NYC
Department of Education
Carmen Fariña, Chancellor

Testimony of the NYC Department of Education on Int. Nos. 85 and 86 Before the NYC Council Committees on Education and Health

January 23, 2015

Testimony of Eric Goldstein, Chief Executive Officer, Office of School Support Services, Division of Operations

Good morning Chairs Dromm and Johnson and all the Members of Education and Health Committees here today. My name is Eric Goldstein, Chief Executive Officer, Office of School Support Services within the Division of Operations at the NYC Department of Education (DOE). Thank you for the opportunity to testify here today.

As you are aware, last month Mayor de Blasio announced a $1.2 million donation to the Public Schools Athletic League (PSAL) from New York Giants Chairman and Executive Vice President Steve Tisch. The donation will provide 54 new certified trainers and EMTs to oversee all contact football practices at schools with varsity and junior varsity teams. As a result, nearly 3,500 high school football players will have trained personnel at their practices, helping avoid injuries and ensuring a swift response if a player is hurt on the field.

With that said it is important to note that PSAL places the highest priority on ensuring the health and safety of its student athletes and has always been an industry leader in providing a safe environment for competitive high school athletics. For example, the PSAL is the first athletic program of any major American school district to appoint a medical director. Dr. Dennis Cardone, a clinical associate professor at NYU Hospital for Joint Diseases in the Department of Orthopaedic Surgery, was appointed last year. Among his first priorities is to ensure compliance with the DOE's concussion policy.

Further, a PSAL football game can only commence if an authorized doctor is present and if a Defibrillator (AED) is on-site. All student-athletes must have on file, prior to start of season: a current medical certificate and a parental consent form. All PSAL coaches are licensed DOE teachers. Teachers other than Physical Education teachers who become coaches must complete three Coaching Certification courses. Prior to conducting their first practice, coaches must be certified in First Aid, CPR, AED and Concussion Management, which consists of both the CDC training as well as a PSAL approved course.

Thank you for the opportunity to testify and I welcome any questions you may have.

City of New York
Parks & Recreation
www.nyc.gov/parks

NYC Parks

Hearing before the New York City Council
Joint Hearing- Committee on Education/Committee on Health
Intros 85 & 86- Health & Safety of Youth Football Teams/Creation of a Youth Sports Health & Safety Taskforce
January 23, 2015

Testimony By: Liam Kavanagh, First Deputy Commissioner

Good morning, Chairman Dromm, Chairman Johnson, and members of the Education and Health Committees, I am Liam Kavanagh, First Deputy Commissioner at the New York City Department of Parks & Recreation. Joining me on this panel is Matt Drury, Director of Government Relations. Additionally, we have with us today _____. Thank you for inviting me to testify today regarding Intro 85, which prescribes new permitting and reporting requirements for youth tackle football, and Intro 86, regarding the creation of a Youth Sports Health and Safety Task Force.

NYC Parks oversees more than 1,000 athletic fields and over 4,000 courts. We issue thousands of sports permits every year, representing over 700,000 hours of playing time.

Football is a popular sport throughout the New York City Parks system. Parks has 76 dedicated football fields and over 70 dual-purpose fields where football is played. The fields are located throughout the five boroughs and host New Yorkers of all ages. There are currently 65 youth tackle football leagues that receive permits for our fields. In 2014, 162 youth tackle football permits were issued, which represented over 17,000 hours of playing time.

NYC Parks commends the Council for its focus on ensuring the health and safety of city youth involved in all sports, as promoting a safe, active and healthy lifestyle for children is a primary goal of our department. Regarding Intro 86, the Parks Department fully supports the goal of promoting an active and healthy lifestyle for children, as evidenced by our many youth-oriented programs, such as Kids in Motion. Addressing the serious concern of youth injuries in sports is vitally important, and we believe the proposed Youth Sports Health and Safety Taskforce will empower a varied group of experts and interested parties to make recommendations to help secure the health and safety of New York City's children.

Participating in the proposed Youth Sports Health and Safety Taskforce would very much align with the agency's ongoing commitment to getting kids off the couch and into their neighborhood parks, in a safe manner. As such, we would be thrilled to join our fellow agencies and other members in participating in such an advisory board.

However, the Parks Department has some serious concerns regarding Intro 85. Firstly, while safety is a top priority regarding the use of our facilities, we are also mindful of the burden this bill would place on community-based organizations. A number of our youth football teams are based in New York City's most under-served and economically disadvantaged neighborhoods. Requiring that a doctor or athletic trainer be present at every youth tackle football game or practice may be cost-prohibitive for these teams and threaten their existence.

Additionally, we feel that many of Intro 85's provisions would be impossible for Parks Department personnel to adequately enforce, creating the false impression of safety. It could inadvertently encourage disregard for other rules and guidelines regarding our parks, if citizens believe that the Parks Department's rules are hard to consistently enforce. Moreover, the legislation would create a serious administrative burden for the Parks Department, regarding the permit application process, on-field enforcement and post-game reporting.

Indeed, on-field enforcement of the legislation would be a serious concern. Football permits are issued for various time periods, seven days a week for both practice and organized games. With close to 70 youth tackle football leagues operating concurrently throughout the five boroughs, it would prove nearly impossible for Parks Department staff to adequately enforce the requirement of having a doctor or athletic trainer on site for games to occur.

Intro 85 further prescribes that a doctor or athletic trainer must complete a post-game form affirming that they attended each game or practice; evaluating the number, severity of injuries, and the results of any concussion tests given. With over 17,000 hours a year in permitted playing time for youth tackle football, this would result in thousands of post-game reports over the course of a season, and the agency does not have trained medical professionals on staff to review and analyze the medical data being reported. Furthermore, there is no accurate way for the Parks Department to follow up or ensure that the youth participants received appropriate care and the Parks Department will be unable to enforce the proposed regulation that states participants who display concussion-like symptoms have been symptom-free for twenty four hours.

Lastly, the collection and archiving of these post-game reports presents very serious potential privacy concerns concerning the collection of children's medical records. This concern may be best addressed further by my colleagues at the NYC Department of Health and Mental Hygiene. We are also concerned about Section 18-142 (b) of the bill, which as currently written, would effectively outlaw casual or "pickup" tackle football in all city parks, even for adults.

I look forward to working with all of you as we help build a healthier and safer future for New York City's youth. Thank you for allowing me to testify before you today and I will be happy to answer any questions that you may have.

NEW YORK STATE
NYSATA
ATHLETIC TRAINERS' ASSOCIATION

NEW YORK STATE ATHLETIC TRAINERS' ASSOCIATION
TESTIMONY FOR HEARING

Committee on Health jointly with the Committee on Education

January 23, 2015

RE: Int. No. 85 - In relation to the health and safety of youth football teams.
Int. No. 86 - In relation to the creation of a youth sports health and safety task force.

NYSATA thanks the Council members for identifying the importance of youth sport safety. Please see Appendix A for contact information for the officers of NYSATA.

The New York State Athletic Trainers' Association (NYSATA) was established in 1976 with a mission to advance, encourage, and improve the profession of athletic training by developing the common interests of its membership for the purpose of enhancing the quality of health care for the physically active in New York State.[1] The National Athletic Trainers' Association (NATA) is the professional membership association for certified athletic trainers. It was founded in 1950 and has over 35,000 members worldwide today.[2] Choosing to join NATA also automatically enrolls an athletic trainer as a member in NATA District and State Associations. NYSATA currently has a membership of over 1800 athletic trainers.

Athletic Trainers (ATs) are regulated by the State Education Department as one of the more than 50 licensed professions in NY. ATs are certified based on completion of accredited college programs at the bachelor or master level, which are offered at 11 colleges in New York State. All professional entry-level Athletic Training programs are accredited by the Commission on Accreditation of Athletic Training Education (CAATE).[4] The NATA Competencies and Proficiencies, published by the NATA, define the educational content of an athletic training education program accredited by the CAATE and have been deemed necessary for effective performance as an entry-level certified athletic trainer. The knowledge and skills identified in the Competencies consist of 8 Content Areas: Evidence-Based Practice, Prevention and Health Promotion, Clinical Examination and Diagnosis, Acute Care of Injury and Illness, Therapeutic Interventions, Psychosocial Strategies and Referral, Healthcare Administration, and Professional Development and Responsibility.[4]

Once an individual graduates from a CAATE accredited program they are eligible to take the Board of Certification (BOC) Certification Exam (administered by the BOC).[5] The primary function of the exam is to assess competence in the discipline of athletic training and the role of the athletic trainer. Only graduates of a CAATE accredited athletic training education program are eligible to take the exam. In addition, in order to maintain national certification, athletic trainers are required to complete continuing education units, maintain continuous certification in emergency cardiac care, and adhere to the BOC standards of professional practice. [5] Because the requirements for national certification are more rigorous than NYS law, ATs who choose to obtain national certification will be eligible for certification by SED.[3] Additionally; NY law requires that schools may employ only ATs who are certified. There are currently 1,861 individuals certified in NYS with 201 of them residing in NYC.[3] Please see the list of ATs certified in NYS in Appendix B with those residing in the counties of NYC highlighted. Also note the number of ATs living in the areas surrounding the 5 NYC boroughs.

NYS Education Law §8352 defines the practice of the profession of athletic training as "health care professionals, who under the supervision of a physician, engage in the prevention, recognition, examination, evaluation, management, treatment and rehabilitation of emergent, acute, subacute, and chronic neuromusculoskeletal injuries, illnesses, or conditions that are within the professional preparation and education of certified athletic trainer and are related to activity that requires physical skill and utilizes strength, power, endurance, speed, flexibility, range of motion or agility. The practice of athletic training may include use of various therapeutic modalities and techniques."[6] Athletic trainers work under the supervision of a physician; however direct supervision is not required.

Athletic trainers are qualified to work with the physically active population in secondary schools, colleges and universities, professional and youth sports, clinics, physician offices and other settings. Today we'd like to focus on the high school/youth sport setting. You should recognize that ATs have a unique relationship with the athletes at these levels (and at the college/university) because the ATs see them nearly every day and as such they are often the most knowledgeable health care professional in the lives of these young athletes. It is also important to recognize that the AT's primary role is to assure the athlete's safety, not win a game. It is important to have an athletic trainer in such a role on the sidelines of a practice or game.

A very recent study indicates that fewer than 55% of high schools nationally have access to an athletic trainer.[7] The results will be published in the next few weeks, but the researchers were willing to verbally provide their results. With a 49% nationwide response rate, 67% of NYS schools report access to an athletic trainer. 27% state they have a full time AT, and 36% have a part time athletic trainer (NATA, oral communication, Jan 16, 2015). We feel these statistics are not a true representation for NYS. It is likely that most of those schools that did not respond do not have access to an athletic trainer.

The Concussion Management and Awareness Act was enacted in NYS in September 2011 and became effective in July 2012.[8] Athletic trainers were actively involved in drafting the Guidelines and Regulations that were promulgated by SED and ATs have

an important role in the Concussion Management Teams in school districts that employ ATs.[9] This legislation states that instructional training will be mandatory for all physical education teachers, coaches, assistant coaches, volunteer coaches, nurses and certified athletic trainers. The NYS Department of Education has designated approved online courses through the Center for Disease Control (CDC), which will satisfy the requirements of this training.[9]

Athletic trainers follow evidence-based practice guidelines provided by top researchers, some of whom are certified athletic trainers. The NATA has provided position statements for athletic trainers and other health care professionals to follow on a variety of topics. Noting the many issues covered, one quickly recognizes the value of the athletic trainer to oversee these situations. Position statements have been published through the NATA[10] for Concussion[11,12], Sudden Death,[13] Heat Illness Guidelines,[14] and Preparticipation[15] to just name a few.

The role in which athletic trainers participate in the high schools includes educating coaches and parents about concussions, recognizing possible Mild Traumatic Brain Injury (MTBI) during games and practices, and performing sideline concussion evaluation on injured athletes. Beyond concussion management, athletic trainers provide emergency management of possibly catastrophic injuries such as Traumatic Brain Injury (TBI) and Cervical Spine Fracture and are trained and prepared to provide management of respiratory and cardiac emergencies. Additionally, they monitor the heat and cold indices in accordance with New York State Public High School Athletic Association[16] guidelines and following evidence-based guidelines[12]. They monitor athletes for possible heat illness, and manage heat illness as necessary as well as other temperature-related conditions. They are an important link in educating coaches and parents on proper hydration and tips for practicing in the heat. Athletic trainers are very knowledgeable in orthopedic type injuries (injuries to the musculoskeletal system, like fractures, muscle strains and muscle sprains) and are invaluable to provide on the field/court recognition, assessment, immediate treatment, and rehabilitation for these injuries as well as guiding them to safe return to activity.

Athletic trainers create Emergency Action Plans (EAPs) that is venue specific at each school in anticipation of emergencies. This allows the athletic trainer to manage an urgent situation so that everyone knows their roles and the expectation that they will assist in the emergency management. (See Appendix C for example)

Research has shown that those high schools that have athletic trainers have athletes that experience fewer overall musculoskeletal injuries.[17] This is likely due to the athletic trainer recognizing, treating, and monitoring return to play.[18] The research also indicates that more athletes are diagnosed with concussions when an athletic trainer is available, however, this is because the concussions are identified, diagnosed and treated, and the researchers promote this as a positive result[18] versus those schools without athletic trainers whose athletes may have concussions that go undiagnosed and untreated which places the athletes at great risk.

Having an athletic trainer work full-time as an athletic trainer at a school is the ideal situation because s/he can provide the athletes with all of these quality services.

However, for those schools that cannot afford a full-time athletic trainer, other models exist in which they can work part-time, or part-time through a physical therapy clinic, or hospital, or physician as well as per diem employees (but always under the supervision of a physician). The NATA has created a document indicating appropriate medical care for the secondary school-age athlete[19] that can be followed by those schools considering athletic training coverage.

NYSATA is pleased to see the interest demonstrated in Intro # 86 to create a safety task force to collect information and then make recommendations. We commend your positive and proactive approach in remedying this issue.

Intro # 85 is very optimistic but NYSATA has concerns with certain provisions of this proposal.

1-We are very pleased that the NYC Council has recognized how athletic trainers can participate in providing safety and prevention in sports. We want to be sure that there is no misinterpretation of your intent. Please note that instead of using the term "doctor", the proposal should use the more precise term "physician" throughout the document and mirror the language used to define "athletic trainer": "physician" shall have the same meaning as section 6522 of the NYS Education law 131.[20] There are many different professions who now have a designation of "doctor" and we want to ensure that a qualified person is utilized for the athletic practice/game coverage. Under section 10-902, we appreciate the completeness that this document provides for ensuring coverage from start to end of the practices/games as well as documentation of any injuries that are incurred, as well as the control over return to play so that an injured athlete would not return prior to the physician's recommendation. This may prove difficult to enforce and we hope we can help to determine a method to ensure that an eligible player does not miss a participation opportunity as a result of delayed/incomplete paperwork.

2-NYSATA is pleased that the Council recognizes the importance of using evidence-based tools to assess concussion. The Council should understand however that there is no single appropriate "standardized assessment of concussion test" that will provide the definitive answer everyone seeks.

3-In section 10-904b, we have a concern. A participant who has been assessed and determined to not have incurred a head injury should be able to return to play. It may be inappropriate to limit a player from participation if tested but deemed qualified to continue. We are pleased that it is ensured that the parents/guardians of the injured or assessed athlete will be informed.

As we have reviewed the proposal, additional questions have been raised and they include: What physicians would be available to provide the statutorily required supervision for these ATs? Which school will be responsible for organizing the mandated coverage? How will employment for the ATs or physicians be arranged?

In closing, I would indicate that this is a very important issue and one that ATs take very seriously. NYSATA appreciates the opportunity to participate in the dialogue since we are experts on the matter and as we have indicated, there are many athletic trainers performing top-level research. There are many athletic trainers who are world-renowned and they are working with world-renowned physicians and researchers in the area of sport safety, including concussion.

Organizations have recognized the importance of athletes having access to athletic trainers causing groups like the NATA to work with the National Football League (NFL) to develop and deliver programming that will provide more schools with access to athletic trainers[21] and there are NFL teams that did not receive those grants who took it upon themselves to provide support to their communities in giving grants to employ ATs.[22] The Buffalo Bills received a grant this past year from the NATA/NFL to provide athletic trainers for high school football games in the western NY region.[22]

We would like to have ATs at all collision games and practices, and we hope that as decision makers like you become aware of the serious threat confronting young athletes, school boards will finally promote school budgets that include funding for more ATs.

References and Resources.

1. New York State Athletic Trainers' Association. NYSATA Mission Statement. NYSATA website. http://www.gonysata2.org/ Published 1/2013. Last Updated 1/2015. Accessed 1/19/15.

2. National Athletic Trainers' Association. NATA Website. http://www.nata.org/aboutNATA Published 2014. Accessed 1/19/15.

3. New York State Education Department. Office of the Professions. Athletic Training License statistics. http://www.op.nysed.gov/prof/at/athletcounts.htm Last updated July 1, 2014. Accessed 1/14/15

4. CAATE. Commission on Accreditation of Athletic Training Education Website. http://caate.net/becoming-an-athletic-trainer/. Accessed 1/19/15.

5. Board of Certification. BOC Website. http://www.bocatc.org/ Accessed 1/19/15.

6. New York State Education Department. SED. Education Law. Article 162. Athletic Training Website. http://www.op.nysed.gov/prof/at/article162.htm Accessed 1/19/15.

7. Svokos, A. A majority of high schools lack access to full-time athletic trainers to keep kids safe. *Huffington Post.* http://www.huffingtonpost.com/2014/11/18/high-school-athletic-trainers_n_6146672.html 2014; Nov 18. Accessed 1/12/15

8. New York State Education Department. SED. Chapter 496, Laws of NYS. http://open.nysenate.gov/legislation/api/1.0/pdf/bill/S3953B-2011.Accessed 1/19/15

9. New York State Education Department. SED. Guidelines for concussion management in the school setting. http://www.p12.nysed.gov/sss/schoolhealth/schoolhealthservices/ConcussionManageGuidelines.pdf

10. National Athletic Trainers' Association. NATA. Position statements. http://www.nata.org/access-read/public/position-statements. Accessed 1/16/15.

11. Broglio SP, Cantu RC, Gioia GA, Guskiewicz KM, Kutcher J, Palm M, Valovich McLeod TC. National athletic trainers' association position statement: Management of sport concussion. *Journal of Athletic TrainingJ Ath Train.* 2014; 49(2): 245-265. http://www.nata.org/sites/default/files/Concussion_Management_Position_Statement.pdf

12. Guskiewicz KM, Bruce SL, Cantu RC, Ferrara MS, Kelly JP, McCrea M, Putukian M, Valovich McLeod TC, National athletic trainers' association position statement: Management of sport-related concussion. *J Ath Train.* 2004; 39(3): 280-297.

13. Casa DJ, Guskiewicz KM, Anderson SA, Courson RW, Heck JF, Jimenez CC, McDermott BP, Walsh KM. National athletic trainers' association position statement: Preventing sudden death in sports. *J Ath Train.* 2012; 47(1): 96-118.

http://www.nata.org/sites/default/files/Preventing-Sudden-Death-Position-Statement_2.pdf

14. Casa DJ, Csillan D. Preseason heat-acclimatization guidelines for secondary school athletes. *J Ath Train*. 2009; 44(3): 332-333. http://www.nata.org/sites/default/files/attr-44-03-332.pdf

15. Conley KM, Bolin DJ, Carek PJ, Konin JG, Neal TL, Violette D. National athletic trainer's association position statement: Preparticipation physical examinations and disqualifying conditions. *J Ath Train*. 2014; 49(1):102-120. http://www.nata.org/sites/default/files/Conley.pdf

16. New York State Public High School Athletic Association. NYSPHSAA Heat index & wind chill procedures. http://www.nysphsaa.org/SafetyResearch/HeatIndexWindChillProcedures.aspx Accessed on 1/19/15.

17. LaBella C, Henke N, Collins C, Comstock RD. A comparative analysis of injury rates and patterns among girls' soccer and basketball players at schools with and without athletic trainers from 2006/07-2008/09. *American Academy Pediatrics.* 2012. https://aap.confex.com/aap/2012/webprogram/Paper15632.html

18. American Academy of Pediatrics. High schools with athletic trainers have more diagnosed concussions, fewer overall injuries. AAP. 2012, Oct. 22. http://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/High-Schools-with-Athletic-Trainers-have-More-Diagnosed-Concussions-Fewer-Overall-Injuries.aspx

19. National Athletic Trainers' Association. NATA. Appropriate medical care for the secondary school-age athlete. http://www.nata.org/sites/default/files/AppropriateMedCare4SecondarySchoolAgeAthlete.pdf. Accessed on 1/14/15.

NYSED. (2009). Education Law: Article 162, athletic training. http://www.op.nysed.gov/prof/at/article162.htm

20. New York State Education Department. NYSED. Education Law: Article 131, medicine. http://www.op.nysed.gov/prof/med/article131.htm. Accessed 1/14/15.

21.Vryhof, M. NATA. An update on the NFL's Athletic Training Initiative. http://www.nata.org/nata-news-blog/update-nfls-athletic-training-initiative. 2014, June 18. Accessed on 1/19/15

22. Smith, C. Giants co-owner donates more than $1M to prevent NYC school football injuries. http://usatodayhss.com/2014/giants-co-owner-donates-more-than-1m-to-prevent-nyc-school-football-injuries. 2014, Dec 3.

Appendix A:
Contact information for NYSATA officers

Aimee Brunelle, MS, ATC, EMT
NYSATA President
Head Athletic Trainer & Adjunct Faculty
Jamestown Community College
716-338-1266
president@gonysata2.org

James Pierre-Glaude, DPT, ATC, CSC
NYSATA Region 1LI Representative
Clinical Assistant Professor/Clinical Coordinator
Athletic Training Program
School of Health Technology and Management
Stony Brook University
631-632-3235
region1LIrep@gonysata2.org

Robert O'Malley, Med, ATC, OTC, CES
NYSATA President-Elect
Coordinator of Sports Medicine Outreach
Excelsior Orthopedics
Williamsville South High School, Athletic Trainer
716-512-4806
pres-elect@gonysata2.org

Deanna Errico, PT, DPT, ATC
NYSATA Past President
Assistant Professor, tDPT program
Utica College
315-386-4386
past-pres@gonysata2.org

Appendix B:
License Statistics NYSED

County	Number	County	Number	County	Number
Albany	25	Jefferson	8	Saratoga	34
Allegany	11	Kings	48	Schenectady	27
Bronx	15	Lewis	1	Schoharie	4
Broome	19	Livingston	12	Schuyler	1
Cattaraugus	11	Madison	12	Seneca	2
Cayuga	6	Monroe	91	Steuben	13
Chautauqua	9	Montgomery	5	St. Lawrence	23
Chemung	12	Nassau	151	Suffolk	170
Chenango	0	New York	59	Sullivan	4
Clinton	8	Niagara	23	Tioga	9
Columbia	5	Oneida	22	Tompkins	34
Cortland	14	Onondaga	70	Ulster	16
Delaware	2	Ontario	22	Warren	4
Dutchess	47	Orange	60	Washington	3
Erie	164	Orleans	3	Wayne	8
Essex	10	Oswego	7	Westchester	81
Franklin	0	Otsego	12	Wyoming	6
Fulton	1	Putnam	15	Yates	1
Genesee	9	Queens	58	NYS TOTAL	1,571
Greene	1	Rensselaer	20	OTHER US	287
Hamilton	0	Richmond	21	NON-US	3
Herkimer	3	Rockland	39	TOTAL	1,861

Appendix C:
Emergency Action Plan example

East Irondequoit/Eastridge Department of Athletics:
Emergency Action Plan
(June, 2012)

HIGH SCHOOL

Venue: High School Gym

Injury Situations: The Certified Athletic Trainer (if available), the Head Coach and Assistant Coach(s) will assess the athlete and determine if the injury is life threatening.

Life Threatening Injury: Assistant Coach, or designated representative, will activate EMS by dialing 911 from cell phone or landline telephone in the male or female PE/Coach's Office. The AED will be within 2 minutes of the gym, either in the possession of the Certified Athletic Trainer or mounted on the wall next to room N-23. The Head Coach and the Certified Athletic Trainer (if available) will remain with the athlete. The Assistant Coach, or designated representative, will meet and greet EMS in the school's main parking lot, and direct them into the gym via the athletic department entrance. The athlete will then be transported to the most appropriate emergency department, and the parents will be notified.

Non-Life Threatening Injury: The athlete will be assisted off the court if he/she cannot leave on his/her own. When available, the Certified Athletic Trainer will determine the level of care needed for the athlete. In the absence of the Certified Athletic Trainer, the supervising coach will administer prudent first responder care. The athlete's parents will be notified if needed.

Venue Supplies and Equipment: In the high school gym it is the coaches' responsibility to supply coolers of ice water, ice, water bottles, and a medical kit for minor cuts, scrapes, and sprains. The AED is mounted on the wall next to room N-23. There is a landline telephone is located in both the male and female PE/Coach's offices.

Venue: Swimming Pool

Injury Situations: The Head Coach and the Assistant Coach(s) will assess the athlete and determine if the injury is life threatening. The Athletic Trainer will be called if he is available.

Life Threatening Injury: Assistant Coach, or designated representative, will activate EMS by dialing 911 from cell phone or landline telephone in the Pool Office. The AED will be within 2 minutes of the pool, either in the possession of the Athletic Trainer or mounted on

the wall next to room N-23. The Head Coach and the Athletic Trainer (if available) will remain with the athlete. The Assistant Coach will meet and greet EMS in the school's main parking lot, and direct them into the pool via the athletic department entrance. The athlete will then be transported to the most appropriate emergency department, and the parents will be notified.

Non-Life Threatening Injury: The athlete will be assisted out of the pool if he/she cannot leave on his/her own. When available, the Certified Athletic Trainer will determine the level of care needed for the athlete. In the absence of the Athletic Trainer, the supervising coach will administer prudent first responder care. The athlete's parents will be notified if needed.

Venue Supplies and Equipment: In the high school pool it is the coaches' responsibility to supply coolers of ice water, ice, water bottles, and a medical kit for minor cuts, scrapes, and sprains. The AED mounted on the wall next to room N-23. The landline telephone is located in the Pool Office.

Venue: Wrestling Room/Auxiliary Gym

Injury Situations: The Head Coach and the Assistant Coach(s) will assess the athlete and determine if the injury is life threatening. The Certified Athletic Trainer will be called if he is available.

Life Threatening Injury: Assistant Coach, or designated representative, will activate EMS by dialing 911 from cell phone or landline telephone in the Wrestling Room/Auxiliary Gym. The AED will be within 2 minutes of the wrestling room, either in the possession of the Athletic Trainer or mounted on the wall next to room N-23. The Head Coach and the Athletic Trainer (if available) will remain with the athlete. The Assistant Coach will meet and greet EMS in the school's main parking lot, and direct them into the room/gym via the athletic department entrance. The athlete will then be transported to the most appropriate emergency department, and the parents will be notified.

Non-Life Threatening Injury: The athlete will be assisted off the mat if he/she cannot leave on his/her own. When available, the Certified Athletic Trainer will determine the level of care needed for the athlete. In the absence of the Athletic Trainer, the supervising coach will administer prudent first responder care. The athlete's parents will be notified if needed.

Venue Supplies and Equipment: In the high school Wrestling Room/Auxiliary Gym it is the coaches' responsibility to supply coolers of ice water, ice, water bottles, and a medical kit for minor cuts, scrapes, and sprains. The AED is mounted on the wall next to room N-23. The landline telephone is located in the Wrestling Room/Auxiliary Gym.

Venue: Free-Weight Room

Injury Situations: The Certified Athletic Trainer (if available) or the supervising coach(s) will assess the athlete and determine if the injury is life threatening.

Life Threatening Injury: Supervising coach, or designated representative, will activate EMS by dialing 911 from cell phone or landline telephone in the weight room. The AED will be within 2 minutes of the weightroom, either in the possession of the Certified Athletic Trainer or mounted on the wall next to room N-23. The supervising coach and the Certified Athletic Trainer (if available) will remain with the athlete. The designated representative will meet and greet EMS in the school's main parking lot, and direct them into the weight room via the athletic department entrance. The athlete will then be transported to the most appropriate emergency department, and the parents will be notified.

Non-Life Threatening Injury: When available, the Certified Athletic Trainer will determine the level of care needed for the athlete. In the absence of the Certified Athletic Trainer, the supervising coach will administer prudent first responder care. The athlete's parents will be notified, if needed.

Venue Supplies and Equipment: The AED is mounted on the wall next to room N-23. The landline telephone is located in the weight room

---

Venue: High School Parking Lot (when used for athletic team practices)

Injury Situations: The Certified Athletic Trainer (if available), the Head Coach and Assistant Coach(s) will assess the athlete and determine if the injury is life threatening.

Life Threatening Injury: Assistant Coach, or designated representative, will activate EMS by dialing 911 from cell phone or landline telephone in the Attendance Office. The AED will be within 2 minutes of the parking lot, either in the possession of the Certified Athletic Trainer or mounted on the wall near room 133 in the science wing. The Head Coach and the Certified Athletic Trainer (if available) will remain with the athlete. The Assistant Coach will meet and greet EMS in the parking lot, and direct them towards the injured athlete. The athlete will then be transported to the most appropriate emergency department, and the parents will be notified.

Non-Life Threatening Injury: The athlete will be assisted off the parking lot if he/she cannot leave on his/her own. When available, the Certified Athletic Trainer will determine the level of care needed for the athlete. In the absence of the Certified Athletic Trainer, the supervising coach will administer prudent first responder care. The athlete's parents will be notified if needed.

Venue Supplies and Equipment: At this venue it is the coaches' responsibility to supply coolers of ice water, ice, water bottles, and a medical kit for minor cuts, scrapes, and sprains. The AED is in the possession of the Certified Athletic Trainer, the supervising coach, or mounted on the wall near room 133 in the science wing. The landline telephone is located in the Attendance Office.

NATIONAL ATHLETIC TRAINERS' ASSOCIATION
HEALTH CARE FOR LIFE & SPORT

January 21, 2015

Committee on Health
Committee on Education
New York City Council
New York, New York

Honorable Members:

Thank you for the invitation to the National Athletic Trainers' Association to attend Friday's hearing on the health and safety of youth football teams and creation of a youth sports health and safety task force. Unfortunately, a previously scheduled meeting of all of our leaders is being held on the same date, and we are unable to provide a witness to appear in person.

However, we are extremely supportive of your research into this matter. The NATA, with almost 1,500 of our 39,000 members living and working in New York, is proud of its record of initiatives to protect young athletes. Our members are the lynch pins of the athletic health care system in secondary schools, and NATA has correspondingly created the Youth Sports Safety Alliance to bring attention to safety matters.

The Alliance now boasts 184 members – parents, sports governing bodies, health care providers, and school administrators – who are committed to the Secondary School Athletes' Bill of Rights and the National Action Plan for Sports Safety.

Aimee Brunelle, ATC, EMT, President of the New York State Athletic Trainers' Association, will appear before you and will share the National Action Plan. In it, you will see the steps that should be taken to ensure a safe sports environment in schools.

If it is the will of the Committees to create a health and safety task force, NATA stands ready to assist in any way that we can. Please do not hesitate to contact NATA's Director of Governmental Affairs, Amy Callender, if we can be a resource. Amy can be reached at 972-532-8853 amyc@nata.org. We hope you will call on us.

Sincerely,

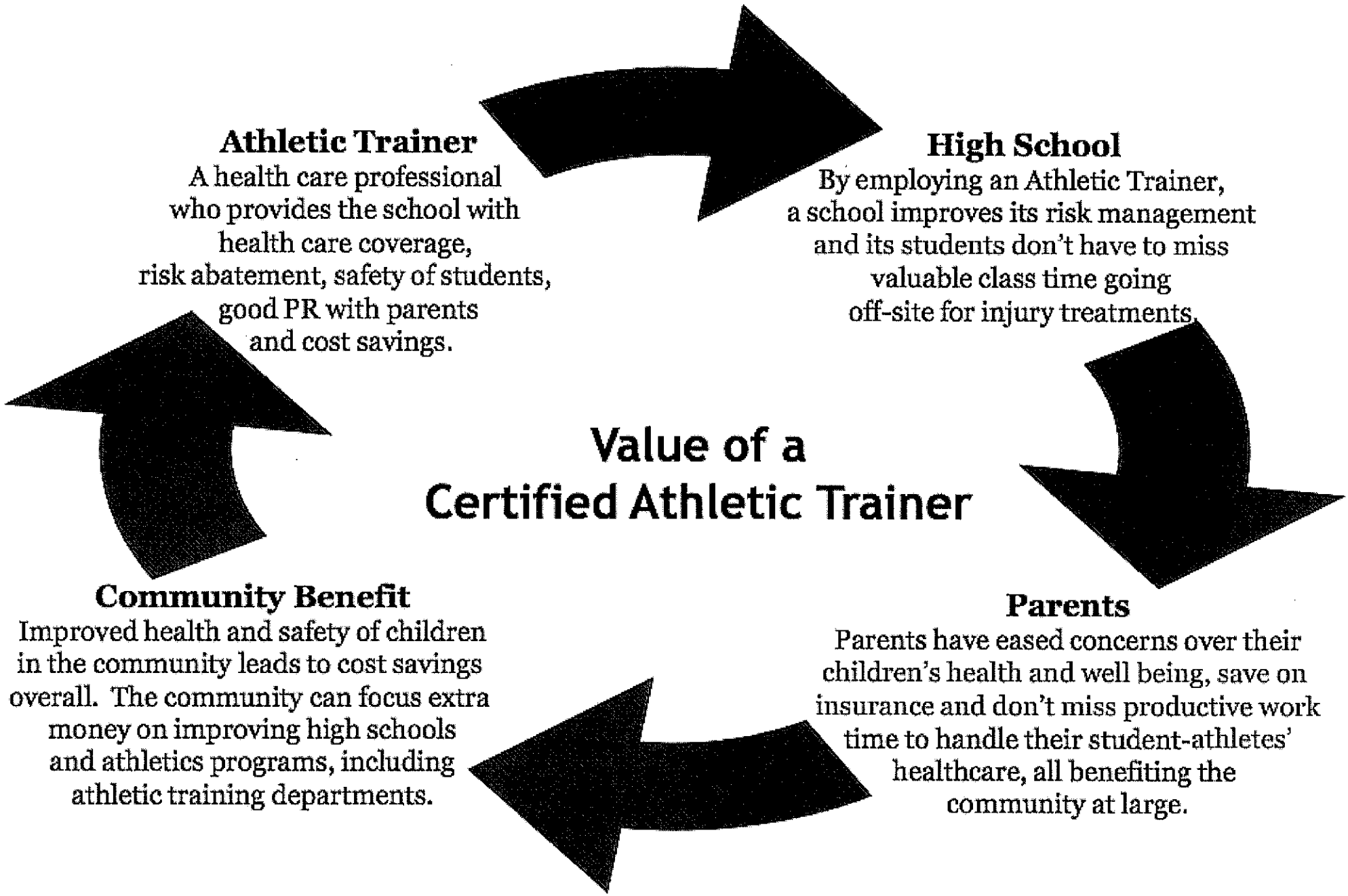
James Thornton, MA, ATC, CES
President

1620 VALWOOD PARKWAY, SUITE 115
CARROLLTON, TEXAS 75006

PHONE 214.637.6282
FAX 214.637.2206

JIM THORNTON, MA, ATC, CES - PRESIDENT
DAVID SADDLER - EXECUTIVE DIRECTOR

Value of a Certified Athletic Trainer



Athletic Trainer
A health care professional who provides the school with health care coverage, risk abatement, safety of students, good PR with parents and cost savings.

High School
By employing an Athletic Trainer, a school improves its risk management and its students don't have to miss valuable class time going off-site for injury treatments.

Parents
Parents have eased concerns over their children's health and well being, save on insurance and don't miss productive work time to handle their student-athletes' healthcare, all benefiting the community at large.

Community Benefit
Improved health and safety of children in the community leads to cost savings overall. The community can focus extra money on improving high schools and athletics programs, including athletic training departments.

YOUTH SPORTS SAFETY ALLIANCE

The Youth Sports Safety Alliance comprises more than 100 health care and sports organizations and parent activists. The YSSA has one goal: make America's sports programs safer for young athletes.

YSSA has created a national action plan to give specific guidance to policymakers about the steps that will accomplish that goal.

Organized sports bring health benefits to children. But the lure of a college scholarship or future professional sports career may tempt kids to ignore pain and injuries, with the result of lifelong injuries or even worse.

To protect one of America's most treasured traditions — amateur and professional sports — we must also assure that they are played safely, and that when inevitable injuries occur, someone knows what to do.

Safety measures are not costly when compared with the tens of thousands — even hundreds of thousands — of dollars spent on sporting events. The investment in a healthy future for student athletes will pay dividends in better students, reduced medical bills and lives free from pain.

YOUTH SPORTS SAFETY ALLIANCE

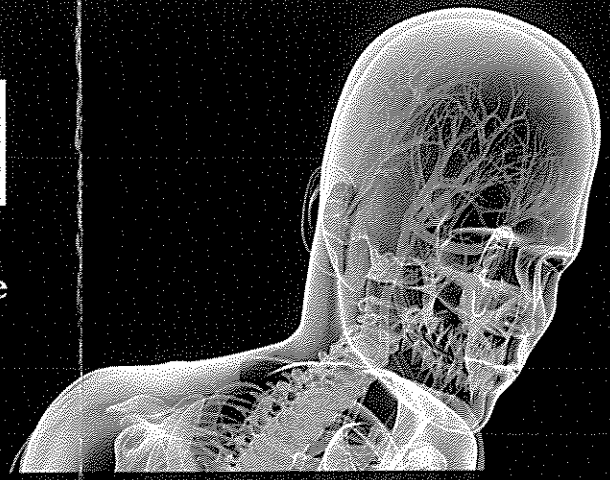
Your organization can join the Youth Sports Safety Alliance at no cost

CONTACT US

info@youthsportssafetyalliance.org

www.youthsportssafetyalliance.org

Founded by the
National Athletic Trainers' Association
www.athletictrainers.org



National Action Plan for Sports Safety

PROTECTING AMERICA'S STUDENT ATHLETES

Assuring the health and welfare of America's young athletes

The National Action Plan for Sports Safety urges schools to adopt safety measures to protect students from injury or illness that mainly occur in four major areas:

- Cardiac Events
- Neurologic Injuries
- Environmentally-Induced Conditions
- Dietary/Substance-Induced Conditions

REQUIRE THAT ALL SCHOOLS:

- ✓ have a comprehensive athletic health care program and a health care team
- ✓ ensure safe practice & play facilities that are regularly inspected and cleaned
- ✓ provide an area in which injured athletes may be evaluated and treated and privacy of medical information is assured
- ✓ have a plan for selection, fit and maintenance of athletic equipment
- ✓ adopt injury & illness prevention strategies
- ✓ inform athletes and parents of potential risks in sports as well as individual responsibility
- ✓ ensure that every student athlete has a pre-participation physical examination including cardiac and concussion testing where appropriate
- ✓ provide immediately available, properly trained health care professionals
- ✓ provide AEDs in locations easily and immediately accessible; ensure equipment is properly maintained and regularly inspected
- ✓ use established protocols for heat acclimatization, lightning, poor air quality and other environmental factors
- ✓ inform parents of the school's emergency policies & procedures
- ✓ train coaches and athletic officials in CPR and use of AEDs
- ✓ adopt venue-specific Emergency Action Plans (EAPs), coordinated by the athletic health care team and routinely rehearsed with local emergency personnel
- ✓ make personnel aware of the psychosocial problems of the student athlete and ensure referral to qualified health care professionals as appropriate
- ✓ ensure that student athletes do not return to physical activity after a concussion or heat stroke without medical clearance
- ✓ make coaches, parents and student athletes aware of potential problems related to the misuse of nutritional supplements, performance enhancing substances and energy drinks

AND FURTHER:

- ✓ the National Action Plan urges the creation of a national fatality registry of secondary school athletes who have died during or as a result of athletic injuries

"Too many injuries have occurred; too many lives have been lost that could have been saved. We cannot wait another minute to act — to put measures in place that further ensure youth sports safety."

Patti James, parent advocate

SECONDARY SCHOOL STUDENT ATHLETES' BILL OF RIGHTS

Protecting America's Student Athletes

I. Student athletes have the right to be coached by individuals who are well trained in sport-specific safety and to be monitored by athletic health care team members.

II. Student athletes have the right to quality, regular pre-participation examinations, and each athlete has the right to participate under a comprehensive concussion management plan.

III. Student athletes have the right to participate in sporting activities on safe, clean playing surfaces, in both indoor and outdoor facilities.

IV. Student athletes have the right to utilize equipment and uniforms that are safe, fitted appropriately and routinely maintained, and to appropriate personnel trained in proper removal of equipment in case of injury.

V. Student athletes have the right to participate safely in all environmental conditions where play follows approved guidelines and medical policies and procedures, with a hydration plan in place.

VI. Student athletes have the right to a safe playing environment with venue-specific emergency action plans that are coordinated by the athletic health care team and regularly rehearsed with local emergency personnel.

VII. Student athletes have the right to privacy of health information and proper referral for medical, psychosocial and nutritional counseling.

VIII. Student athletes have the right to participate in a culture that finds "playing through pain" unacceptable unless there has been a medical assessment.

IX. Student athletes have the right to immediate, on-site injury assessments with decisions made by qualified sports medicine professionals.

X. Student athletes have the right, along with their parents, to the latest information about the benefits and potential risks of participation in competitive sports, including access to statistics on fatalities and catastrophic injuries to youth athletes.

Agency for Student Health Research

Testimony of Charlie Wund, President
Agency for Student Health Research

Before The New York City Council Health & Education Committees

Public Hearing – Int. No. 85, Int. No. 86

January 23, 2015

I am Charlie Wund, President of the Agency for Student Health Research.

Thank you Chairperson Johnson, Chairperson Dromm, and committee members for the invitation to testify on such progressive legislation. It is an honor to support legislation requiring the presence of an athletic trainer or doctor at all practices and games for the sport of contact football. We truly want to thank Councilmember Levin for his leadership on this critical issue facing the youth of New York City (and frankly the Country). We are extremely appreciative of your willingness, and the other co-sponsors, to be on the forefront of this issue.

Youth Sports Injuries In America

The stated mission of the Agency for Student Health Researchis achieving the safest possible environment for all children, by integrating technology and data analysis to improve injury understanding and injury management. Since 2010 we have been advising school districts, youth sport governing bodies and governmental agencies on the establishment of medical oversight at youth sporting events, increased communication among all caregivers and the importance of aggregated injury report data. In these experiences I have witnessed the positive impact data-driven decisions and medical oversight has on youth football populations.

Concussions and their long-term consequences are so compelling that injury-management legislation is wisely being debated, composed and set into law in all 50 states. I hope to provide statistical information, case study results, and personal experience to inform the committee's decision regarding this proposed legislation.

As a former collegiate football, lacrosse and rugby player, high school football coach and athletic director, I can attest to the extraordinary value athletics provide their participants. Physical activity improves brain

function, information retention and, of course, general long-term health and well being. Team sports impart life lessons in collaboration, goal setting and self-efficacy.

An estimated 20-30 million children each year participate in youth sports programs. That's 50-75% of children ages 6-17 in the US, and therefore it is a communal responsibility that safe and affordable athletic experience is provided for these children.

Proposed legislation Int. No. 86 includes the creation of a youth sports health and safety task force, with members representing the medical, educational, health and public facility sectors. This is theexact type of organizational presence necessary to develop effective injury policy and, more importantly, to establish continual oversight focused on the long term effects of these policies. We applaud the efforts to bring all stakeholders and caregivers together to discuss the safety of NYC's youth.

Legislative Impact

At the same time, increased administrative and financial burden on the youth sports organizations [complying with new legislation] cannot be overlooked. Without proper support, some programs, under the strain of these laws, may be forced to discontinue their availability. We need to balance communities demand to maximize safety, with the financial cost of the most effective/proven safety solution: providing an athletic trainer and/or doctor at every practice and game. The optimal solution exists, and legislation must aim to find it. We personally believe current technology presents the opportunity for such solutions.

The Agency for Student Health Research and the New York State Athletic Trainer Association (NYSATA), are committed to offering support for the schools, youth clubs and public agencies as they establish compliance under this legislative mandate. This includes the establishment of a mobile HIPAA and FERPA compliant injury reporting system, the centralization of injury report data [accessible to the proposed task force], organizational injury education, and the availability of athletic trainers at football games and practices.

Here are examples of [expected] outcomes we have witnessed in our current participating communities and school districts.

Case Study #1

In a case study performed at a single high school, an athletic trainer (using

the InjureFree reporting platform) recorded injuries within the freshman, junior varsity and varsity football teams. During the first three weeks of practice, eight (8) concussions were reported, within a population of 150 athletes, drawing the attention of team administrators.

Using collected data, it was identified that all eight concussions were sustained using parent-bought helmets, rather than school-issued. While the public school district supplied all necessary equipment, parents were given the choice to purchase their own helmets; similar to most schools throughout the US. This discovery provided valuable information to district officials who feared possible lawsuits.

The summer preceding this case, the death of NFL Hall of Famer Junior Seau, who suffered Chronic Traumatic Encephalopathy (CTE) as a result of repeated head trauma, and the media's focus on his condition, caused parents to react by purchasing "top-rated" football helmets for their children. While these proactive attempts to protect children are commendable, in this case the sporting goods store helmets were not properly fitted. There are no policies requiring salespeople to be trained to properly fit helmets, so these eight students ended up playing with poorly sized equipment.

After identifying a potential catalyst for concussion "epidemic", an email alert was triggered by InjureFree to the parents of football players notifying them to "see the athletic trainer if your son is not using a school issued helmet," and fitting adjustments were made. During the remaining 12 weeks of the football season only two concussions were reported, both during game play.

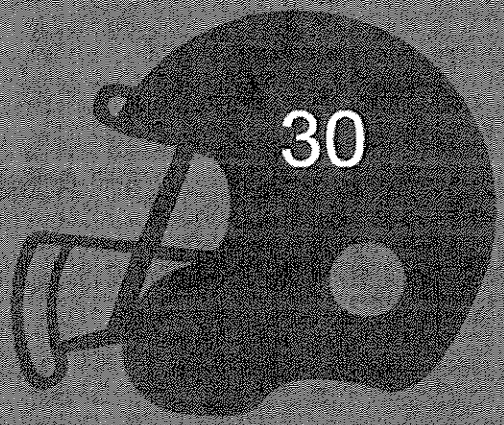
Case Study #2

Lately, concerns for athlete safety, particularly concussions, has compelled state athletic associations to develop policy aimed at reducing injuries. One recent example, CIF Bylaw 506, limits practice hours for a single team to 18/week and 4/day. Further, "Double day practices shall not be held on consecutive days" and "Must include a minimum of three (3) hours rest in between practices".

Following these efforts, we decided to examine the effect of California Interscholastic Federation's (CIF) recent policy update. From a random sample of 13 California high schools, we compared football injury rates for the month of August 2013 to August 2014.

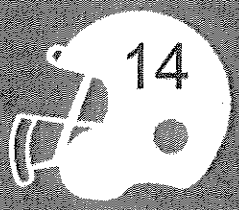
Head Injuries: Concussions/MTBI

2013



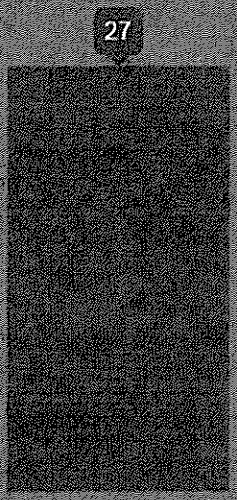
A reduction of over 50% was reported year over year. Reduced practice hours and increased concussion awareness could be factors. Further study is needed.

2014

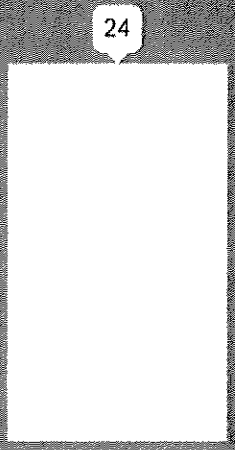


Muscle Strains

Strains In 2013



Strains In 2014



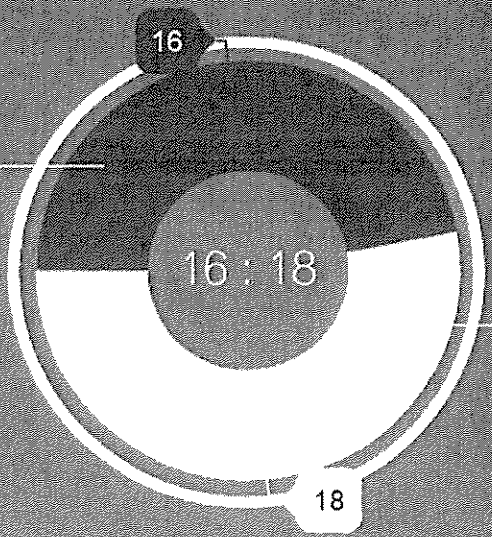
Muscle pulls/strains remained constant. It's been implied summer exercise programs have insufficiently prepared athletes for the rigors of fall practice. These results don't dispute that.

"A lot of youth don't think they need to get in shape. They are couch potatoes right up to the first day of practice."

- James Chesnutt, MD
Sports Medicine Specialist at Oregon Health & Sciences University

Ligament Sprains

No significant reduction in sprains were reported from 2013 2014.



Sprains In 2013

Of 16 reported, 7 were KNEE injuries.

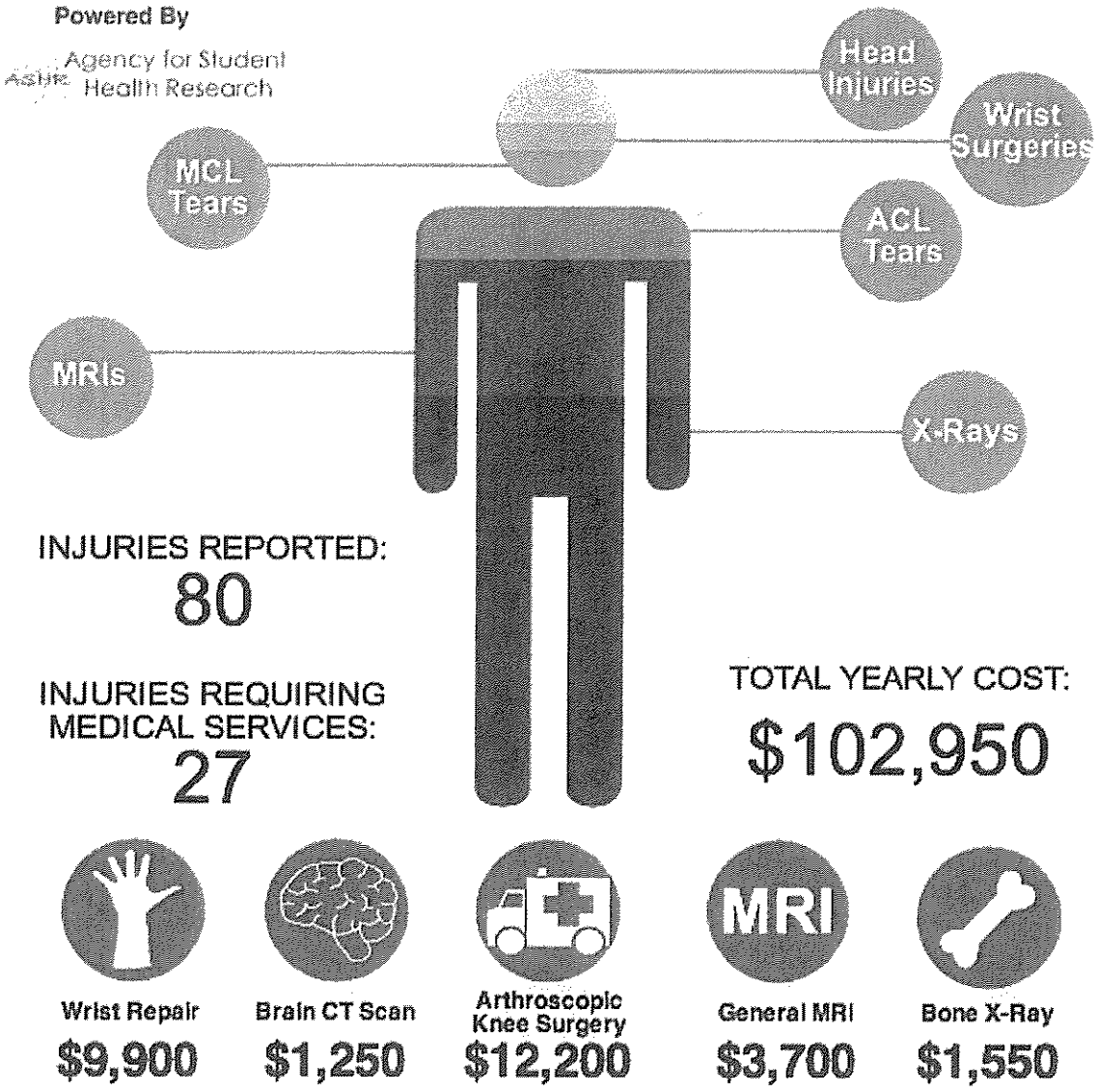
Sprains In 2014

Of 18 reported, 8 were ANKLE/LOWER LEG and 6 were KNEE.

While the numbers of sprains and strains were unchanged, InjureFree's data shows a 50% reduction of the total number of head injuries. Without knowing specifics of which schools have pre-emptively reduced full contact practices, we assume that any reduction of practice hours has the potential to reduce head injuries. And while clearly other variables are at play, such as player fatigue, concussion education, improved coaching models and so on, what is ultimately clear at this stage is the need for more robust sampling data.

Case Study #3

The infographic displays statistics collected during a case study completed within a single 2,200 student high school. Using our InjureFree web-based software, 80 athletic related injuries were reported by the athletic trainer during the entire school year. Of those 80 injuries, 27 required additional medical services. When national averages (for medical services) were applied, the resulting price tag was $102,950.



Primary financial contributors included the parents of the student athletes, the family's insurance providers, and the school's insurance policy. Since this was a public school, that means local taxpayers contributed as well.The school in this case study employed an athletic trainer. Imagine the bill had athletes visited doctors instead of the AT.

Closing Remarks

In closing, I'd like to re-iterate our support for the proposed legislation and commend its supporters for their leadership. If enacted, New York City will be cast into the national spotlight [amid the concussion debate] as a community dedicated to the safety of its children. Likewise, I would like to pledge the available resources of the Agency for Student Health Research to ensure timely and effectual implementation of this important law protecting future generations of New York City student athletes.

Thank you.

HEAD HEALTH NETWORK

Friday, January 23, 2015
New York City Council
Joint Hearing of Committees of Health and Education
Health and Safety of Youth Football Teams

Written Statement
Dr. Peter Salgo

Good Morning and thank you for inviting us today to discuss this important topic.

I'm Dr. Peter Salgo. I was the Health and Science correspondent for Channel 2 News here in New York for more than two decades. I've anchored the health broadcast America's Vital Signs for CNBC, and currently host Second Opinion on PBS. I am a professor at the Columbia University College of Physicians and Surgeons.

I am here, now, as part of a consortium of concerned professionals, the Head Health Network. We have gathered together leading sports health experts and companies with the mission of making kids sports, including football, as safe as possible.

My time in the media has given me an extraordinarily complete look at the value of sports to our children. I'm a dad, by the way. Three kids. Twins 4, and an older girl 10.

It is abundantly clear that sports are important. Our children need to learn the values of team play, sportsmanship and effort. They also need exercise to make sure their bodies mature and develop properly.

As you'll hear, all sports have risk. Football is no exception. But, the vast majority of young football players do well, and get terrific benefits from the game.

We are all charged with making sports accessible, and as safe as possible. In order to do this we need to recognize that equipment advancements alone, such as better helmets, will not achieve these goals. Rather, we need to find a more global approach; we need to implement the most effective ways to change behaviors and to provide access to expert care.

The bill we are considering today is an excellent effort to do just that. We support the bill, and its objectives. In fact, we believe that our Head Health Network can complement the bill and greatly expand on its effectiveness.

My biggest concern is that a person on the sidelines watching the game cannot identify players in trouble. It is impossible to watch eleven players simultaneously, and to assess how hard each has been hit on each play.

HEAD HEALTH NETWORK

What is needed is a solution that can effectively monitor all participants at the same time, provide access to expert care, all while being cost effective. We believe our network can help deliver such a comprehensive solution.

However, as it is written, the bill before us today prevents such a solution because it clearly delineates between on-site caregivers and tele-health doctors. We suggest you amend the proposal to include a telemedicine component.

As you know, telemedicine has been approved, in Albany, as an acceptable, reimbursable, healthcare option. Many hospitals use telemedicine to evaluate patients and provide advice. Mine monitors diabetics using telemedicine technology.

An additional benefit of the Head Health Network is that our telemedicine doctors are experts trained in the field of concussion care, sideline caregivers may or may not have such expertise. As a result, the Head Health Network solution can complement the care on-site doctors or trainers can provide and it can effectively substitute for on-site caregivers where none are available, or where they would be too expensive.

In closing, we believe this bill is a big step toward making youth football as safe as it can be, and we believe that with minor changes it can be made even more effective.

HHN
HEAD HEALTH NETWORK

Friday, January 23, 2015
New York City Council
Joint Hearing of Committees of Health and Education
Health and Safety of Youth Football Teams

Written Statement
Merril Hoge

Outside of my family, nothing has shaped or been more central to my life than football. From the time I was a kid and first dreamed of playing professionally, to my eight years in the NFL, to my 10 years coaching youth football and to my current role as a football analyst on ESPN; nearly all of my days have been built around the game that I and so many others love. I know my experiences can offer a unique and helpful perspective on the state of youth football as it exists today.

It is well documented that my NFL career was ended prematurely as the result of concussions - nobody is more aware of the serious nature of brain injuries than me. However, and this is critical, my injuries were the result of, and an indictment on, the manner in which head injuries were cared for and the culture that used to encourage and glorify head to head impacts.

Through improved efforts to educate players, coaches, parents and caregivers about brain injuries and a changing culture within the sport, youth football has never been safer. However, as a former player, coach and parent, I understand this is not enough. We must continue to work toward a higher standard of concussion care for players at all levels and we need to continue encouraging behavioral changes that will make football safer. I know these are the goals of the Head Health Network and for these reasons I support their efforts.

In my regular interactions with parents who are concerned about the well-being of their children, I tell them the same thing I am telling you today; one of the keys to safe participation is being educated about head injuries, how to care for them and how to play the game in a way that reduces their likelihood. It is important to understand that we won't ever be able to prevent concussions, but we can learn to better detect and care for them. That burden falls on EVERYONE not just the medical staff, who, save for the very highest levels of play is ill-equipped and under staffed to effectively monitor and care for every player at the same time. What is needed is a better way to monitor players and to provide expert care.

I encourage the city council to consider the implications of this bill holistically. I am in strong support of providing the safest environment as possible for our children, but please understand that simply placing doctors on the sidelines does not solve the problem at hand because it does not fully address the issues of injury detection or expert care. With recent technological

HEAD HEALTH NETWORK

advancements, I believe solutions exist that can address all of these issues and it is in our best interests to implement them.

Thank you for the opportunity to contribute to this forum today. This is a topic which I am passionate about and I am eager to support any work that helps create the safest possible environment so that our kids can enjoy all sports and learn all the valuable life lessons provided through sports.

HHN
HEAD HEALTH NETWORK

Friday, January 23, 2015
New York City Council
Joint Hearing of Committees of Health and Education
Health and Safety of Youth Football Teams

Written Statement
Dr. Joseph Maroon

Although I am a founder of ImPACT, the neurocognitive test for assessing concussions, a team physician for The Pittsburgh Steelers for over 25 years and a clinical professor of neurosurgery at the University of Pittsburgh, I am not here on behalf of any of these organizations. I am here to discuss not only the importance of youth football but also opportunities for enhancing the safety of youth football.

I personally began playing football at age 6 on the cobblestone streets and slag yards of Wheeling, West Virginia. I subsequently obtained a football scholarship at Indiana University where I was voted Scholastic All American in football. Subsequently I was the team neurosurgeon for the University of Pittsburgh and then for the last 25+ years, the team neurosurgeon for The Pittsburgh Steelers.

Over 20 years ago I told four time Super Bowl coach, Chuck Noll, that his starting quarterback couldn't play against the Dallas Cowboys the following week because he had a concussion. He very sharply informed me that if I wanted him to keep one of his players out of a game because of a concussion he wanted objective data not some specious guidelines drawn up by a committee of doctors. After thinking about this I contacted Mark Lovell and subsequently Mickey Collins, both brilliant neuropsychologists, and together we devised a neurocognitive test that measures reaction time, the ability to process information and memory. This test has now become the standard of care in the NFL, NHL and for thousands of high schools and colleges across the country. To date over 8 million athletes have taken this baseline test prior to contact sports participation. Close to 200 peer reviewed, scientific papers attest to its validity and reliability.

Nevertheless, concussions rightfully remain a major concern in sports and it is our duty to take a more aggressive approach to ensuring the safety of our youth. I believe that this goal can be achieved without implementing rules or regulations that risk making participation prohibitively expensive or impractical.

The key to achieving this will require changing behaviors and raising the standards for concussion care in all sports. There is a growing body of data that supports that simple modifications to the way we teach and coach the game reduce the likelihood of concussions; and I believe that we can further minimize the incidence and effects of concussions by implementing a few reasonable standard of care requirements.

HHN
HEAD HEALTH NETWORK

One of the cornerstones of an elevated standard of concussion care is baseline neurocognitive testing because it ensures that we can more reliably diagnose concussions. The other cornerstones of elevated standards of care include impact monitoring and access to medical experts trained in concussion diagnosis and care.

At the professional level, impact monitoring refers to dedicated spotters looking out for dangerous impacts, but when I use the term here, I am referring to helmets that utilize impact sensors. The reason impact monitoring is a necessary component is because it provides actionable data that will drive the changed behavior we are all seeking. Sensors do not and will not determine whether a concussion has occurred, but they will tell us when a player has sustained a potentially dangerous hit or a potentially dangerous number of sub-concussive hits. This information will be used as a trigger for when to remove a player from play and ensure that player receives a full assessment.

Finally, providing access to experts trained in detecting and caring for concussion injuries is vital because improper assessments can result in further injury. In the instances of head trauma, it isn't enough to simply have a family practitioner assess and provide care recommendations because head trauma science is evolving rapidly and doctors engaging in the treatment of these injuries need to be aware of the latest best practices.

Such a compilation of services; impact detection, injury assessment and access to expert care exists at the professional level in multiple sports, but nowhere else. The Head Health Network's integration of these services is novel in its approach and will be effective in ensuring youth football players everywhere receive a standard of concussion care, regardless of that players skill level, location or financial means.

In closing, I'd like to leave you with a quote; General MacArthur, when commandant at West Point here in New York, said:

"On the fields of friendly strife are sown the seeds that on other days and on other fields will lead to victory."

Those "seeds" include teamwork, development of leadership, loyalty, commitment in the face of adversity, self-esteem and other positive character traits. These traits also markedly contribute to the future social and economic success of the athlete—and the reduction in the youth obesity epidemic. Had I personally not engaged in football, I clearly would not be here this morning. I encourage you to be open about the incredible benefits learned on the fields of friendly strife and to support programs and services that will help make youth football even safer than it is today.

HEAD HEALTH NETWORK

Friday, January 23, 2015
New York City Council
Joint Hearing of Committees of Health and Education
Health and Safety of Youth Football Teams

Written Statement
Dr. Julian Bailes

I am a neurosurgeon and professor who has been in practice for 25 years, have had the opportunity to have cared for athletes of all ages, and have been a sideline team physician at the NFL and NCAA levels during that time. I am a father and a former football player, and also serve as the Chairman of the Medical Advisory Committee for Pop Warner Football, the nation's largest and oldest youth football organization.

For the last 15 years, I have directed a brain injury research laboratory, where scientific investigations are carried out concerning the effects of both major and mild brain injury, also called concussions. While we and many researchers have uncovered important clues into the reaction of the brain to both concussive and sub-concussive impacts, there is still progress to be made. I have seen first-hand that there is no medical or scientific consensus that the youth brain is more susceptible to injury than in older persons, however I can appreciate that this is a highly sensitive topic and it is our responsibility to be conservative in nature in working to preserve the safety of our youth.

To this point, I am pleased that as a result of recent efforts to educate athletes, coaches, and parents, implement rule changes to eliminate egregious head to head hits, and to reduce or eliminate head contact in practice, youth football has never been safer. To cite a specific example, four years ago at Pop Warner we were the first football league to legislate against head to head contact in practice. This has resulted in Pop Warner football players sustaining only 60 or fewer head contacts every season.

Unfortunately the incidence of head contacts increases in high school, as do the severity of the impacts. Thus, we need to continue our reformation of football, and all sports by encouraging the appropriate behavioral changes and providing sufficient impact monitoring, injury assessment and care.

I believe that we can help drive behavioral change and address, in large part, the concussion crisis through the adoption of best practices at all levels of participation. These best practices include effective monitoring of head impacts, immediate head injury assessments and immediate access to expert care. While these steps may seem intuitive, historically it has been a challenge to implement them anywhere other than the highest levels of participation. However, given recent advances in science in technology I believe we can now implement such a service across all levels of play.

HEAD HEALTH NETWORK

In closing, it is important that we work to find a solution which would allow youth and high school football players to continue to enjoy the innumerable benefits of America's greatest game which include physical activity, teamwork, leadership, sacrifice, and achievement. We have the opportunity, capability and responsibly to continue to evolve football in terms of style of play, safety rules, and to raise the standard of care for head injuries. I believe that if we can follow this road map that we can begin to effectively manage the concussion crisis and that our children can continue to play the game that they love and that they benefit enormously from.

HEAD HEALTH NETWORK

Friday, January 23, 2015
New York City Council
Joint Hearing of Committees of Health and Education
Health and Safety of Youth Football Teams

Written Statement
Robert Golden

My name is Rob Golden and I am the Chairman of Marucci Boditrak and the Head Health Network. My background is in flexible pressure mapping sensor development for medical applications and electronic medical record development. This broad range of experiences has given me a unique viewpoint and brought me into contact with medical professionals throughout the world, none more impressive than the gentlemen that are here today in support of the Head Health Network and the safety of youth football teams.

The intent of the bill before us today and the mission of the Head Health Network are perfectly aligned; both intend to raise the standard of concussion care in youth sports. In fact, the Head Health Network extends to a level of care well beyond what the bill aims for.

Participants in the Head Health Network will receive the following services: baseline cognitive testing prior to their season's start, impact monitoring during every practice and game, regularly scheduled and post-injury concussion assessment testing, immediate access to trained concussion experts through a telemedicine connection, a $25,000 excess insurance policy to cover all concussion related expenses, and a HIPAA-compliant electronic medical record that will track each player's lifetime hit history and baseline/post-injury cognitive testing results.

Some of the key benefits of the Head Health Network are:

- Electronic hit monitoring ensures each player is under constant watch, their hits can be counted and can be objectively assessed, regardless of how mundane or severe the hit might have looked to an on-site observer.
- We ensure that players will have immediate access to trained concussion experts and that if necessary additional experts can be brought into the fold to help with any given situation.
- Sideline assessment tests are standardized and administered by trained professionals.
- Baseline cognitive testing will be required for all players which greatly enhances the effectiveness of any subsequent tests, whether scheduled or post-injury.
- Electronic Health Records track a player's head health throughout their sports career

- Excess Insurance coverage for every player diminishes the reluctance to seek expert care

Through partnerships with leading companies in each distinct discipline covered by the Head Health Network, we are able to ensure the reliability, effectiveness and scalability of our network. We are not inventing each of these solutions, to the contrary, we are consolidating existing and proven solutions into a single service. In fact, the recent growth and competition in the fields of telemedicine and cognitive assessment testing ensure competition and thus help ensure competitive costs.

To expand on the affordability of the Head Health Network, this subscription based service will cost approximately $20 per player per month during their season. For a typical three month season this works out to about $60 per player. This cost includes each of the services that have been described and we expect the cost to decrease over time as participation in the program grows on a national scale.

In summary, we are pleased to see New York City is looking proactively at the safety and well-being of its youth football participants and we share in the belief that more can and should be done to protect our kids. We believe that any solution that aims to change potentially harmful behaviors and strives for elevated concussion care standards is a step in the right direction and we are optimistic that you will consider comprehensive solutions such as the Head Health Network as a way to protect youth football players.

William Solomon
Brooklyn Titans Youth Football
917-667-5193 – BrooklynTitans@aol.com

My name is Bill Solomon. I am a former youth, high school and college football player; the father of a football player; a youth football coach; the founder of a football and cheer program serving over 200 youth in Brooklyn; a founder and administrator for a city-wide football and cheer league serving over 3,000 youth in the new york city metro; and the state representative for American Youth Football; I have been active in economic development in the borough; and I am a voter. I have been involved in youth football in New York City for the past 15 years. I can cite numerous examples of success stories directly attributable to benefits provided by youth football.

I grew up in a football hotbed in Western Pennsylvania. I played football from the time I was 8 years old, and football helped both my brother and me get Ivy League educations: me at Harvard and my brother at Brown. I have a son, who chose to play football at the age of 7, and who is now playing football for the University of Pennsylvania. I know first-hand, the benefits and risks of tackle football.

If the legislation being proposed here is an attempt at grandstanding and taking advantage of the nation-wide hysteria over concussions in football, then my words here will more than likely fall on deaf ears. However, if we are here to have an honest and open discussion regarding the safety and well-being of the children in the city of New York, then I am more than confident what I have to say here will resonate.

From what I have been able to gather, councilman Levin and his supporters have canvassed the body of research that exists regarding concussions in football, and sought out input from various national bodies regarding youth football. However, I find it disturbing that none of the men and women who volunteer hundreds of hours each year to youth football programs in New York City have been consulted regarding this legislation. I find it disturbing that apparently none of the thousands of the parents of the children directly impacted by this legislation have been contacted or consulted regarding **their** desires. And further, as the operator of a youth football program within spitting distance of Councilman Levin's district in Brooklyn, I find it troubling that I have not been contacted by the Councilman's office regarding this matter. The last point is particularly ironic because I recall actually meeting councilman Levin several years ago, while he was running for office, outside a school in Carroll Gardens where I was distributing flyers for my program.

Concussions are not unique to football. In fact, according to a recent study published by the National Institutes of Health, the incidence of concussion in girls' collegiate soccer is actually **higher**, on a per exposure basis, than their football counterparts. Why then is this esteemed body not considering Youth **Sports** Safety legislation rather than Youth **Football** Safety? If medical staff is required on football sidelines, shouldn't soccer and basketball have the same benefit? Shouldn't there be medical staff mandated at skateboard parks and city playgrounds where the incidence of concussion during largely unsupervised activity far exceeds football?

William Solomon
Brooklyn Titans Youth Football
917-667-5193 – BrooklynTitans@aol.com

The sad fact of the matter is that the children in many of the neighborhoods served by youth football programs are more likely to have their lives negatively impacted by gun violence, childhood obesity, diabetes and school drop out, than concussions in football. According to FBI data, the time of day these young people are participating in football, is prime time for bad things to happen to them. And as regards violence, football provides an outlet for aggressiveness that might otherwise find less positive ways of manifesting itself. Rituals imitate violence in order to keep violence at bay (Aristotle).

The only thing we really know for certain regarding concussions and their effects, is that we really don't know very much, particularly as regards youth. The FACT is that there is not yet any reliable data regarding the incidence of concussions in youth football. The FACT is that one cannot extrapolate data from high school, college and professional sports to make assumptions about youth football; the game differs significantly at each level.

Rather than spending time and effort pursuing an unfunded mandate, that unnecessarily burdens financially strapped volunteer-based programs, our time would be better spent providing training for the volunteers who are providing the programming so desperately needed by the kids in New York City. If there is a problem with concussion, what is being proposed here only addresses the symptoms, not the root cause. An ounce of prevention, in the form of funding training for coaches and other volunteers, beats a pound of excessive cost in the form of unnecessary and misguided spending, every day of the week.

The term "Power of the Permit" has been thrown around as regards the City's ability to use permitting as a means of influencing behavior. It would be tragic to see the youth of New York City crushed at the intersection of the Power of the Permit and the Law of Unintended Consequences. At a time when physical inactivity among the youth in our country has been described as epidemic, and foreshadowing a potential watershed of health problems for our country in the future, now is NOT the time to take kids off the playing field.

UCLA Steve Tisch BrainSPORT
Sports concussion
Prevention
Outreach
Research and
Treatment Program

UCLA BRAIN INJURY RESEARCH CENTER
UCLA Steve Tisch BrainSPORT

FACTS:

- Concussion and Traumatic Brain Injury (TBI) is a major public health problem – estimated at 1.6-3.2 million annually in the U.S. The highest rates of concussion/TBI occur in youth and adolescents.
- Sports activities provide many benefits to students – including physical fitness, improved attention, leadership opportunities and learning teamwork.
- Sports also have a risk for concussion/TBI and repeat concussion/TBI which have been associated with cognitive and neurological impairments.

Our PRIMARY GOAL is to allow youth athletes to participate in sports as safely as possible, but also to provide the best neurological care possible when an injury does occur.

RECENT GUIDELINES: *All* of the major Sports Concussion guidelines recommend that:

- When a concussion is suspected, the athlete should be removed from play to avoid risk of repeat concussion.
- Proper diagnosis of concussion should not rely on a single test.
- Proper management of concussion should be individualized to the unique circumstances for each athlete.
- Properly managed, the vast majority (>90-95%) of concussions recover completely.

PILLARS of a collaborative UCLA program:

1. Cutting-edge athlete baseline and post-concussion care
2. Student/athlete, coach and trainer education
3. Parent and teacher education
4. Research and student research education, if desired

What UCLA offers: Our UCLA Steve Tisch BrainSPORT program, in conjunction with a national consortium of universities and the NCAA, has developed comprehensive baseline and post-injury protocols that are currently in use. Our program will bring this same Collegiate level of assessment and care to high school and youth team partners.

1. Comprehensive baseline (neurological and/or neuropsychological) testing annually
2. Use of our UCLA Post-Concussion Protocol for assessment and management by athletic trainers
3. Expedited access to post-concussion care in our multidisciplinary sports concussion/TBI program
4. Up-to-date basic and continuing education with certification for athletes, coaches and trainers
5. Parent/teacher education
6. Assistance for local student neuroscience/brain safety organization
7. Participation in National Sports Concussion Outcomes Study – including possibility for helmet-based or patch-based impact monitoring
8. Future potential for telemedicine concussion consultations

Comprehensive baseline testing = neurological baseline + neuropsychological baseline testing
Neurological baseline testing includes:

- Focused neurological history
- Graded symptom checklist (GSC)
- Standardized assessment of concussion (SAC)
- Neurological examination
- Balance error scoring system (BESS)
- Clinical reaction time testing (RTclin)
- King-Devick number reading test (KD)

Neuropsychological baseline testing: Computerized testing (6 athletes per proctor) – ImPACT or whatever brand your school prefers.

Mattel Children's Hospital UCLA

Division of Pediatric Neurology
10833 Le Conte Avenue
Room 22-474 MDCC
Los Angeles, CA 90095
Ofc. 310-825-6196
Fax: 310-825-5834

Verbal Summary Statement of Dr. Christopher Giza, Professor of Pediatric Neurology and Neurosurgery and Director of the UCLA Steve Tisch BrainSPORT Program at Mattel Children's Hospital – UCLA.

Dear Ladies and Gentlemen of the New York City Council:

Thank you for inviting my testimony and I applaud your efforts to improve safety in youth sports in your city. In these times of increased childhood obesity and sedentary lifestyles, it is important to provide healthy physical activities for our youth. My intent here is to provide a summary of the current best evidence for youth concussion management.

A concussion is a brain movement injury. The good news is that it is mostly a recoverable injury.

Current concussion guidelines recommend that when a concussion is suspected, the athlete should sit it out and not return to play the same day! Persons with suspected concussion should be removed from the game to prevent additional injuries. No single test can be used to diagnose concussion, as each injury may have different symptoms and impairments, which is why persons with suspected concussion need to be evaluated by a licensed clinician with expertise in concussion and traumatic brain injury. There is no set timeline for return to activity or return to play. Individuals who have recently experienced a concussion are known to have problems that increase their risk for injury if they return to play prematurely, and problems that interfere with their main job – learning! Return to school and return to play should be individualized and are not cookie cutter protocols. There is no 'one size fits all' for either concussion assessment or concussion recovery.

The proposed legislation prioritizes brain health and safety for our children. This is exceedingly important. The establishment of a youth sports health and safety task force is a strong step in this direction. The multidisciplinary composition of the task force is also highly recommended. The effectiveness of the task force will be maximized by providing sufficient resources for them to complete their charge.

The youth football safety law is well-intentioned but deserves further consideration. It is a reasonable requirement that schools with a program of contact or collision sports have at a minimum, a certified athletic trainer. It is also proper that a youth suspected of having a concussion be removed from play and not be permitted to return to contact risk until evaluated by a licensed, experienced health care provider.

The challenges in this law are also evident. Despite the fact that concussions occur in many sports, this draft pertains only to football. Students in other equally risky sports, and female student-athletes in general, are no less worthy of protection than football players. The requirement of a standardized assessment of concussion test implies that such a tool exists for all ages and is capable of identifying all concussions. Tools may assist the experienced health care provider in making a diagnosis, but ultimately the diagnosis of a concussion is a clinical synthesis of multiple types of information, just like any other medical condition.

In closing, the New York City council should be commended for taking on such a significant task as youth sports safety and brain health. This is a major public health problem that affects society's most precious resource, our children, our future leaders and thinkers. I strongly urge that you take the time to carefully review the existing information and then move forward with a modified plan that takes into consideration the important points provided by me and the other experts. I regret being unable to attend this meeting in person, encourage your feedback and questions, and readily offer my skills in any way to assist in your development of this important program.

Sincerely,

Christopher C. Giza, M.D.
Professor of Pediatric Neurology and Neurosurgery
Director, UCLA Steve Tisch BrainSPORT
Mattel Children's Hospital - UCLA

UNIVERSITY OF CALIFORNIA, LOS ANGELES **UCLA**

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

PEDIATRIC NEUROLOGY
MATTEL CHILDREN'S HOSPITAL
DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA
LOS ANGELES, CA 90095-1752
TELEPHONE: (310) 825-6196
FAX: (310) 825-5834

Friday, January 23, 2015

Written Testimony of Dr. Christopher Giza to the New York City Council on the topic of youth sports safety and brain health

Dear Ladies and Gentlemen of the New York City Council:

Thank you for inviting my testimony and I applaud your efforts to improve safety in youth sports in your city. Particularly in these times of increased childhood obesity, diabetes and sedentary lifestyles, it is important to provide safe and healthy physical activities for our youth. As you know, concussions and other injuries occur in the setting of sports but occur outside of sports as well. My intent here is to provide an overview of the issue of youth sports concussions as well as the current best evidence for concussion diagnosis and management, including the distinctions inherent to a youth sports setting.

A concussion is a brain movement injury. The good news is that it is mostly a recoverable injury. The challenge is that a concussion is not visible to the outside observer and doesn't show up on a CAT scan. A concussion is a form of traumatic brain injury (TBI) at the milder end of the spectrum, although the symptoms can be anything but mild.

In the short term, concussions cause neurological and behavioral symptoms like:

- headache
- nausea
- dizziness
- imbalance
- inattention
- memory problems
- emotional changes

Often these symptoms start immediately after the impact, but the onset of symptoms can be delayed by minutes or hours. Thus, the clinical diagnosis of concussion may require more than a single assessment. Once diagnosed, concussion symptoms recover over time (usually days to

weeks) if the brain is protected from further injury. However, an individual with a concussion is also 3-6 times more likely to get another concussion if they return to play prematurely, and the second concussion is likely to be more severe and take longer to get better. About 10% of individuals with concussion will develop more chronic symptoms, called post-concussion syndrome.

The long term consequences of concussion are less clear. At professional levels of collision sports, those exposed to multiple concussions score lower on cognitive tests. At amateur levels of sport, some studies show impairments and some do not. It is known that more severe TBI may increase the risk for neurodegenerative diseases like Alzheimer's and Parkinson's. There is recent research to suggest that repeated concussions may also lead to neurodegenerative brain disease, but the risks for this are not able to be determined with the current data.

Expert consensus and evidence-based research recommends that:

1. All athletes (and parents) be educated to recognize signs & symptoms of concussion
2. When a concussion is suspected, the athlete should sit it out and not return to play the same day!
3. There is no equipment yet proven to prevent concussions, although mouthguards and helmets protect against other injuries and should be well-maintained, properly fitted and used correctly.
4. No *single* test should be used to diagnose concussion, as each injury may have different symptoms, impairments and severity, and no test for concussion is fool-proof.
5. Persons with suspected concussion should be protected to prevent additional injuries and evaluated by a licensed health care provider with expertise in concussion and TBI.
6. There is no set timeline for return to activity or return to play. Return to school and return to play are not cookie cutter protocols and need to be individualized based upon the student's symptoms, injury, past medical history, risk factors and environment. There is no 'one size fits all' for either concussion assessment or concussion recovery.
7. There is also no evidence for absolute rest.
8. Individuals who have recently experienced a concussion are known to have pain, slower thinking, worse attention, poorer coordination and delayed reaction time, problems that increase their risk for injury if they return to play prematurely and problems that interfere with their main job – *learning*!

The proposed legislation prioritizes brain health and safety for our children. This is exceedingly important.

- The establishment of a youth sports health and safety task force (Int. No. 86) is a strong step in this direction.
- The multidisciplinary composition of the task force is also highly recommended, and should include members with experience in brain science, behavior, sports and education.
- The effectiveness of the task force members will be maximized by providing sufficient resources for them to complete their charge. An under-resourced task force will likely struggle to objectively and comprehensively track and analyze injuries, education and behavior as they are being called to a tall order.

The youth football safety law (Int. No. 85) is well-intentioned but deserves further consideration.

- It is a reasonable requirement that schools with a program of contact or collision sports have at a minimum a certified athletic trainer to provide care for the inevitable injuries that occur.
- It is also proper that a participant removed from play suspected of having a concussion not be permitted to return to contact risk until evaluated by a licensed health care provider with expertise in concussions.
- The collection of accurate injury and recovery data is essential to measure efficacy and improve future management and policy.

The challenges in this law are also evident.

- First, despite the fact that concussions occur in many sports, this draft pertains only to football. Students in other equally risky sports, and female student-athletes in general, are no less worthy of protection than football players, who are almost exclusively male.
- Second, the requirement of a standardized assessment of concussion test implies that such a tool exists for all ages and is capable of identifying all concussions. As stated above, validated tools for younger kids are scarce, and no single tool routinely diagnoses all concussions. Tools may assist the experienced health care provider in making a diagnosis, but ultimately the diagnosis of a concussion is a clinical synthesis of multiple types of information, just like any other medical condition.

In summary, the New York City council should be commended for taking on such a significant task as youth sports safety and brain health. This is a well-recognized public health problem that affects society's most precious resource, *our children, our future leaders and thinkers.*

I strongly hope and urge that you take the time needed to expeditiously gather and review the existing information and then move forward with a modified plan that takes into consideration the important points provided by me and the other experts. I regret being unable to attend this meeting in person, encourage your feedback and questions and readily offer my skills in any way to assist in your development of this important program.

Sincerely,

Christopher C. Giza, M.D.
Professor of Pediatric Neurology and Neurosurgery
Director of the UCLA Steve Tisch BrainSPORT program
Interdisciplinary Programs for Neuroscience and Biomedical Engineering
Mattel Children's Hospital - UCLA
David Geffen School of Medicine at UCLA

NYU Langone Medical Center
NYU Comprehensive Epilepsy Center

William B. Barr, Ph.D., ABPP
Chief of Neuropsychology
Associate Professor of Neurology and Psychiatry
223 East 34th Street
New York, NY 10016
Tel: 646.558.0809; Fax: 646.385.7167
E-mail: william.barr@nyumc.org

Testimony of William B. Barr, Ph.D., ABPP to the Council of the City of New York Health Committee: Youth Football Safety. January 23, 2015

I thank council for the opportunity to testify. My name is Dr. William Barr. My field of specialization is Clinical Neuropsychology, which is the study of the brain and behavior. I am an associate professor of Neurology and Psychiatry at the NYU School of Medicine and the Director of the Neuropsychology Division in the Department of Neurology. I am Board certified in my field. I have evaluated athletes with concussion for over 20 years at the youth, high school, collegiate, and professional levels. I have also conducted or participated in a number of published research studies on the assessment at natural recovery of sports concussion using some of the same methodology proposed in this bill. I'm here today to provide testimony supporting the bill, from the perspective of both a practicing clinician and researcher specializing on the topic of sports concussion.

I will address three major points:

1. **Regarding §10-902 - Doctor or athletic trainer required:**

   I support the requirement of having trained personnel, such as an athletic trainer or doctor at all practices and games. Symptoms of concussion are often difficult to detect and athletes often try to conceal them. It is important to have an individual with training in the recognition, assessment, and management of concussion symptoms present at all activities where athletes are susceptible to developing concussions in order to maintain their safety. While I believe that these individuals will need to work closely with the team coaching staff, it is important that they operate independently of the staff in order to provide an opinion that is not susceptible to any conflict of interest with regard to effects on team performance.

2. **Regarding §10-904 - Standardized Assessment of Concussion tests:**

   I have participated in a number of published research studies assessing the validity and reliability of the *Standardized Assessment of Concussion,* which is known in the field by it's acronym as "the SAC". I believe that the SAC is an effective performance-based instrument for evaluating

symptoms of concussion. It provides a valuable numerical method that will be effective for assessing and tracking symptoms of concussion in its proposed context. However, our research has found that this measure can be used even more effectively in conjunction with other measures, which are included in a larger instrument known as the *Sports Concussion Assessment Tool – 3rd Edition,* otherwise known by acronym as the SCAT-3. The SCAT-3 adds to the SAC by its inclusion of a symptom checklist (completed by athlete) and a measure of balance (completed by ATC or doctor). The inclusion of these instruments is known to increase the sensitivity of the SAC to detection of concussion effects. I urge all teams using the SAC as proposed by this bill to consider adding additional measures from the SCAT-3 to utilize what has been demonstrated empirically to be the most sensitive and effective means of tracking concussion.

3. **Regarding §10-905 - Reporting:**

Testifying as a clinician involved in assessment of sports concussion and a researcher on this topic, I support the mandate for annual reporting of the number of concussions sustained during games and practices and specific details of those concussions. At this point, most of what is known about sports concussion is based on relatively homogeneous samples of athletes from affluent suburban areas. From a public health perspective, much more needs to be learned about how concussion manifests in a more ethnically and economically diverse sample of athletes, such those participating in tackle football in the New York City Schools and youth leagues. I believe that this important information needs to be collected and analyzed appropriately to study the effects of concussion and monitor the safety of <u>all</u> of our children.

To conclude, I strongly support this bill and its aims at providing the personnel and tools to maintain the safety of our athletes in addition to establishing a standard for reporting that will enhance our ability to track and understand the effects of sports concussion on youth football players in a diverse urban setting such as New York City.

Pop Warner Little Scholars, Inc.
586 Middletown Blvd. Suite C-100 ▪ Langhorne ▪ PA ▪ 19047
Phone: 215-752-2691 ▪ Fax: 215-752-2879
www.popwarner.com

New York City Council
Committee on Health & Committee on Education
January 23, 2015

Thank you for the opportunity to discuss the perspective of Pop Warner Little Scholars, on safety for young athletes. I'll focus on three items that we believe are relevant for your consideration: the relative safety of youth sports, rules changes already made, and cost factors of providing Certified Athletic Trainers.

Youth sports in general, and youth football in particular, are relatively safe activities. As you can see on enclosed handout from a recent Study by the University of Alabama at Birmingham, the injury rates in youth football are lower than injuries riding bicycles until age 12. As children get bigger, faster and stronger, the injury rates increase significantly. It's important to keep in mind that Pop Warner's age range overall is ages 5-15; however the core of our participation is ages 7-12.

Dr. Julian Bailes, Chairman of the Department of Neurosurgery and Co- Director of the NorthShore Neurological Institute, and Chairman of the Pop Warner Medical Advisory Committee, states, "We promote advancing safety and medical technologies and rule changes in contact sports to protect players of all ages. We believe in a balanced approach, preserving the physical and mental health benefits of sports and remind parents that organized youth football, in particular, has never been safer."

The number one priority for us in Pop Warner is the safety of our young athletes. With that goal constantly in mind, we were the first national youth sports organization to implement our own concussion rule in 2010 where a player who suffers a suspected head injury is not allowed back in the game or practice until he gets clearance from a certified medical professional.

In 2012, we were the first football organization to enact rules limiting the amount and type of contact allowed in practice. The other handout included summarizes a Study done by Stefan Duma of Virginia Tech University with colleagues from Wake Forest University. After our 2012 rules changes limiting contact in practice, Dr. Duma found that Pop Warner players had almost 50% fewer hits to the head in practice compared to non-Pop Warner players.

Beginning in 2014, all Pop Warner coaches are required to take and pass the "Heads Up Football" training course every year.

Additionally, our rules require that , "All practices must be attended by one person holding a Red Cross Community CPR and First Aid Certificate, or the P.R.E.P.A.R.E. Course by the National Center for Sport Safety (www.sportsafety.org) or their equivalent, if not by an EMT or volunteer physician (such as a parent of one of the participants)." The Rule book is updated and distributed annually.

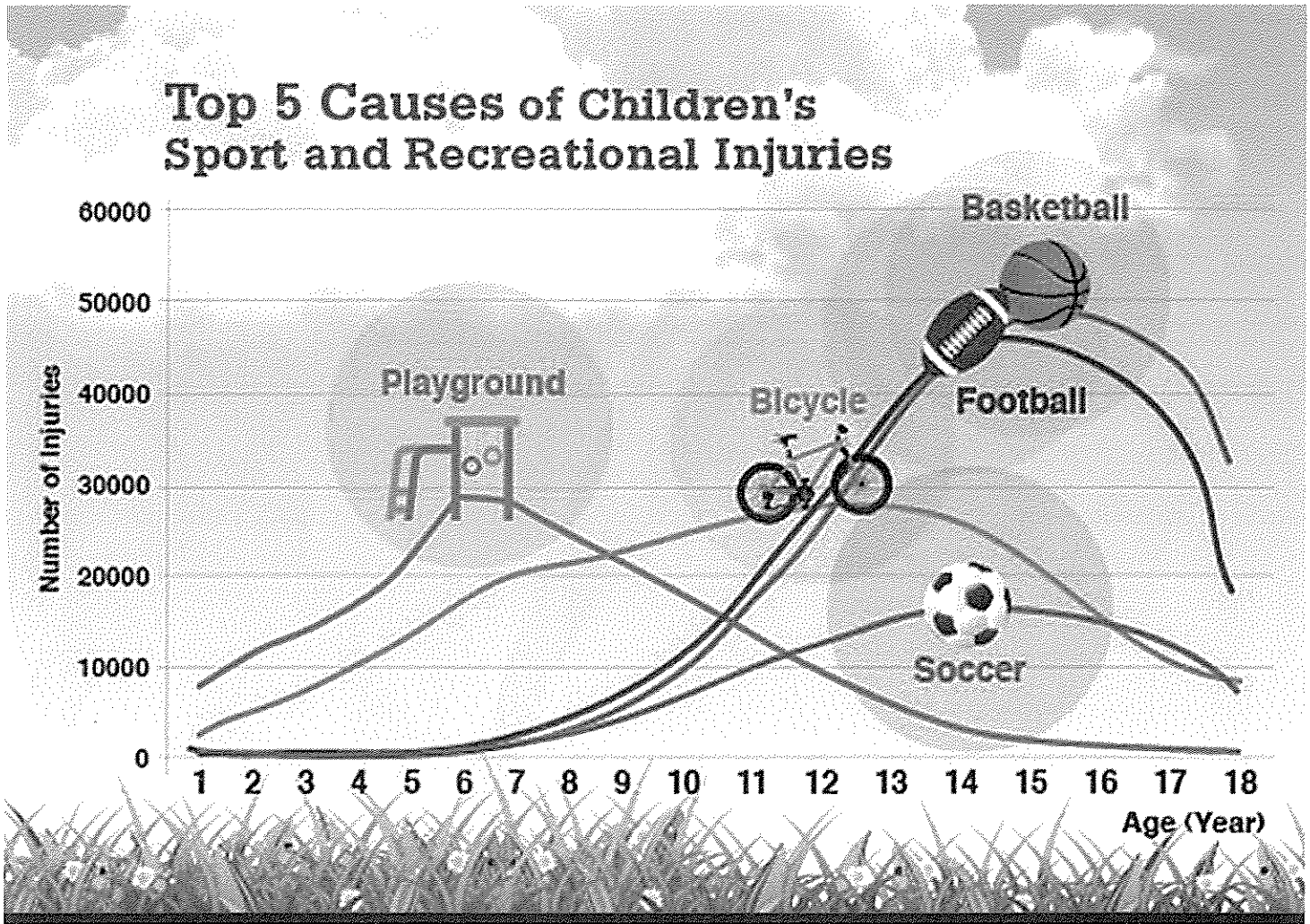
Philosophically, we welcome the presence of a Certified Athletic Trainer or Physician at all practices and competitions. With the increase in childhood obesity and Type II Diabetes, it's more important than ever to provide safe opportunities for young people and encourage them to participate for fun and health.

Our concerns, which we hope are shared by the Commission, are the availability of the required number of Certified Athletic Trainers, and the funding to pay the requisite fees for those trained professionals.

Local Pop Warner programs in New York City must raise all the funds necessary to field their multiple teams. We estimate the cost of having a Certified Athletic Trainer at every practice and every competition at approximately $8,000 - $9,000 per season for each Association. Not only would that seriously impact the finances of the local Pop Warner organizations, but it will directly impact parents and others who help fund the programs. These local programs are already working very hard to raise the funds for their current budget.

We will continually explore avenues to make the game better and safer for our young athletes but we need to do so with certain realities in mind. Having to raise that significant additional revenue would be near impossible for most programs, and, in a number of instances, will mean the demise of that local program. I know that is not the intent of the Committee but I do fear it could become an unintended consequence.

Thank you again for the opportunity and please be assured that we share your desire to study appropriate avenues to make sports better and safer for young athletes.

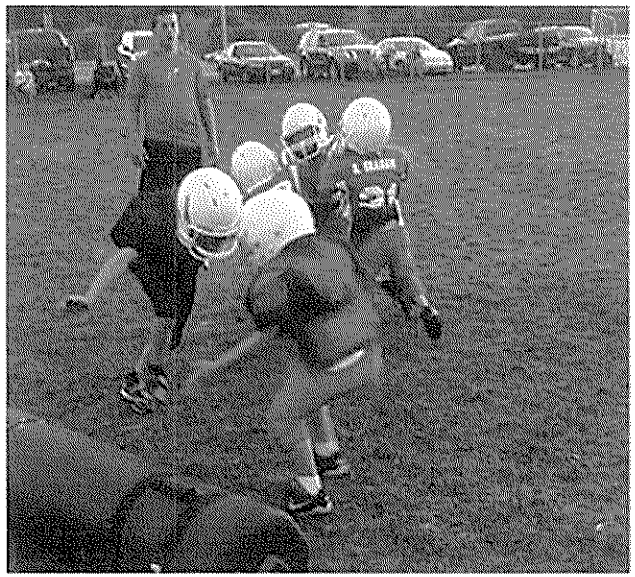


YOUTH SPORTS INJURY RATES EXAMINED IN STUDY

Date: October 13, 2014.
Source: University of Alabama at Birmingham.
Examined in Study: Over 2½ million children.

Identifying High-Risk Head Impacts

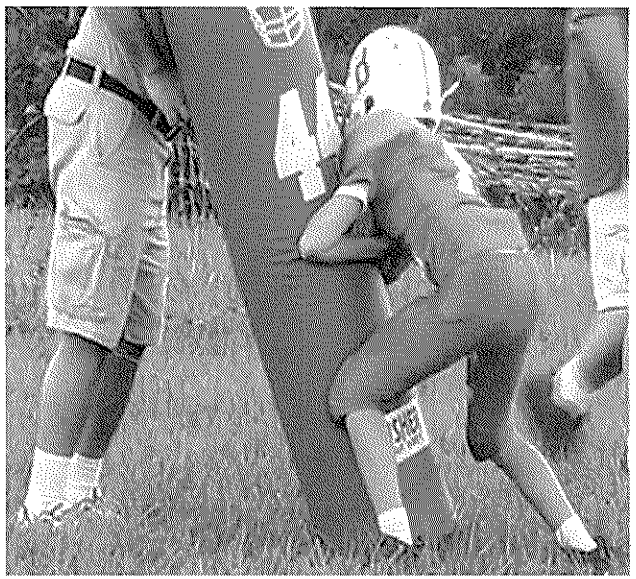
Year 1



Majority of high head acceleration impacts occurred during practice

Pop Warner instituted new rules to limit contact in practices

Year 2



Compared teams that adopted new rules with teams that didn't

Observed nearly a 50% reduction in head impact exposure

Va. Tech/ Wake Forest Study – 2013 Season

Testimony – John Pizzi

My name is John Pizzi and I am the Executive Secretary for the Athletic Association of the New York State Association of Independent Schools (NYSAIS), as well as the Director of Athletics at Riverdale Country School in the Bronx. I am also a National Specialist with the National Council on Youth Sports Safety, Inc., specifically dealing with technology in concussion management.

Thank you for having the representatives from NYSAIS testify today. I commend the Committee for your work in trying to take the lead Nationally in dealing with the concussion epidemic.

As a director of athletics that is dealing with football players, athletic trainers, equipment managers, parents, and doctors, at the ground level, I have some reactions to Introduction Number 85. First, it is important to note that with a few tweaks this is a very strong piece of legislation that can positively affect the City's youth football players.

In Section 10-901, adding a definition for the word "doctor" is important. Specifically, that a "doctor" would encompass a medical doctor with expertise in youth sports injury.

In Section 10-901, Subsection C, we would like to see a more detailed definition of the word "tackling." In football, there are 6 types of tackling. Full Contact Tackling, which is a football drill or live game situations where "live action" occurs. Live Action Tackling, which is contact at game speed where players execute full tackles at a competitive pace taking players to the ground. Air, Bags, Wraps, and Thuds are types of tackling that involve limited contact or no contact at all. Many times airs, bags, wraps and thuds are completed without the use of helmets or shoulder pads. In these cases, the risk for a concussion is decreased tremendously.

As tackling in some form at 99% of practices, a possible pitfall of the legislation as written may be the ability for schools to find a doctor or athletic trainer to be "present" at every practice.

Changing the definition of tackling may potentially allow for more flexibility and ease the burden for athletic trainer or doctor coverage. Essentially there would be fewer practices to cover.

For your reference, these are the definitions for Air, Bag, Wrap and Thud tackling:

- *Air: Players should run unopposed without bags or any opposition.*
- *Bags: activity is executed against a bag, shield or pad to allow for soft-contact surface, with or without the resistance of a teammate or coach standing behind the bag.*

- *Wrap: Drills run at full speed until contact, which is above the waist with players remaining on their feet.*
- *Thud: Same as wrap but tempo is competitive with no pre-determined winner and the players are not tackling to the ground.*

In Section 10-902, Subsection A, we know that finding a doctor to be present at Friday night or Saturday football games will typically not be an issue for many of the NYSAIS Schools. In most cases, we already have a medical doctor at our varsity games.

However, many middle school and junior varsity games take place during the weekday, typically starting between 3:00-4:00; these games take roughly two hours. Finding doctors, who would want to leave their medical practice during normal office hours, to cover a football game for a nominal fee will be difficult and may limit the opportunity for schools to play games if they cannot find coverage. In addition, this requirement may be a financial burden for schools to procure a doctor.

This also ties into 10-903 that a field permit cannot be obtained without affirmation of a doctor. Again, this may limit the number of games that potentially can be played. Especially for our middle school teams and/or junior varsity teams.

In Section 10-902, Subsection B, the word “present” as it pertains to athletic trainers has many variations. Many of our schools have an athletic trainer on campus or on call, often times covering several sport practices or games at the same time from one central location. If present means “physically on the sideline at the football practice,” we fear that there will not be enough available athletic trainers or doctors to cover all of the practices. Changing the definition of tackling may also help in mitigate this issue.

Our last recommendation has to do with Section 10-903, Subsection B, the wording of this section is troubling. When students know that they will not be allowed back into a contest or practice after reporting a head injury our fear is that students will hide head injuries to remain in games. Rewording this sentence to: *Holding students out when an assessment leads to a positive or unclear result* would be make more sense.

We would also encourage the committee to consider a weekly limitation on full contact as well as a protocol for return to learn/school. NYSAIS is very much in favor of the formation of the Youth Sports Health and Safety Task Force, Introduction Number 86 and will offer our staff to help in any way that we can.

Thank you again for hearing out testimony.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 85+86 Res. No. _____

☑ in favor ☐ in opposition

Date: 1/23/15

(PLEASE PRINT)

Name: Dr. James Pierre-Glaude; Would like to

Address: testify w/ Aimee Brunelle

I represent: New York State Athletic Trainer's Association

Address: & Stony Brook University Athletic Training Education Program

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: DR. JOSEPH MAROON - will be reading

Address: the testimony of DR. JULIAN

I represent: BAILES,

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: WILLIAM B. BARR, PhD

Address: NYU School of Medicine

I represent: Field of Clinical Neuropsychology

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Julian Bailes

Address: _____

I represent: Doctor

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Merill Hoge

Address: _____

I represent: ESPN Broadcaster

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Courtney Tollins

Address: 9218 ave L

I represent: Youth Football Big Apple Football

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: ROBERT GOLDEN

Address: 13470 NORTHWOOD MANOR VIEW KY 41063

I represent: HEAD HEALTH NETWORK

Address: SAME

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: ~~23-APR~~ 2015

(PLEASE PRINT)

Name: ERIC GOLDSTEIN

Address: _____

I represent: NYC DEPARTMENT OF EDUCATION

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: JOE MAROON M.D.

Address: 318 ACADEMY AVE SEWICKLEY, PA

I represent: MYSELF

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 1/23/15

(PLEASE PRINT)

Name: Dr. Cheryl Lawrence

Address: Medical Director, Office of School Health

I represent: DOHMH

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 086 Res. No. _____

☒ in favor ☐ in opposition

Date: 1/23/15

(PLEASE PRINT)

Name: Dr. Marianne Engle

Address: 29 Washington Square West

I represent: NYU Sports + Society Program

Address: NYU

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Dr.

Date: _____

(PLEASE PRINT)

Name: PETER SNGO

Address: 300 E 76 St NY NY

I represent: HEAD HEALTH NETWORK / COLUMBIA

Address: SAME

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

~~085~

I intend to appear and speak on Int. No. 085 Res. No. _____

☐ in favor ☒ in opposition

Date: 1-23-15

(PLEASE PRINT)

Name: William Sislowich

Address: 322 E 17th Brooklyn, NY

I represent: NYC Youth Football Council / Brooklyn Bronx

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 085 Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Lloyd Rodriguez - Director

Address: 162 Albany Ave

I represent: Brooklyn Pitbulls Youth Sports / PoP Warner

Address: (718) 752-2194

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 085 Res. No. 086

☑ in favor ☐ in opposition

Date: 1/23/15

(PLEASE PRINT)

Name: Charlie Wund

Address: Po Box 927383, San Diego, CA 92192

I represent: Agency for Student Health Research

Address: Po Box 927383, San Diego, CA 92192

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 085/086 Res. No. _____

☐ in favor ☒ in opposition

Date: 1/23/15

(PLEASE PRINT)

Name: Jon Butler

Address: 27 Baldwin St, Pennington, NJ

I represent: PAL Warner Little Scholars

Address: 586 Middletown Blvd, Langhorne, PA

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 85 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: JOHN PIZZI

Address: 233 WEST 252ND ST BRONX, NY 10471

I represent: NYSAIS / RIVERDALE COUNTRY SCHOOL

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 85 Res. No. _____

☒ in favor ☐ in opposition

Date: 1/23/15

(PLEASE PRINT)

Name: Aimee Brunelle

Address: 114 Springdale Ave Jamestown NY 14701

I represent: New York State Athletic Trainers' Association

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 085 & 086 Res. No. _____

☐ in favor ☐ in opposition

Date: 1/23/15

(PLEASE PRINT)

Name: Matt Drury

Address: 830 5th Ave

I represent: NYC Parks

Address: Central Park

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 085 & 086 Res. No. _____

☐ in favor ☐ in opposition

Date: 1/23/15

(PLEASE PRINT)

Name: Liam Kavanagh

Address: 830 5th Ave

I represent: NYC Parks

Address: Central Parks

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 85, 86 Res. No. _____

☒ in favor ☐ in opposition

Date: 1/23

(PLEASE PRINT)

Name: Max Zeiger

Address: 18077 Le Conte Ave, Los Angeles CA

I represent: Dr. Chris Giza

Address: 18077 Le Conte Ave, Los Angeles CA

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 85/86 Res. No. _____

☒ in favor ☒ in opposition

Date: 1/23/15

(PLEASE PRINT)

Name: MARK LAHRA

Address: 1 MORNINGSIDE DR 10025

I represent: NYSAIS

Address: 17 ELK STREET, ALBANY 12207

Please complete this card and return to the Sergeant-at-Arms