Certified Nurse Midwife First Assisting: Benefits, Barriers and Future Education

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Executive Summary

**Background:** Many Certified Nurse Midwives (CNMs) in the United States have expanded their practice as surgical first assistant beyond their basic midwifery education. In February 2012, the Association of periOperative Registered Nurses (AORN) issued a proposal statement change regarding the Advanced Practice Registered Nurse (APRN) as surgical first assistant.

**Purpose:** The purpose of this project was to explore the potential effect of the proposed APRN guidelines on CNMs who practice first assisting, and what benefits or barriers arise in general for CNMs when they add the role of first assistant to practice. This project also reviewed and compared educational programs available for the advanced practice nurse who wishes to expand practice to include first assisting.

**Aims:** The aim of the questionnaire was to identify the benefits and barriers of the expanded practice of first assisting. Questions focused on the perceived effect of AORN’s proposed APRN position statement on current and future practice of CNMs.

**Methods:** An extensive literature review was completed regarding the history of nurses as first assistants and the previous and current position statements from the AORN and ACNM were reviewed. First assisting and formal RN first assistant (RNFA) educational courses available to APRNs/CNMs were identified and reviewed. The *Framework for effective management of change in clinical practice: Dissemination and implementation of clinical practice guidelines* was chosen as the theoretical framework for this project (Moulding, Silagy, & Weller, 1999). A pilot questionnaire was developed to explore CNM first assist issues. The questionnaire, conducted using Survey Monkey, was distributed November 11-October 4, 2012.

**Outcomes:** Descriptive statistics and qualitative data were reported. There was a 36% response rate from Utah CNMs and 38% response rate from Utah student nurse midwives (SNMs). 47% of Utah CNMs are currently first assisting. 16% have past experience and 4.5% want to add first assisting to practice. 86% are assisting in cesarean section with 14% assisting in cesarean and gynecological surgeries. CNMs reported how they obtained training in first assisting as follows: 24% took continuing education courses, 4.8% reported taking a continuing education course at the national ACNM convention. The majority (90.5%) trained on the job with local surgeons. One respondent (4.8%) reported taking an RNFA course. The majority (95%) reported not having first assistant training in their midwifery practicum and 4.5% did. 79% of those currently assisting report that if a separate credential was required to practice, it would affect their current practice. 80% reported they would be willing to take a course to continue first assisting. 86% of those currently assisting and 75% of SNMs would like an RNFA program incorporated into the core midwifery program. Only 47% of CNMs currently assisting would be interested in a post-master’s RNFA program, while 75% of SNMs would be interested depending on cost, location, and/or hours of study. Regarding reimbursement and billing, 86% reported being reimbursed for surgical first assisting. 62% reported that their practice was billing under their unique provider number (UPIN) with 33% unknown.

**Recommendations:** Consider replication of the questionnaire to the national ACNM. Continue future research regarding reimbursement for CNM first assist through insurance and Medicaid. Add an elective course for RNFA didactic completion at the University of Utah for CNMs, APRNs, student NPs, SNMs and post-baccalaureate RNs who hold certification in the OR.

**Conclusions:** Extra education in the RNFA role is important to consider when expanding practice as a CNM or APRN.
Certified Nurse Midwife First Assisting: Benefits, Barriers and Future Education

**Problem Statement**

Many Certified Nurse Midwives (CNMs) in the United States have expanded their practice, adding surgical first assistant skills beyond their basic midwifery education. Most states recognize CNMs as Advanced Practice Registered Nurses (APRNs). This depends on regulations placed under the board of midwifery, the board of medicine, or the board of nursing in that state. Multiple avenues have been used for CNMs to obtain education and training to be credentialed in the first assistant role. In February 2012, the Association of Perioperative Registered Nurses (AORN) issued a proposal statement change regarding the APRN as surgical first assistant. Although the “…AORN endorses the Consensus Model for APRN Regulation,” their new proposed guidelines include that the APRN “…has successfully completed a Registered Nurse First Assist (RNFA) program that meets the AORN standards for RN First Assistant education programs” (AORN, 2012d). Currently, many CNMs first assisting in the U.S. are not required to hold the added credentialing of Registered Nurse First Assistant (RNFA), but have credentialed to first assist through other means as part of their midwifery scope of practice. AORN’s proposed position statement gives rise to several important questions. What will be the effect on current and future practice of CNMs? If the draft is accepted, how will the proposed position statement affect CNMs who are currently first assisting?

**Purpose of Scholarly Project**

The purpose of this project was to explore the potential effects of the proposed APRN position statement *Perioperative Advanced Practice Nurse First Assistant* and identify benefits or barriers that may arise for CNMs when they expand practice to include acting as first
Assistant. This project also reviews and compares educational programs available for advanced practice nurses to learn first assisting. A pilot questionnaire was developed addressing CNM first assist issues and was approved by IRB and for distribution locally to the Utah ACNM email list September 2012. Questions focused on how the proposed APRN position statement may affect current and future practice of CNMs. In addition, questions explored what documented education, training, and credentials medical staffs already require of CNMs who first assist, including whether credentialing as a Registered Nurse First Assist (RNFA) is an expectation. The questionnaire gathered preliminary data to determine if the first assisting education and credentialing processes are important topics for CNMs locally in Utah and if there are benefits or barriers to this expanded midwifery practice. The questionnaire explored how CNMs are currently educated and trained in obstetrical and gynecological first assisting and how hospital medical staffs add first assisting to the CNMs delineated privileges. The cost-effectiveness of CNMs as first assistants was explored. Current position statements of the AORN and ACNM were reviewed in the literature review and sent to study subjects. RNFA education programs and the process to reach AORN RNFA certification was researched as part of the literature review and compared to programs currently being taken for education by CNMs. Finally, results from the questionnaire and review of literature were presented Nov. 16, 2012 to faculty, chair and DNP committee. The project results are to be presented to the Utah Affiliate of ACNM Dec. 11, 2012, and abstracts for poster presentations were submitted to both the Utah CNM Mini-Conference and the national ACNM meetings in 2013 and are awaiting approval.

Significance: Clinical and Policy Implications

Through the ACNM (2012) position statement, The CNM/CM as Surgical First Assistant during Surgery, the ACNM provides clear guidance for CNMs to expand clinical practice to
include first assisting with obstetrical or gynecological surgery. The AORN is in the process of developing a position statement on APRN practice as a surgical first assistant. The purpose of the new AORN position statement is to provide clarification for APRNs, which includes CNMs in some states, who seek to expand their practice to include first assisting. Presently, ACNM is the only APRN certifying body that includes first assisting within the role’s scope of practice. This project seeks to explore the issues significant to first assist education and credentialing for CNMs. Review of the proposed recommendations by the AORN is indicated, as the recommendations may have an effect on CNMs currently practicing as well as those coming into practice after graduation. Depending on the final phrasing and how it is interpreted, the proposed position statement by the AORN, *Perioperative Advanced Practice Nurse First Assistant*, will hold the potential to affect how CNMs are credentialed as first assistants. If facilities choose to have this position statement supersede the ACNM position statement, *The CNM/CM as First Assistant during Surgery*, CNMs who first assist will be required to acquire and document additional education, clinical experience leading to the RNFA credential, and CRNFA certification. The ACNM continues to be the national governing body for CNMs. In April 2012, the ACNM updated its position statement in regards to the education and training of CNMs who first assist and reminded members that a CNM can be educated and trained through a number of methods. If the AORN position statement, *Perioperative Advanced Practice Nurse First Assistant*, is accepted and used by facilities in place of the ACNM position statement, possible barriers for CNM practice and advancement would include an extra program of study in first assist, cost of attendance, time away from work to attend the program, or longer midwifery programs to add the content. A question to be explored is whether the ACNM will need to add first assist training into its core competencies. Some new graduates may seek the added
education in their program prior to starting work. There are CNM programs that already incorporate first assist courses in their curriculum and a few programs are offering a post master’s degree for RNFA. Benefits of the added curriculum would include more in-depth study of anatomy, physiology, suturing skills and aseptic techniques along with education and training with a supervising physician and more experience in surgical cases. Stakeholders involved include practicing CNMs, graduate CNMs, nurse-midwifery graduate programs, ACNM leadership, AORN leadership, American Congress of Obstetricians and Gynecologists (ACOG) leadership, hospital medical staffs, surgical teams within hospitals, obstetrician/gynecologists working with CNMs, health insurance companies and, eventually, the women undergoing the surgical procedure.

Objectives

In order to meet the scholarly project guidelines relating to CNM first assistant practice, project objectives were established as follows:

- Develop and distribute a pilot questionnaire to CNMs and SNMs in Utah regarding first assisting. Explore questions regarding current practice, credentialing, education, reimbursement, and possible benefits or barriers.
- Review first assistant educational programs for CNMs. Compare programs in length, cost, education and required surgical hours.
- Report findings to the Utah Affiliate of ACNM members in December 2012.
- Submit abstracts for poster presentations at the Annual Utah CNM Mini-Conference held in the spring of 2013 and at the National ACNM Meeting 2013.

Project Description
During the summer of 2012, the key elements of the proposal were developed and a literature review was performed on existing knowledge about CNM first assist, with a theoretical framework to guide the project. The proposal was defended in July 2012; upon approval, the project then moved into the questionnaire approval and implementation phases.

In September 2012, IRB approval/exemption was obtained. A unanimous vote among the active members of the Utah ACNM affiliate was obtained in order to distribute the questionnaire to the Utah ACNM email list. The pilot questionnaire was sent to Utah CNMs and student nurse midwives (SNMs) September 2012. (See Appendix A for letter and questionnaire).

It was proposed that the questionnaire be approved by the Utah ACNM Affiliate as an individual DNP project and dispersed electronically through email and Survey Monkey to the Utah Affiliate email list. Content experts and project chair reviewed the questionnaire prior to implementation. Ideally, this pilot questionnaire gives information to present locally and nationally to the ACNM. It is projected that the questionnaire be approved nationally through ACNM and replicated after revisions are done and an amendment is sent to the IRB. The project was successfully defended in November 2012 at the University of Utah College of Nursing by the DNP faculty and chairs.

The project results will be presented to the Utah Affiliate of ACNM December, 11, 2012. An abstract was submitted for poster presentation for the Utah Women’s Health Mini-Conference for the spring conference. An abstract was submitted for poster presentation in September 2012 for the 2013 national ACNM Conference.

**Literature Review**

**Search Strategy**
A review of the literature regarding CNMs as first assistant was conducted. Initially, PubMed was searched using United States history nurse as surgical assistant, yielding 5 articles; 2 were used. Another PubMed search, hospital credentialing and nurse midwife, yielded 50 articles with 3 used. PMC (the US National Library of Medicine, National Institutes of Health) was searched for the terms obstetrical first assist and nurse midwives, yielding 45 articles; 2 were used, one being a review article. PMC was searched with another term, cesarean section surgical assistant and nurse midwife, yielding 5 articles; 2 were used. The American College of Nurse Midwives (ACNM) also had resources to link to full text articles for the Journal of Midwifery and Women’s Health. A search was conducted using the search terms nurse midwife first assist, yielding 20 articles; 5 used with some articles repeats of other searches. The AORN website was searched for past and new guidelines. The ACNM website was searched for past and new position statements. The AORN website was searched for position statements. CINAHL, the Cumulative Index for Nursing and Allied Health Literature, was searched for registered nurse first assist, yielding 7 articles, 4 being used. Pub Med was searched for articles using certified nurse midwife reimbursement issues, yielding 15; several were abstracts and others were not applicable. Of the 15, 3 were under 10 years old and were not applicable, 2 were 12 years old and applicable but dated. A Google search of RNFA programs and sponsoring schools was also done.

**History of Nurses Assisting in Surgery**

During World War II, nurses set a foundation for surgical nursing and assisting in surgery. “Nurses were credited with lowering battlefield casualty rates due to their dedication during the war” (Zarnitz & Malone, 2006, p. 876). During the Korean War, nurses worked in “…mobile army hospital units, providing preoperative, intraoperative and postoperative
care….They functioned as RN first assistants at surgery in suturing, handling tissue, providing exposure, and hemostasis during surgical procedures” (Zarnitz & Malone, 2006, p. 876).

Hodson (1998) reported that eighty percent of operating rooms (ORs) were staffed by nursing students between 1870 and 1930. She states that the “…senior nurse was in charge of the OR and became known as the circulator. One junior nurse filled the role as assistant to the surgeon, and another junior nurse handled instrumentation. The fourth nurse administered anesthesia” (p. 1001). She indicates it was during this time that the roles of surgery assistant and anesthesia were recognized. Interestingly, she discusses debates during the 1970s and 1980s about nurse’s role in the operating room, with reports of perioperative nursing leaving the nursing curriculum at that time. Hodson says that in 1980, the American College of Surgeons (ACS) supported nursing with a statement about the benefits of nurses assisting in surgery. Now, RNFAs are recognized in all 50 states and exams for credentialing started in 1979 by the AORN, where testing of competencies have evolved ever since.

In her review article, *First Assisting in Obstetrics: A Primer for Women’s Healthcare Professionals*, Tharpe (2007) found that since 2006, a rise in elective inductions has been a cause of many women’s health professionals expanding practice and certifying in the first assistant role. She reports that since 1996, there has been a “…40% increase in cesarean, while the vaginal birth after cesarean rate has decreased by 67%, [this] coupled with mandated decreases in medical resident work hours, has increased the need for surgical first assistants skilled in assisting with cesarean section” (p. 30).

Marks, Thacher, and Camargo (1998) report the success of a formal nurse-midwife first assist educational program at their community teaching hospital. This program was added because of minimal physician insurance reimbursement to first assist. The nurse-midwives were
taught “the principles and procedures of obstetrical anesthesia, anatomy and physiology of the gravid abdomen” (p. 207). It was a one-day course and they had a training video along with an operating room setup with instruments. Twenty-four CNMs were educated through the course and received a certificate of course completion as well as recognition through the obstetrical/gynecological department. The hospital approved them for first assisting through risk management and hospital credentialing. Results show that their malpractice rates did not increase, cesarean section start to finish times did not increase, and there were not delays in waiting for a surgical assistant. They reported: “…the patient is more relaxed since they know that their provider during labor is also one of their surgeons for the cesarean section” (Marks et al., 1998, p. 208).

**Nurse as first assistant**

Today, RNs train to assist in surgery, and credential as registered nurse first assistants (RNFAs) through the AORN. To prepare for the RNFA, the *AORN Position Statement on RN First Assistants* gives recommendation that the RN should hold a bachelor’s degree and complete an RNFA program that “…is equivalent to 1 academic year, post-basic nursing study” (AORN, 2012b, p. 2). Preparation also includes holding certification in perioperative nursing as an RN. The AORN position statement on RN first assistants also requires that “nurses with an advanced practice degree must complete an RNFA course prior to practicing as a RNFA” (p.2).

The AORN is a non-profit organization in Denver, Colorado, which sets the standards for operating rooms nationally. Their vision is for evidenced-based practice in surgical care and their “…mission is to promote safety and optimal outcomes for patients undergoing operative and other invasive procedures by providing practice support and professional development opportunities to perioperative nurses” (AORN, 2012c).
APRNs are recognized nationally and statewide in several specialties. APRNs are known to have a master’s or doctoral degree in nursing. They practice in the fields of anesthesia, acute care, adult, family, psychiatric, pediatric, neonatal, gerontology, and women’s health (Schroeder, 2008). In some states, clinical nurse specialists (CNSs) are also recognized as APRNs. CNMs are recognized as APRNs and it varies from state to state whether they fall under the board of nursing or a separate midwifery or medical board. For instance, in Hawaii the CNM is dually recognized as an APRN/CNM under the board of nursing. In Utah, the midwifery and nursing boards are separate, with the CNM being recognized as an APRN, but two separate licenses are obtained from each regulatory body. Many CNMs have expanded their scope of practice to assist in cesarean sections and gynecological procedures. Moes & Thacher (2001) discussed the role of the midwife in assisting, saying that it is becoming more popular and that physicians also appreciate being able to employ nurse midwives who can assist in surgery and bill for the service. Patients who have been seeing a midwife are more reassured when they have one of their midwives assisting in their surgery.

Position Statements

In March 2012, the Utah affiliate of ACNM received an email from Elaine Germano, CNM, DrPH, FACNM, senior education policy advisor for the national ACNM. The forwarded email was sent by Nell Tharpe MS, CNM, CRNFA. Ms. Tharpe is a nationally-known CNM, CRNFA who has been teaching first assisting at ACNM annual meetings, across the country (free-lance) and through Philadelphia University (US and Canada). Many of these midwives have gone on to be obstetrical first assistants. Tharpe (2012) was notifying the national ACNM of a new proposed draft statement about APRNs being RNFAs. Tharpe states:
The statement implies that this is the sole route for APRNs to become first assistants, and offers no other avenue. As a powerful and well respected organization AORN sets the standard for surgical services in the US. ACNM currently supports alternate ways to attain first assisting education and experience for CNMs and CMs. Should this draft statement be accepted as it stands, the effect would be that many facilities would no longer allow CNMs to function as first assistants unless they met the AORN standards.

(p. 1)

A reply from the national ACNM president Holly Powell Kennedy (2012) was addressed to Linda Groah, the Chief Executive Officer of the AORN on April 16, 2012. She writes that the ACNM was disappointed in the statement referencing APRNs, stating “…ACNM respectfully requests that the statement be withdrawn entirely” (p. 1) and asking to meet with AORN further to discuss concerns. In her statement, Powell Kennedy addresses CNM/CM credentialing through the American Midwifery Certification Board (AMCB) and the added practice standards that many midwives incorporate into practice after basic competencies are reached, commenting that after completion of a core program, CNMs can add to their scope of practice with first assisting in cesarean and other gynecological surgeries.

In April, the board of directors at ACNM approved a new position statement *The CNM/CM as First Assistant during Surgery*. They reiterated that first assisting is within CNMs’ scope of expanded practice, and extra credentialing isn’t required. They still accept various training programs for CNM first assistants and further outlined the skill set necessary to be a qualified and competent first assistant (ACNM, 2012).

The AORN has a current position statement titled *Perioperative Advance Practice Nurse*, which was approved in 1995. This statement discusses the role of the perioperative advanced
practice nurse, but does not discuss first assist credentialing for the APRN. The AORN recognizes advanced practice nurses such as nurse practitioners, CNMs, certified registered nurse anesthetists, (CRNAs), nurse practitioners and clinical nurse specialists (CNSs). They noted that the perioperative advanced practice nurse incorporates practice, education, research and management in the surgical arena. They also noted that the perioperative advanced practice nurse practices in collegial relationship with physicians, RNs, healthcare organizations and systems surrounding the surgical patient (AORN, 2012e). An additional document, entitled AORN Position Statement RN First Assistants, first drafted in 1984, defines the RN as first assistant, delineates the scope of practice for RNs and allows APRNs to function as RNFA according to institutional policy and state nursing laws (AORN, 2012b). A draft of the AORN’s proposed position statement, Perioperative Advanced Practice Nurse First Assistant, was being reviewed by board members and the AORN had a link for members to comment on the new proposed RNFA statements starting July 23, 2012. They have drafted two statements, one for the RNFA and one for the perioperative advanced practice nurse first assistant. They propose that the ARPN is board certified, has completed an RNFA program, complies with all policies for RNFAs, and continues to excel, encouraging them to progress to the certification level or CRNFA. They also give recommendations to the organizations privileging the APRN for first assisting (AORN, 2012d).

Credentialing and Scope of Practice of Certified Nurse Midwives as First Assistants

Currently, CNMs who have completed their basic midwifery practice can expand their practice to include various procedures, including first assisting in cesarean section, circumcision, and assisting in other gynecological surgeries. Powell Kennedy (2012) gives reference to the ACNM’s Standard VIII allowing CNMs to incorporate new procedures into practice. This is a
competency-based program where the CNM can take a course and train through ACNM-approved continuing education programs. Programs of study range from workshops offering medical education hours to home study with hands-on workshops. The ACNM has published a clinical handbook entitled *The Midwife as First Assistant*, a guide to help CNMs implement first assisting into practice.

Tharpe (2007) discusses scope of practice related to surgical first assisting. She reminds that each provider may have a range of skills between full-scope to limited practice. She expresses the need for education, training and experience depending on the providers’ intention to practice. She also stressed the importance of documenting this education and training for credentialing.

Schuiling and Slager (2000) also refer to the *ACNM’s Guidelines for the Incorporation of New Procedures into Nurse-Midwifery Practice*. They contend that each midwife needs to keep current on credentialing and skills to maintain practice and refer midwives to contact their own state regulatory agencies in regards to scope of practice and first assisting laws.

A survey (Moes & Thacher, 2001) comparing state laws and regulation of first assisting by nurse midwives reports that each state has their own governing laws on midwives first assisting. Some states reference ACNM statements and guidelines for practice; others refer to AORN recommended standards and require credentialing as an RNFA. The results show that some states are unaware of advanced practice nurse guidelines and surgical first assist recommendations. Moes & Thacher also describe the joint commission, JCAHO, which ensures that providers who give patient care are authorized to do so. The commission requires medical staffs to enter providers’ information and qualifications in a national databank which is renewed every two years. JCAHO gives six steps needed to incorporate expanded practice for CNMs,
especially for first assisting: “…identify the need, review state and institutional regulations, evaluate the procedure as a midwifery function, develop and document an education process, evaluation, and report to the ACNM” (p. 309).

Cooper (1998) confirms the ACNM as the CNM credentialing body in the United States. She also defines the CNM scope of practice as the “…independent management of women’s health care, focusing particularly on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and gynecologic needs of women” (p. 31-32). Nurse-midwifery is practiced in all 50 states, but practice scopes differ between states. As mentioned before, some CNMs fall under nursing; others fall under a midwifery board; Cooper mentions that still others may fall under public health or medicine. She felt that clinical privileges should be based on education, competence and laws of each state, with each midwife being able to show documentation of education and competency.

Further, a 1994 survey of midwives’ expanded practice found that nurse-midwives were “…performing many technical obstetric procedures such as ultrasonography, forceps and vacuum deliveries, colposcopy, endometrial biopsy, serving as first assistant at cesarean sections, and the performance of breech version” (Stone, 2000, p. 529). Stone also found results showing that nurse midwives were using and providing homeopathic remedies such as herbs, tinctures, therapeutic touch and visualization.

Rothrock and Seifert (2009) provide a chapter on institutional credentialing in their book Assisting in surgery patient-centered care. They discuss credentialing for the allied health professional and discuss challenges with scope of practice issues for the first assistant. They do not list policies directly related to certified nurse midwives in their text.

**Advanced Practice Reimbursement**
There is little information regarding exact reimbursement for the advanced practice first assistant. Reimbursement rates depend on patients’ individual insurance and Medicaid coverage. It also depends on whether the practitioner is employed by a hospital, a group of private practice physicians or owns their own practice. In Wadas’ (2008) discussion of reimbursement for advanced practice nurses who provide first assisting services, she describes three ways of reimbursement: fee for service, accepting a portion of the surgeon fee, or billing by self. She states that Medicaid claims need to be submitted by the actual provider number with modifiers for surgical assistant codes.

Tharpe (2007) says that “…health insurance companies will typically cover first assistant professional services only when the assistant is credentialed for the service, and bills separately from the hospital” (p. 36). Moes & Thacher (2001) show that services are billable for the first assistant in surgery with the last 2 digits being a modifier for a non-physician. They report that a patient’s private insurance pays a percentage of the surgeons’ fee to the surgical assist. They have found managed care to lump fees, so if assistant services are billed, they are subtracted from the surgeon fee. Medicaid reimbursement depends on each state.

When discussing reimbursement issues for CNMs in general, there is still very little data documented in current literature, but dated sources were available for evaluation. Roberts (2001) examines practice of CNMs from public clinics to private obstetrical offices or birth centers. In her survey results show that 59% of women using CNMs as their care provider are on public health insurance or Medicaid, are self-pay, or are unable to pay. She recommends preserving the midwifery model of care by assessing the revenue and considering a productivity model. She suggests considering adding practice with reproductive services, adding billing codes and adding technology to be able to retain profits.
Ament (2000) reports on a survey conducted in 1996 of midwifery practices. It was mailed to 1,839 known practices and resulted in a response rate of 495 or 27%. Incomplete surveys were returned and 6 of them had comments as to why it was not completed. These comments ranged from no midwives in the practice, to have midwives but bill as nurse practitioners. There were 121 complete or partially completed surveys. Responses regarding reimbursement policies for CNM practices to maintain clients were minimal. Many respondents didn’t know the answer or answered incorrectly. Some answered no, that their state did not have mandatory reimbursement, some answered yes when their state did not have mandatory reimbursement. In regard to whether a midwife provider number was used for billing, 5% felt the question did not apply, 2% did not know if the midwife provider number was used. Twelve percent of the midwives completing the survey had some knowledge about how billing was being done at their practice. Interestingly when answering questions about who had the responsibility of maintaining contracts at their office, 5% said it did not apply to them, and 1% did not know who was responsible. Five percent also replied they did not know what was required on their provider application. Finally, when asking the clinic director about their client base, 11% did not know the answer. The majority answered yes when asked if an easier process was needed for reimbursement, while 13% stated no, and 11% said this did not apply to them.

Further research is needed in regards to CNM reimbursement for general practice and first assisting. Practitioners and office billing managers need to bill correctly under the providers’ UPIN. Providers need to be more knowledgeable about reimbursement in their current practice.

**First assistant workshops versus RNFA programs and curriculum**
The AORN’s proposed statement desires the APRN who functions as a first assist to be board certified in their specialty, to complete an RNFA program, and to comply with policies and standards for graduate level education in advanced practice. They expect the APRN to progress from basic level to an experienced level in first assisting and to certify as a CRNFA and maintain competencies (AORN, 2012d).

Currently, CNMs who first assist have had education through various programs. Some are educated through hospital-based programs; others learn in on-the-job training such as continuing medical education CME or CEU courses. A popular program of study is a continuing education course from Philadelphia University. Nell Tharpe, MS, CNM, CRNFA teaches a sixty-hour, online course for women’s health professionals. Course topics include asepsis, first assistant roles, anatomy, physiology and pathophysiology. Preoperative, surgical and first assisting skills for cesarean section are also included, along with postoperative care, billing and credentialing assistance. (Philadelphia University, n.d.)

The ACNM holds an annual meeting each year, with current courses at this year’s convention including Pelvic Surgical Health: First Assist, Advanced Suturing, & GYN Surgical Procedure Updates and Advanced Suturing: Taking it to the Next Level. Previously, one-day workshops have also been taught at the annual meeting on CNM as first assistant.

Multiple community colleges and universities have programs for RNFA and many have placement for APRNs. Most want documentation of two years of scrub and circulating experience in the operating room as a nurse. Several of the programs allow APRNs into their programs but do a pre-assessment of their skills if they don’t meet the admission criteria, such as scrub or circulating experience. The RN who applies to the RNFA program needs to hold certification as a nurse in the operating room (CNOR) but this is waived for the APRN who
shows proof of advanced practice licensure. RNs who wish to become CNOR certified have to hold an unrestricted RN license, work full time in perioperative nursing, and they have to complete “a minimum of 2 years and 2,400 hours of experience in perioperative nursing, with a minimum of 50% (1,200 hours) in the intraoperative setting (CCI, 2012).

Three post-master’s nursing certificate programs exist to reach the RNFA credential. For acceptance, the RN who holds a master’s degree in nursing must apply to the program separately. Angelo State University in San Angelo, Texas, has a post-master’s certificate for APRNs; requirements for admission are licensure as an APRN in the practitioners’ state of residence and eligibility to sit for exam. They also require cardiopulmonary resuscitation (CPR), basic cardiac life support (BCLS) or advanced cardiac life support (ACLS), immunizations, liability insurance, and clinical privileges as an RNFA student prior to starting clinical (Angelo State University, n.d.). They start a class each fall and spring. Deadlines for registration are listed on the website. Tuition rates are for graduate level courses at in-state and out-of-state rates. Rush University in Chicago, IL lists a two-course series for the APRN for a post-master’s certificate, with classes starting fall of 2012. An applicant needs to be an RN and be certified in an APRN role, hold a GPA higher than 3.0, present transcripts and letters of recommendation, including one from someone who will be a preceptor; admission is contingent upon payment of fees and English language tests if necessary (Rush University, 2012). The University of Alabama College of Nursing has a post-master’s degree for the RNFA. Application deadlines apply and the course is started in the fall only. The program runs fall and spring semester for a total of 9-10 graduate credits depending on the applicant’s experience. Graduate tuition applies (UAB, 2012).
The National Institute of First Assisting (NIFA, 2012) offers 3-and 6-day courses for RNFA training; they require the APRNs to complete the 6-day course. Their program reports teaching additional suturing skills and simulator practice; then the practitioner completes 125 hours of home surgical hours after the course. A professional nursing seminar taught by Louise Pasaka RN, BSN, CNOR, RNFA is available for RNs and APRNs in New Mexico. It is a 6-day course, conducted several times a year. This program offers 6 days of didactic with an added 120 hours that the student completes with surgeon supervision within a year after the didactic program is completed. When the course is completed, participants are awarded 6 college credits and are eligible to sit for the RNFA exam for certification (Professional Nursing Seminars RN First Assistant Program, 2012). Ms. Pasaka priced the program at $2,285, which can be paid in 2 separate payments. Coordinators arrange lodging for the conference as well (personal communication, July 21, 2012). Most of the programs do not list cost on their websites.

An online curriculum located at Lorain County Community College in Ohio is held over a 2-semester period, each comprising 5 credits of study. Included in the course are 135 hours of practice with a supervising surgeon in the nurse’s own state. RNs and APRNs are accepted into the program. The program costs $1,900 for Ohio residents and $2,500 for out of state residents, per course (Lorain County Community College/Division of Allied Health and Nursing, 2012). Degon (2010) comments on a distance learning program for the RNFA. This program is located at Rock Valley College in Rockford, Illinois. They have three parts to the program: an online portion, which consists of 70% of the program; hands-on workshop consisting of a 6 day course, and 300 hours of clinical time. They report no admission deadlines to the program.

Lakeland Community College (2012) in Kirtland, Ohio offers another RNFA program which accepts RNs and APRNs. The program, directed by Dr. Nancymarie Phillips, offers a 5-
day intensive course with 120 hours of surgical assisting performed at the students’ local facility. Cost of the program is dependent on in-state tuition, which is listed as $84.45 per credit, or out-of-state tuition, listed as $255.65 per credit, plus an $80 lab fee. The program awards 6 elective credits at the completion of the program. Upon completion, the nurse receives a grade and a certificate of completion. Medical staffs can verify credentials through the director.

UCLA Extension (2012) also offers a 6 day 52 hour didactic RNFA course in Westwood Village, CA. Following the course the student interns 120 hours at their home facility. Costs include a $75 application fee and $1995.00 course fee. Classes will be held April 12-17 and May 17-19, 2013. Application guidelines are listed on the website.

Anne Arundel Community College (2012) in Maryland offers a 2 class sequence RNFA program the student takes the 4 credit didactic portion online equaling 60 hours, then enrolls to the final 7 credit course which includes 210 surgical internship hours. It is an AORN, CCI approved program. In-state and out-of state tuition applies.

Nursing has come a long way in surgical first assisting. CNMs, who want to expand their practice to first assist, need to know that there is a need for experienced practitioners in the field who are educated properly. Documentation of the need of experienced practitioners is important for CNMs to continue wanting to add first assisting education into their own scope of practice. Common feedback of CNMs who first assist is that patients are more satisfied to have their nurse-midwife presently assisting in their cesarean section. CNMs need to be actively knowledgeable of reimbursement of midwifery care and how their office bills for the advanced practice nurse as first assistant. Programs ranging from online post-master’s programs with minimal campus visits to 5-6 day educational courses awarding college credit with clinical hours spent at the providers’ state of residence are available for APRNs and CNMs to obtain the RNFA
credential. Upon completion of these programs the nurse is eligible to use the title RNFA, and show advanced skills as an assistant in the operating room.

**Theoretical Framework**

Multiple theories apply to this scholarly project; thus, a framework utilizing many theories has been implemented. The *Framework for Effective Management of Change in Clinical Practice: Dissemination and Implementation of Clinical Practice Guidelines* was chosen as a guideline for this project. To develop this theory, Moulding, Silagy, and Weller (1999) implemented theory from the social sciences. Concepts from the following theories were used in their framework: diffusion of innovation theory, transtheoretical model of behavioral change, aspects of health education theory, social influence theory, and social ecology theory.

The five main steps are as follows (see Appendix E):

- **Step 1**: Assessment of practitioner’s stage of readiness to change.
- **Step 2**: Assessment of specific barriers to guideline use.
- **Step 3**: Determination of appropriate level of intervention.
- **Step 4**: Design of dissemination and implementation strategies.
- **Step 5**: Evaluation of the implementation strategies (p. 181).

These steps are crucial to evaluating the benefits and drawbacks of changes to first assisting practices and policies. The first two steps, assessment of readiness to change and assessment of specific barriers to guideline use, will be examined in the CNM population in general through a locally-distributed pilot questionnaire. As they answer the questions provided, each CNM will be given the opportunity to internally assess their own readiness to add skills to expand their practice, their reactions to possible changes in certification and barriers that would keep them from following current and future policies. Intervention, the next step of the
framework, will then be driven by the responses given in the questionnaire. With the information provided, local and national organizations can work with CNMs to discuss and alleviate concerns and barriers to first assist certification. The fourth step, design of dissemination and implementation strategies, will be closely tied to intervention, with concerns and needs of individuals affected influencing policy changes. As needs are assessed, concerns alleviated and policies put in place, leaders in the field can evaluate the entire process and consider options to ease future policy changes and educational standards.

Moulding et al. (1999) also give nine key theoretical concepts to consider for the success of clinical practice development and implementation of the five steps mentioned above. Many of these key concepts directly apply to CNMs and the process of change when adding first assisting or added skills of the provider (See Appendix F). Each concept will be addressed as it applies to CNM practice. In concept 1, behavior change is said to be a process. The CNM can progress in practice, autonomy and education by interventions and encouragement, moving from one stage to the next. During concept 2, those involved in the change among APRNs, CNMs or those making the change will need to identify concerns of other providers involved who are adapting to the changes. During concept 3, assessing the CNM’s readiness to change is important to adopting new policies or guidelines. Many aren’t ready to make changes, while others want to embrace the change. Identifying the specific reasons for barriers to change, in concept 4 is appropriate and important in order to decide on change strategies. It is important to realize while assessing concept 5 that multiple methods of implementing changes in practice may be important, as many practitioners are in different stages of the change, rather than implementing all changes at once. Interestingly, concept 6 applies well to this project because CNM and provider education that encourages implementing new guidelines or making a change will focus
on “knowledge, attitudes, and skill development” (Moulding et. al, p. 181). Implementing concept 7 must include strategies for education that are interactive and participatory. An example would be first assist programs where hands-on skills and participating are mandatory to the learning experience. It is important to realize one’s own biases when discussing concept 8, as social influence, attitudes of other peers and opinions of stakeholders can affect behavior positively or negatively. Concept 9 states that “environmental support is central to encouraging and maintaining guideline change” (Moulding et. al, p.181). Examples of support when implementing extra roles as practitioners would be support of the physicians and staff encouraging the extra knowledge and training each CNM could bring to practice.

This framework is multifaceted and uses its key elements to assess level of change and implementing change in CNM practice. Each practitioner has to decide if or when they want to implement change into their own individual practice. For the purpose of this project, it is for the individual CNM to determine if first assisting is an expanded practice worth adding. The developed pilot questionnaire for this project will serve to gain information regarding expanding practice to add first assisting into their role as a CNM, educational programs, barriers and benefits to CNM first assist practice as well as information about credentialing and reimbursement issues. Qualitative data from the survey will be evaluated to determine the right level of intervention, which stakeholders should receive the pertinent information in order to make a change in practice. This framework further allows practitioners to determine the level of change desired in other areas of practice, such as adding skills or further education into practice.

Project Implementation
A comprehensive literature review was completed regarding history of CNMs as first assistant, current training and credentials, position statements, reimbursement issues, and available programs.

Potential content experts were discussed in person with the project chair by email in May and June. Emails were sent to Nell Tharpe CNM, MSN, RNFA. Ms. Tharpe agreed to be a content expert for the project. Contact with the national ACNM was done via email, and Tina Johnson, ACNM Director of Professional Practice & Health Policy, was called to discuss another potential content expert (personal communication, June 21, 2012). Lisa KaneLow CNM, PhD, at the University of Michigan was contacted by email upon their recommendation. She provided copies of the past and revised ACNM guidelines. In July, Roberta Ward, CNM, FNP, DNP, a local practitioner working in Utah was contacted to be a content expert. Ms. Ward is a full time practitioner with many years’ experience in the operating room. Ms. Ward agreed to be a content expert.

CITI training, a preliminary step for IRB approval was completed in June 2012 and a potential questionnaire was done for the project. The questionnaire was planned to be sent nationally to CNMs to find information about current practice, practice barriers regarding obstetrical first assist and if CNMs will be willing to obtain more training if necessary. The questionnaire explored how CNMs have been trained in first assisting in the past. It also explored if credentialing agencies are already requiring extra credentialing of the CNM and what type of training that is. Tina Johnson, ACNM Director of Professional Practice & Health Policy, offered assistance in the future with questionnaire approval and distribution through the national ACNM (personal communication, July 21, 2012).
Because of limitations, it was decided with the faculty chairs and content experts to implement the project locally at the Utah level instead of nationally. A vote among members of the Utah ACNM Affiliate was conducted to approve distribution of the pilot questionnaire to the Utah ACNM email list (see Appendix A). IRB approval by exemption was obtained to pilot the questionnaire to Utah CNMs and student nurse midwives (SNMs) in September 2012 (see Appendix B). The inclusion criteria for the project were to be between age 25-75 and a CNM or student nurse midwife (SNM) on the current Utah ACNM email list. Exclusion criterion was CNMs or SNMs in Utah without an active email address on the Utah ACNM list. The Survey Monkey program was used to conduct the pilot questionnaire. The questionnaire design was a series of 13 questions regarding current practice, programs, education, billing, and reimbursement. On September 11, 2012, the questionnaire was sent with the IRB approved cover letter (see Appendix C) to 121 CNMs. An encryption code was imbedded into the cover letter for security of the participant and consent was implied for those taking the questionnaire. An identical email was sent with the same questionnaire to 21 SNMs. The project was conducted for two weeks then a reminder went out to the study subjects and the project was ended ten days later on October 4, 2012.

**Project Results and Evaluation**

Objective 1: Develop and distribute a pilot questionnaire to CNMs and SNMs in Utah regarding first assisting. Explore questions regarding current practice, credentialing, education, reimbursement, and possible benefits or barriers.

After meeting in August 2012 with the project chairs and committee it was decided that a pilot questionnaire would be conducted within the Utah ACNM instead of nationally. This was done because of time constraints and costs to obtain the national email list. Key barriers and
limitations for distribution nationally were that the national ACNM required IRB approval prior to approving a project and IRB wanted approval from the organization prior to approval. Cost of the national ACNM list was $100 per 100 active members to use the email list. There are currently over five thousand members. Key facilitators of the project were the primary investigator, project chair, content experts and DNP program director to do the project at a local level. Also key facilitators of the project were Utah ACNMs willing to support the project. Forty-four CNMs completed the survey for a response rate of 36% and eight SNMs completed the survey for a response rate of 38%. The primary investigator met with Dr. Maija Reblin on October 16, 2012 to discuss how to report the data. Excel spreadsheets were made to filter responses of those who currently first assist from the total surveyed, to better analyze the responses.

Results of the questionnaire reported qualitative data as well as descriptive statistics. Results showed that 21 of the 44 responding CNMs (47.7%) are first assisting in Utah. Seven (15.9%) had previous experience first assisting, 8 (18.2%) had never first assisted and two (4.5%) would like to expand their practice to first assist. Of the 8 SNMs who completed the questionnaire, one is currently first assisting as an RN and 3 would like to expand their practice first assisting after graduation. When asked about what type of surgeries CNMs were assisting in, 18 (85.7%) replied that they assist in cesarean section only and 3 (14.3%) assist in both cesarean and gynecological surgeries. When asked about how the respondents obtained their first assist education, training and preliminary clinical experience, the results were as follows: 2 (9.5%) attended a continuing education conference; 1 (4.8%) attended a conference course at the national ACNM conference; 19 (90.5%) reported on-the-job training with surgeons at a local facility; 1 (4.5%) had completed an RNFA program endorsed by the AORN. Open responses
noted that 3 of the respondents had several years of experience in the operating room as a nurse prior to becoming a CNM and one completed the ACNM course taught by Nell Tharpe. Of the 21 CNMs who are currently first assisting, 19 (90.5%) reported that they are working for a facility where a separate credential (requiring extra education and surgical hours) is not required to first assist as a CNM. Fifteen (78.9%) reported that if their facility required a separate credential to first assist, that it would affect their current practice. Sixteen (80%) responded that they would go through an additional educational course to continue first assisting if it was required by their facility.

When asked if first assistant education (leading to the RNFA) should be incorporated into the core midwifery program of study, 18 (86%) of those currently assisting answered yes. Six out of 8 SNM respondents (75%) also answered yes, and 26 of 41 total CNMs who completed the question answered yes (63%).

Open ended responses for and against adding first assisting curriculum into the midwifery core were obtained. Comments in favor of adding first assisting curriculum were as follows: “It should be an option but not mandatory;” “elective;” “It is necessary and benefits the MDs we practice with;” “Just add a course related to what we do, not a full RNFA course;” “It is a billable skill and leads to continuity of care;” “Beneficial to have the training in midwifery school or at least an elective course;” “Program has lots of clinical hours to fill and feel it would be beneficial that CNMs would be first assisting in underserved areas.” There were also comments against adding a program into the core: “May not be useful to large population of midwives;” “Already have residents to first assist;” “Midwifery education is about the normal;” “Too many other skills taking up the time;” “Not enough time in the core program to add the
skill set and first assisting doesn’t mesh with core philosophy;” “It is already hard enough to get students clinical experiences for core competencies.”

Forty-seven percent of CNMs first assisting were interested in a post-master’s RNFA program and 5 of 7 students (75%) would also be interested depending on cost, length and online versus an on-campus program. Only 2 respondents out of 44 CNMs (4.5%) obtained first assistant training in their midwifery practicum and none of the SNMs surveyed received first assistant training in their program.

Thirty-four CNMs reported that they believe that when CNMs first assist with cesarean section, it saves time and improves quality of life in emergency situations. Five responded did not. Assenting comments included: “…it was not different than any other assist;” “It may save time from calling in another physician,” and comments related to it being beneficial in small community or rural hospitals. Other comments mentioned that in larger, urban facilities there was always an MD and resident in-house and CNMs were not needed to assist. Student midwives also responded on this question. Four responded that they felt that a CNM as first assistant would be cost effective. A common theme from total respondents was continuity of care by having the midwife follow the patient and assist when necessary.

Respondents were given the opportunity to comment on the question “What benefits or barriers do you foresee for CNMs who first assist in surgery?” Benefits mentioned were as follows: new skills learned, patient continuity of care, uniform training, ability to bill and generate revenue, building a broader scope of practice, faster cesarean delivery if a CNM is already on-site in an emergency, improved colleague relationships, enhanced job satisfaction, that it is beneficial to assist MDs who are supportive of midwife practice, an increased response
rate with better fetal outcome, and respect as a member of the medical staff who can surgical assist.

Barriers mentioned were: not wanting to add new skills, no extra salary for first assist, cost and time for extra training, lack of surgical knowledge, increased risk of litigation and malpractice, competition with MDs and residents in an academic center, time, efficiency of skills, difficulty maintaining competencies if not used, physician acceptance, physician utilization of the midwife as first assistant, lack of Medicaid coverage for first assistant, hospital requirements, lack of training during basic midwifery program, time away from clinic and supporting other labor, a feeling that it is unnecessary to train for RNFA if only doing one procedure appropriate insurance reimbursement, being asked to do more training in some hospital systems, and billing issues.

In regards to billing and reimbursement, 85.7% of CNMs currently assisting answered that their practice is being reimbursed for first assisting. When asked if their current practice is billing under their unique provider identification number (UPIN), 61.9% responded yes, 4.8% no, and 33.3% of respondents currently assisting responded unknown.

An unintended consequence of the questionnaire was the finding that more research on billing and reimbursement is needed. It was also interesting to find that many of the CNMs first assisting in Utah have on-the-job training, but only a few have taken a CEU course and only one an RNFA program. Interest in a core RNFA program was favored over a post-master’s RNFA program.

Objective 2: Review first assistant educational programs for CNMs. Compare programs in length, cost, education and required surgical hours.
A thorough online search was done for RNFA programs as well as other first assist surgical assistant courses available. Facilitators to the search were that the primary investigator was previously aware of some of the programs. Barriers were that the primary investigator was not an active member of AORN, which may have given the investigator access to more programs available. Also, the link to RNFA programs on the AORN website was not working. A positive unintended consequence of doing the search of programs was that the primary investigator enrolled and completed the didactic portion of the Lakeland, OH RNFA course. Another unintended positive consequence for the primary investigator was to have more confidence assisting in surgery, tissue handling, suturing and hand ties in surgery directly following the course. Key facilitators were having supportive physicians willing to mentor 120 surgical hours following the course. Barriers to the course were one week of vacation time from work to complete the 5 day course and costs of the program, flight, hotel and car rental.

Objective 3: Report findings to the Utah Affiliate of ACNM members in December 2012.

The primary investigator is scheduled to present findings to the Utah ACNM Affiliate at the December 11, 2012 meeting. A key facilitator to this presentation is that the Utah Affiliate voted to support the pilot questionnaire and that the Utah Affiliate president is the primary investigator. No barriers were noted. An unintended consequence occurring from doing the questionnaire is that the primary investigator has had several emails from Utah CNMs and SNMs wondering when the results will be presented.

Objective 4: Submit abstracts for poster presentations at the Annual Utah CNM Mini-Conference held in the spring of 2013 and at the National ACNM Meeting 2013.
An abstract was submitted to the national ACNM in September 2012 and approval for participation was granted December 4, 2012. No barriers were noted in submitting the abstract. Possible barriers will be attending the convention in May, requesting time off work, and costs to attend and fly to Nashville. Time off work has been requested to attend. An abstract for poster presentation was submitted November 2012 to the Utah Mini-Conference committee and is awaiting approval. Key facilitators would be that the primary investigator is in contact with the chair of the conference committee by being the Utah ACNM president. Foreseen barriers will be requesting time off work to attend the conference.

Unintended consequences or outcomes from the project were that during the project implementation in August 2012, it was noted that the AORN had taken the draft statement of the APRN first assistant off their website. It is unknown if they plan to continue revising their statement.

**Recommendations**

After analyzing a pilot questionnaire of Utah CNMs regarding first assisting benefits, barriers, and compensation issues, it is important that further research is done at the national level to see if the same issues are felt nationally. It is proposed that the research be conducted through the national ACNM. The initial IRB application mentioned the need to also proceed at the national level and an amendment would need to be sent. Approval from IRB and criteria and funds to send the questionnaire to the national ACNM email list would need to be acquired. Further research outside of this DNP project are to investigate compensation issues for CNMs who are billing for first assistant and to see if adequate reimbursement is being received from insurance companies and Medicaid. Although an RNFA program is not mandatory for CNMs to expand their scope of practice at this time, it is proposed that the University of Utah College of
Nursing (CON) add an elective course to their current curriculum to cover the didactic portion leading to the RNFA. This would benefit not only CNMs, but also WHNPs and other APRNs. Currently, some of the programs mentioned in this literature review offer college credit and continuing education credit. Staff experienced in RNFA curriculum would be needed to teach the didactic portions and hands-on skills in the classroom setting, then students would be responsible to find a physician mentor where they work as an RN or after completion of their advanced program to allow them to complete 120 hours as an RNFA intern. The AORN (2012) has standards available for the creation of programs with appropriate hours, admission requirements, and curriculum. The program requires faculty in the following roles: “…a perioperative nurse with a master of science in nursing degree; an RNFA or preferably, a certified RNFA and a board certified surgeon” (AORN, 2012 f.p.2). Employers, medical staffs and obstetricians will note extra training in first assisting as a bonus when hiring CNMs, if first assisting is needed as an expanded skill.

**DNP Essentials**

This project met six essentials of doctoral education for nursing practice (DNP). Advanced nursing practice, merged with first assisting in surgery, enhances the role of the nurse and meets the goals of DNP Essential I in “…developing and evaluating new practice approaches based on nursing theories and theories from other disciplines” (AACN Task Force, 2006, p. 8). This project also met objectives in DNP Essential II, as the primary investigator was able to “…assess the impact of practice policies and procedures on meeting healthcare needs” (AACN Task Force, 2006, p. 9). As CNMs work in more rural areas, their expertise as a provider and a readily available assistant is needed. The CNM first assistant is an expanded role, but as new policies and statements come into practice the DNP will allow the advanced practice nurse to
evaluate these new policies in relation to practice. Also, the DNP can evaluate the cost-effectiveness of expanding to the role of first assistant and its cost effectiveness in care. This project allows the DNP to evaluate care needs of the population in practice and to determine if first assisting the surgeon in cesarean section is a need for the patient population. The advanced practice nurse who first assists also meets DNP Essential III by becoming a leader in more than one discipline through applying knowledge from obstetrics and surgical skills. This project will enhance the DNP graduate’s role as a CNM and first assistant, as well as a leader in nursing and midwifery. DNP Essential V was met in this project when the primary investigator analyzed health policy proposals, served as a nursing leader by extending the project to the Utah Affiliate of ACNM, and educated and advocated for CNMs and SNMs who expand practice in the first assistant role. In the future, DNP Essential VI will be met when interprofessional team collaboration and leadership is shown through continued implementation of first assisting into practice. Finally, DNP Essential VIII was met when the primary investigator expanded knowledge in the RNFA role by enrolling in extra education and interning in surgery. Specialized practice and advanced clinical judgment will be needed, as well as analytical skills, to look at the policies of the organization and the financial aspects of billing and reimbursement.

Conclusions

In conclusion, extra education in the RNFA role is important to consider when expanding practice as a CNM or APRN. ACNM still supports CNMs to expand practice to first assist through various educational programs and it is unknown if the AORN will propose changes again. Outcomes from the Utah pilot questionnaire show that CNMs and SNMs are interested in CNM programs adding RNFA education into the core program. Questionnaire results also noted this may be difficult, as it is already a challenge finding clinical placement for students for
midwifery practicum. A compromise in adding an elective RNFA course would be feasible. This course would be accredited by CCI and follow AORN guidelines for admission and completion of the course. It would give student nurse practitioners, SNMs, graduated NPs and CNMs the ability to take a course and complete hours in their own practice with a surgeon mentor.
References


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Appendix A

Letter from Utah Affiliate of ACNM

August 31, 2012

Ms. Jennifer A. Cook CNM, APRN, MSN
Doctorate of Nursing Practice Student
University of Utah, College of Nursing
Salt Lake City, Utah

RE: Proposed Project: Certified Nurse Midwife First Assisting: Benefits, Barriers and Future Education

To: Whom it may concern

On August 31, 2012, the Utah Affiliate of ACNM voted to unanimously support your proposed project, entitled: Certified Nurse Midwife First Assisting: Benefits, Barriers and Future Education. We are pleased to provide access to our membership database and email list for the purpose of completing this valuable project that will support Certified Nurse Midwives in Utah.

If there are any questions, please let me know.

Sincerely,

Celeste R Thomas, CNM, Utah ACNM Affiliate Secretary
Appendix B

Letter from IRB

INSTITUTIONAL REVIEW BOARD
THE UNIVERSITY OF UTAH
75 South 2000 East Salt Lake City, UT 84012 | 801.581.3655 | IRB@utah.edu

IRB: IRB_00058997
PI: Jennifer Cook
Title: Certified Nurse Midwife First Assisting: Benefits, Barriers and Future Education

Thank you for submitting your request for approval of this study. The IRB has administratively reviewed your application and a designated IRB member has determined that your study is exempt from further IRB review, under 45 CFR 46.101(b), Category 2, from the Federal regulations governing human research.

It is the policy of the University of Utah that all human subject research which is exempt under this section will be conducted in accordance with (1) the Belmont report (http://ohrp.osophs.dhhs.gov/humansubjects/guidance/belmont.htm), (2) this institution's administrative procedures to ensure valid claims of exemption, and (3) orderly accounting for such activities. All research involving human subjects must be approved or exempted by the IRB before the research is conducted.

Since this determination is not an approval, it does not expire or need renewal. This determination of exemption from continuing IRB review only applies to the research study as submitted to the IRB and you are expected to follow the protocol as outlined. Before implementing any changes in the study, you must submit an amendment application to the IRB and secure either approval or a determination of exemption.

If you have questions about this, please contact our office at 581-3655 and we will be happy to assist you. Thank you again for submitting your proposal.

Click IRB_00058997 to view the application.

Please take a moment to complete our customer service survey. We appreciate your opinions and feedback.
Appendix C

Consent Cover Letter

Certified Nurse Midwife First Assisting: Benefits, Barriers and Future Education

You are invited to participate in a study conducted by Jennifer A. Cook, CNM, APRN, MSN, doctoral candidate. The main purpose of this research is to explore the potential effect of proposed statement changes regarding advanced practice nurses (APRN) as surgical first assistant issued by the Association of periOperative Registered Nurses (AORN) in February 2012. The project will explore the potential effect of the proposed guidelines on certified nurse midwives (CNM) who practice first assisting, and what benefits or barriers arise in general for CNMs when they add the role of first assistant to practice. Participation in this study may benefit you by making you more aware of first assist guidelines for advanced practice and whether you want to expand your role as a CNM.

This questionnaire has been approved by the University of Utah Human Subject Review Board. Solicitation of CNM/CM participants for this questionnaire has been approved by the Utah ACNM Affiliate.

If you choose to participate in this survey, you will be asked to complete the approved questionnaire by clicking on the link below directing you to Survey Monkey. The questionnaire should take no more than 10 minutes to complete. By returning this questionnaire, you are giving your consent to participate. The information collected will be completely anonymous, confidential, and only used for study purposes. No personal identifiers will be linked with the data. Participation in the study is completely voluntary. You may choose not to take part. You may choose not to finish the questionnaire or to omit any question you prefer not to answer without penalty or loss of benefits.

https://www.surveymonkey.com/s/S7JPGY7

If you have questions, complaints or if you feel you have been harmed by this research please contact Jennifer A. Cook at alohanursejenn@msn.com or by phone 801-921-0535. You may also contact the University of Utah IRB if you have questions regarding your rights as a research participant. You may also contact the IRB if you have questions, complaints or concerns which you do not feel you can discuss with the investigator. The University of Utah IRB may be reached by phone at 801.581.3655 or email at IRB@hsc.utah.edu if problems arise during the course of this study.

Thank you for your time and participation in this research to benefit CNMs,

Jennifer A. Cook, CNM, APRN, MSN
Appendix D
Pilot Questionnaire

Certified Nurse Midwife First Assisting: Benefits, Barriers, and Future Education

1. As a CNM, do you first assist in your current practice? (Choose all that apply)

☐ As a CNM, do you first assist in your current practice? (Choose all that apply) Yes
☐ No
☐ Previous experience first assisting
☐ I have never first assisted (Please continue answering 7-11)
☐ I would like to expand my practice by first assisting

2. Do you assist in the following surgeries? (Choose all that apply)

☐ Do you assist in the following surgeries? (Choose all that apply) Cesarean section assisting only
☐ Gynecology surgical assist only
☐ Both cesarean section and gynecology surgical assisting
☐ I am not currently first assisting. (Please continue answering 7-11)
☐ Other (please specify)

3. How did you obtain your education, training, and preliminary clinical experience as a first assistant? (Choose all that apply)

☐ How did you obtain your education, training, and preliminary clinical experience as a first assistant? (Choose all that apply) CME/CEU conference
☐ ACNM national conference course
☐ On-the-job training with surgeons a local facility
☐ RN First Assistant (RNFA) course for advanced practice endorsed by the Association of periOperative Registered nurses (AORN)
☐ Other (please specify)
4. Are you working for a facility where a separate credential (requiring extra education and surgical hours) is required for CNMs to first assist?
- Yes
- No

If yes, list type of credential:

5. If your facility required a separate credential for first assist education, would this affect your current practice?
- Yes
- No

Other (please specify):

6. If an added credential is required at your facility to first assist, will you go through the extra educational courses to continue first assisting?
- Yes
- No
- Not Applicable

7. Do you believe that first assistant education and training leading to RN First Assistant (RNFA) should be incorporated into the nurse-midwifery core program of study?
- Yes
- No

Why or Why not?

8. Would you be interested in a post master’s RN First Assist (RNFA) educational program? (answer all that apply)
Would you be interested in a post master’s RN First Assist (RNFA) educational program? (answer all that apply)  Yes
☐ No
☐ Depends on cost
☐ Depends on length of program
☐ Depends where program is located
☐ Interested in online program
☐ Interested in on campus program

Comments

Did you obtain any first assistant training in your midwifery practicum?
☐ Did you obtain any first assistant training in your midwifery practicum?  Yes
☐ No

What benefits or barriers do you foresee for CNMs who first assist in surgery?

Do you believe that when CNMs first assist with cesarean section, it saves time and improves quality of life in emergency situations?
☐ Do you believe that when CNMs first assist with cesarean section, it saves time and improves quality of life in emergency situations?  Yes
☐ No

Comments

Is your practice being reimbursed for surgical first assisting performed by CNMs?
☐ Is your practice being reimbursed for surgical first assisting performed by CNMs?  Yes
☐ No
☐ Unknown

Is your practice billing under your unique provider identification number (UPIN) for first assisting?
☐ Is your practice billing under your unique provider identification number (UPIN) for first assisting?  Yes
☐ No
☐ Unknown
Appendix E

Theoretical Framework

Figure 1: Five key steps to conceptual framework.

1. Assessment of CNMs state of readiness to change
2. Assessment of specific barriers to guidelines
3. Determination of appropriate level of intervention
4. Design of dissemination and implementation strategies
5. Evaluation of the implementation strategies

Implemented from Moulding et al. 1999
Figure 2: Nine key concepts to conceptual framework

Implemented from Moulding et al. 1999