

Tuesday, September 8, 2020

Dear Members of the Athletic Trainer Credentialing Review Committee,

Thank you for the opportunity to speak today. My name is Eric Smoyer. I have been a physical therapist since 2015 and a certified athletic trainer since 2010. I will also note that I am an active member of the Nebraska State Athletic Trainers' Association (NSATA), and current Executive Board member. I am speaking today in support of the amended proposal put forth by the NSATA.

As I have followed the credentialing review process, I appreciate the views that all groups have brought forth. It has been rewarding to see professions work together to enhance patient choice when it comes to their health, while keeping safety a top priority. While I respect the views of the Nebraska Chapter of the American Physical Therapy Association, as a physical therapist, I do not support their stance regarding limiting the populations athletic trainers are able to work with vis-à-vis their suggested revisions. The NSATA has worked to ensure patient safety throughout their proposal. Athletic trainers are educated and trained to recognize, evaluate and treat a wide variety of injuries, illnesses, and conditions. They work under guidelines with a physician in traditional settings such as high schools and colleges and require specified referrals in the outpatient rehabilitation setting. They do not have direct access to the general public in an outpatient setting, and it is my understanding they are not seeking direct access, in this regard, as part of their proposal.

As a physical therapist and athletic trainer, I have observed, first-hand, my fair share of practice overlap between the professions when it comes to the treatment of similar conditions. The treatment and rehabilitation of a 32-year old recreational soccer player who has sustained a distal radius fracture in a match, is often treated similarly to a 32-year old experiencing the same injury after slipping on ice while walking into a store. Based on the recommended language from APTA-NE, because the 32-year old, that fell walking into a store, does not exercise, is not an athlete, does not participate in any recreational activities, and their injury was not related to their employment, they cannot see an athletic trainer for their injury. My education and training to become an athletic trainer prepared me to recognize and treat a spectrum of injuries, including the example above, just as well as my education and training to become a physical therapist.

In contrast, I do acknowledge the previous examples provided by the APTA-NE to the Technical Committee of patient populations with several co-morbid diagnoses from diabetes to cancer, as well as their concerns regarding infant care. These included an assumption of caring for hospitalized patients in an intensive care unit or a specialized inpatient, outpatient or pediatric setting. From my practice in both professions, there are areas of a physical therapist's education and training that would certainly fall outside of the scope of an athletic trainer. Though, the intent of the examples provided is somewhat debatable. A physical therapist, or any professional for that matter, may be educated and trained, but this does not equate proficiency. Many of these example populations listed by the APTA-NE are now often treated by practitioners who subspecialize or have received advanced training in these respective areas on top of their traditional education.

For practical context, take a 19-year-old volleyball player who trips over their flip-flops and falls down a flight of stairs as they head into the locker room for practice, resulting in a traumatic brain injury. This injury can yield some of the same co-morbid symptoms and considerations the APTA-NE listed in their example of a stroke patient. Based on this athlete's history, one could argue an athletic trainer could work with this patient, however, the athletic trainer likely would not. Why, do you ask?

To start, this type of injury would admit this athlete in an inpatient facility for quite some time, an area that athletic trainers are rarely, if ever, employed. More importantly, based on my experiences with various interdisciplinary teams and settings, I would contend and have confidence that a physician would have the education and professional knowledge to not refer this athlete to an athletic trainer in cases like this; just as an athletic trainer would have the professional cognizance to recognize this type of condition falls outside their education and training.

Overall, practice overlap in any profession comes down to interdisciplinary awareness and knowing the needs and safety of the patient come first. Acknowledging a patient would best be served by another discipline or specialized professional who is not only educated but experienced to provide the patient the most optimal outcomes. These principles were taught to me through my classroom education, observed first-hand during my clinical experiences in both professions and have become a staple for many well-known medical and health professional education programs.

Thank you again for your time and I appreciate the opportunity to share my views stemming from my professional knowledge and experiences. I fully support the amended proposal set forth by the Nebraska State Athletic Trainers' Association. I would be happy to entertain any questions from the committee.

Sincerely,
Eric Smoyer, PT, DPT, ATC, CSCS