Ohio House Health Committee
Proponent Testimony HB 484 (Carfagna, Abrams) Athletic Training
Tuesday, May 19, 2020

Good morning, Chairman Lipps, Ranking Minority Member West, and members of the House Health Committee. Thank you for the opportunity to testify today in support of HB 484. I am Brian Hortz. I currently work as an Athletic Trainer and Educator providing care for collegiate and professional athletes well as educating Athletic Trainers, Physical Therapists, and Chiropractors across the United States on advanced practice manual therapy skills. Prior to my current position, I was the Director of Sports Medicine at Denison University or 24 years and served on the Ohio PTOTAT board for 9 years reappointed by 2 governors. I am testifying today on behalf of the Ohio Athletic Trainers' Association (OATA), as a member of their Legislative Committee. I have been very involved in the years of discussion and preparation in drafting the bill that is before you today.

The OATA is the statewide trade association that supports the athletic training profession in Ohio, representing over 1800 licensed athletic trainers in the state of Ohio. There are currently over 2,000 licensed ATs in Ohio and approximately 24 higher education athletic training programs across the State. Ohio has a rich history in the athletic training profession, including being one of the first states to license ATs in 1991, and the athletic training Hall of Fame is located at Ohio University.

The changes proposed in HB 484 are necessary, since the scope of practice for ATs have not received a wholesale update by the profession since the initial enactment of our state licensure in 1991. While there have been incremental updates over the past couple of decades, this is the first update proposed by the profession. While Ohio was one of the first states to license athletic trainers, as such other states that have licensed ATs more recently have scope of practice acts that are more aligned with what is contained in HB 484. These states have a practice act that is more current with the ongoing changes in athletic training education that have followed the advancements in the delivery of health care today.

There have been 3 major athletic training educational changes since the enactment of our state licensure in 1991. These changes have culminated in new national education standards for athletic training recently being adopted to require a master's level entry for all athletic trainers beginning in 2022. Prior to this change, the national standard was a bachelor's degree, however, over 85% of Ohio's ATs have a master's degree or higher level of education. With the three generations of change, along with the current national education standards, we felt it was an appropriate time to update our state practice act. This bill as proposed will ensure that Ohio's graduates of athletic training will be able to practice the skills they are taught in the classroom daily. Ohio currently has more accredited programs than any other state. These changes will help facilitate the retention of Ohio's graduates. It will also attract athletic trainers from out of state to Ohio as they will be able to practice at the top of their license.

For those of you that may not be familiar with athletic trainers, we provide care in various settings. They can work for a professional sports team, colleges and universities, primary and secondary schools, health clinics, wellness facilities, youth sports programs, hospitals, sports clinics/outpatient rehab, performance arts, public safety, military, and industrial/occupational settings. Within these settings, we are often the front-line health care provider. We may be the only health care provider present in a collegiate, secondary school, or youth sports facility while patients are engaging in physical activity. This requires our ability to bring lifesaving techniques to bear on emergent situations that inevitably arise.

Athletic training rooms at a college or university are a microcosm of care coordination models that we hear so much about in health care. Athletic trainers work closely with physicians throughout their education and training in athletic training rooms, with the physician as the center of the care delivery team. Athletic Trainers work in collaboration with the physician to provide effective care coordination, resulting in better health outcomes for the patient. As such, we are seeking a change from a "referral" to a "collaboration" with a physician that better reflects this care delivery model. The bill also requires an AT to enter into a "collaboration agreement" with a physician. This modification is not entirely different than how we currently practice, which is through a "standard operating protocol" (SOP) as outlined in our administrative code. We believe the inclusion of a collaboration agreement strengthens our practice act as well as our relationship with our team physicians.

The bill also updates the definition of athletic training that is more appropriate to our qualifications and the populations we serve. The athletic trainer can serve a physically active individual and should not be limited to the mindset of an athlete with a number on a jersey. If I am playing golf on the weekend and I injure my knee, the care required for the injury is still the same regardless of any association to a team. When we were originally licensed, our profession was in its infancy, most people confused athletic trainers with "personal trainers". But today the public is more familiar with athletic trainers. In fact, most people that have children have worked with the athletic trainer at their school surrounding the ongoing care of their injured son or daughter. As such, the definition needed to be modernized to reflect the reality of current athletic training education and practice. We are working with the physical therapists regarding their concerns with the language as introduced. We are hopeful we will be able to achieve an agreeable solution. But I would like to point out, they have often updated their practice act as their professional education has changed.

The last issue concerns the ability of athletic trainers to administer prescriptions as prescribed. I want to explain the need for this change and to clear up any confusion about it. The current language limits an AT to only administering topical drugs despite the fact that athletic training educational competencies have included education in pharmacology since the third edition of our competencies, published 2 decades ago. But what does this mean in practice? This means that I cannot provide aspirin or Tylenol to a patient even when directed by a physician. It has hampered our ability to provide emergency care to our patients. While I was on the board the state passed previous legislation for the emergency use of EpiPen's to be administered by school employees with the appropriate training. Athletic trainers as licensed health care providers were prohibited by our practice act to use an injectable and we as a board had to seek an exception by the Board of Pharmacy. Similar issues have hampered emergency care for those with emergent asthma, as we had to seek an exception by the Board of Pharmacy to use emergency inhalers for the emergent treatment of this condition. This provision does not mean that any athletic trainer will be administering prescriptions to their athletes on their own. But it will provide the ability for those team physicians to directly order the administration of particular

drugs as the physician sees fit. It will allow athletic trainers to be able to administer lifesaving drugs for emergent conditions as directed by their team doctors.

The OATA is grateful for the assistance and support of our bill sponsors, the OSMA, and OOS that have worked with us to address our concerns and the needs of the profession that is reflected in the bill before you today. On behalf of the OATA, I respectfully request your support of the bill and am available to answer any questions at this time.