seat at the administrative table and provides a better framework for initiatives to be addressed. This new platform best prepares the University for future collaboration, integration, growth and development.

5. Unanimously, all of the groups we interviewed feel they are in a much better place now than they were eighteen months ago.

6. Interview Comments

Staff:

a. "Structure has recently changed. A restructure. It was a horizontal structure and now it is a growing vertical structure."
b. "Working with Joi in the last month to create a manual for staff as resource and on-board people with. Hopefully this review is to help us create policy and procedures."
c. "Grad Assistants— they are leaving. Phasing out GA's and now it will be intern or employees. GA's were not mentored."
d. "Do you ever have performance team meetings—with the Athletic trainers and the strength and conditioning staff? Yes, now with the new directors and structure it happens."
e. "Had meetings in past and the meetings did not go well. Young staff were not encouraged to ask questions."
f. "What is going to be the big fix, how do we support the 750 athletes?"
g. "Dining hall is the hub of the program—it has to be starting process for all student athletes to understand the Nutrition process—create a common language and common understanding."
h. "Want it to be consistent and controlled—sustainable programming."
i. "Currently working on creating Policies and Procedures—much overdue."
j. "How does the committee work? They are all committed to follow through. We will create policy, procedures and process and make sure it is sustainable. Still a very young committee."
k. "I love going to Committee meetings—they are all committed to the health and well-being of the student athletes—Have the best interests of student athletes as number one priority."
l. "July 1 was roll out of new structure. The four units—Athletic Performance, Sports Psychology, Sports Nutrition, Athletic Medicine (ATC and MD)."
m. "Athletic trainers also have dotted line to team physicians."
n. "Get everybody together and create new structure. Previously these 4 units bounced around."
o. "Previously, decisions were made, and upper management levels did not consider day to day operations. It has been bad until recently."
p. "There was always a team approach to the overall care."
q. "Historically, globally the two did not collaborate very well. If you got down to the team level, you would see the trainer and strength staff talking to each other but that was about it."

r. "I believe conflict discussions are great—two groups, strength and conditioning and athletic trainers are moving in the right direction."
s. "We now feel we have huge support from institution."
t. "What is the interaction like—it used to be a lot of isolation in the group—not anymore."
u. "Now it is very collaborative—one of the assets of the new structure and organization."
v. "How is this working? Great—I enjoy the new structure. Struggles are being heard by them—they felt marginalized for a number of years—largely in part because of the former administration."

ii. Are the changes meeting the expected standards of care for a Power Five Division 1 University?

1. Yes. We believe the changes that have been put in place are allowing the athletic department to establish a more modern organizational structure.

2. The restructuring is allowing the Department of Athletics to reach its ultimate goal for Student Athlete Health and Performance—provide the best health care and safety for student athletes where the University of Minnesota can emphatically state the student athlete health care is a recruiting tool to enhance the overall landscape for recruits.

iii. Summary conclusions

1. The Department of Athletics is better meeting the needs of the student athletes.

2. There continue to be further opportunities for growth. However, there now exists a better construct to allow progress and development to continue to move forward.

3. The division of responsibilities has allowed more opportunity to specifically address issues. There is clearly more collaboration and communication with Athletic Medicine team and the Athletic Performance team.

4. Continued collaboration is needed as athletes rehabilitate from injured status to performing in their sport status.

5. It is fair to make the following statement—The University of Minnesota has the resources to meet best practices in all areas of student athlete health and safety.

IV. Final Recommendations and Opportunities for Growth

a. Engaging in ongoing internal and external review and engagement will allow the University of Minnesota to identify any blind sports in student athlete health care as Department of Athletics continues to develop health care, safety and wellness policies and procedures with the goal of providing optimal health care for all student athletes.

b. Continuing to support transparency where inter-department communication is paramount to success and is of import to all stakeholders.

c. Committing to provide standardized health care to all athletic programs will address the expectations of all groups interviewed for student athlete health care and safety.

d. Developing formal processes for education and compliance analysis regarding student athlete health and safety will further ensure the success of current efforts. This process would include health, wellness and safety education for all athletic staff, coaches and student athletes, as well as regular policy and procedure application review.