

# Bemidji State University Athletics Concussion Management Plan

*Revised: 5/24/18*

## 1. Basic Principles:

- 1.1. A student-athlete suspected of having a concussion must be removed from play and evaluated promptly by an athletics healthcare provider (team physician or certified athletic trainer).
- 1.2. No student-athlete with any symptoms of a concussion is permitted to participate in practice or competition. This includes symptoms that are only present when provoked by activity. Use of medications to treat symptoms is equivalent to having symptoms.
- 1.3. A student-athlete diagnosed with a concussion shall be withheld for the remainder of the competition or practice and shall not return to participation for the remainder of that day. That athlete must then complete the full return to play progression prior to resuming full participation.
- 1.4. Athletics healthcare providers should assume a concussion when unsure and waiting for a final diagnosis. When in doubt, sit the athlete out.
- 1.5. An athletics healthcare provider has unchallengeable authority to determine management and return-to-play eligibility of any ill or injured student-athlete, as he or she deems appropriate.
- 1.6. Final authority for return-to-play eligibility shall reside with the team physician or the physician's designee.
- 1.7. Student-athletes that sustain a concussion outside of their sport will be managed in the same manner as those sustained during sport activity.
- 1.8. The most current consensus statement on concussion in sport— from the 5<sup>th</sup> international conference on concussion in sport held in Berlin, October 2016 recommends physical and cognitive activity (sub symptom threshold) after the initial rest period of 24-48 hours. It is also recommended that symptom specific rehabilitation is initiated if symptoms persist longer than 2 weeks. These activities should be done at the discretion of the designated healthcare provider (MD, ATC).

## 2. Education:

- 2.1. Prior to the start of the each school year, NCAA concussion fact sheets and institutional concussion policies will be made available and reviewed with all of the following parties:
  - 2.1.1. Student-athletes
  - 2.1.2. Coaches
  - 2.1.3. Team physicians
  - 2.1.4. Athletic trainers
  - 2.1.5. Director of athletics
- 2.2. This will include strategies for reducing head trauma exposure.
- 2.3. Each party will sign an acknowledgement that they have received, read, and understood the concussion material.

## 3. Protocol:

- 3.1. Baseline assessment will be conducted for each student-athlete prior to the first practice of their initial season at BSU.
- 3.2. Baseline assessment for student-athletes will consist of: detailed history, symptom evaluation, neurocognitive assessment, (iMPACT baseline) and a balance evaluation (modified BESS).
- 3.3. Following return to play from concussion the student athlete's scores from follow-up neurocognitive and balance testing will become their new baseline scores.
- 3.4. Student-athletes should have new baseline balance testing following lower extremity injury.
- 3.5. Players, coaches, officials, team staff, athletic trainers, and team physicians are all responsible for identifying student-athletes that may have sustained a head injury and for ensuring that injured student-athletes are evaluated properly.
- 3.6. Certified Athletic Trainer/s will be at all Home events. As well as at all practices for football and Ice Hockey (both men's and women's). Certified athletic trainers will be at or available for immediate contact for all other sport practices, depending on timing of practice and time of year.
- 3.7. When a student-athlete is suspected of having a concussion, he/she must be removed from play and evaluated promptly by an athletics healthcare provider (certified athletic trainer or team physician).
- 3.8. A student-athlete, having sustained a concussion, must have an evaluation by a designated team healthcare provider (Athletic Trainer, M.D.)

### 3.9. Immediate evaluation will include:

- 3.9.1.1. ABC's of Basic Life Support (BLS)
- 3.9.1.2. Assessment for catastrophic neck of spine injury
- 3.9.1.3. Assessment for other severe of life threatening injury
- 3.9.1.4. Glasgow coma scale of <13
- 3.9.1.5. Prolonged loss of consciousness
- 3.9.1.6. Focal neurological deficits suggesting intracranial trauma
- 3.9.1.7. Repetitive emesis
- 3.9.1.8. Persistently diminished/worsening mental status or other neurological signs/symptoms
- 3.9.2. If life threatening or other severe injury condition is suspected emergency action plan will be utilized
- 3.9.3. If a concussion (but no life-threatening or other severe injury) is suspected, the player will be taken to a safe area off the field-of-play for concussion assessment.
- 3.10. Sideline concussion assessment will consist of: a symptom assessment, physical and neurological exam, cognitive assessment, and balance exam. (ex. SCAT 5, VOMS)
- 3.11. If the student-athlete has any signs or symptoms of a concussion, they will not be permitted to return to play.
- 3.12. A student-athlete with a concussion will be serially monitored for worsening of condition using physical and neurological examination.
- 3.13. Instructions for care of the student-athlete will be given to both the student-athlete and another responsible adult (parent, roommate, etc.). These will include directions for rest (both physical and mental), symptoms to look for, and instructions in case of worsening symptoms.
- 3.14. If a student-athlete is diagnosed with a concussion they will not be permitted to return to play until completing a stepwise progression of activities.
- 3.15. Final return to play will be determined by the team physician or their medically qualified designee.
- 3.16. Prior to beginning a stepwise progression of activity, the student-athlete must be symptom free. Prior to doing any contact the student-athlete must return to baseline on their neurocognitive and balance testing.
- 3.17. This progression will be determined and managed by athletics healthcare providers (athletic training staff or team physician), and is subject to clinical judgement based on the student-athlete's history, exam, signs and symptoms.

3.18. The stepwise progression will, at a minimum, consist of the following stages, and will require 24 hours between stages:

- 3.18.1.1. Physical and cognitive rest until asymptomatic at rest
- 3.18.1.2. Light aerobic exercise, 15-20 minutes with increased heart rate, e.g. walk or stationary bike.
- 3.18.1.3. Sport specific exercise (skate, run, swim, jump...)
- 3.18.1.4. Non-contact training drills, full intensity exertion
- 3.18.1.5. Full contact training after medical clearance
- 3.18.1.6. Unrestricted competition

3.18.2. The student-athlete should regress backward one step for 24 hours if symptoms recur during or post-exertion with any progression of activity.

3.18.3. Symptom assessment and evaluation will be recorded before advancing after each step.

3.19. Student-athletes will be encouraged to begin some light physical activity following an initial period of rest (24-48 hours). This activity should remain below the symptom exacerbation threshold.

3.20. Student-athletes with prolonged recovery (symptoms lasting greater than 7 days) will undergo further M.D. evaluation.

#### **4. Return-To-Learn:**

4.1. Treatment for concussion should include both physical and cognitive rest. This may require restrictions and accommodations for school, work, and social activities.

4.2. Student-athletes that have sustained a concussion should have no classroom activity the same day as the concussion.

4.3. If the student athlete continues to have symptoms and needs accommodations for school the designated team healthcare provider (MD, ATC) shall create an individualized plan to return to learn using additional resources as necessary. This should be a multidisciplinary team including but not limited to: instructors, advisors, DSS, and medical team at Sanford Health, Student health and counseling services, coaches, athletic trainers, and athletics administrators.

4.4. The student-athlete's sport athletic trainer will be the point person to help create the individualized plan and coordinate services with the rest of the concussion management team.

4.5. Classroom accommodations shall be in compliance with ADA

4.6. Return to learn should involve a gradual return to classroom activities. Increasing both duration and intensity of academic activities as tolerated. Modifications shall last as long as needed for full concussion recovery.

4.7. Bemidji State University Disability Services should be contacted regarding any academic accommodations that may be needed to aid in the concussion recovery.

4.8. If symptoms continue to worsen with academic endeavors the team physician must be involved for re-evaluation.

## 5. Reducing Head Trauma Exposure:

5.1. In an effort to reduce head trauma exposure Bemidji State Athletics will:

5.1.1. Adhere to the Interassociation Consensus: Year-Round Football Practice Contact Recommendations.

[http://www.ncaa.org/sites/default/files/Year%20Round%20Football%20Practice%20Contact%20Recommendations\\_20170111.pdf](http://www.ncaa.org/sites/default/files/Year%20Round%20Football%20Practice%20Contact%20Recommendations_20170111.pdf)

5.1.2. Adhere to the Interassociation Consensus: Independent Medical Care for College Student-Athletes Best Practice.

[http://www.ncaa.org/sites/default/files/2016%20Independent%20Medical%20Care%20Best%20Practices\\_\\_\\_\\_\\_20170116.pdf](http://www.ncaa.org/sites/default/files/2016%20Independent%20Medical%20Care%20Best%20Practices_____20170116.pdf)

5.1.3. Reduce gratuitous contact during practice

5.1.4. Take a safety first approach to sport

5.1.5. Take the head out of contact

5.1.6. Coaches and student-athletes will be educated at the beginning of each year regarding safe play and proper technique

## 6. Other Considerations:

6.1. For student-athletes that are having prolonged recoveries, rehabilitative exercises may be required to address specific concussion related symptoms (e.g. light aerobic activity, vestibular-oculomotor exercises, etc.). These will be done at the direction of the designated health care provider (MD, ATC).

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