



## Making the Case for Case Management: A Holistic Care Approach for Athletic Organizations

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*Driven by recent athlete advocacy and evolving organizational policies, sport organizations must implement comprehensive strategies to address athletes' mental health needs. Scholars advocate for a holistic approach that integrates mental, social, spiritual, and physical health. However, the sport industry currently lacks a practical, interprofessional model that supports holistic wellness at both individual and systemic levels. This conceptual study reviews eight evidence-based healthcare models, revealing that while each offers valuable insights, most focus on individualistic care and lack adaptable implementation strategies for sport organizations. To bridge this gap, we propose three best practices for an athlete-centered, collaborative care model: (1) adopting an interdisciplinary approach, (2) hiring dedicated case managers, and (3) investing in top-down organizational training.*

*Keywords: athlete well-being, case management, holistic care, interdisciplinary care*

Adequate and equitable mental healthcare in athletics is a primary goal across multiple collegiate and professional sport organizations (National Collegiate Athletic Association [NCAA], 2023; National Football League [NFL], 2024; Women's National Basketball Association [WNBA], 2023). Sport management scholars have suggested that a holistic approach—addressing an athletes' mental, social, spiritual, and physical health—is the most effective care model (e.g., Beasley, et al., 2021; Berg & Warner, 2019; Waller et al., 2016). For example, Waller and colleagues (2016) suggested that college athletes need a variety of different actors with their areas of expertise (i.e., a chaplain) to provide the best level of care for the athlete. However, the sport industry lacks a practical, interprofessional, and comprehensive model of care (MOC) that encapsulates holistic wellness of athletes on an individual and systematic level. Coupled with the call from athletes for greater mental health care (Purcell et al., 2019; Tran, 2024), it is evident that athlete healthcare delivery and structure needs to be addressed (Barkley et al., 2018).

To fill this gap in research, this conceptual study reviewed the strengths and limitations of eight different evidence-based healthcare models (i.e., standard mental health care, injury prevention) to understand what an empirically based, athlete-specific holistic model of care (MOC) could look like. We approach this discussion from the theoretical foundation of Ecological Systems Theory (Bronfenbrenner, 1994), or a systems approach, to gain a more complete understanding of the impacts of these MOCs. More specifically, the Ecological Systems Theory posited that an individual's development and well-being is a product of five explicit systems: (1) microsystem, (2) mesosystem, (3) exosystem, (4) macrosystem, and (5) chronosystem (Bronfenbrenner, 1994). Table 1 details the distinctions between each of the systems.

*Table 1. An Adaptation of Bronfenbrenner's (1994) Ecological Systems Theory*

System Level	Details	Example
Microsystem	An individual's immediate environment	An individual's family
Mesosystem	Connections between an individual's different microsystems	Relationship between a parent and a coach
Exosystem	Larger organizations and systems that can influence an individual's life	A sport organization deciding practice times
Macrosystem	Cultural values and norms that impact an individual, if not directly	Mental health stigma
Chronosystem	The passing of time	An individual's maturation

These distinctive systems, however, do not operate in isolation. Each level impacts each other, making them integral in understanding an individual's well-being. A systems perspective is often used to both consider the different influences in an athlete's life and utilize each system to provide adequate and appropriate care (Beasley et al., 2021; Saxe et al., 2022).

Using this perspective to guide our review, we found that many MOCs take primarily an individualistic approach, which does not consider systemic issues. Further, we argue that there is no implementation of these models that can easily be adapted to the setup of sport organizations (i.e., athletic department). Namely, there is currently no comprehensive, athlete-specific MOC to address holistic health concerns of athletes. Taking these critiques, the purpose of this research is two-fold: (1) propose an athlete-centered MOC using the strengths found in our conceptual review, and (2) outline actionable steps that can be implemented both on a wide-scale and individual level for different sport organizations within the industry.

### Literature Review

The following section reviews eight areas of physical and behavioral healthcare that frequently use a MOC. We provide an overview of each model, the model's strengths, critiques of the model, and, if applicable, the ways in which the model has been applied in a sport context. In addition, Table 2 outlines aspects of each MOC's best practices and what these could look like in an athletic context.

*Table 2. Synthesis of Literature Review*

MOC	Aspects Incorporated	Best Practices in an Athletic Setting
PPM	structured delivery, evidence-based, and relationship-based practices	An AT showing a structured care plan to an athlete and their coach for mutual understanding
PCC	Patients playing an active role in their care	A PT asking for feedback from the athlete on their recovery plan
Hospice and Palliative	Comfort care	Structuring in a feedback loop to make sure an athlete is comfortable during their recovery
Childbirth	Patient-centered, case manager	Hiring a case manager to coordinate care for the athletes
IPE	Increased communication and understanding between care professionals	Providing education for all care professionals in an organization to increase communication and knowledge of others' roles
Mental Health	Interdisciplinary care, patient-centered	All members of an athlete's care team communicate effectively and understand their role in the structured care plan, and there is a consistent feedback loop between the athlete and all members of the care team.
Holistic Care	Incorporating many care professionals into one organization	Increasing athletes' access to resources such as a chaplain or life skills coordinator
Sport Injury Rehabilitation	Systems-based approach	Incorporating a case manager to help manage and coordinate care for an athlete throughout different systems level (e.g., athletic department, outside community)

## PPM and Nurse Care

A Professional Practice Model (PPM) is “how registered nurses practice, collaborate, communicate, and develop professionally to provide the highest-quality care for those served by the organization” (UC Davis Health, 2023, para. 1). Within a patient-centered PPM, core to nursing care delivery, Parreria and colleagues (2021) outline the five phases for care delivery: (1) analysis/diagnosis of the situation, (2) goal setting, (3) strategy selection, (4) implementation, and (5) outcome evaluation. They argue that this model allows for the adaptation of patient’s needs, intentionality with treatment, and cooperation across nurses to provide the best care (Parreria, et al., 2021).

Further, the University of California, Davis provides an in-depth example on their website of their PPM, including their values (love, compassion, courage, integrity), vision, and philosophy, all which fall under the ideology of patient-centered care (UC Davis Health, 2023). They discuss expectations regarding nursing care delivery, which include evidence-based practice, autonomy, and collaboration. They highlight their emphasis on relationship-based care and how that helps promote their culture of healing and a healthy work environment. The site then ends with examples of how they provide exemplary professional practice (culture, evidence-based practice) and governance (leadership, system structure; UC Davis Health, 2023). This is a great example to understand the primary principles of a nursing community; however, it does not reveal implementation examples or details to highlight the success of their program. Wolf and colleagues (2023) conducted a database search to understand popular components of PPMs. They found that PPMs place, “an emphasis on patient- or family-centered care, a commitment to quality nursing services, nursing's professional distinctiveness” (Wolf et al., 2023, p. 204) and engagement. This holds congruent with that of UC Davis’ PPM (UC Davis Health, 2023), suggesting a core theme across multiple PPMs.

PPM’s tenets of patient- and/or family-centered care is an effective approach to yield optimal outcomes for patients. Relying on evidence-based practices help to ensure proper care is being delivered and collaboration among the institution’s nursing community is a great avenue to increasing trust among coworkers and thus a better-working team. Yet, there are several limitations to PPM. From a cultural, macro perspective, this model fails to incorporate different family structures beyond the White standard where two parents are the main sources of support. To operate fully within family-centered care, more consideration must be given to incorporate all types of family structures, as well as the lack of a familial support system. Additionally, little information is given within PPM on how to coordinate care within different nursing departments. There is a broad assumption given that all nurses understand the different departments within a hospital and know each other’s contribution to the patient’s care. Yet, while there is little professional crossover between a nurse and athletic setting, key components of structured delivery, evidence-based, and relationship-based practices are important to consider when

developing an athlete-focused MOC. Within a sport organization, this could look like an athletic trainer showing a structured care plan to an athlete and their coach so that everyone has a mutual understanding of what is most effective for the athlete.

### **Patient-Centered Care**

Patient-centered care (PCC) is a type of MOC that operates at the micro, meso, and exo levels within the healthcare industry. In other words, it is an approach to care that impacts personal, professional, and organizational relationships (Epstein & Street, 2011). Grounded in giving patients a more active role in their healthcare treatment, PCC is an engaging model that works to provide patients with the best experience and outcomes possible. Within PCC, patients' preferences are adhered, based on the model's emphasis on expanded involvement for patients (Epstein & Street, 2011).

PCC has a variety of sub-models each with their own adjustments and evolutions, yet all have the goal of providing care for the whole person by involving integrated systems and coordinating teams (John et al., 2020). John and colleagues (2020) explored the function of a patient-centered medical home (PCMH), which incorporates comprehensive and coordinated care with patient engagement through a general practitioner and a multidisciplinary team. Multidisciplinary practice draws on knowledge from other disciplines, but professionals do not often work in collaboration in a coordinated care plan (Choi & Pak, 2006). Research found significant improvements in patient depressive episodes, health-related quality of life, self-management outcomes, and hospitalizations (John et al., 2020).

A prominent example of the patient-centered approach is within the Chronic Care Model (CCM), which highlights the health system as one component of the larger community. Taking both different aspects of the health system (i.e., delivery design, decision support) and the community (i.e., location, culture), health care providers can make informed decisions to have productive interactions with the informed, active patient, to yield improved health outcomes (Wagner, 1998). Yet within CCM, there are a variety of barriers that inhibit the implementation process in a primary care setting, including organizational culture, organizational structure, networks, communication, climate readiness, supportive leadership, and provider attitudes (Kadu & Stolee, 2015).

PCC practices are found to be more effective than standard MOCs and are multidimensional in practice for the patient's many needs (Chouvarda, et al., 2015; John et al., 2020). They can provide continued engagement for patients and contribute to the sustainability of long-term care (Chouvarda, et al., 2015). However, there are still several limitations to PCC. Financial costs of training, education, and staff, burnout due to empathy, and exclusion of certain groups make-up large issues with the current model (Meranius et al., 2020). To expand, cultural competency on both the micro and macro levels is lacking, making PCC inaccessible and/or

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inadequate to all cultures or backgrounds. Additionally, with PCC practices utilizing multidisciplinary strategies, there is often no communication between care team members, creating issues with patient care efficiency.

Within athletics, athletic trainers (ATs) play a vital role in PCC (Redinger et al., 2021; Wilson et al., 2022). Wilson and colleagues (2022) surveyed ATs on their perspective of utilizing PCC. They found that while ATs valued the same core competencies as PCC, they lacked formal training in the implementation of the model itself. From the athletes' perspective, Redinger and colleagues (2021) found via a mixed-method analysis that athletes agree that their ATs centered the core dimensions of PCC in their care. They perceived PCC to be individualized and prioritizing health care, of which they believe their ATs adhere to these definitions (Redinger et al., 2021). Authors also found when considering potential barriers to implementation in sport that effectively incorporating an athlete's support system proved to be difficult. Additionally, managing the impact of a coach's opinions on care could prevent an AT's proper execution of PCC (Redinger et al., 2021).

### **Hospice and Palliative Care**

Literature around hospice and palliative care also stresses the effectiveness of PCC. Hospice is the treatment provided, emphasizing comfort and quality of life, to a person approaching the end of their life (National Institute of Health, 2021). With this type of care, there is no curative intent. Palliative care, on the other hand, emphasizes the same qualities of hospice care, but has the option to have curative intent (National Institute of Health, 2021).

Dobrina and colleagues (2014), using existing hospice and palliative care models and theories, derived 10 core concepts that encapsulate what is prioritized in these types of care. Overall, these themes reflect the practices of patient-centered philosophies as well as urge the importance of an interdisciplinary team approach. Additionally, the Agency for Clinical Innovation (2022) published their principles for palliative care which include:

- (1) Care is patient, family, and caregiver centered
- (2) Care provided is based on assessed need
- (3) Patients, families, and caregivers have access to local and networked services to meet their needs
- (4) Care is evidence-based, clinically and culturally safe and effective
- (5) Care is integrated and coordinated
- (6) Care is equitable (para. 1-6).

These principles offer a great overview of expectations for the patient, caregiver, and family, while including examples on how to practice these principles. While this offers great content and guidance on the overall frame of care, little is provided on how to achieve these principles both

on an individual and widescale level. This model operates under the assumption that all actors within the care team know one another, have a broad understanding of one's field, and can work well together. Another limitation of hospice and palliative care is the assumption that there is a strong support system for the patient.

However, while there are no ties to athletics, there is great benefit to understanding the strengths of this model. Patient-centered and comfort care are great strategies that can be utilized in an athletic setting, specifically when we are thinking of athlete injury and ongoing health considerations of the athlete. This could look like checking in with athletes on their comfort levels throughout different stages of their recovery plan. Additionally, a large strength of this model is its ability to incorporate family-centered care. This is an important consideration for the athlete population, specifically college athletes, as this is likely their first time away from home and may need assistance from family members in navigating the healthcare system.

### **Childbirth**

Within childbirth practices, midwifery has been identified as having a distinctive model of care in comparison to standard practices. In particular, the midwife-led continuity model, where a midwife follows a patient from the initial appointment to early parenthood. It is patient-centered, with the midwife as the point person, or 'case manager', throughout the whole pregnancy (Sandall et al., 2016).

Sandall et al. (2016) conducted a robust study targeting whether this MOC is successful. Researchers found that patients who chose a midwife-led continuity care model were more likely to have safer births (for the parent and the child) and were least likely to have adverse outcomes during pregnancy over other models of care. Lastly, patients reported that they were satisfied with their care (Sandall, et al., 2016). These benefits are long-lasting and provide great care for patients. However, it lacks specific steps needed to be reproduced in other settings, such as in sport settings. In addition, this model in its foundation lacks the inclusion of other disciplines that might be necessary during one's pregnancy, such as a nutritionist or endocrinologist.

Regarding athletes, the NCAA has the Model Pregnancy and Parenting Policy document that outlines specific care instructions for all members of the athletic department, specifically ATs as they are usually the first to note if an athlete is pregnant. While this policy is a great resource, it is informationally based, including the first signs of pregnancy, how to practice gender neutral pregnancy, and physiological concerns for pregnant athletes, it does not include a model of care, guidance to best practices for athletic departments to adhere to, or care for the whole person (NCAA, 2021). This policy is reactive and fails to offer a proactive pregnancy education aspect that would enhance the health and safety of athletes. Additionally, this policy is geared to AT. While ATs operate with close contact with college athletes, there is an assumption that ATs are trained to look for and handle pregnancy. In this way, ATs are operating as case

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managers for college athletes; managing different aspects of their health and well-being that is not a part of their job description. This can lead to feelings of burnout amongst ATs as they are overwhelmed with a variety of roles they were not trained for (Mazerolle et al., 2010; 2013). Lastly, in professional leagues, no specific model of care for pregnant athletes is publicly available.

## **IPE**

Interprofessional education (IPE) is a popular approach to engaging healthcare students, focusing on collaboration between professionals and professional development, and involving two or more professions. The main goal of IPE is to provide interdisciplinary knowledge between professions and create shared values in the realm of patient care. Interdisciplinary care provides coordinated practice between different disciplines and healthcare providers, wherein all providers are in communication and care is often managed through a case manager (Choi & Pak, 2006), separating itself from multidisciplinary care. IPE can present itself in various ways. Grace (2021) highlights that, primarily, pedagogy falls either within an (1) extracurricular-centric or partially integrated model or (2) a fully integrated model, where IP opportunities are embedded across the curriculum. They also note that within these two models, around 40% utilize phases within their models to “incrementally develop interprofessional capability” (Grace, 2021), or enhance one’s skills, in a structured pedagogy, to work in a coordinated team across multiple disciplines. This is a great opportunity for students to get practical experience working with other students and/or professionals across disciplines and emphasizes the important role that interdisciplinary care has in their career. Bridges and colleagues (2011) support these findings and delve into three IPE models from the Rosalind Franklin University of Medicine and Science, the University of Florida, and the University of Washington. All models emphasize community-based experience and interprofessional-simulation experience. Building an understanding of professional roles in a healthcare team was also a primary goal. They end the paper by discussing key factors to the success of these programs: administrative support, program infrastructure, and student success acknowledgements (Bridges, et al., 2011).

The current literature notes some potential barriers to the current IPE models, including lack of resources for training and professional health programs, lack of institutional support, and scheduling process (Breitbach et al., 2013; Hammick et al., 2007; Lash et al., 2014; Reeves et al., 2013; Sheldon et al., 2012). To elaborate, who is involved in IPE is an important question that is often overlooked. In a professional setting, how do we ensure that all actors know each other and have a basic understanding of what each other does? IPE operates under the assumption that all disciplines in healthcare (e.g., nutrition, nursing, psychology, social work) are receiving this training and are prepared to be a part of a coordinated care system.

In an athlete setting, athletic training programs are known to utilize IPE yet lack proper education on the pedagogy of IPE (Breitbach et al., 2015). Breitbach and colleagues (2015) note

this and provide “model pedagogy” to stakeholders on how to implement IPE to professional athletic training programs. They emphasize building skills including cultural competence and ethical decision-making through imperative learning experiences (advocacy through group community-based projects). Breitbach and colleagues (2015) reveal that these skills can be taught through reflection exercises, simulation, problem-based learning, community projects, and service learning. They conclude by noting that facilitator training is a necessary component for well-conducted IPE.

Additionally, Van Slingerland and colleagues (2022) conducted a case study exploring these types of resources through collaborative care. They found that collaboration performance was hindered by logistics, the overlaps of scopes between the professionals, and individual characteristics of the athlete (Van Slingerland et al., 2022). Beasley and colleagues (2021) found similar issues when exploring the emerging role that social workers can play in the mental health care of college athletes. While an important factor in college athlete healthcare, there are still a variety of misconceptions surrounding the care licensed social workers can provide (i.e., therapy vs. sport performance/psychology). They state that social workers are a prime example of in-milieu work and provide great benefits due to their proximity to college athletes. However, a variety of challenges arise regarding their roles in the athletic department that need to be addressed to optimize interprofessional collaboration and comprehensive quality care for college athletes. Participants stated a prominent issue is the lack of education in the department. They felt as if they spent a lot of time educating other department members of their capabilities as a social worker instead of spending time with college athletes (Beasley et al., 2021). Beasley and colleagues (2021) end by proposing a top-down education model, starting with the athletic director, to educate the department on the role of licensed social workers and create an institutionalized understanding of what licensed social workers can and cannot offer to the department. Thus, it appears lack of IPE is a major barrier in effective care in athletic settings.

## **Mental Health**

With regards to mental health care, there is an impending call for holistic change in how healthcare providers approach mental health care and the strategies that they use. Lake and Turner (2017) re-envision current MOCs for mental health care delivery and propose a shift to collaborative, true interdisciplinary care, which can include complementary and alternative approaches (e.g., massage, acupuncture, meditation). Integrative treatment styles or utilizing multiple treatment techniques such as meditation and cognitive-behavioral therapy, are at the forefront of Lake and Turner’s agenda as they believe this approach can better address the complex needs of patients (Lake & Turner, 2017), including those experiencing a mental health crisis (Wright et al., 2016). Additionally, creating multiple models that can better address everyone within a population should be considered as effective. Considering age and mental health care, Singh and Tuomainen (2015) posit the need for mental health MOCs as children transition into adulthood. They stress the importance of patient-centered and co-coordinated

transitions between different treatments and the staff involved in each (Singh & Tuomainen, 2015). Looking specifically into youth and college sports, this is important to consider as many athletes are transitioning to adulthood, thus altering their method of care.

However, within all these different models, implementation is difficult as it's through an individual lens as opposed to systematic; iterative steps do not tell the whole story. Further, many assumptions across these models exist. The theme of understanding all actors within interdisciplinary care is prominent here. Additionally, the macro perspective is not fully integrated. Cultural differences of attitudes towards mental health care do exist; however, these perspectives are not taken into consideration under these models. Greater adaptation to account for these differences and prioritize one's culture in their health care is needed.

Within athletics, mental health care has been an increasing concern (Chang et al., 2019; Strohle, 2018). Beasley and Hoffman (2023) conducted a review of mental health literacy of college athletes to determine if they're knowledgeable about mental health management, different disorders and treatment, action to decrease mental health stigma, and effective help-seeking behaviors. They note that athletes and non-athletes presented high levels of mental health literacy but athletes in particular display high levels of mental health stigma. This is a great indication of the current state of mental health care in athletics. Currently, most programming emphasizes the individual functional level (i.e., treatment) and not the societal level (i.e., stigma reduction).

### **Holistic Care Model**

The Holistic Care Model for college athletes (Waller et al., 2016) is an innovative conceptual framework that incorporates various areas (both traditional and emerging) of care within sport:

1. Sport Media Advisor
2. Sport Psychology Consultant
3. Psychiatrist
4. Attorney
5. Academic Advisor
6. Nutritionist
7. Strength & Conditioning
8. Medical Doctor
9. Athletic Trainer
10. Coach
11. Chaplain
12. Life Skills Coordinator
13. Transition Counselor (Waller et al., 2016).

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These personnel encapsulate the management of athletes' physical, psychological, and social health. Waller and colleagues (2016) focus specifically on the role of a chaplain to aid in athletes' spiritual journey while they participate in college sport, currently and understudied area. This model provides a great overview of the resources that college athletes need to achieve and sustain holistic wellness. However, missing are the specific types of mental health professionals, especially as there are distinct differences between clinical and performance care (McHenry et al., 2021), the process of interactions between these different actors, equitable implementation tactics for all sports, institutions, and divisions, and proper assistance to help athletes navigate these resources.

Barkley and colleagues (2018) take this a step further with their Holistic Athletic Healthcare Model, which considers the holistic needs during adolescent development, cultural competency, health equity, and integration with the campus medical care community. This comes as an application to the social-ecological model and contains micro and macro factors influencing the individual athlete: healthcare provider relationship, campus community, and society (Barkley et al., 2018). These levels aim to address current gaps in comprehensive quality care for college athletes, including culturally competent care, substance abuse treatment, mental health stigma reduction, and attention to spiritual health. The model is robust and provides great direction to providing quality and holistic care for college athletes while also attempting to address the macro-level. Yet, implementation processes, and coordination between different campus actors are not addressed in detail. This results in an issue of case management. How can a department coordinate holistic care for over 400 college athletes? Frequently, this responsibility falls to the AT or coach, which as previously mentioned, is not a part of their job description, and thus, they lack training to properly address and coordinate needed care.

### **Sport Injury Rehabilitation**

Sport-based injury rehabilitation is a large, multifaceted sector of athlete wellness, as experiencing an injury sometime throughout one's athletic career is common. When approaching rehabilitation, Clement and Arivnen-Barrow (2013) take a multidisciplinary approach, incorporating a multi-level team of professionals via coordinated care to provide both psychological and physiological care to the injured athlete. Their model, multidisciplinary team rehabilitation, is structured into two teams: primary and secondary. Primary includes an athlete's AT and physician/surgeon. Secondary includes actors such as coaches, family members, psychiatrists, podiatrists, dentists, and teammates. The goal of this approach is to emphasize current structures within treatment care:

Medical professionals in regular contact with the athlete (that is, the primary team) during treatment are in an ideal position to inform, educate and assist with both the psychological and physical process of injury. Whilst members of the secondary team may not be directly involved in the physical treatment of the injured athlete, they often

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contribute to the injured athlete's rehabilitation experience in numerous ways (Clement & Arivnen-Barrow, 2013, p. 159).

By assigning a primary team to help coordinate different aspects of an athlete's rehabilitation, it streamlines the multidisciplinary nature of healthcare to provide the best results for the athlete. The idea of a primary and secondary team, under the lens of a case coordinator, is a strong method in coordinating rehabilitation care for the athlete. However, given this, there are many assumptions that this model takes that result in its limiting factors. Firstly, there is an assumption that all these resources are available to an athlete and offer strong support. What happens when an institution does not have a psychiatrist or family support for this athlete is not prevalent? Secondly, once again we see an AT as the primary care distributor or case manager. Given their proximity to athletes, this is a strong idea. However, ATs are not trained as case managers, nor do they have time to add these responsibilities into their profession (Beasley et al., 2022a). Lastly, a multidisciplinary approach is robust in incorporating different actors into an athlete's care team. However, this form of care lacks the communication aspect between different care team members, something that an interdisciplinary approach can provide. As previously mentioned, the latter allows for greater use of coordinated care, providing strong holistic outcomes for the athlete (Choi & Pak, 2006).

### **Proposed Approach: Best Practices**

Taking the above models into consideration, it is evident that essential in a MOC for athletes is an athlete-centered approach. Integrating an athlete's personal support system(s) into the care process as well as considering an athlete's many needs is reflective of different successful characteristics of sub models within PCC (Chouvarda, et al., 2015; John et al., 2020). Additionally, research indicates that an interdisciplinary approach proves to be a successful strategy in a MOC (e.g., Breitbach et al., 2015; Bridges et al., 2011). As opposed to multidisciplinary strategies, an interdisciplinary approach includes interactions between different actors in the care system, ensuring that everyone is on the same page and working toward similar goals for the athlete.

However, there are several barriers when thinking about an interdisciplinary approach. Firstly, research suggests that it is hard to successfully provide IPE in educational settings (e.g., Lash et al., 2014; Reeves et al., 2013). This problem translates to the workforce, often creating the assumption that there is proper knowledge surrounding an actor's role and how to successfully incorporate them into an organization (Beasley et al., 2021). Secondly, it is difficult to translate IPE into interactions in the industry and create understanding of the details in coordinated care (Van Slingerland et al., 2022). There are many times no set structure of who coordinates an athlete's care with the different providers. And, if there is, such as the AT in the multidisciplinary Sport-based Injury Rehabilitation Model (Clement & Arivnen-Barrow, 2013), there becomes an issue of case load, as an AT does not have the time or proper training to

coordinate care for an athlete (Beasley et al., 2022) Lastly, frequently mentioned in the literature review are model's failure to provide reproducibility steps, as each organization has different structures, actors, and needs.

With the limitations in implementation of PCC and interdisciplinary approaches, there are challenges in proposing a “model” of care. As previously mentioned, difficulties arise in reproducing different models across organizations, as they are all unique in structure and client needs. On the other hand, curating a model that is reproducible would result in a framework that is far too broad and lacks actionable and effective steps for sport organizations. Taking these factors into account, we suggest best practices, including making the case for case management, as an appropriate way to incorporate the needs of different sport organizations at all levels of an ecological system, and provide steps for reproducibility. These recommendations are detailed enough to be applicable to all sport organizations but also provide enough space to adapt and incorporate these practices to fit the needs of each unique sport organization. The following sections describe three best practices for creating a model of care for athletes: (1) An Interdisciplinary Approach, (2) Case Managers, and (3) Top-Down Organizational Training. In addition, each section will conclude with actionable steps for implementation across a variety of sport organizations.

## **1. An Interdisciplinary Approach**

Primary to this set of best practices is the idea of interdisciplinary care throughout the sport organization. An interdisciplinary approach involves coordinated care between different healthcare professionals (i.e., an athletic trainer and a nutritionist; Choi & Pak, 2006). Once all care providers and actors in an organization understand what each other provides (See Best Practices #3), athlete care can incorporate multiple actors. Organized by and facilitated through a case manager at the micro level (See Best Practices #2), an athlete can receive care through multiple professionals. What is unique, however, is that these professionals will communicate with each other on the athlete's progress and/or notes of concern, at the mesolevel. Everyone is on the same page, and, in fact, these meetings can provide insights that can better target care and perhaps implement new strategies for the athlete (McHenry et al., 2022). In addition, with streamlined communication protocols, organizational efficiency can improve.

### ***Actionable Step #1: Implementing Interdisciplinary Care***

Sport organizations can implement their own structure of interdisciplinary care. This may vary by who an interdisciplinary team involves, both per an athlete's needs and who an organization has access to. Examples of care team members can include certified mental performance consultants (CMPCs), ATs, strength and conditioning coaches, licensed professional counselors (LPCs), licensed social workers (LSWs), licensed psychologists (LPs), nutritionists, and medical doctors (McHenry et al., 2022; Waller et al., 2016). McHenry and

colleagues (2022) suggest that, specifically within mental health services, CMPCs, LPCs, LSWs, and LPs can serve different roles within the care team to optimize care for athletes, such as intakes versus consultation plans. Extending on this, each member of the interdisciplinary care team, including nutritionists and coaches, can bring their unique competence and skillset to contribute to shared decision making for the athlete.

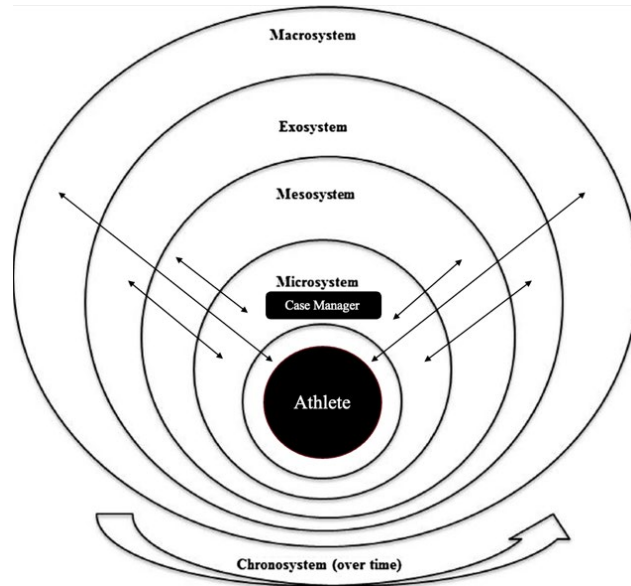
However, for true interdisciplinary care to be implemented, there needs to be a case manager to assure that communication is happening, care is being adequately coordinated, and that the responsibility of care management is not placed on the athlete. Presently, ATs are often put in this position (Mazerolle et al., 2010; 2013); however, ATs do not have the proper training for this role and are already overworked (Beasley et al., 2022a; Mazerolle et al., 2010; 2013). Therefore, it is essential that someone is hired whose sole responsibility is to manage case load and coordinate care for the athletes.

## 2. Case Managers

To properly manage all actors and their corresponding care for an athlete, there needs to be adequate case management to guide an athlete through these resources. This leads to the importance of case managers. A case manager, such as an LSW, is a healthcare professional who serves as a care coordinator for clients (Beasley et al., 2022b). They are trained to provide strong case assessment and utilize community and organizational research to put together a care team and plan for the patient. Additionally, an integral part of a case manager position is integrating an evaluation system to ensure they are provided with the most appropriate care for the patient.

Case managers are integral for sport organization's best practices as they have the best training to not only manage the individual needs of athletes in an athletic department or organization, but to advocate within the organization and surrounding community to provide the needed care for the athlete (McHenry et al., 2022). In this way, a case manager can appropriately navigate all systems within an athlete's life. For example, a case manager can operate in the mesosystem, bridging communication gaps between different microsystems (i.e., coaches, AT, family members) and exosystems (i.e., athletic department) in an individual's life (See Figure 1). A case manager can also gauge impacting microsystems, such as mental health stigma in athletics, and advocate for resources to improve these conditions (i.e., mental health literacy training; Moore et al., 2022).

Figure 1. A Visual Adaption of Bronfenbrenner's (1994) Ecological Model



As an adaption to Clement and Arivnen-Barrow's (2013) Sport-based Injury Rehabilitation Model, a case manager can replace the AT and act as the leader in an athlete's primary team, as they have the best training for this role and can offer proper care assessment (Beasley et al., 2022b). Additionally, a case manager can constantly assess who needs to be involved in an athlete's care team, offering a level of flexibility and adaptation to these teams. To explain further through an example, a case manager can loop in the AT to the primary care team for a season as an athlete is going through a rehabilitation protocol. However, once an athlete is back to full play, the AT may not be needed as an actor in the primary care team and can be removed to a secondary care team member who does not need to be as closely involved. The members of each team can be individualized to the athlete. Essential is that this group is guided by the case manager, who can ensure effective meso-level interactions (Beasley et al., 2021) by facilitating meetings with the whole care team, adding and removing people based upon an athlete's needed care, and connecting athletes to community resources when an athletic organization may not have needed services in-house.

In scholarship, this best practice is supported by several studies (e.g., Beasley et al., 2021; Newman et al., 2022). From an industry perspective, case managers in athletics are not common yet. However, top collegiate athletic departments, such as Baylor, Tulane, and Alabama (*Staff Directory – Baylor, 2024; Staff Directory - Tulane University Athletics, 2024; Staff Directory -*

*University of Alabama Athletics*, 2024), are beginning to hire LSWs who can act as case managers, marking an innovative, and we argue effective, practice for the industry.

### ***Actionable Step #2: Hire a Case Manager***

Sport organizations should hire a case manager, such as an LSW (Beasley et al., 2022b). Being able to operate between different systems in an athlete's life is integral in understanding their complete picture and providing the most appropriate care. Additionally, case managers have the proper training to manage large caseloads of athletics, taking this responsibility off coaches and/or athletic trainers, who do not have the time or training to provide this care. Within this line of thought, it is essential for these case managers to conduct strong case assessments when working directly with athletes. Adequate care starts with case assessment, as it is essential to understanding the whole picture and thus, pulling in the needed resources. Additionally, strong case assessment must begin at the macrolevel with attention to cultural competency, a lacking element in many current MOCs and in athletics (Gorczyński et al., 2021). By gaining a holistic understanding of an athlete's background (i.e., familial values) a case manager can better assist the needs of the athlete and, again, loop in or advocate for the proper resources.

### **3. Top-Down Organizational Training**

Lastly, for case managers, and thus interdisciplinary care, to be effective in a sport organization, the entire organization needs an understanding of what a case manager can and cannot do, as well as the roles and responsibilities of each other member of the interdisciplinary team both in the organization and in the care of the athlete. It is recommended sport organizations at the exolevel take a top-down approach to organizational training for several reasons. First, it is integral for members of a sport organization to understand each other's roles and responsibilities. This can provide streamlined communication at the mesolevel (e.g., everyone knows who to go to for a certain situation) and allows for the best care to be provided for the athlete (McHenry et al., 2022). In addition, Moore and colleagues (2022) suggested that this training allows for greater respect between care team members regarding their roles, cultures, values, and service delivery processes. Building respect for one another between these different microsystems in an organization, in return, maximizes the informational diversity of the care team, again allowing the best care possible to reach the athlete (Moore et al., 2022).

Second, a top-down approach to this training should be implemented as it sets the precedent that this education and understanding throughout the organization is important and should be prioritized. Thus, education should start with the head of the organization (i.e., an athletic director) and trickle down to other administrations and then to coaches and athletes (Beasley et al., 2023). Recent studies have suggested there is often confusion amongst sport organizations about the roles and limits of certain care team members, usually stemming from lack of knowledge from those in leadership positions (Beasley et al., 2022a; Eckenrod et al.,

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<https://doi.org/10.33043/27dc47cz3>

2023). This process is also an opportunity for de-stigmatization of mental health resources. If an athletic director is discussing these issues and learning the different resources in the department, it becomes less taboo for athletes to talk about these issues and seek the appropriate resources (Beasley et al., 2023; Eckenrod et al., 2023). Additionally, this aids in dissemination of knowledge within the organization's ranking, allowing for greater utilization and efficiency within the care team (Eckenrod et al., 2023).

### ***Actionable Step #3: Implement Organization-wide Training***

Organizational training looks different in every case. Essential to this process is the idea of a top-down approach. Thus, it is integral to gauge where the organization is at in terms of everyone understanding each other's roles and responsibilities. From there, training can look like an interactive seminar where each employee talks about their job. It can also look like an organization-wide infographic for everyone member (Eckenrod et al., 2023), listing out both contact information and a summary of what each person can and cannot help with. Another important area of this training is cultural competency. From the tenets of IPE, cultural competency training can help professionals better understand different needs of athletes and feel confident in providing the best and most appropriate care (Breitbach et al., 2015). Again, essential to this process is the idea that it is initiated by the organization head.

### **Implications for the Field**

These best practices, coupled with direct, actionable steps for implementation on a variety of levels within the sport industry, aim to transform how care is provided to athletes. These best practices, focalized by the inclusion of a case manager to an organization, centers athletes' needs, involve multiple healthcare professionals, and create conducive and collaborative environments for all actors and all ecological systems of an organization. As a result, athlete care is holistic, prioritized, and effective. We urge sport organizations to implement these best practices where appropriate to enhance the level of care for athletes and provide a conducive environment for employees. For example, current care professionals in a sport organization can begin to implement their own lines of communication between themselves and advocate for training to properly understand each other's roles. These strategies can produce more efficient care procedures within the organization, benefiting both the organization's care professionals and athletes.

Yet, we argue it is of the utmost importance to integrate a case management system (i.e., hiring a case manager) in sport organizations. While literature suggests that collaborative, interdisciplinary and patient-centered care is a robust approach to athlete care (Moore et al., 2022), missing is functional and sustainable ways to integrate these approaches. Case managers, such as LSWs, can solve this issue. Not only do they have the professional capacity and training to manage the needs of athletes within an organization, but case managers also have the training

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to coordinate care and advocate for resources, with cultural competence, throughout all ecological systems.

There is the potential for concern regarding the financial implications of hiring a case manager. However, it can be argued that hiring a case manager is a good financial decision. Due to the nature of the positions, case managers primarily work through resource connections. Further, if a sport organization can only hire one case manager, and solely a case manager, that person can utilize community resources and make referrals for athletes to receive their needed care. In other words, instead of hiring five professionals, a sport organization could hire one case manager who can coordinate any outside care needed, through athlete insurance. Not only does this provide more efficient allocation of financial resources, but this strategy can also contribute to more efficient care procedures for a sport organization.

### **Limitations and Future Research**

While this model of best practices is derived from existing MOCs and provides flexibility of implementation based upon the sport organization, there are still limitations. Mainly, this model has not been fully executed in the industry to vet for barriers of implementation. Instead, it is based on strengths and weaknesses of existing MOCs and calls for social work in sport in the scholarship.

Yet, we understand there could be difficulties and limitations in incorporating these best practices into a sport organization. Primarily, if the best practices are not implemented in tandem, then such a proposed model of care may not be effective. For example, if there are not organizationally supported IPE efforts, then an interdisciplinary care model, even with inclusion of a case manager, will be challenging. Mainly, there could be budgetary constraints. As previously mentioned with the hiring of a case manager, these financial decisions are likely to be beneficial not only to the efficiency of the sport organization, but also to the care of athletes. However, these need to be empirically tested. As a counter, we call for investigation into the effects of the case managers in sport organizations to build support of these best practices and limit potential difficulties in implementing these practices. In addition, a cost-benefit analysis of hiring a case manager could prove to be beneficial in supporting these best practices and provide further tangible evidence for sport organizations.

Lastly, we urge future research to consider the role that athlete-centered, interdisciplinary care, through our outlined best practices, has on holistic athlete well-being. As argued, this approach to athlete well-being is a necessary step for sport organizations to consider as it can lead to more efficient care practices for the organization, benefiting the well-being athletes. We call for pilot studies to be conducted in a variety of sport organizations to better understand the long-term impacts of implementing these best practices.

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