

TESTIMONY

Ohio House Bill 423 — 136th General Assembly

House Health Committee | Opponent/Interested Party Hearing

Submitted by: Robin Jenkins, CEO, National Board of Surgical Technology and Surgical Assisting
(NBSTSA®)

March 18, 2026

Chairwoman Schmidt, and members of the House Health Committee — thank you for the opportunity to submit this testimony. My name is Robin Jenkins, CEO of the National Board of Surgical Technology and Surgical Assisting®, known as NBSTSA®. We are the credentialing body for more than 3,000 Certified Surgical Technologist® professionals (CST®) and Certified Surgical First Assistant® professionals working in Ohio and nearly 100,000 nationwide. We are an interested party regarding Ohio House Bill 423.

HB 423 addresses a genuine patient safety gap. Surgical technologists and surgical assistants — the professionals who organize the sterile field, pass instruments, handle surgical specimens, and assist with incisions, suturing, and wound care — currently have no consistent credentialing requirements in Ohio. Establishing those requirements is the right thing to do. NBSTSA® thanks Representative Deeter for her leadership on this issue.

NBSTSA® supported the introduced version of HB 423 as a well-intentioned bill with three specific gaps we asked the committee to close. The substitute bill that has emerged addresses none of those gaps. It introduces new ones that, taken together, risk making the bill worse than no bill at all — because it would give Ohio hospitals, legislators, and the public false assurance that the credentialing problem has been solved when it has not.

The substitute bill, as drafted, has five structural problems NBSTSA® asks this committee to address:

First: the bill still recognizes credentials that do not require a single verified surgical case before a candidate sits for the exam — including credentials from organizations that have never been independently reviewed by any accreditation body.

Second: the substitute adds two new surgical assistant credentials — the ABSA SA-C and the NCCSA CSA — neither of which holds accreditation by the National Commission for Certifying Agencies (NCCA), the independent accreditation arm of the Institute for Credentialing Excellence. In fact, one of them is a for-profit corporation that was administratively dissolved by its home state before reconstituting.

Third: the substitute removes surgical assistant licensure through the State Medical Board entirely. The introduced bill included Board-issued licenses and criminal penalties for unlicensed practice. The substitute replaces this with employment-based conditions only — meaning no individual license, no Board enforcement, and no accountability for surgical assistants who move between employers or practice settings.

Fourth: the substitute delays all credentialing requirements three years, with nothing taking effect until 2029. At the same time, it creates a grandfather clause that permanently exempts anyone practicing in Ohio during the six months before the effective date. The committee should

understand how these two provisions interact: the three-year delay does not merely postpone the credentialing requirement — it expands the pool of people who will never be subject to it. Every uncredentialed individual who enters an Ohio operating room between now and mid-2028 becomes eligible for a permanent exemption when that grandfather window opens. The longer the delay, the larger the permanently exempted class. Together, these are not a transition — they are a permanent escape route built directly into the bill and put Ohio patients at risk.

Fifth: the waiver provision — which in the introduced bill applied only to surgical assistants in physician shortage areas — has now been expanded to cover surgical technologists and moved from State Medical Board oversight to the Director of Health, with no minimum competency floor for either role.

NBSTSA® respectfully urges the committee to reject the substitute bill and return to the introduced version of HB 423, with the three targeted amendments NBSTSA® has previously proposed. The introduced bill was well-conceived. The substitute, as drafted, would not achieve what the introduced bill was designed to do — and would give Ohio hospitals, legislators, and the public false assurance that the credentialing problem has been solved, putting lives at risk and breaking trust with the very communities this bill was meant to protect. If the committee chooses to proceed with the substitute, we ask that the five structural problems identified above be addressed. The details are in the pages below. We are prepared to assist in developing statutory language and are grateful for the committee's time.

DETAILED TESTIMONY

NBSTSA® recognizes that the credentialing organizations named in the substitute bill serve practitioners who have dedicated themselves to surgical care. This testimony is not an attack on those organizations or the individuals they certify. It is an attempt to provide this committee with the complete factual picture — the kind of information that legislators deserve to have before writing specific credentials into Ohio law. NBSTSA® shares Representative Deeter's commitment to patient safety and Ohio citizens. That shared commitment is precisely why we believe the committee should have full transparency about what each recognized credential does and does not require, and about the oversight structures that stand behind each credentialing body. Ohio's patients are counting on this committee to ask those questions. We are here to help answer them.

I. About NBSTSA®

The National Board of Surgical Technology and Surgical Assisting® (NBSTSA®) is the nationally recognized credentialing body for surgical technologists and surgical assistants. NBSTSA® administers two credentials: the Certified Surgical Technologist (CST®) and the Certified Surgical First Assistant (CSFA®). Only a surgical technologist certified by the NBSTSA® has earned the right to be called a CST® and cannot be interchangeably used among other credentials.

The CST® and CSFA® are not self-certified credentials. Both are accredited by the National Commission for Certifying Agencies (NCCA), the independent accreditation arm of the Institute for Credentialing Excellence — and both require verified clinical training before a candidate is eligible to sit for the examination. That combination, independent oversight and a verified clinical floor, is what distinguishes these credentials from those the substitute bill adds.

NBSTSA® was established as a collaborative effort between the Association of Surgical Technologists and the American College of Surgeons. To earn the CST®, a candidate must graduate from a program accredited by CAAHEP or ABHES, complete a minimum of 120 in-person patient cases (translating to 300 to 400 verified clinical hours) in actual operating rooms across multiple surgical specialties, and pass a nationally validated examination. To maintain the credential, CST® holders must earn 30 continuing education credits every two years, including a minimum of 4 hours of live instruction, submitted through the Association of Surgical Technologists before NBSTSA® processes renewal. CSFA® holders must earn 38 credits per cycle, including 8 hours of live instruction.

The American College of Surgeons has independently affirmed that this is the correct standard for the profession. In its *Revised Statement on Surgical Technology Training and Certification* — approved by the ACS Board of Regents in October 2022 — the ACS formally states that it “strongly supports adequate education and training of all surgical technologists, the accreditation of all surgical technology educational programs, and the examination for certification of all graduates of accredited surgical technology educational programs as well as maintenance of ongoing professional certification.”

Source: American College of Surgeons, Revised Statement on Surgical Technology Training and Certification, approved by the ACS Board of Regents, October 2022. Available at facs.org/about-ac/s/statements/surgical-technology-training-and-certification/

Accredited program. Verified clinical training. Certified graduate. Ongoing certification. That is the CST® pathway. Ohio's credentialing law should reflect the position of the organization that helped create the credentialing body it now seeks to reference. The substitute bill, as drafted, does not.

II. Five Credentials, But Not All Equal

The substitute bill recognizes five credentials for two roles: the CST® and NCCT TS-C for surgical technologists, and the CSFA®, ABSA SA-C, and NCCSA CSA for surgical assistants. Three of these five credentials hold NCCA accreditation: the CST®, the CSFA®, and the TS-C. Two do not: the ABSA SA-C and the NCCSA CSA. On the surgical technologist side, the critical distinction is not NCCA accreditation — it is verified clinical training before certification. On the surgical assistant side, the problem is even more dire: the two new credentials the substitute adds have never been independently reviewed by any accrediting body.

Part A — Surgical Technologists: CST® vs. TS-C

Program accreditation

- **CST®:** Must graduate from a CAAHEP- or ABHES-accredited program evaluating faculty qualifications, curriculum rigor, and clinical infrastructure.
- **TS-C:** No programmatic accreditation required. Any training program qualifies, including fully online programs with no laboratory and no clinical site.

Clinical training before the exam

- **CST®:** Candidate must document a minimum of 120 verified first-scrub surgical procedures on real patients (approximately 300 to 400 verified clinical hours) in actual operating rooms, completed and reviewed by NBSTSA® **before exam eligibility is granted.**
- **TS-C:** Zero clinical cases required before the exam for the student, graduate, and high school pathways — the pathways fed primarily by online programs. Cases may be documented up to two years **after** certification is granted.

Verification of clinical training

- **CST®:** Institution-certified case logs submitted to and validated by NBSTSA® as a condition of eligibility. External, documented, and completed before the exam.
- **TS-C:** For the student/graduate pathways, no verification occurs before the exam. Post-certification documentation is self-directed and may not be audited before the credential is used to gain employment.

What NCCT will tell this committee — and what it will not

The committee should expect to hear that the TS-C requires clinical training. That is true for one pathway: candidates with an associate degree from an accredited program. NCCT will highlight that pathway. What NCCT will not volunteer is that the student, graduate, and high school pathways — fed primarily by online programs with no laboratory and no clinical site — allow candidates to certify before completing a single documented surgical case. These pathways represent that majority of the credential holders.

The Ohio scale matters. As documented in Section VII, only three Ohio COE-accredited institutions use the TS-C pathway, producing approximately 31 graduates in 2023–24. Those 31 came through structured programs with clinical infrastructure. They are not the population this committee is evaluating when it considers what a TS-C credential represents across Ohio's hospitals. The TS-C holders arriving from online programs — no laboratory, no clinical site, no pre-exam case documentation — are. The committee deserves to know which pathway most TS-C candidates actually use, not just which pathway presents best.

What this means in practice: A candidate can complete a fully online program, pass the TS-C examination, receive NCCT certification, and arrive at an Ohio hospital on day one having never held a surgical instrument in an operating room. The substitute bill would recognize that as a qualifying credential.

The Bottom Line: Treating these pathways as equivalent, as the substitute bill does, obscures a fundamental difference in what these credentials actually represent and undermines the goals of HB 423.

Part B — Surgical Assistants: CSFA® vs. ABSA SA-C vs. NCCSA CSA

The substitute adds two SA credentials not in the introduced bill. Both lack the qualities that define a credible credentialing standard: verified clinical training before certification and independent accreditation oversight.

CSFA® (NBSTSA®)

- Requires graduation from a CAAHEP-accredited surgical first assisting program with documented clinical cases before exam eligibility is granted.
- Holds current NCCA accreditation — independently reviewed through April 2030.
- Nonprofit. Co-founded by the American College of Surgeons and the Association of Surgical Technologists.

ABSA SA-C (American Board of Surgical Assistants)

- Requires formal training and documented clinical experience, but ABSA sets and reviews its own eligibility standards with no independent oversight.
- Does not hold NCCA accreditation.
- For-profit, privately held corporation. Administratively dissolved by the Colorado Secretary of State in 1998 for failure to file required corporate reports; reconstituted in 2000. Reports 4,475 active SA-C holders nationally.

NCCSA CSA (National Commission for the Certification of Surgical Assistants)

- Requires a CAAHEP/ABHES-accredited program or documented experience pathway. CE requirements comparable to the CSFA®.
- Does not hold NCCA accreditation. Active certified count not publicly disclosed.
- Nonprofit; the certification arm of the National Surgical Assistant Association.

Part C — The Common Thread

On the surgical technology side: both the CST® and the TS-C hold NCCA accreditation — but NCCA evaluates examination quality, not clinical training floors. The TS-C holds NCCA accreditation and still requires no verified OR experience before certification for its primary

pathways. On the surgical assisting side: the two new credentials the substitute adds have never been reviewed by any independent accrediting body. Ohio is being asked to write into law credentials whose examination development, pass/fail standards, and eligibility requirements have never been audited by anyone.

The Bottom Line: The substitute adds two SA credentials that have never been independently reviewed — one operated by a for-profit corporation that was previously dissolved by its home state.

III. The Joint Commission Problem Ohio Hospitals Cannot Ignore

The practical consequences of the clinical training gap do not fall on the credentialing bodies but on Ohio's hospitals — and specifically on their standing with The Joint Commission.

The Joint Commission accredits more than 20,000 healthcare organizations and programs in the United States. For virtually every Ohio hospital, Joint Commission accreditation is not optional — it is the basis for Medicare and Medicaid participation, insurance reimbursement, and institutional credibility.

The Joint Commission's Human Resources standards impose independent obligations on hospitals and surgery centers that exist regardless of what a state credential says. Under Standard HR.01.06.01, hospitals are required to define competencies for all staff who provide patient care, treatment, or services — and to verify that individuals can demonstrate those competencies before delivering care. The Joint Commission is explicit that for surgical environments, this includes competency in sterile technique, sterilization, and high-level disinfection.

The Joint Commission further distinguishes between education, training, and competency in ways that matter here. As the Commission states in its official Standards Interpretation guidance: competency requires three attributes — **knowledge, technical skills, and ability**. Ability, in the Commission's framing, is "the capacity to synthesize and correctly apply knowledge and technical skills to a task." A passing score on an online examination, achieved by a candidate who has never stood in an operating room, provides evidence of the first attribute only. The hospital must then supply the other two — **or risk a finding of noncompliance in a Joint Commission survey**.

Standard HR.01.06.01 also requires that Key Safety Content be completed **before staff provides care, treatment, and services**. When an Ohio hospital hires a practitioner whose credential required no verified clinical experience, the hospital assumes the full burden of assessing and verifying those competencies. The surveyors will come. They will trace patient care. They will ask what the hospital did to verify that this individual was competent to perform the tasks they performed. "Ohio said they were credentialed by HB 423" is not a sufficient answer to a Joint Commission deficiency finding.

Source: The Joint Commission, Standards Interpretation FAQ No. 000002152 (HR.01.04.01 / HR.01.06.01): "Knowledge and skills related to sterile technique, sterilization, and high-level disinfection would be competencies expected of an OR Nurse, surgical assistants and sterile processing staff." jointcommission.org (HR chapter, Hospital and Hospital Clinics accreditation program)

Source: The Joint Commission, Standards Interpretation FAQ No. 000002254 (HR.01.05.03): "Competency requires a third attribute — ability...The ability to do something 'competently' is based on an individual's capability"

to synthesize and correctly apply the knowledge and technical skills to a task. Competency (see HR.01.06.01) differs from education and training in that competency incorporates all three attributes: Knowledge, technical skills, and ability — all are required to deliver safe care." [jointcommission.org](https://www.jointcommission.org) (HR chapter)

The ACS's position, noted in Section I, reflects a core principle that extends to every role in the operating room: who is in the surgical field, and what they have actually demonstrated they can do, is foundational to quality. On the surgical technologist side, NCCA accreditation does not answer the clinical training question — the TS-C holds it, yet still requires no verified OR experience before certification. On the surgical assistant side, the two new credentials the substitute adds have never been independently reviewed by any accrediting body. Neither problem is resolved by the substitute bill as drafted, and both leave Ohio's hospitals holding the compliance burden and Ohio citizens at risk.

The Bottom Line: The Joint Commission does not care what Ohio law recognizes. It cares whether the hospital verified competency before the practitioner provided care. For every TS-C holder who arrives with no clinical experience, that verification burden falls entirely on the hospital. For every surgical assistant certification that does not have any third-party validation, that too falls on the hospital.

IV. What the Research Says About Clinical Training and Patient Safety

The relationship between verified clinical training and patient safety in surgical environments is not a matter of professional preference — it is documented in the peer-reviewed literature.

A study published in *Annual Review of Biomedical Engineering* (Vedula et al., 2017) reviewing objective assessment of surgical technical skill found: "*A considerable body of research suggests that poor technical skill is associated with severe adverse outcomes in patients, including death, reoperation, and readmission.*" The same study noted that in an analysis of U.S. medical malpractice claims, technical errors — most of which were manual in origin — were implicated in permanent disability or death of patients two-thirds of the time.

A systematic analysis published in *BMC Surgery* examining latent risk factors in the operating room identified "shortfalls in training" as one of the primary error-producing conditions in surgical environments — alongside inadequate staffing and equipment failures — that create the conditions under which human error causes patient harm. (Gosbee et al., *BMC Surgery*, 2012.)

Research on surgical skill decay (Fritz et al., *PMC/Surgery*, 2025) further demonstrates that surgical technical skills deteriorate measurably with time away from clinical practice. Among the skills most adversely affected: accuracy and speed — "In a real-life scenario, increases in completion times and error rates, and decreasing accuracy, could adversely affect patient safety and result in worse healthcare outcomes."

Surgical site infections (SSI) — a category of adverse outcomes that a properly trained and competent surgical technologist exists specifically to prevent through sterile field integrity — cost more than \$20,000 per admission and extend patient hospital stays by an average of 9.7 days. Nationally, SSIs cost the healthcare system more than \$3.3 billion annually. The pathway from under-trained surgical technologist to surgical site infection is not hypothetical. It is well-documented. And HB 423, as currently written, does nothing to interrupt it.

Bottom Line: The implication for Ohio's hospitals is direct: a surgical technologist or surgical assistant who arrives with no verified clinical training or from unverified certification standards does not merely lack experience. They lack the foundation on which the entire structure of clinical competency assessment depends. The hospital must build that foundation while patients are on the table.

V. This Is Not a Theoretical Argument

The research above documents the risk. The following is what that risk looks like in an Ohio operating room.

Earlier this month, I spoke with an educator in Northeastern Ohio who had received an angry call from a hospital leader — a leader who assumed these surgical technologists had become credentialed through her program, they had not. She reported: “A Level I trauma center in Northeastern Ohio recently hired two graduates of a fully online surgical technology certificate program. On their first day, they were asked to scrub in. They could not. They had never been in a skills laboratory. They had never been in an operating room. They had never handled a surgical instrument.” The hospital’s HR department had reviewed their credentials and found nothing irregular — because under current Ohio law, nothing was. The credential they held was legally sufficient. The preparation it represented was not.

Bottom Line: HB 423, as currently written, would codify the TS-C as a recognized credential. A hospital that hires a TS-C holder in good faith, having complied with state law, will still face the same day-one problem — but now without any basis for recourse. Ohio law will have told them the credential was sufficient, and this scenario will continue to play out every day in Ohio.

VI. Who Bears the Cost — and the Risk

When a holder of any credential that requires no verified OR experience arrives on day one having never stood in a sterile surgical field, it is the hospital that must train them. It is the hospital that pulls experienced staff off other duties to supervise someone learning on the job in a live surgical environment. It is the hospital that carries the malpractice exposure when something goes wrong during that learning curve. And it is the Ohio patient on the table who bears the risk while it plays out.

The costs are not hypothetical. A landmark study published in *JAMA Surgery* by UCLA researchers using financial data from California hospitals and widely cited as the definitive U.S. benchmark found that OR time costs an average of \$36 to \$37 per minute, with higher-acuity and specialty settings running considerably more (Childers & Maggard-Gibbons, *JAMA Surgery*, 2018).

A break in sterile technique, a missing instrument, a mishandled specimen, the precise errors that verified clinical training exists to prevent, can translate into tens of thousands of dollars in lost OR time per incident, before malpractice exposure is ever calculated.

A Stanford University analysis using the federal Healthcare Cost and Utilization Project (HCUP) national inpatient database found that surgical site infections (SSIs) account for a disproportionate share of all healthcare-associated infection (HAI) costs nationally. SSIs and *Clostridioides difficile* (C. diff) infections together represent nearly 80 percent of all HAI-related costs across U.S.

hospitals — underscoring the outsized financial and patient safety consequences when surgical procedures go wrong (Forrester, Maggio & Tennakoon, *Journal of Patient Safety*, 2022).

A 2024 study in the Joint Commission Journal on Quality and Patient Safety confirmed that patients who develop SSIs face longer stays, higher readmission rates, and significantly higher 12-month mortality. NCCT will not be present for any of that accounting. Neither will ABSA. Neither will NCCSA. Ohio's hospitals will.

The Bottom Line: Every time a surgical technologist or surgical assistant arrives credentialed by an unaccredited body or without verified clinical training, Ohio's hospitals absorb all the risk and liability. They also absorb the full cost of training someone who should have arrived ready — and the operational burden of running an OR while that learning curve plays out. HB 423 should not write that arrangement into law.

VII. A Note on Ohio's Career Technical Centers

Representative Deeter has appropriately asked about Ohio's career technical centers and their relationship to the TS-C credential. The record should be clear.

Of the 47 institutions holding COE (Council on Occupational Education) accreditation in Ohio, only three use the NCCT TS-C pathway: Collins Career Technical Center in Chesapeake, Scioto County Career Technical Center in Lucasville, and EHOVE Adult Career Center in Milan. These three schools collectively produced approximately 31 surgical technology graduates in 2023–24.

The other COE-accredited institutions in Ohio that offer surgical technology — along with ACCSC-accredited schools such as Stautzenberger College and Fortis College — prepare their students for the CST® examination through CAAHEP or ABHES-accredited programs. They are already aligned with the clinical training standards NBSTSA® is asking this committee to require.

In fact, Buckeye Hills Career Center in Rio Grande holds both COE institutional accreditation and CAAHEP programmatic accreditation for its surgical technology program, proving conclusively that the two are not in conflict. COE accreditation and rigorous clinical training requirements are not mutually exclusive. The three schools currently using the TS-C pathway could make the same alignment.

The Bottom Line: Three of Ohio's 47 COE-accredited institutions use the TS-C pathway. The other 44 are already aligned with the standards NBSTSA® is asking this committee to require — and Buckeye Hills Career Center proves COE accreditation and clinical training requirements are not in conflict. The real threat to Ohio's CTE programs is a competing credential that can be earned in weeks entirely online for under \$2,000. HB 423, as written, rewards these online programs at the expense of Ohio schools.

VIII. NBSTSA®'s Amendment Request

NBSTSA® respectfully requests that the committee amend the substitute bill to address the following five structural problems:

Amendment 1: Verified Clinical Training as a Condition of Exam/Certification Eligibility

Any credential recognized under HB 423 must require, as a condition of examination eligibility, documented and verified clinical training — including a minimum number of supervised surgical procedures performed on real patients in an accredited clinical setting. This requirement must be satisfied before the examination is taken and a credential is issued, not as a post-certification condition.

Amendment 2: NCCA Accreditation of Credentialing Bodies

Any credentialing body whose credential is recognized under HB 423 must hold current accreditation from the National Commission for Certifying Agencies (NCCA), the accreditation arm of the Institute for Credentialing Excellence. NCCA accreditation requires independent review of examination development, validation, pass/fail standard-setting, and candidate eligibility requirements — providing the kind of third-party oversight that gives a state credential its integrity. This is not a high bar. It is the minimum standard Ohio should require before writing a credential into law.

Amendment 3: Minimum Standards for Waiver Hospitals

The substitute bill expands the waiver provision beyond the introduced bill in two ways: it now covers surgical technologists as well as surgical assistants, and it moves oversight from the State Medical Board to the Director of Health — an authority with no established framework for evaluating surgical workforce qualifications. As expanded, the waiver allows a hospital to employ individuals in both surgical technologist and surgical assisting roles with no credential, no verified clinical training, and no minimum competency standard of any kind. Rural patients undergoing surgery deserve the same protection as patients in Columbus or Cleveland.

NBSTSA® asks the committee to amend the waiver provision to require that any individual practicing as a surgical technologist or surgical assistant under a waiver must, at minimum: hold a credential from a recognized credentialing body or demonstrate documented clinical training equivalent to the minimum required for a recognized credential; and be subject to competency verification by the employing facility, consistent with Joint Commission HR.01.06.01, before providing direct patient care. The waiver can remain. The absence of any minimum standard cannot.

Amendment 4: Replace the Three-Year Delay and Reform the Grandfather Clause Together

These two provisions must be addressed as a unit because they compound each other. The three-year delay does not merely postpone the credentialing requirement — it expands the pool of people who will never be subject to it, because the grandfather clause permanently exempts anyone practicing in Ohio during the six months before the effective date. Every uncredentialed individual who enters an Ohio operating room between now and mid-2028 becomes eligible for that permanent exemption. The longer the delay, the larger the permanently exempted class.

NBSTSA® asks the committee to replace the three-year blanket delay with a targeted transition provision for the specific programs that need alignment time — with a maximum period of 18 months and defined milestones. NBSTSA® further asks that any grandfather provision require, at minimum, an employer attestation of competency and a defined pathway to credential within that same transition period — not a permanent exemption with no floor and no sunset.

Amendment 5: Restore State Medical Board Licensure for Surgical Assistants

The introduced bill required surgical assistants to hold a State Medical Board-issued license and established criminal penalties for unlicensed practice. The substitute eliminates this entirely, replacing it with employment-based conditions at facilities only. This means a surgical assistant who moves between employers, works across multiple facilities, or operates outside a traditional employment relationship faces no individual licensing obligation and no Board enforcement. The protection the bill creates exists only as long as the employment relationship does. NBSTSA® asks the committee to restore individual surgical assisting licensure through the State Medical Board, consistent with how Ohio regulates other allied health professionals performing invasive clinical procedures.

Respectfully submitted,

Robin Jenkins, CEO

National Board of Surgical Technology and Surgical Assisting (NBSTSA®)

robin@NBSTSA.org

Submitted: March 17, 2026