1999 HOUSE HUMAN SERVICES

HB 1471

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1471

House Human Services Committee

❑ Conference Committee

Hearing Date January 27, 1999

Tape Number	Side A	Side B	Meter #
1		X	35.8 - End
2	X		0.0 - 24.7
Committee Clerk Signature Susann Lindteigen			

Minutes:

Rep. WANDA ROSE, District 32, testified (Testimony attached).

Rep. CLARA SUE PRICE asked are most of the nurses employed by the hospital and how are they reimbursed? Rep. WANDA ROSE stated most are employed by the hospital. Rep. CLARA SUE PRICE asked would nurses quit working for the hospital and freelance? Rep. WANDA ROSE stated some might. The clinic or hospital could recoup fees and pay them a salary. There would be no double-dipping. Rep. CLARA SUE PRICE expressed concern whether the hospital would save money.

Rep. PAT GALVIN asked about the RNFA meeting requirements of a backup surgeon?

SUE McNABOE, testified (Testimony attached).

Rep. ROBIN WEISZ asked are you reimbursed? SUE McNABOE said I'm free and I work hard. Rep. ROBIN WEISZ asked have you tried to bill the third party? SUE McNABOE said we have not; we wanted to wait until we have something.

Rep. RALPH METCALF asked do you think they should be reimbursed at a higher rate because of additional skills? Sue McNABOE said yes.

Rep. DALE HENEGAR asked are you asking for a piece of the pie or a bigger pie? SUE McNABOE stated if the surgeon isn't there and I am, then we should bill; if there are two surgeons, no bill; if one surgeon and me, a lower rate bill.

Rep. TODD PORTER asked how is equity returned to the hospital if you're already paid at an hourly rate? SUE McNABOE stated we haven't talked about that; others have different ways, it depends on the locale.

JOSEPH MYERS, Preoperative Nurse, testified on the qualifications of a nurse. It requires significant education. The RN with technical skills is the most qualified to assist the surgeon, a minimum of two years OR experience. Courses are based on core curriculum. A degree is issued. We attend clinical workshops. What are the alternatives? Less qualified people. Others who do it are surgical technologists.

Rep. ROBIN WEISZ asked is it billed as an additional person? JOSEPH MYERS explained this would pull it off and bill as a person.

Rep. DALE HENEGAR asked is there curriculum in ND? JOSEPH MYERS stated there is none. Rep. DALE HENEGAR asked do you have to have technical training? JOSEPH MYERS stated yes. Rep. DALE HENEGAR asked do you need to have specialization in a particular area? JOSEPH MYERS stated yes.

Rep. RALPH METCALF asked are all third person payments established by law? JOSEPH MYERS stated in certain instances where it requires third parties to pay.

Rep. TODD PORTER asked for an explanation on the surgical technician and who they practice under. JOSEPH MYERS stated most surgical technicians are graduates of the Northwest Technical College in East Grand Forks, MN. As far as assisting, the primary function of surgical technicians is to handle the instruments during surgery. They are also certified. Rep. TODD PORTER asked who do surgical techs answer to? JOSEPH MYERS stated they function under the circulating nurse and do not need licensure.

Rep. ROBIN WEISZ asked is it the hospital's practice to always have an assistant to the physician? JOSEPH MYERS stated they would like to have one but its not always possible.

STACEY GRAY, Minot Trinity Hospital, testified on being the coordinate for open-heart surgery; started as a certified operating room technician with a bachelor's degree, RNFA. Testified in support of the bill so the hospital can get reimbursed for the services.

Rep. CLARA SUE PRICE asked do you get called in for after hours to assist in surgery? STACEY GRAY stated I am on full-time call.

OPPOSITION

DAN ULMER, Director Government Relations, Blue Cross Blue Shield of ND, testified that they pay on 1,570 different surgical codes. Physicians are paid at 20% and the advanced practice nurse is paid at 75%. There is no separate payment for RN's or assistants. Blue Cross paid $900,000 for assistant surgical fees - 3,000 physicians. This issue should be taken to the Board of Nursing. We allow for reimbursement of advance site nurses. The Board of Nursing determines who is an advance practice registered nurse.

NEUTRAL TESTIMONY

SALLY OLSON, President, ND Nurses Association, testified on language concerns: (1) this is not advanced practice first nurse, and (2) discrepancy between two advanced practice nurses.

CONSTANCE KALANEK, Executive Director, ND Board of Nursing, testified (Testimony attached).

Rep. AMY KLINISKE asked for an explanation for the additional requirement. CONSTANCE KALANEK explained the advanced practice role.

Rep. RALPH METCALF asked if the Board of Nursing is considering adding this?

CONSTANCE KALANEK stated the 1995 group approached the Board of Nursing. They need a masters degree.

DAVID PESKE, Lobbyist, ND Medical Association, testified that they reviewed the issue and are not clear on what the bill does. We have a committee of surgeons who did not favor the concept.

Hearing closed.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1471

House Human Services Committee

❑ Conference Committee

Hearing Date February 1, 1999

Tape Number	Side A	Side B	Meter #
1		X	20.1 - 47.0
Committee Clerk Signature	Susann Lindteigen		

Minutes:

Rep. WANDA ROSE introduced an amendment to insert "certified" on page 1, line 7.

Rep. WANDA ROSE moved to ADOPT AMENDMENT.

Rep. AMY KLINISKE second the motion.

Rep. ROBIN WEISZ asked should the amendment also be included on lines 3, 7, 12, 19, and 22?

Rep. WANDA ROSE stated yes, in every case.

ROLL CALL VOICE VOTE: 15 yeas, 0 nays, 0 absent.

Further Committee Discussion.

Rep. WILLIAM DEVLIN asked can the certified registered nurse practice without the presence of a physician. Rep. WANDA ROSE said no, there wouldn't be a surgery if there wasn't a surgeon. Rep. WILLIAM DEVLIN asked why doesn't the Board of Nursing deal with this? Rep. WANDA ROSE stated we are dealing with reimbursement. The primary surgeon is

reimbursed and the assistant to the surgeon wants reimbursement. Rep. WILLIAM DEVLIN stated the Board of Nursing should made the decision and not the Legislature.

Rep. WILLIAM DEVLIN moved DO NOT PASS as AMENDED.

Rep. CHET POLLERT second the motion

Further Committee Discussion

ROLL CALL VOTE #6: 12 yeas, 3 nays, 0 absent

CARRIER: Rep. AMY KLINISKE

Adopted by the Human Services Committee
February 1, 1999

VL 2/1/99

HOUSE AMENDMENTS TO HOUSE BILL NO. 1471 **HUMSER 2-2-99**

Page 1, line 3, after "by" insert "certified"

Page 1, line 7, after "a" insert "certified"

Page 1, line 12, after "**or**" insert "**certified**"

Page 1, line 22, after "or" insert "certified"

Renumber accordingly

Date: 2-1-99
Roll Call Vote #: 6

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1471

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass As Amended

Motion Made By William Devlin Seconded By Chet Pollert

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairwoman	X		Bruce A. Eckre	X	
Robin Weisz - Vice Chairman	X		Ralph Metcalf	X	
William R. Devlin	X		Carol A. Niemeier		X
Pat Galvin	X		Wanda Rose		X
Dale L. Henegar	X		Sally M. Sandvig	X	
Roxanne Jensen		X			
Amy N. Kliniske	X				
Chet Pollert	X				
Todd Porter	X				
Blair Thoreson	X				

Total Yes 12 No 3
Absent 0

Floor Assignment Amy Kliniske

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1471: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (12 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HB 1471 was placed on the Sixth order on the calendar.

Page 1, line 3, after "by" insert "certified"

Page 1, line 7, after "a" insert "certified"

Page 1, line 12, after "**or**" insert "**certified**"

Page 1, line 22, after "or" insert "certified"

Renumber accordingly

1999 TESTIMONY

HB 1471

House Human Services Committee
Testimony on HB 1471
January 27,1999
Rep. Wanda Rose

Chairman Price and Member of the House Human Services Committee.

For the Record I am Wanda Rose, Representative from District 32.

I stand before your committee in support of HB 1471. I have introduced this bill on behalf of a group of nurses who practice as RN first assists. RN first assists are members of the surgical team who directly assist the surgeon during a surgical procedure.

The unique role of the RN first assist has emerged out of changes in the health care delivery system and insurance cutbacks. The RNFA is the only licensed alternative to the MD to assistant in surgery and can provide cost-effective, knowledgeable, educated surgical assisting without reducing the quality of patient care.

Requirements to become a certified RNFA include a current RN license, 2000 hours of practice in the area of assisting a surgeon and passing a national certifying exam.

HB 1471 will allow RNFA who meet the qualification outlined in the bill to be reimbursed by insurance companies for services rendered at a significantly lower cost to the consumer and the insurance industry without compensating the quality of patient care.

I would like you to give this bill a positive consideration.

Career Options and Practice Settings

Changes in nursing practice have created many opportunities and career options for the RNFA. RNFAs may be employed by an institution (hospital, clinic, or ambulatory care center), a surgeon, or self-employed as an independent contractor. Other RNFAs are employed as educators in RNFA programs or as health care administrators. The duties that each RNFA performs depends on his/her practice setting, experience, state laws, institutional regulations, and specialty area in which they practice.

RNFAs are already contracting with hospitals, surgeons, and other health care agencies to provide in home and preoperative and/or postoperative assessments. As many surgical procedures are performed on an outpatient basis; an experienced, knowledgeable, collaborative practice team is required to assess and evaluate patients at home. In the future, as a cost containment factor in health care, surgeons may perform minor surgical procedures in the patient's home. RNFAs will be there to assist.

As the future of health care changes shape, so will the evolving role of the RNFA. The decision to practice as a RNFA is a personal and professional choice. In addition to assisting during surgical procedures, RNFAs use the nursing process to obtain patient history, perform physical examinations, implement nursing diagnoses, coordinate patient treatment plans, and educate consumers about the prevention of illness.

If you are seeking a challenging, rewarding career in nursing; one with autonomy, responsibility, educational opportunities, and an unlimited potential for growth, then consider the deeply rooted, ever changing, futuristic role of the RNFA.

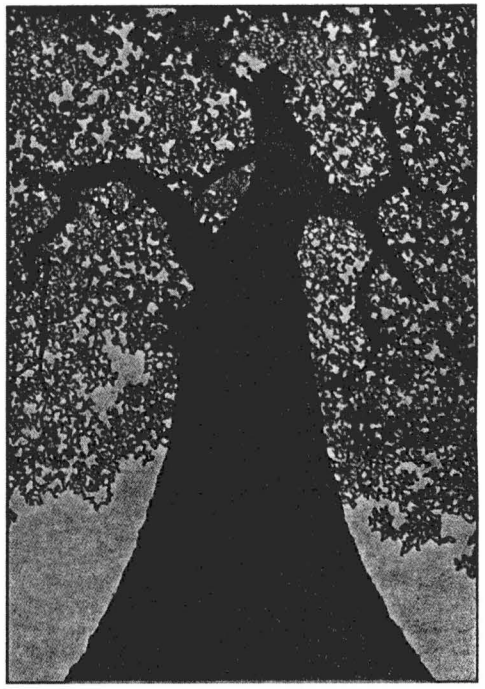
For further information regarding the RNFA, please contact:

Association of Operating Room Nurses, Inc.
RNFA Specialty Assembly
2170 South Parker Road
Denver, CO 80231-5711

Revised 12/95

Association of Operating Room Nurses, Inc.
2170 South Parker Road, Suite 300
Denver, CO 80231-5711

Registered Nurse First Assistants



Deeply Rooted,
Bending with Change,
Branching Toward the Future

The Role of the RNFA

The registered nurse first assistant (RNFA) is a technically skilled and highly educated nursing professional who renders direct patient care as part of the perioperative nursing process. Intraoperatively, the RNFA functions interdependently with the operating surgeon. Through post-basic education, the RNFA acquires skills, knowledge, and judgement necessary to assist the surgeon in performing a safe operation that yields optimal results for the patient.

In addition to assisting in surgery, RNFAs are involved in the preoperative and postoperative phases of patient care. They provide personalized patient interaction by using the perioperative nursing process to plan and implement patient care and education.

The quality and value of the services provided by RNFAs are recognized by physicians and institutional employers in all surgical settings and specialties. RNFAs are nationally recognized by the American College of Surgeons, the Association of Operating Room Nurses, the American Nurses Association, and all State Boards of Nursing.

The scope of practice for RNFAs is regulated by the individual state's Nurse Practice Act and each RNFA must function within these respective guidelines.

Growth of the RNFA Profession

Registered nurses first began assisting during surgery in the late 1800s as "private duty nurses" in the patient's home. They have continued to provide this need driven service over the past century, but the ranks have flourished since the 1980s. In the early 1980s, AORN developed its "Official Statement on RN First Assistants" which provided guidelines for nurses practicing in this role. The American College of Surgeons included the RN as a provider of first assistant services in its official definition of a first assistant. By 1985, structured educational programs for RNFAs were established and legislative efforts began to seek third party reimbursement. In 1990, AORN published *Core Curriculum for the RN First Assistant*, (revised edition 1994), and the National Certification Board: Perioperative Nursing, Inc. administered the first national certification exam in 1993.

The acceptance and expanded use of RNFAs by recognized health care organizations has strengthened the market for the RN as the first assistant in surgery.

Impact on Health Care Delivery

As a provider of health care, the RNFA is a viable solution for controlling rising health care costs. Working in collaborative practice with surgeons, RNFAs are cost effective to the patient and the health care industry. They are reimbursed at a lower rate than surgeons who first assist, and through patient education and counseling, they aid in decreasing the frequency and length of costly hospital stays.

Currently, research is in progress to define the impact of the RNFA on nursing and the quality improvement of patient care.

Experience, Education, and Credentials

Perioperative nurses who wish to practice as RNFAs must develop a set of cognitive, psychomotor, and affective behaviors that demonstrate accountability and responsibility for identifying and meeting the needs of the recipients of their nursing services.

Development of this set of behaviors begins with and builds upon the education program leading to licensure as an RN, which provides basic knowledge, skills, and attitudes essential to the practice of perioperative nursing. Further preparation for the RNFA includes perioperative nursing practice with diversified experience in scrubbing and circulating. This should culminate in the nurse achieving certification as a CNOR. Additional preparation is then acquired through completion of formal education programs including didactic instruction and supervised clinical learning activities.

These programs should consist of curricula that address all of the content areas of the modules in the *Core Curriculum for the RN First Assistant*, take place in institutions approved by the appropriate regional accrediting body for higher education, and award a degree or certificate of RNFA status upon successful completion of all requirements.

National certification (CRNFA) for the RNFA is voluntary. The certification process provides a means for the individual RNFA to be recognized for having achieved excellence, but the RNFA seeking certification must meet rigid requirements before applying. She/he must:

1. Be currently licensed as a RN, without provision or condition, in the United States.

2. Be certified in perioperative nursing (CNOR) at the time of application and must maintain CNOR status during the entire period of CRNFA certification.

3. Have completed a minimum of 2000 hours of practice as a RNFA that includes preoperative, intraoperative, and postoperative patient care.

4. Provide documentation of RNFA proficiency from both primary surgeon mentor/preceptor and a CNOR colleague.

5. Pass the national RNFA certification examination offered by the National Certification Board: Perioperative Nursing, Inc.

House Bill 1471 Reimbursement for Certified Registered Nurse First Assistants

The origin of the nurse's role as assistants during surgery is evidenced throughout history. For centuries nurses have assisted physicians during surgical procedures in the home and the hospital. The evolution of medicine and surgery is paralled by the development of professional nursing and the place of the nurse in the operating room.

By 1980 the American College of Surgeons (ACS) had defined the duties of the first assistant. The role of the registered nurse as provider of first assistant services was affirmed in this definition. However, the ACS emphasized that when the registered nurse functions in this capacity, those assigned duties must fall within the scope of practice of the particular state nurse practice act. No states of the union have ruled that assisting in surgery is outside of the scope of practice for the registered nurse.

Movement toward specialization in nursing is initiated by three forces:
new knowledge pertinent to the field,
technological advances,
and response to public need or demand.
Specialization in nursing practice has been a major advance in nursing over the last few decades.

Definitions and categories of advanced nursing practice do not include the specific title of "Registered Nurse First Assistant". The registered nurse who practices as a first assistant is considered by the Association of Operating Room Nurses (AORN) to be in an "expanded" role of practice.

In 1979 the AORN House of Delegates approved the following statement: "In the absence of a qualified physician, the registered nurse who possesses appropriate knowledge and technical skills is the best qualified non-physician to serve as the first assistant." The RN first assistant practices under the supervision of the surgeon during the intraoperative phase and collaborates with the surgeon in performing a safe operation with optimal outcomes for the patient.

The necessity of continued and structured education was recognized as the demand for RN's as first assistants increased. Educational courses flourished and the certification process was developed in 1992. There are now over 2200 Certified RNFA's in the United States. We are slowly making progress.

Experience is a prerequisite for expertise, and the certification process ensures this truism. To qualify for the certification exam the nurse must be a licensed nurse in good standing. In the year 2000 a Bachelor of Science in Nursing is required. The Certified Nurse Operating Room (CNOR) must be obtained and maintained. This in itself requires a minimum of two years of experience. The registered nurse must sucessfully complete the course of study and document 2000 hours of practice as a first assistant before sitting for the exam.

As you see there are two certifications required for this expanded practice role. The CNOR ensures expertise in perioperative nursing and the CRNFA means that a standard of fulfilling specified educational and examination

requirements is met.

Both certifications must be renewed after five years. Recertification for both may be accomplished by re-exam or 200 hours of continued education. The educational requirements are extensive and rigid. Our practice area is exclusively perioperative nursing, which is preoperative, intraoperative, and postoperative nursing.

The Certified RNFA indeed brings experience and expertise to the first assistant role. The request for reimbursement is obvious and legitimate. We furthered our education, increased our responsibility, increased our accountability, and increased our liability. The service we provide is reimbursable to other professionals, who often do not have the operating room experience that we do.

The ideal situation would be that a physician provides first assisting services. Reality proves that this is not so. In our rural communities availability is simply not there. Our surgical suite consists of four "major" rooms and two "minor" rooms. We do the same surgeries that larger hospitals do with the exception of "heads and hearts", but during the time that I have been in Williston we have done both on an emergency basis. There are no advanced practice nurses or physicians assistants available. A surgical patient is generally frightened and/or sedated when they come to the operating room. The are also one hundred percent dependant on the people who care for them. The citizens of North Dakota deserve experienced and well educated professionals to care for them when they go beyond those closed doors. The certified RNFA fulfills that role.

Certified RNFA's typically bill at a lower rate (often 16% of the surgeons fee) because they are not physicians or advanced practice nurses and do not claim to be. This is basically a win-win situation. The surgeon is provided with a competent assistant, the insurance company will be billed at a lower rate, and, most importantly, the patient is cared for by another educated professional.

I am very proud of the work that I do. I know that it is a plus for me and for my community. Whenever possible I visit my patients preoperatively and postoperatively. The time spent with them and their families helps to alleviate some of their fears, it promotes their "wellness", and improves their recovery period.

I hope that you understand that we are not requesting anything from third party payers that is not already being paid to other professionals. We request reimbursement for the first assistant services that we provide when a physician is not assisting. Our numbers are very small. I am one of two certified RNFA's in North Dakota. There are others that are eligible to take the test and will be doing so, and others who are in the educational process. I certainly hope that our number increase steadily because this would prove to me that the citizens of North Dakota who are undergoing a surgical intervention are being cared for by increasingly competent and educated professionals.

Thank you.

Sue McNabb

Bibliography

1. Rothrock, Jane (1993). THE RN FIRST ASSISTANT; AN EXPANDING PERIOPERATIVE ROLE. J.B. Lippincott: Philadelphia

2. Core Cirriculum for the RN First Assistant: Association of Operating Room Nurses. 1994

3. Association of Operating Room Nurses: AORN official statement on RN first assistants. AORN Journal 39:404-405, 1984

M. CLAY VAUGHAN, M. D.
ORTHOPAEDIC SURGEON

ORTHOPAEDIC CLINIC
1213 15th Avenue West - Suite E
Williston, North Dakota 58801
(701) 774-1043
TOLL FREE 1-800-633-7057

FAX (701) 774-0421

January 22, 1999

To Whom it May Concern:

As a very busy Orthopaedic Surgeon in Williston, North Dakota, I would greatly appreciate third party reimbursement for our CRNFA (Certified Registered Nurse First Assistant). Ms. Susan McNaboe provides first assistant services for me on almost all major cases (including nights and weekends). I frequently am not able to obtain a physician first assistant and Ms. McNaboe provides the services that I require to provide quality intra-operative care for my patients. She frequently comes back to the hospital to assist me at times when she is not "on call" and I feel that it is imperative that she be remunerated by third party payors for this very significant service to this community and it's surgical patient clientele.

Very truly yours,

M. Clay Vaughan, M.D.

MCV:mc

Susan McNaboe, RN, CNOR, CRNFA

First Assisting, 1997

EAR, NOSE, THROAT
- Parotidectomy - 1
- Rhinotomy (Lateral) - 1
- Submandibular Mass - 1

GENERAL
- Appendectomy - 1
  - Laparoscopic - 3
- Axillary node dissection - 1
- Cholecystecomy - 6
  - Laparoscopic - 60
- Colostomy - 2
- First Rib Resection - 1
- Flap Closure With STSG - 1
- Gastrostomy Tube Placement - 2
- Gastric Resection - 1
- Hemi-Colectomy - 4
- Hernia
  - Inguinal - 39
  - Umbilical - 5
  - Ventral - 16
- I&D Pelvis Abscess - 1
- Laparotomy - 8
- Mastectomy
  - Bilateral - 1
  - Simple - 1
  - Modified Radical - 8
- Thyroidectomy - 1

GYNECOLOGY
- Anterior and Posterior Vaginal Repair
- Hysterectomy
  - Abdominal - 15
  - Vaginal - 7
- Laparoscopy - 53
- LAVH - 1

OBSTETRICS
- Cesarean Section - 5

ORTHOPEDICS
- Arthroplasty
  - Hemi-Hip - 4
  - Hemi-Shoulder - 1
  - Total Hip - 1
- Arthroscopically Assisted ACL Reconstruction - 6
- Arthrotomy (knee) - 1
- Bankardt Procedure - 1
- Biceps Tendon Repair - 1
- Hardware Removal - 1
- Intramedullary Rodding - 2
- Laminectomy - 3
- Open Reduction, Internal Fixation
  - Ankle - 2
  - Hip - 19
  - Pelvis - 1
  - Tibial Plateau - 1
- Rotator Cuff Repair - 5
- Shoulder Mass Excision - 1

UROLOGY
- Bladder Neck Suspension - 4
- Cystectomy with Ileo-Diverson -1
- Hypospadius Repair - 1
- Kidney Cyst (I&D) - 1
- Nephrectomy (Radical) - 3
- Orchiectomy (Radical) - 2
- Orchiopexy - 1
- Protatectomy (Radical Retropublic) - 7
- Retroperitoneal Lymph Node Dissection - 1
- Ureteral Reimplantation - 3
- Ureterectomy - 1
- Ureterotomy - 1

VASCULAR
- Carotid Endarterectomy - 3
- Saphenous Vein Bypass Graft - 1
- Varicose Vein Stripping - 2

Sue McNaboe, RN, CNOR, CRNFA
First Assisting, 1998

GENERAL
Appendectomy - 3
Axillary node dissection - 3
Cholecystectomy
    open - 4
    laparoscopic - 51
Colostomy closure - 2
Gastrostomy tube insertion - 3
Gastric resection - 1
Gastrojejunostomy - 1
Hemi-colectomy - 2
Hernia
    Inguinal - 35
    Umbilical - 4
    Ventral - 9
Laparoscopy - 2
Laparotomy - 8
Mastectomy - Radical - 5
Nissan Fundoplication - 1
Thyroidectomy - 1
Thyroglossal duct cyst - 1

GYNECOLOGY
Hysterectomy
    Abdominal - 10
    Vaginal - 1
Laparoscopy - 42
LAVH - 1
Uterine polypectomy - 1
Vaginal repair - 1

THORACIC AND VASCULAR

Fem-fem bypass graft - 1
Thoracotomy - 1
Varicose vein stripping - 1

ORTHOPEDIC
AC joint repair - 1
Amputation (AKA) - 1
Arthroplasty
    Hemi (hip) - 5
      (Shoulder) - 2
    Total (hip) - 1
      (Knee) - 7
    Revision - 2
ACL reconstruction - 3
Bankardt procedure - 2
Intramedullary rodding - 1
Laminectomy - 6
Open reduction, internal fix
    Ankle - 2
    Hip - 17
    Humerus - 3
    Tibia - 1
Rotator cuff repair - 9
Autologous cartilage reimplantation - 2

UROLOGY
Artificial sphincter - 2
Bladder neck suspension - 3
Cystectomy with diversion - 1
    Segmental resection - 1
Hydrocelectomy - 3
Nephrectomy (radical) - 1
Orchiectomy (radical) - 3
Orchiopexy - 2
Penile plastic repair - 1
Prostatectomy (radical) - 10
Retroperitoneal lymph node dissection - 1
Ureteral reimplantation - 1
Urethroplasty -1
Ureterostomy (cutaneous) - 1
Vasovasotomy - 2

REGISTERED NURSE FIRST ASSISTANT CONSUMER FACT SHEET

"A quality, cost-effective alternative for the surgical patient"

Amid America's inevitable health care reform changes and insurance cutbacks, the nationally recognized profession of Registered Nurse First Assistant (RFNA's) is proud to announce its unique position to offer cost-effective, quality first assisting and nursing care for the surgical patient.

As an educated, certified, and licensed professional, the RNFA can provide a multiple-role solution to our health care crisis that is in alignment with today's health care reform philosophy.

As a provider of surgical assisting, the RNFA may be reimbursed by insurance companies for services rendered at a significantly lower cost to the consumer and insurance industry without compromising the quality of patient care.

The RNFA is a Registered Nurse with a minimum of five years clinical/didactic education, certification, and experience. These five years include the following chronological requisites:

- At least two years secondary education for Registered Nursing (RN) licensure;
- At least two years practicing professional nursing in the operating room milieu;
- Achievement of national Certification in Operating Room Nursing (CNOR) which indicates

    - satisfactory completion of two years perioperative nursing,
    - proficiency in the practice of caring for patients perioperatively, and
    - documented validation of professional achievement of identified standards or practice as defined by the national Association of Operating Room Nurses (AORN).

- One academic year of tertiary education for the RNFA that indicates the ability to assist the surgeon at the operating room table as well as at the "bedside," evidenced by

    - competency in performing individualized surgical nursing care management before, during, and after surgery;
    - competency in recognizing surgical anatomy and physiology and operative technique related to first assisting;
    - competency in carrying out intraoperative nursing behaviors of handling tissue, providing exposure, using surgical instruments, suturing, and controlling blood loss;
    - competency in recognizing surgical hazards and initiating appropriate corrective and preventive action including, but not limited to, recognizing abnormal lab values and diagnostic test results; and
    - achievement of Basic Cardiac Life Support (BCLS) and/or Advanced Cardiac Life Support (ACLS) Certification.

The RNFA is responsible preoperatively for

- interviewing the surgical patient for a comprehensive health history;
- performing nursing physical assessments;
- educating the patient and offering emotional support; and
- evaluating the needs of the patient and of the surgical team on a continuum, throughout the surgical encounter.

The RNFA is responsible intraoperatively for

- collaborating with the surgeon and other health care professionals for an optimal surgical outcome;
- assisting the anesthesiologist when applicable;
- assisting with patient positioning, skin preparation, and draping;
- providing wound exposure;
- handling tissue appropriately to reduce the potential for injury;
- using and manipulating surgical instruments skillfully;
- controlling blood loss; and
- suturing tissue.

The RNFA is responsible postoperatively for

- assisting in the safe delivery of the patient to the recovery room,
- communicating to appropriate health care personnel and family members,
- performing follow-up care to evaluate patient condition, and
- participating in discharge planning and postoperative teaching.

RNFA employment opportunities include

- hospital-based settings,
- ambulatory care settings,
- collaborative practice with physicians, and
- independent practice (self employed).

First assisting is within the scope of nursing practice of all fifty state boards of nursing. Many major professional organizations recognize the RNFA role, including

- The American College of Surgeons (ACS),
- The Association of Operating Room Nurses, Inc (AORN),
- National League of Nursing (NLN),
- The American Nurses Association (ANA), and
- The National Association of Orthopedic Nurses (NAON).

As a concerned health care consumer, you can empower and "assist" YOURSELF by requesting your surgeon employ the services of an RNFA. In so doing , you will be supporting the endeavers of the RNFA professionally and politically! Support RNFAs legislatively, and you will positively "assist" health care reform! For further information regarding Registered Nurse First Assistants contact

Association of Operating Room Nurses, Inc
RN First Assistant Specialty Assembly
2170 South Parker Road, Suite 300
Denver, CO 80231-5711
(800) 755-2676

Registered Nurse First Assistant:
"Combining knowledge and skill for assistive solutions!"

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CNOR EXAM OFFERED BY CERTIFICATION BOARD PERIOPERATIVE NURSING

Definition

CNOR certification is defined as: The documented validation of the professional achievement of identified standards of practice by an individual registered nurse providing care for patients before, during and after surgery.

Objectives of the Certification Program

- Recognizes the individual registered nurse who is proficient in practice.
- Strengthens conscious use of theory in assessing, planning, implementing, and evaluating patient care.
- Enhances professional growth through continued learning that results in broader knowledge and expanded skills.

Purposes of Certification

- Demonstrate concern for accountability to the general public for nursing practice.
- Enhance quality patient care.
- Identify registered nurses who have demonstrated professional achievement in providing preioperative nursing care.
- Provide employing agencies with a means of identifying professional achievement of an individual perioperative nurse.
- Provide personal satisfaction for practitioners.

Eligibility

Any registered nurse who meets the following requirements may apply for certification. **EVERY REQUIREMENT MUST BE MET AT THE TIME OF APPLICATION.**

1. The applicant must be currently licensed as a registered nurse, without provision or condition, in the country where currently practicing.
2. The applicant must have completed a minimum of two year perioperative practice as a registered nurse in an administrative, teaching, research, or general staff capacity. The practice may be full or part time. There must be at least 2400 hours during that two year period.
3. The applicant must have been employed at some time within the last two years prior to application, either full or part time, in an administrative, teaching, research, or general staff capacity in perioperative nursing as a registered nurse.

Recertification

1. Achieve a passing score on the program.
2. Provide written documentation of 100 acceptable contact hours.

CERTIFICATION PROGRAM FOR REGISTERED NURSE FIRST ASSISTANTS OFFERED BY THE CERTIFICATION BOARD PERIOPERATIVE NURSING

Definition

Certification is defined as: The documented validation of the professional achievement of identified standards of practice by an individual registered nurse providing care for patients before, during and after surgery.

Objectives of the Certification Program

- Recognizes the individual registered nurse who is proficient in practice.
- Strengthens conscious use of theory in planning and implementing patient care.
- Enhances professional growth through continued learning that results in broader knowledge and expanded skills.

Purposes of Certification

- Demonstrate concern for accountability to the general public for nursing practice.
- Enhance quality patient care.
- Identify RNFA's who have demonstrated professional achievement in providing care for patients during surgical intervention.
- Provide employing agencies with a means of identifying professional achievement of an individual RNFA.
- Identify professional nurses practicing in an expanded role.

Eligibility

Any registered nurse who meets the following requirements may apply for certification. **EVERY REQUIREMENT MUST BE MET AT THE TIME OF APPLICATION.**

1. The applicant must be currently licensed as a registered nurse, without provision or condition, in the country where currently practicing.
2. The applicant must be a CNOR at the time of application and must maintain CNOR status during the entire period of CRNFA certification.
3. The applicant must have successfully completed a structured educational course based on the core curriculum for the RNFA.
4. The applicant must have completed at least 2000 hours of practice as an RNFA. This practice includes pre and postoperative patient care as well as practice within the operating room. It may include hours of practice in an RNFA internship or practicum. It does not include attendance of classes, programs or seminars. **Written documentation of the 2000 hours of practice must accompany this application.**
4. The applicant must have completed at least 500 of the required practice hours within the two years prior to application.

The CBPN (Certification Board Perioperative Nursing) recently included, as part of its strategic plan, the BSN or MSN as a criterion for certification. This plan will be implemented in the year 2000. This change reflects the Board's decision to support a professional standard. This criterion brings certification in accordance with its purpose. Meanwhile, the time frame provides sufficient notification for those nurses without plans for further education to become certified. It is not the Board's wish to penalize nurses without nurses degrees, but to encourage them to meet this professional standard.

Those who are already certified will not need a BSN or MSN as long as CNOR certification does not lapse.

Recertification

CRNFA certification is conferred for a period of five years. To recertify, CRNFA's must either:

1. Achieve a passing score on the examination; or
2. Provide written documentation of 100 acceptable contact hours related to RNFA practice (over and above the CNOR contact hours)

Documentation of 2000 practice hours as an RNFA will be required as part of the eligibility criteria.

REGISTERED NURSE FIRST ASSISTANT
EDUCATIONAL COURSE

The Registered Nurse First Assistant program is designed to provide the experienced perioperative nurse with the advanced preparation necessary to assume the role of first assistant. The nursing process is utilized as the basis for providing nursing care to patients requiring surgical intervention. The program is based on the Core Curriculum for the RNFA.

Prerequisites

A. Two years of recent perioperative experience in scrubbing and circulating, and/or first assisting.

B. Must be CNOR or CNOR eligible with CNOR status obtained before a certificate of program completion is awarded. Verification of current RN license and CNOR status must be submitted.

C. CPR certification required.

D. Must submit two letters:
   1. One of recommendation validating:
      a. Proficiency in the roles of scrubbing, circulating, or first assisting
      b. Ability to perform effectively in stressful and emergency situations
      c. Ability to perform effectively and harmoniously as a team member
      d. Ability to perform effectively as a leader
   2. One from surgeon/physician agreeing to fulfill the preceptor role during the independent clinical internship.

The program consists of three components:

A. Preclassroom Component - Consists of reading assignments with accompanying feedback analysis to be complete prior to the one week didactic session. Begins approximately six weeks prior to didactic component.

These texts are required:

1. Core Curriculum for the RNFA - (from AORN)
2. Rothrock, J. (1993). THE FIRST RN ASSISTANT; AN EXPANDED PERIOPERATIVE ROLE. J. B. Lippincott: Philadelphia
3. Clinical surgical text of choice
4. Also suggested:
   Current AORN standards
   Bates, B. (1987 or most recent edition). A GUIDE TO PHYSICAL EXAMINATION AND HISTORY TAKING. 4th edition. J. B. Lippincott: Philadelphia
   Zollinger. ATLAS OF SURGICAL PROCEDURES. Anatomy and Physiology.
   Brown. Physical Assessment Text

B. The Didactic Learning Session - The classroom component is designed to provide the RNFA

candidate with the intellectual concepts and manual techniques necessary to first assisting. This session includes 48 hours of lectures and manual dexterity laboratory sessions on knot tying and suturing. The objectives are based on the Core Curriculum for RN First Assistants.

1. Discuss the evolution of the RN as a first assistant and their role as a surgical team member
2. Identify behaviors of the RN first assistant
3. Describe factors influencing scope of practice
4. Discuss legal issues and documents that delineate legal responsibilities for the RN first assistant
5. List methods of providing exposure, hemostasis, and safe tissue handling
6. Demonstrate basic knots with modifications and combinations of same
7. Demonstrate basic suturing methods for wound closure
8. Recognize proper techniques of asepsis, infection control, and wound healing.
9. Describe the anatomy, physiology, and disease processes as they relate to each of the specialty areas and specific operations
10. Recognize surgical hazards and identify appropriate nursing actions
11. Discuss types of job descriptions, personnel scheduling systems and implement evaluation systems within a hospital facility
12. Identify and demonstrate knowledge of drugs used in pre and postop care, OR and anesthesia
13. Discuss current credentialing processes available to the RNFA's
14. Discuss application methods for practice privileges and reimbursement

C. Independent Clinical Internship - This component is designed to practice the necessary clinical learning experiences for the perioperative nurse who wishes to function in the expanded role of an RNFA. The internship will be supervised and mutually planned by the physician preceptor and the RNFA student. Each student will actively participate in determining their objectives, identifying learning resources, and evaluating attainment of goals for their individual learning needs. The physician preceptor will assist the student in learning independent intraoperative behavior necessary for the RNFA role. These include:

- tissue handling
- suturing and knot tying
- providing hemostasis and exposure
- use of surgical instruments

The RNFA student will consult with the program faculty coordinator and function under the direct supervision of the surgeon preceptor during the entire clinical internship. The independent structure of the clinical internship component demands the student to be highly disciplined, motivated, and self-directed with attention directed toward goal setting and achievement. The internship will be 120 hours specific to the role of the RNFA. This component must be completed within the maximum time frame of twelve months. A certificate of program completion will be issued after successful completion of all components.

The RNFA is responsible preoperatively for:

- Interviewing the surgical patient for a comprehensive health history
- Performing nursing physical assessments
- Educating the patient and offering emotional support
- Evaluating the needs of the patient and of the surgical team on a continuum throughout the surgical encounter

The RNFA is responsible intraoperatively for:

- Collaborating with the surgeon and other health care professionals for an optimal surgical outcome
- Assisting the anesthesiologist when applicable
- Assisting with patient positioning, skin preparation, and draping
- Providing wound exposure
- Handling tissue appropriately to reduce the potential for injury
- Using and manipulating surgical instruments skillfully
- Controlling blood loss
- Suturing tissue

The RNFA is responsible postoperatively for:

- Assisting in the safe delivery of the patient to the recovery room
- Communicating to appropriate health care personnel and family members
- Performing follow-up care to evaluate patient condition
- Participating in discharge planning and postoperative teaching

Registered Nurse First Assistant

Combining knowledge and skill for assistive solutions!

OR Manager
The monthly newsletter for OR decision makers
September 1997
Vol 13, No 9

WHO'S FIRST ASSISTING?

ORs turn to non-MDs but reimbursement lags

As payment has declined for physicians who assist at surgery, ORs are turning to others to help.

A new survey indicates that close to 70% of ORs use personnel other than physicians to first assist. Most of the respondents were community hospitals.

The survey, conducted jointly by *OR Manager* and the RNFA Specialty Assembly of the Association of Operating Room Nurses (AORN), was sent to about 400 *OR Manager* readers. The return rate was 42%.

For the largest group—four in ten—the first assistants are employees of the organization. Physicians are the hirers for 20%.

But reimbursement is spotty. The majority of respondents who have first assistants on their payroll say they are not receiving third-party payment to cover the service.

A number of respondents commented that, though they are striving toward more formal training and credentialing for first assistants, they sometimes assign staff members to assist without this kind of preparation.

•

Who is first assisting? A mixed bag

Which types of first assistants do you use?	
• Combination	68%
• RN first assistant	16%
• Physicians' assistant	7%
• Surgical technologist	5%
• Other	3%

of personnel provides assistant services. Only about a third of managers rely exclusively on a single category of assistant; most use a combination. The common types are RN first assistants (RNFAs), physicians' assistants (PAs), and surgical technologists (STs).

For those using a single category, RNFAs were somewhat more common—used by 16%. Another 7% rely solely on PAs, 5% use only surgical technologists, and 3% rely exclusively on some other type of personnel. Among those in the "other" category are foreign medical graduates. Four facilities indicated they used foreign physicians. There did not seem to be a geographic pattern to this practice, which was reported by medium-sized ORs from the Southeast, Northeast, and Midwest. Also listed

Continued on page 16

Fall conferences focus on coping with change

Battered by change, managers are seeking ways to help their staffs keep their sense of commitment and regain a feeling of connection.

Managers gathering this fall for the Managing Today's OR Suite conferences on both coasts will hear from speakers who have earned their reputations helping organizations and their teams survive and cope with change.

Dates are Sept 10 to 12 in Chicago and Oct 1 to 3 in San Diego.

The meetings are cosponsored by OR Manager, Inc, with, in Chicago, Evanston (Ill) Hospital and the University of Chicago Hospitals and, in San Diego, with the OR Nursing Council of California.

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Balancing commitments. Keynoting the conference is one of nursing's most recognized leaders, Marjorie Beyers, RN, PhD, FAAN. As executive director of the American Organization of Nurse Executives (AONE), Beyers has a thought-provoking message about how nursing can balance its commitment to the care of patients with the strong business imperatives driving health care today.

•

Recovering connections. In a special event, Peter Block, the well-known business consultant and author of *The Empowered Manager* and *Stewardship* adds his insights about how managers can help their organizations and employees recover the sense of connection and purpose so central to a meaningful work culture.

Managers need to be less about control and more about connections, he advocates. In his talk, Block will describe how managers can begin to

Continued on page 8

Managing Today's OR Suite

Conference issue

Chicago Sept 10 to 12

Marjorie Beyers, RN, PhD, FAAN, presents the keynote address at fall meetings.

WHO'S FIRST ASSISTING?

Continued from page 1

in the "other" category were surgical assistants, orthopedic assistants, and physicians' office personnel.

Most of the managers (57%) say RNs who first assist, on average, spend less than half of their scheduled time performing assisting duties.

•

Who employs the assistants? While 42% of respondents using RNFAs have them on the payroll, 20% have them provided by physicians, and 29% have a variety of arrangements. This may include a combination of first assistants on staff, employed by surgeons, and on contract. The remainder—about 8%—use only RNFAs who are self-employed or independent contractors.

For ORs that use assistants other than RNs, the employer is slightly more likely to be a physician, with 49% reporting that kind of arrangement. For 40%, the facility is the employer, and for 11%, the assistants are independent contractors.

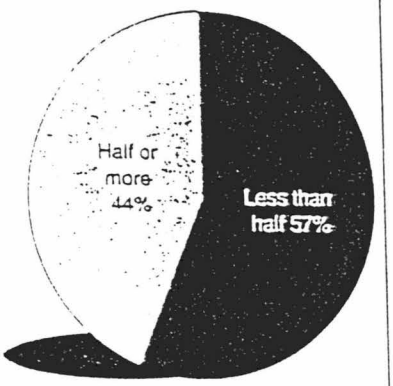
•

How are first assistants paid? Are assistants who are on the facility's payroll getting extra money for the service?

Most managers said they are not. More than half who employ RNs as first assistants say the assistants are paid on the same basis as staff RNs. About one-fifth give them an increase in base pay only during the hours when they are first assisting. A slim segment, about 13%, grant RNFAs an overall increase. A small number, about 4%, provide for extra compensation by including RNFAs in their clinical ladder systems. A couple noted other methods of payment, including salaries for RNFAs and PAs, who then take all first assistant call.

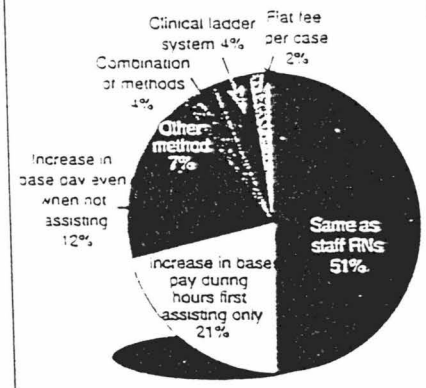
For other types of assistants, the picture is unclear. Close to 60% said they used a method of compensation other than those listed on the questionnaire. About one-fifth said they paid the assistants on the same basis as staff RNs. Due to the wording of the question, results are difficult to interpret.

What proportion of RNFAs' scheduled time, on average, is spent as first assistant?

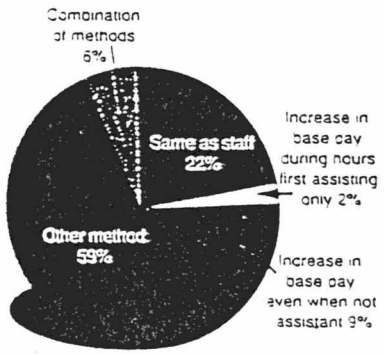


If employed by facility, how are first assistants compensated?

RNFAs

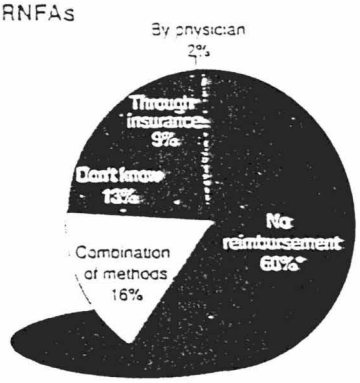


Other non-MD assistants

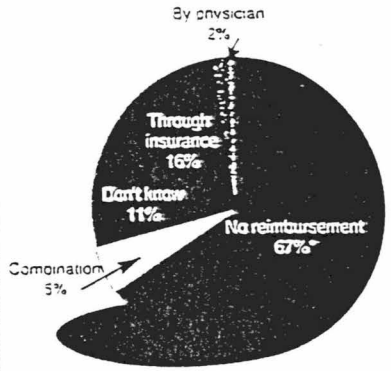


How is facility reimbursed for RNFA services?

RNFAs



Other non-MD assistants



**Note: May include some who use first assistants who are self-employed or employed by physicians.*

Professional associations encourage first assistants to be certified.

How are assistant services reimbursed? Not well, it would seem. Most ORs report they aren't receiving any kind of payment. Fully 60% of those employing RNFAs and 67% of those hiring other practitioners say their facility does not receive third-party reimbursement for first assistant services. Though some of these may be using assistants provided by physicians, the number who answered this question is roughly the same as the number who said the first assistants are employees of their facility.

Continued on page 18

WHO'S FIRST ASSISTING?

Continued from page 16

Only a fraction—9% of those employing RNFAs and 16% of those employing other providers—say they receive payment from insurance companies. A few said they charge for the first assistant as an additional person in the room. Another 13% of the RNFA employers and 11% of those using other practitioners did not know what type of payment they received. The remainder are paid through a combination of methods, with a sliver—2% or less—receiving compensation from the physicians who use the assistants' services.

•

How are first assistants prepared? A blend of education and training were reported. Choices listed were:

- on the job
- hospital-sponsored program
- (for RNs) program that meets AORN education standards for RNFA programs
- other.

Close to two-thirds of the respondents say RNFAs they use are prepared in a program that meets the AORN education standards. Approximately one-fourth are prepared on the job, and a few attend a hospital-sponsored program.

For other types of assistants, more—46%—reported on-the-job training. Fully 50% listed "other" as the method of preparation. Among these were community college programs, accredited programs for surgical technologist first assistants, and PA programs. Only a few (4%) referred to a hospital-sponsored program.

•

Certification for first assistants. Professional associations encourage first assistants to be certified. This provides evidence of proper preparation.

At this point, however, only about 40% of the responding facilities using RNFAs require them to be certified when eligible. That number is slightly higher, about 49%, for facilities using other types of personnel. This probably reflects the fact that PAs can be prepared as surgical assistants within their basic programs and, to practice, must be registered or licensed by the state.

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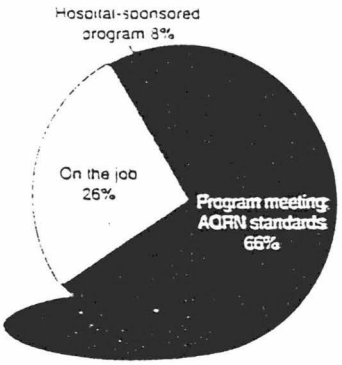
Are first assistants credentialed? Experts recommend that facilities using first assistants have a formal process for reviewing their credentials. The vast majority of managers responding—more than 75%—do indeed have such a process. For most of these, credentialing is done through the medical staff office rather than nursing administration or allied health.

One manager commented, "We have specific criteria for non-MD assistants even if they are employed by the surgeon. We felt this was necessary, as two of our surgeon groups employ LPNs and two employ RNs to come from their office to help them. Only one surgeon employs a registered physician assistant. The criteria are pretty specific as to what they can and can't do, and this applies to my staff as well."

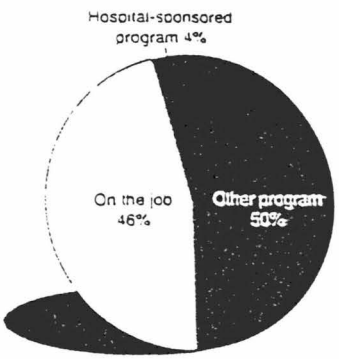
The criteria were passed by the OR committee. She adds: "So far we have not had any problems, and it's been at least six years." ❑

How are first assistants prepared?

RNFAs

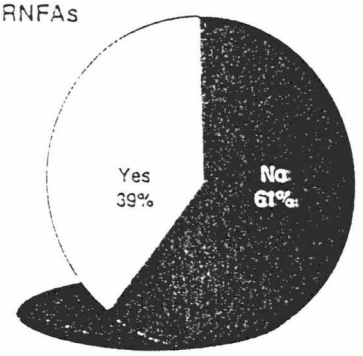


Other non-MD assistants

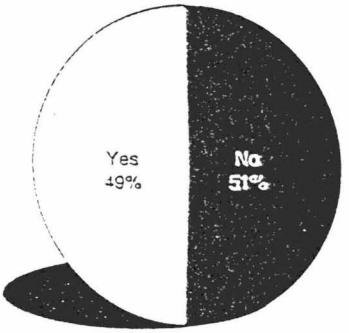


Do you require first assistants to be certified when eligible?

RNFAs

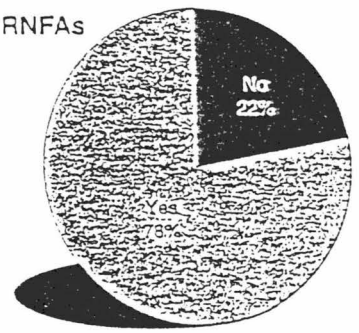


Other non-MD assistants

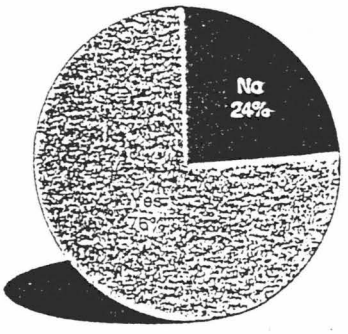


Do you require that first assistants be credentialed by the facility?

RNFAs



Other non-MD assistants



WHO'S FIRST ASSISTING?

Personnel used as FAs: Are they qualified?

If you're using personnel other than physicians as first assistants to the surgeon, make sure they are qualified and have been through a formal credentialing process set up by your organization.

That's hardly news, but it's a message worth reinforcing.

Since physician reimbursement for assisting has been cut back, ORs are relying more on other types of personnel. These include RNs, surgical technologists (STs), and physicians' assistants (PAs), among others. The assistants may be employed by the facility or by the surgeon, or they may be independent contractors.

Most of the time, facilities see that credentials are reviewed. (See survey report on page 18.) But not always.

Earlier this year, the Texas attorney general made headlines when he sued a group of surgical assistants whom he alleged had questionable credentials. The group had been assisting in Houston-area hospitals. The attorney general charged some of the assistants passed themselves off as licensed physicians when they were not and posed as surgeons when billing insurance companies. The suits were dismissed by a judge in February because of the way the attorney general used patient records.

The incident made the public aware that not all hospitals are as thorough as they could be in credentialing.

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Main line of defense. Because there are no licensing laws governing who may first assist, the facility's credentialing process is the main line of defense for safe practice. Managers are in a position to make sure the process is sound.

Although professional societies have statements on first assisting, and there are voluntary certification programs (sidebars), there is no requirement that a person must be certified to be a first assistant. Individual facilities may require certification as part of their credentialing process.

•

Not just an extra pair of hands. Who is assisting, and what are their duties? Our survey provides some answers.

What is a qualified first assistant?

According to a working definition by the American Association of Physician Assistants, the Association of Operating Room Nurses, and the Association of Surgical Technologists developed in 1991, qualified first assistants are:

Physicians, residents, physician assistants, certified perioperative nurses, or surgical technologists who:

- are authorized to practice in the state where the services are performed
- have completed an educational program or appropriate training that prepares them for the required credentialing process.

The credentialing process should determine whether the practitioner has:

- the appropriate manual dexterity and is technically proficient
- has an in-depth knowledge of surgical asepsis, surgical anatomy, physiology, and operative technique related to the specific procedures for which assistance is provided
- has sufficient education or medical training to make appropriate intraoperative decisions concerning care of the patient and progress of the intended procedure in the context of the patient's medical history and physical condition should the surgeon be unable to complete the procedure. ❐

Source: Physician Payment Review Commission. Annual Report to Congress 1991.

But there are gray areas.

What about the scrub nurse who is asked to lend an "extra pair of hands"? Or the medical assistant who comes with the surgeon? Or the foreign medical graduate who is well liked by the surgeons and seems to have good skills?

Also, when does a person cross the line between acting as a scrub person or a retractor holder and serving as a first assistant?

These are especially important questions when many ORs say they are not receiving reimbursement or providing extra pay for staff members who assist. Special preparation as a first assistant takes time and money, and credentialing always means more time and paperwork.

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No place for shortcuts. But this is no place for shortcuts, experts advise.

An OR that allows staff to slide into assisting duties without a proper review would have a tough time defending itself in a lawsuit.

Alan Horowitz, RN, JD, senior risk management analyst for ECRI, says he sees red lights flashing when he hears someone say, "Oh, we only provide a first assistant occasionally. We don't have a formal process."

"From my perspective, the fact that such an occasion arises infrequently is *not* a reason to avoid having a credentialing process," he cautions.

In fact, the fact that such a case is unusual is exactly the reason it could lead to trouble.

"If a hospital knew or should have known that someone who was first assisting lacked the appropriate training and credentials, the hospital could be exposing itself to serious risk," comments Horowitz, who in addition to his background as an RN and attorney, worked as a surgical assistant earlier in his career. ECRI of Plymouth Meeting, Pa, is a nonprofit organization that conducts independent research on health care technology and issues.

What about the surgeon who says, "Oh, don't worry. I'm comfortable," when he asks a veteran scrub to handle instruments or place retractors? Or the surgeon who brings his own employee to act as an assistant?

Credentialing still must be done, says Horowitz. Even though first assisting is considered a delegated medical act, the hospital has a duty to patients to see that personnel who assist in its OR are qualified.

Continued on page 21

WHO'S FIRST ASSISTING?

Who's qualified?

Continued from page 19

"The OR manager has every right to say, 'Wait, we have a policy, and we have determined that a person must be credentialed in order to first assist.'" That applies equally to employees of the institution and employees of a surgeon.

Evaluation of malpractice coverage needs to be part of the credentialing process. If the first assistant is an employee of the facility, the person may be covered by the facility's insurance (though experts recommend professionals carry their own coverage as well).

But for independent contractors, individual coverage is a must.

"They want to see my malpractice coverage even before they want to see my license," comments Bob Salsameda, RN, MPA, CNOR, CRNFA, of hospitals where he has applied for privileges. Salsameda, of Los Angeles, has taught more than 500 RN first assistants through the University of California, Los Angeles, and works primarily with a surgeon. He adds that he pays for his own malpractice coverage.

What distinguishes the role from that of a scrub person or second assistant?

What is a first assistant? What are the duties of a first assistant and what distinguishes the role from that of a scrub person or second assistant?

Professional societies came up with a working definition in 1991 (sidebar).

The Association of Operating Room Nurses (AORN), in its official statement on RN first assistants, says observable intraoperative behaviors of the first assistant may include:

- handling tissue
- providing exposure
- using instruments
- suturing
- providing hemostasis.

The behaviors may vary, depending on the patient population, practice environment, state nursing practice act, and so forth. First assisting duties must not overlap with the scrub role.

AORN says: "The decision by an RN to practice as a first assistant must be made voluntarily and deliberately, with an understanding of the professional accountability that the role entails."

Every nurse who wants to assist is urged to review the state's nurse practice act. All 50 states recognize that first assisting by RNs is within the scope of their nurse practice acts, but not all have adopted the AORN position statement or issued a written statement on assisting.

According to standardized procedures in California, an RN first assistant may assist the surgeon with these specific technical functions:

- retraction
- hemostasis
- tissue manipulation
- wound closure.

Under rulings in California and New York, only licensed persons may carry out delegated medical acts such as first assisting. New York State has a similar ruling. That means surgical technologists are not permitted to first assist in these states.

The Association of Surgical Technologists (AST) distinguishes first assisting from second assisting. Second assisting duties, which may overlap with the scrub role, are considered entry-level activities for a surgical technologist and may be performed at the same time as the scrub role. Examples of second assisting activities are:

- holding retractors or instruments
- sponging or suctioning
- applying electrocautery or clamps on bleeders
- cutting suture materials as directed by the surgeon
- connecting drains to suction apparatus
- applying dressings to the closed wound.

Crossing the line. When does someone cross the line into first assisting? *Continued on page 23*

Certifying bodies for first assistants

Physician assistants

Certifying body: National Commission on Certification of Physician Assistants, Atlanta. Phone 770/399-9971.
Requirements:

- Graduation from accredited physician assistant program. Typical program is 25 months. Admission to a program normally requires a bachelor's degree and four years of health care experience.
- Certification exam (has a surgical component). Certification valid for five years; must be maintained with continuing education credits submitted every two years.

RN first assistants

Certifying body: National Certification Board: Perioperative Nursing, Inc, Denver. Phone 303/369-9566.
Requirements:

- RN license
- OR nurse certification (CNOR)
- 2,000 documented hours of practice as an RN first assistant
- Certification exam. Certification valid for five years; may recertify by exam or continuing education.
- In 1998, completion of formal RNFA program will be required; in 2000, BSN or MSN will be required.

Surgical technologists

Certifying body: Liaison Council on Certification for the Surgical Technologist, Englewood, Colo. Phone: 303/694-9130.
Requirements:

- Current certification as a surgical technologist (CST). CST certification requires graduation from formal surgical technology program or equivalent of at least 9 months and 900 hours.
- Graduation from approved formal first assistant program.
- Two full years' experience as a first assistant during past four years.
- Certification exam. Certification valid for six years; may recertify by exam or submitting continuing education credits. ❐

WHO'S FIRST ASSISTING?

Continued from page 21

"My rule of thumb," says Jane Rothrock, RN, DNSc, CNOR, a leader in RNFA education, "is to consider whether the procedure would ordinarily require a first assistant. If so, then an extra pair of hands is not appropriate."

Even if the procedure might not ordinarily require a first assistant, Rothrock would ask, "What is required for this patient?"

If the patient's condition or history is such that assistance is needed to decrease operative risks (such as time on the table, bleeding, etc), then "an extra pair of hands is not adequate."

Rothrock argues that even if the procedure doesn't meet either of these conditions but uses behaviors of a first assistant, such as clamping, ligating, or suturing, "then I believe an RNFA is required."

Without a policy, "practice becomes anybody's guess about what should occur."

Managers are too inclined to see the role as task oriented, Salsameda adds.

Tasks "are not what society is asking us to do," he maintains. "Surgeons are asking us to identify tissues and organs. They're asking us to apply our knowledge of clinical anatomy, and we're being held accountable for that."

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Is direct supervision needed? Is it all right for a first assistant to close the wound after the surgeon leaves the room? Must the surgeon provide "direct supervision"?

AORN's Official Statement on RN First Assistants says, "The RN first assistant practices under the supervision of the surgeon. . . ." The word "direct" was removed from the statement several years ago, implying that over-the-shoulder supervision is not needed.

Practice differs among facilities. Some institutions allow first assistants to close the wound after the surgeon leaves the room, provided the surgeon is still in the OR suite.

"It is really important that each facility make its own policy regarding that," says Louise Pasaka, RN, CNOR, CRNFA, a first assistant and educator in Taos Ski Valley, NM.

She strongly advises managers to institute a policy that includes a job description and practice guidelines for first assistants. She includes that material in her RNFA courses.

Without a policy, "practice becomes anybody's guess about what should occur—including sometimes dangerous and legally questionable behavior."

The AORN core curriculum for RNFAs includes a section on first assistant policies.

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How first assistants are prepared. It is strongly recommended that first assistants have additional preparation, preferably a formal course.

AORN has published education standards and a core curriculum. (See resources.) The association's RNFA manual lists courses that are available. A typical RNFA course consists of 48 to 50 hours of lecture and a guided clinical internship of 120 hours. Tuition averages about $1,000, not including books and lodging.

The Association of Surgical Technologists says additional preparation for STs who assist may consist of formal education, continuing education, a preceptorship, or a combination.

For those who want to be certified as first assistants, education requirements are becoming more demanding. Starting next year, RNFAs who want to be certified must complete a formal course; in 2000, a bachelor's or master's in nursing will be required. Surgical techs who wish to be certified in first assisting must graduate from a formal one-year course. AST is developing an accreditation program for these courses.

Physicians' assistants can be prepared to assist in a few basic PA programs or in a postgraduate program. The typical student entering a PA program has a bachelor's degree and four years of health care experience. The program is about two years long.

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Resources on first assisting

American Academy of Physician Assistants

Information on PA education and certification. Call 703/836-2272.

American College of Surgeons

Statements on Principles. As part of this larger document with official positions, the College outlines its perspective on first assistants to the surgeon.

Call 312/664-4050 or obtain from the College's Web site at http://www.facs.org.

Association of Operating Room Nurses

RNFA Guide to Practice. Denver, AORN, 1997. A new resource that includes the AORN statement on RN first assistants, related standards and recommended practices, certification and education information, reimbursement suggestions, and other information. Available October.

Core Curriculum for the RN First Assistant. Denver, AORN, 1994 (Item #MAN-030). Outlines the content for an education program.

Call AORN at 800/755-2676 or 303/751-0337.

Association of Surgical Technologists

Job Description: CST Surgical Assistant. Outlines job duties for the surgical technologist who serves as a first assistant.

Practice and Reimbursement Issues for the Surgical First Assistant. Englewood, Colo: AST, 1996. Includes AST's official statements on first assistants, discussion of practice issues, and guidance on obtaining third-party payment.

Call AST at 303/694-9130.

Related resource

Rothrock, Jane C. *The RN First Assistant: An Expanded Perioperative Nursing Role.* Philadelphia: Lippincott, 1993. $42.95.

Order from the publisher at 800/777-2295. ☐

WHO'S FIRST ASSISTING?

A patchwork of payment for first assistants

Though first assisting is calling for more formal credentials, not much money comes with the extra requirements.

Most responding to our survey (see related article) say their facilities don't receive extra reimbursement when nonphysicians first assist. Nor are they paying extra to employees who assist.

For staff who become assistants, the main payoff seems to be closer participation in surgery. Though some may think about hanging out their own shingle as an independent contractor, those who've done so advise it takes hustle and tenacity.

> "I think we need to put our energy into managed care contracts."

Patchwork of payment. Payment is a patchwork that varies by carrier and by state.

From the federal government, there's little reimbursement and not much prospect of more. Except for physicians' assistants, Medicare does not pay for the services of nonphysicians who assist at surgery. RNs have been seeking equal treatment since 1986, so far without success.

"I see it as a dead issue," comments Bob Salsameda, RN, MPA, CNOR, CRNFA, of Los Angeles, who's taught an RNFA course for years. He does not expect to see added reimbursement from government programs such as Medicare or California's MediCal program.

"I think we need to put our energy into managed care contracts. I think hospitals need to look at how they can tie in with that."

A few RNFAs who also are clinical nurse specialists may qualify for Medicare and Medicaid reimbursement if they meet the state's definition of an advanced practice nurse and work in a "rural area" as defined by the federal government.

Some first assistants (FAs) are having success with state governments. This spring, Florida became the first state to authorize direct payment for RNFAs under the state's Medicaid program. The legislation authorizes payment of at least 80% of the fee paid a physician for the same service.

Two years ago, Florida passed a bill making RNFAs eligible for payment by private insurers and managed care plans. Minnesota has passed a similar bill.

Non-MD first assistants can become providers under Arizona's state public health insurance system if they are licensed (PA or RN) and meet qualifications, including certification and liability insurance. The program is the state's alternative to Medicaid.

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Commercial payers. Payment by commercial carriers shows considerable variation.

"People always want to know which companies will pay, but it varies by state," says Louise Pasaka, RN, CNOR, CRNFA, a first assistant and educator in Taos Ski Valley, NM.

First assistants who are self-employed or who work for physicians find they have to apply to each insurer individually. And because a company pays in one state does not mean it will in another.

Still, the picture seems to be improving.

"We are seeing fewer denials than we used to," comments Nancy Lilliott, CRNFA, who is employed by an orthopedic practice in Oceanside, Calif, north of San Diego. "On the whole, reimbursement probably is more consistent, but the amount is less, just as it is with physicians."

> It's important to have someone doing the billing who fully understands the RNFA role.

Her group has signed contracts with HMOs that include FA payment. Typically, the payment is for 10% of the surgeon's fee for cases in which an assistant to the surgeon is approved. An MD who assists normally gets 16% to 20%.

Dolores Fazzino, RN, CNOR, RNFA, who has an independent group RNFA practice in San Diego, has negotiated contracts with two HMOs and is working on an arrangement with an independent physicians' association (IPA).

San Diego is highly competitive, with 70% of the area's insured population under managed care. There is an oversupply of physicians, and she

Who's qualified?

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To practice, PAs must pass a certification exam and be licensed or registered by the state.

First assistant education has become a business. The National Institute of First Assisting, a for-profit company based in Denver, offers courses for both RNs and STs. The tuition of $2,895 for RNs and $2,695 for techs includes a week-long workshop offered at various locations around the country (not including books or lodging) and a guided clinical experience of 137 hours.

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Who's paying for first assistant education? Salsameda estimates that for his course at UCLA, about 15% of students have tuition paid by their employers, and 85% are on their own.

Joan Koehler, RN, RNFA, who has taught 360 RNFAs from all over the country in her Phoenix-based course, sees a wide variety of arrangements. Those who are physician employed often have their tuition paid. For hospital employees, it's a mixed bag. Koehler notes she is seeing less hospital sponsorship, probably because of cost pressures. Some RNs share the cost with their employers. Still others, are coming on their own because they want to expand their job possibilities. ❑

—Pat Patterson

WHO'S FIRST ASSISTING?

sometimes competes with general practitioners for assistant jobs.

"I can prove I am better qualified and provide better continuity," says Fazzino, a perioperative nurse who's working on her master's. She says to potential clients, "'Just give us a three-month trial.' That usually works well."

Her assignments usually come through the surgeon's office, which calls her when a case is scheduled. To bill for the case, she obtains billing information from the surgeon's office and submits her bill directly to the insurance company or HMO.

An HMO typically pays about 10% of the surgeon's fee. Though Fazzino has heard that RNFAs should get 16%, in southern California, "that's dreaming," she says.

If the patient is covered by Medicare or MediCal, she arranges to be paid an hourly rate, because no RNFA reimbursement is available.

The credentialing process varies with each organization. Fazzino has privileges at eight hospitals and surgery centers. Some charge for the review, up to $150 plus $75 in annual dues.

The process is helped by the fact that in California, any person performing a delegated medical act must be licensed and practice under a standardized procedure. The Board of Registered Nurses provides guidelines for writing standardized procedures.

"I have generic standardized procedures that I submit when applying for practice privileges," Fazzino explains. This makes it easier for the reviewer to understand an RNFA's duties and qualifications. Review can take three to nine months.

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Tips for facilities. Pasaka had advice for managers who want to employ RNFAs and bill for their services:

- Incorporate the charge for the assistant into the room charge by adding an additional staff member.
- Use a line-item charge (an hourly amount decided by the facility) for the first assistant fee.

(See sidebar for one RNFA's experience in doing this.)

Pasaka says commercial insurers and the federal employee health insurance system can be billed directly using standard CPT codes and code modifiers. The CPT modifier most often used for RNFA billing is 80.

"It's important to have someone doing the billing who fully understands the RNFA role and exactly what procedure was done," says Pasaka. If the form is not filled out correctly, the claim will be denied.

The hospital billing department may need to be educated about the RNFA's role so it can appeal rejected claims.

How do payers decide which procedures warrant an assistant and thus reimbursement?

"Insurers would like to believe a surgical procedure doesn't require an assistant," she remarks.

"Everyone billing for assistants' fees needs to educate the insurance industry on why it is important to have an assistant for safe patient care."

She suggests composing a standard letter describing RNFAs and their credentials to send to claims processors.

Though not all claims may be paid initially, persistence will pay off, she believes.

"Independent RNFAs and those employed by physicians are testimony that there is a learning curve for both the person who does the billing and the insurance companies."

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Which procedures? How do payers decide which procedures warrant an assistant and thus reimbursement?

Two guides insurers use are:

- The American College of Surgeons's *Use of Physicians as Assistants at Surgery*, which lists CPT-4 codes for surgical services and tells whether each requires an assistant almost always, sometimes, or never. Ratings are provided by panels of surgeons. The publication is free and can be ordered by faxing a request to 202/337-4271.

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Congress rejects "single-fee" that surgeon would share with assistant

There's unlikely to be a dramatic change in Medicare payments for physicians who assist at surgery, at least for the time being.

The House and Senate rejected a proposal in President Clinton's budget plan that would have cut back on payments for MDs who assist.

"This is the third or fourth time Congress has rejected it, but it keeps resurfacing," says Cynthia Brown, manager of the American College of Surgeons' (ACS) Washington office.

The White House had proposed that Medicare institute a "single fee" for surgery. The arrangement would have required the principal surgeon to share a single fee with any assistant.

Estimated savings were $400 million over the next five years.

The ACS strenuously objected, saying the single fee plan didn't allow for "clinical judgment" about the medical needs of the patient. The principal surgeon would be obligated to pay the assistant out of the fee the surgeon would have received if doing the procedure alone.

ACS chided the administration for not having the "fortitude" to identify cases where assistant services are medically unnecessary and deny payment for them instead.

Surgeons already are bruised by other plans to reduce their payments. Medicare is considering adopting a single "conversion factor" for its physician payment system that would reduce payments for an operation by about 13%. ACS pointed out the "single payment" plan would reduce the surgeon's payment still further.

Under current policy, Medicare pays MD assistants 16% of the primary surgeon's fee. Payment for an assistant is denied if claims data show an assistant is used for a procedure less than 5% of the time. A physicians' assistant who first assists gets 65% of the 16% a physician would receive. Services of other types of nonphysician assistants are not reimbursed under Medicare. ☐

WHO'S FIRST ASSISTING?

RNFA's line-item billing gains success with payers

First assisting can be a revenue producer for a hospital, but it takes effort.

An RN first assistant (RNFA) in Mississippi has worked with the hospital's CFO and other administrators to set up line-item billing for her services. Every time a patient bill is generated for a case on which an RNFA is used, the charging system generates a line-item bill for the RNFA's services.

"We haven't been denied payment since we started the system in May 1995," she says. She reports success with commercial insurers as well as workers' comp and the state employees' benefit plan. The hospital received almost enough reimbursement last year to pay her salary.

Rebecca Swan, RN, MSN, CRNFA, also a clinical nurse specialist (CNS), is a full-time RN first assistant for the nine-room OR department at Methodist Hospital of Hattiesburg. Another RNFA assists part time.

The big exception in payment, of course, is Medicare. Though RNFAs in general are not eligible for Medicare reimbursement, clinical nurse specialists working in rural areas can be paid as assistants at surgery. Swan believes she is eligible because Hattiesburg is in a rural area. She is working with Medicare officials to obtain a provider number.

Mississippi does not yet have a significant amount of managed care.

Swan is salaried. Though she receives higher pay than a staff nurse, she notes that she works long hours, typically 55 to 60 a week, saving the hospital what would otherwise be paid in overtime.

Swan notes that she also helps save OR time and surgeon time. She can close the wound and apply the dressing and assist with admitting the patient to the PACU while the surgeon dictates notes and talks to the family. At her institution, though she functions under the supervision of the surgeon, the surgeon does not need to be in the room during closing of the wound as long as he or she is in the OR suite.

"Yesterday, we did four total knee replacements and were done by 12:20," she notes.

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Setting up for billing. In setting up the billing system, Swan first met with the CFO and vice president to discuss duties of an RNFA.

> **"We haven't been denied payment since we started the system. . ."**
> —Rebecca Swan, RN, MSN, CRNFA

She also met with surgeons who use RNFA services. She explained that, to set up line-item billing, she needed access to their charges for procedures on which she assisted. The hospital charges 16% of the surgeons' fee for the RNFA.

A charge master was then set up for RNFA services. Like any other revenue-producing department, the RNFAs were assigned their own CDM (charge description master) number. Swan developed a charge sheet for each specialty that uses an RNFA. The sheet has a space for patient information, date of procedure, a space to mark the procedure on which the RNFA assisted, the CDM number, description of procedure, and CPT code.

The RNFA charges are documented separately from the general OR charge sheets. After every case, Swan takes the charge sheet to the person who keys in the charging information for billing purposes. When a bill is generated, the charging information is included. At the end of each month, Swan checks to see that the charges balance with her own records.

As the first non-MD first assistant at her hospital, "I had to sell myself," Swan comments. RNFAs had an opportunity to get in on the ground floor because Mississippi is the only state that does not recognize physicians' assistants.

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Combining skills. Swan combines her RNFA skills with her preparation as a CNS. This background was helpful when she led a team that developed a clinical pathway for total joint patients, which shaved two days off the typical hospital stay.

"I do preop education with the patients," which has been instrumental in shortening the stay, she says. As an aid, the team developed a 15-minute video.

"In the video, we walk patients through the whole process so they can see what to expect." With this preparation, patients are more compliant with their postoperative care and rehabilitation.

When Swan assesses her patients prior to surgery, they often say, "I remember you from the video," adding that the film helped them understand what to expect throughout their hospital experience. ❐

Patchwork pay

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- Milliman & Robertson's assistant surgeon guidelines. The consultants and actuaries based in Seattle, well-known for the strict length-of-stay guidelines many insurers rely on, publish assistant guidelines in *Healthcare Management Guidelines*, Vol 1, which deals with inpatient and surgical care. The guidelines list CPT-4 codes, with a yes or no to indicate whether an assistant is used. Cost of the volume is $425. Phone 206/464-7813.

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What are the prospects? In a time of retrenchment, it's probably unrealistic to expect a great deal more in the way of reimbursement for first assistants without a lot of work. Managers who want to see better reimbursement—and staff members who want better pay—need to work closely with their CFOs and learn the ins and outs of managed care contracting. Those who want to go out on their own will need to develop business savvy that matches their skills in the OR. ❐

NORTH DAKOTA BOARD OF NURSING

919 S 7th St., Suite 504, Bismarck, ND 58504-5881

Telephone # (701) 328-9777
Nurse Advocacy # (701) 328-9783
Fax # (701) 328-9785

January 26, 1999

TO: Members of the Human Services Committee

FROM: Constance Kalanek , Executive Director
North Dakota Board of Nursing

RE: HB 1471 Relating to Reimbursement for Services Provided by Registered Nurse First Assistants.

The North Dakota Board of Nursing if maintaining a neutral position on HB 1471. The board does not perceive this bill to be a regulatory issue. While maintaining a neutral position, the North Dakota Board of Nursing offers the following comments:

- Concern about the academic preparation of RNFA-lack of at least a requirement for a bachelor's degree or master's degree.
- The RNFA role is an expanded role not an advanced practice role; it does not meet requirement for advanced practice as defined by NDAC.
- The RNFA does not perform a primary role that includes diagnosis and treatment.
- RNFA are not independent practitioners.

Thank you for your attention to these comments.