

Testimony of Vicky Graham, MS, ATC, LAT before the Public Health Committee, in Support of Raised SB 356, AAC Athletic Trainers

March 7, 2016

Good afternoon Senator Gerratana, Representative Ritter, and honorable members of the Public Health Committee. I am an athletic trainer (AT) who has practiced in Connecticut for over 20 years. I am currently employed at Head Zone Concussion Care in Shelton, am a Past-President of the Connecticut Athletic Trainers' Association (CATA), and the Incoming Secretary of District 1 (New England states) of the National Athletic Trainers' Association (NATA). I am testifying in support of SB 356, but ask you to refer to the complete version of proposed language submitted into testimony by the CATA today.

SB 356 would update the AT practice act to reflect current practice. It is needed because the profession has evolved since the practice act was passed in 2000, and ATs in Connecticut are being restricted by conflicting interpretations of the patient population ATs may treat under the current practice act. A change in language to allow ATs to treat "physically active individuals" will allow ATs in Connecticut to practice to the full extent of their education and training. It will ultimately create employment opportunities for ATs, and keep more of the graduates of our AT education programs in the state after graduation.

In the past, concerns have been expressed by other professions that ATs do not receive adequate education to allow us to treat patients with co-morbidities, or patients who are not "pre-screened," referring to the pre-participation physical examination required of athletes in secondary school, college and professional sports. You have testimony from a number of AT educators in Connecticut, as well as from the Board of Certification (BOC), Commission on Accreditation of Athletic Training Education (CAATE), and the NATA Executive Council on Education explaining the educational preparation of ATs. The suggestion that ATs are not adequately educated to treat patients with co-morbidities is inaccurate. ATs are educated in pathophysiology, general medicine, and pharmacology in both the didactic and clinical settings, over 2 to 3 or years after general education requirements have been fulfilled. The simple fact is that even young, healthy athletes have co-morbid conditions. Clinicians providing treatment or rehabilitation for musculoskeletal injuries do not treat the co-morbid conditions. They should, however, understand the disease state at a level adequate to make treatment or rehabilitation of the injury safe. For example, in providing knee injury rehabilitation to a patient with lupus, the clinician simply needs to understand lupus to the point of ensuring safe rehabilitation strategies for the patient. That is a significantly different level of knowledge than is required to treat lupus or manifestations of lupus, which is the domain of the patient's primary care physician or specialist. That level of knowledge is clearly demonstrated in existing educational competencies for athletic trainers. It is also entirely within the realm of possibility that someone who received education about a particular condition during their training may not encounter it in clinical practice for several years, and therefore may not be aware of current evidence regarding the condition. Actually, this happens quite often in health care. That's why we have different kinds of physicians and specialists. We consult with the referring provider, other clinicians and colleagues, and the medical literature to gain an understanding of the condition itself and current

best practices in managing the condition in order to develop a treatment plan tailored to the patient. ATs are not unfamiliar with such situations. In fact, in the traditional sports setting, the AT's management of such a patient is often complicated by the need to manage such conditions while the athlete participates in competitive sports. So in addition to having an understanding of how a particular medical condition may impact a patient's rehabilitation, ATs also have to be able to help manage the patient when he or she resumes activity. Some conditions, such as sickle cell trait or diabetes, are potentially life-threatening during participation in physical activity. I had a patient several years ago who was recovering from multiple pulmonary emboli, and was cleared to resume activity playing a college sport. I worked closely with her treating physician and our Team Physician to manage her appropriately for the duration of her season. My point is that ATs have situations of this nature all the time. Our culture is one of interdisciplinary collaboration, and we are accustomed to providing health care as part of a team. The suggestion that we are not properly trained to treat patients with co-morbidities fails to acknowledge the fact that we have always treated patients with co-morbidities, often in complicated circumstances. I respectfully urge you to support SB 356, with the proposed changes submitted by the CATA.

I am happy to be a resource for you moving forward, and can answer any questions you have today.

Sincerely,

A handwritten signature in cursive script, appearing to read "Vicky Graham".

Vicky Graham, MS, AT, LAT