

BEFORE THE SURGICAL FIRST ASSISTANTS TECHNICAL REVIEW  
COMMITTEE, DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF PUBLIC HEALTH  
STATE OF NEBRASKA

\_\_\_\_\_)  
IN THE MATTER OF ) TRANSCRIPT  
A PUBLIC HEARING REGARDING THE ) VOLUME I of I  
SURGICAL FIRST ASSISTANTS ) (Pages 1 through 101)  
PROPOSAL. )  
\_\_\_\_\_)

1526 K Street  
4<sup>th</sup> Floor, Conference Rm. D  
Lincoln, Nebraska

Convened, pursuant to notice, at 1:00 p.m.,  
July 8, 2015,

BEFORE:

Diane Jackson, APRN, Chairperson.

COMMITTEE MEMBERS PRESENT:

Michael F. Kinney, J.D.; Mary C. Sneckenberg;  
Jeff Baldwin, Pharm. D., R.P.  
- - -

DHHS STAFF PRESENT:

Matt Gelvin, Administrator  
Marla Scheer, Administrative Staff

I N D E X

Reporter's Certificate 3

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## REPORTER'S CERTIFICATE:

State of Nebraska            )  
  ) ss  
County of Lancaster        )

I, LINDA W. ROHMAN, reporter for GENERAL REPORTING SERVICE, certify that I reported the proceedings in this matter; that the transcript of testimony is a true, accurate, and complete extension of the recording made of those proceedings; further, that the disposition of the exhibits is referenced in the index hereto.

IN TESTIMONY WHEREOF, I have hereunto set my hand at Lincoln, Nebraska, this \_\_\_\_\_ day of July, 2015.

\_\_\_\_\_  
Reporter

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1 PROCEEDINGS:

2 CHAIRPERSON JACKSON: So, we'll start the public  
3 hearing. I'll ask the Committee members to hold any  
4 comments or questions until the end of each group's  
5 testimony. We'll start with the applicant group. They'll  
6 have a total of one hour of time to give us their  
7 information. Then there'll be time for questions. And  
8 then, we'll move on to the other groups.

9 MR. GELVIN: Did everyone that wants to testify  
10 get signed up?

11 (No response.)

12 I have seven applicant group members, three  
13 proponents, one opponent, and one neutral.

14 CHAIRPERSON JACKSON: We'll start with the  
15 applicant group.

16 MR. GELVIN: Yeah.

17 CHAIRPERSON JACKSON: So, who's first on the list?  
18 They can all just join us.

19 MR. GELVIN: Yeah.

20 CHAIRPERSON JACKSON: Okay.

21 We ask that you state your name and spell your  
22 name.

23 ELISABETH HURST

24 MS. HURST: Good afternoon. My name is Elisabeth  
25 Hurst. E-l-i-s-a-b-e-t-h, H-u-r-s-t. And I am the Director

1 of Advocacy with the Nebraska Hospital Association and a  
2 sponsor of the credentialing review application for surgical  
3 first assistants.

4 I've handed out two documents. The first is the  
5 amendment, dated July 8<sup>th</sup>, for this particular application;  
6 and the second is the responses from Sidney Regional Medical  
7 Center and the Nebraska Hospital Association addressing the  
8 questions and issues that were posted as a result of our  
9 last meeting. If it's okay with the Chair and the members  
10 of the Committee, I would like to first address the question  
11 and issue responses as part of my testimony.

12 CHAIRPERSON JACKSON: Okay.

13 MS. HURST: The first, as we've referenced already  
14 today in our meeting, is regarding the definition of  
15 misdemeanors being used and what are some examples. We had  
16 handed out examples at our last meeting, which, I apologize,  
17 I hadn't given those to Matt since our last meeting so  
18 they're posted online, but I do believe you have copies. If  
19 not, I have extras. Those identified misdemeanor and felony  
20 definitions within current professional and occupational  
21 licensure definitions. And as we discussed in the meeting,  
22 we want to make sure there isn't subjectivity in the  
23 interpretation of those definitions through the application  
24 process. And, as a result, our recommendation is that, for  
25 both licensure of the surgical first assistants and for the

1 registry of the surgical technologists, that there be an  
2 exclusion of minor traffic violations and, as just  
3 mentioned, non-moving violations and not limiting the  
4 definition of a misdemeanor and felony.

5 For question number two, as discussed at the June  
6 18<sup>th</sup> meeting, inclusion of functions within a statutory  
7 scope of practice are specific to the occupation addressed  
8 and do not preclude other allied health care professionals  
9 or health care practitioners from performing them. In  
10 meeting with the Department, this was clarified, and it was  
11 recommended that any functions that we think are integral to  
12 the particular occupation or proposed scope should be  
13 included. Therefore, these functions will remain in the  
14 proposed scope of practice for the surgical first assistant.

15 Regarding the role of the surgical first assistant  
16 in the closure of body planes, we have included within the  
17 scope the definitions, as defined through the Association of  
18 Surgical Assisting for closure of body planes, as listed  
19 there, a through d. And this will be reflected in the  
20 amendment.

21 For question number four, as mentioned at our last  
22 meeting and as indicated in the proposed scope, licensed  
23 practitioners under this proposal will be able to prepare  
24 specimens, including grafts only, as -- which is an accepted  
25 function for the occupation. Harvesting of grafts is not

1 included in the proposed scope of practice.

2           Regarding who should and should not be required to  
3 sit for the surgical technology assessment procedure, the  
4 Association of Surgical Technologists and their  
5 representative have met with the Department. And, based on  
6 this meeting, it is the recommendation of the applicant  
7 group that proof of current national certification would  
8 exempt registry applicants from the competency requirement  
9 if the Department deems it appropriate.

10           For number six, regarding which board or boards  
11 should administer the regulation of surgical technologists  
12 and first assistants, as indicated in the application  
13 amendment -- and there's a correction here. It should be  
14 dated July 8<sup>th</sup>. The applicant group recommends that the  
15 Board of Medicine and Surgery administers licensure of  
16 surgical first assistants, and, as registered nurses are the  
17 primary supervisors of surgical technologists and delegate  
18 tasks integral to the field of surgical technology, the  
19 Board of Nursing is best suited to regulate the registry of  
20 surgical technologists.

21           For number seven, which health professionals  
22 should administer or evaluate the competency assessment, we  
23 recognize that the Department will be the one who determines  
24 this process through application to the registry. Our only  
25 recommendation in line with what they may require is that

1 the licensed health care professional who evaluates the  
2 competency of the applicant must indicate his or her  
3 occupation as well as their medical license number. This is  
4 also reflected in the current medication aide registry,  
5 which we had handed out at the last meeting, and I have  
6 copies of that as well.

7 Number eight, on the nature of the assessment  
8 process for surgical technologists, is it a formal  
9 examination, an interview, or something else? As is the  
10 case for medication aides in Nebraska, the competency  
11 assessment is a demonstration of the registry applicant's  
12 ability to perform basic functions of that occupation. The  
13 licensed health care professional must observe and certify  
14 that he or she witnessed the registry applicant's ability to  
15 successfully complete the functions listed. This may occur  
16 during the educational process, on-the-job training, or in  
17 the course of the applicant's employment. As the compliance  
18 officer at Sidney Regional Medical Center, Linda Shoemaker  
19 can actually speak to this process, as she does this as part  
20 of her role at the hospital.

21 Number nine, comment on the idea of defining a  
22 scope of practice for surgical first assistants and a range  
23 of functions for surgical technologists under the terms of  
24 the proposal. As licensed health care professionals under  
25 this proposal, surgical first assistants will have a scope

1 of practice that dictates the functions an individual can  
2 perform under the license. The functions are statutory and  
3 limiting to that role.

4 This proposal creates a mandatory registry for  
5 surgical technologists. The proposed registry does not  
6 limit the functions of the surgical technology occupation.  
7 It simply dictates minimum standards for competencies  
8 through a required assessment during the application  
9 process. The best model of this type of regulation is in  
10 Nebraska's medication aide registry. Under this proposal,  
11 the only limiting factor on the full range of functions of a  
12 surgical technologist will be determined through a hospital  
13 or clinic's job description and/or competency requirements.  
14 And it's important to note that, beyond regulation, a  
15 hospital or clinic, any kind of a facility, can further  
16 define what the functions of a surgical technologist would  
17 be through their own policies, competency requirements, or  
18 job descriptions.

19 Turning to the amendment, only a few changes have  
20 been made from the amendment that was submitted on June  
21 18<sup>th</sup>, and I'll just reference those quickly. However, this  
22 particular amendment, as presented today, will substitute  
23 and replace the amendment as presented on the 18<sup>th</sup>.

24 At the end of the first paragraph under Part A, we  
25 have included that the applicant group recommends that the

1 Board of Medicine and Surgery oversees the license for  
2 surgical first assistants.

3 Moving down the page to number six on the proposed  
4 scope of practice, we've included the four items defining  
5 closure of body planes.

6 Under Part B, at the end of the first paragraph,  
7 the applicant group recommends that the Board of Nursing  
8 oversees the creation and maintenance of the registry.

9 Under number four, at the bottom of the page, to  
10 qualify for placement on the registry, this would be an  
11 example of a model for registry application requirements, we  
12 have changed, under 4, sub (a), part one, that only the last  
13 four digits of the applicant's Social Security number would  
14 be required.

15 Turning to page three, for the minimum competency  
16 requirements on the registry, we've included numbers 13, 14,  
17 and 15, as discussed at our previous meeting. And below  
18 that, the sentence has been included, "The applicant group  
19 recommends that proof of current national certification  
20 exempts registry applicants from the competency requirement  
21 if the Department deems it appropriate."

22 And now I'll move on to my prepared testimony.  
23 The surgical first assistant credentialing review  
24 application stemmed from an August 2013 facility survey at  
25 Sidney Regional Medical Center that brought to the forefront

1 a Nebraska law prohibiting physicians from delegating tasks  
2 to unlicensed health care professionals. Soon after, the  
3 State of Nebraska issued a cease and desist order informing  
4 facilities that it was illegal for the physician to delegate  
5 in this manner. Specifically, as identified in the survey,  
6 the physician could not delegate surgical tasks to the  
7 surgical first assistant.

8 Linda Shoemaker, the compliance officer and risk  
9 manager at Sidney Regional Medical Center, began researching  
10 the role of surgical first assistants in Nebraska. She  
11 quickly found that surgical assisting, like many allied  
12 health occupations, is not regulated in Nebraska and began  
13 the preliminary research for developing licensure of  
14 surgical first assistants. Linda drafted a white paper and  
15 submitted it to the Nebraska Hospital Association's Board of  
16 Directors for review.

17 The NHA Board of Directors voted to sponsor the  
18 effort of Sidney Regional Medical Center and to partner  
19 through the credentialing review process for surgical first  
20 assistants. Shortly after, a stakeholder group was convened  
21 to further develop the application. The collaboration  
22 resulted in the application submitted on February of this  
23 year, and the credentialing review process officially began.

24 And here we are. We can all agree that this has  
25 been a learning experience. Much information has been cast

1 upon you, and we all know a lot more about how allied health  
2 professionals support the surgical team.

3 The primary goal of this proposal is patient  
4 safety through increased regulation of surgical first  
5 assistants and surgical technologists. Licensure of  
6 surgical first assistants will ensure that individuals in  
7 the field of surgical assisting meet a standard of education  
8 and training that the State of Nebraska determines is  
9 appropriate for this role. Surgical first assistants  
10 possess training specific to the intricacies involved in the  
11 surgical first assisting position, and licensure will allow  
12 them to function, as trained, under the law.

13 Licensure will also increase access to services  
14 across the state. Surgeons will have greater access to the  
15 assistance necessary for providing services to patients in  
16 need. A licensed surgical first assistant can increase the  
17 availability of appropriate surgical staff. This will  
18 promote cost-effective employment of qualified individuals  
19 to assist surgeons, enabling them to provide a higher  
20 quality of care while lessening the risk of surgical  
21 procedures.

22 Additionally, licensure of surgical first  
23 assistants will boost workforce development as more  
24 individuals seek out the training necessary to fulfill  
25 licensure requirements. Those functioning as a surgical

1       technologist may realize the benefits of attained increased  
2       education. Increased demand will create new training  
3       programs in Nebraska, which will boost the workforce for  
4       this occupation.

5               Finally, creation of a mandatory registry for  
6       surgical technologists with a competency assessment  
7       requirement will assist the State of Nebraska in ensuring  
8       that individuals functioning in the surgical technology  
9       occupation meet the competency requirements necessary to  
10      provide quality care in the state.

11              To highlight the application proposal, amended  
12      from its original form, there are several individuals who  
13      will testify as part of the applicant group. Linda  
14      Shoemaker will review the educational pathway that an  
15      individual follows to become a surgical first assistant.  
16      She will also discuss the supervision of a licensed  
17      practitioner of surgical assisting under this proposal.

18              Chris Wilson, a surgical first assistant by  
19      training, will review the proposed scope of practice for  
20      this license and explain the trainee exemption which will  
21      facilitate training of surgical first assistants in  
22      Nebraska.

23              Casey Glassburner, a certified surgical  
24      technologist and program educator, will explain the  
25      educational pathway of a surgical technologist, the

1 supervision of surgical technologists, and the benefits of  
2 the registry under this proposal.

3 Dr. Erik Otterberg, an orthopedic surgeon, is  
4 testifying on behalf of the applicant group and the Nebraska  
5 Medical Association in support of this effort.

6 Melissa Florell, with the Nebraska Nurse's  
7 Association, will briefly discuss the Association's position  
8 in support of this effort.

9 I have also submitted to Marla written testimony  
10 from Nancy Gondringer, the Director of Surgical Services at  
11 CHI St. Elizabeth's, in support of this effort. She was  
12 unable to be here at the last minute, and so we submitted  
13 her written testimony.

14 Finally, Bruce Rieker of the Nebraska Hospital  
15 Association will discuss the credentialing review criteria  
16 and corresponding elements of the proposal.

17 We appreciate the many stakeholders who have  
18 contributed their expertise, time, and resources to bring  
19 this proposal to its current form. On behalf of the  
20 applicant group, I would like to thank all involved.  
21 Additionally, we would like to thank the Nebraska Medical  
22 Association, the Nebraska Nurses Association, and the  
23 Nebraska Association of Independent Ambulatory Centers for  
24 their letters of support.

25 And, at this time, I will take any questions that

1       you may have.

2                   MR. KINNEY:  When you addressed the  
3       misdemeanor/felony issue and decided to exclude, -- how did  
4       you describe it?

5                   MS. HURST:  Minor traffic violations.

6                   MR. KINNEY:  Minor traffic violations.  Did you  
7       give any consideration to juvenile matters?  That was the  
8       other thing we had talked about.  And the reason I'm asking  
9       you, and I'm not an expert in this area, but it's my  
10      understanding that, generally, juvenile matters are  
11      confidential and sealed.  And to ask one to acknowledge a  
12      juvenile conviction of some sort might be going beyond the  
13      purpose of privacy and secrecy in terms of at that stage in  
14      life.

15                  MS. HURST:  Sure.  In discussions with the  
16      Department, it had never come to light -- had not come to  
17      light that it was an issue that is prevalent, but it is one  
18      that I'll make another notation of in discussions with them.  
19      Generally, I think it's understood that juvenile matters  
20      aren't disclosed as part of this type of a process, but we  
21      want to make sure that's clarified.

22                  MR. KINNEY:  If you're able to live with putting  
23      something in there excluding minor traffic violations, I  
24      don't know why, if it's compatible with your thought  
25      process, you could not also include "and also excluding

1 juvenile matters," or something like that.

2 MS. HURST: Sure.

3 MR. KINNEY: Just because I think -- I agree, it's  
4 probably very rare that it would ever come up, but it may.

5 MS. HURST: Absolutely. I'll make a notation of  
6 that.

7 MR. KINNEY: Thank you. That's all I have.

8 MS. HURST: Thank you.

9 CHAIRPERSON JACKSON: Any other questions?  
10 Comments?

11 MS. HURST: Don't be shy. I'm prepared.

12 MS. SNECKENBERG: I've got one. Maybe this might  
13 not be the time. I was going to wait the end of your  
14 testimony. But I'd asked at an earlier meeting for a  
15 projection of how many would -- because it's my  
16 understanding that the number of surgical first assistants  
17 is fairly limited right now?

18 MS. HURST: Uh-huh.

19 MS. SNECKENBERG: And I'd asked for a projection  
20 of if, in fact, licensure did occur, what the projection was  
21 of how many you felt would -- what that population would  
22 look like. If there was a trajectory of what that would be.

23 MS. HURST: The only thing I can answer to  
24 personally at this time is that we know there's a rough  
25 estimate of somewhere around 20-plus certified surgical

1 first assistants in the state, but --

2 MS. SNECKENBERG: And you mentioned that the last  
3 time, but I think we had also talked about looking at other  
4 states and trying to do some analysis to say, if they're  
5 licensed in other states, here's approximately how many  
6 there are. The intent was to beef up your numbers, to look  
7 and see if the numbers would change --

8 MS. HURST: Uh-huh.

9 MS. SNECKENBERG: -- from seven and 20 to a higher  
10 number.

11 MS. HURST: True.

12 MS. SNECKENBERG: So, did you look at the other  
13 states and --

14 MS. HURST: No, this --

15 MS. SNECKENBERG: Could you do that?

16 MS. HURST: Yeah, absolutely.

17 MS. SNECKENBERG: Okay, thanks. I think that  
18 would get us a bigger population to --

19 MR. KINNEY: Putting first assistants under the  
20 auspices of the Board of Medicine and Surgery and surgical  
21 techs under the Board of Nursing, are you at all concerned  
22 that that could result in some inconsistent positions  
23 because it's two different boards, or is that outweighed by  
24 the fact that one board is very familiar with one group and  
25 the other is a better fit for the other group?

1 MS. HURST: I would say it's more in line with  
2 that. The surgical first assistant is going to be  
3 supervised personally by the physicians, and they're the  
4 ones who are working more hand-in-hand with that particular  
5 role. The Board of Nursing, as nurses are the ones who  
6 supervise and delegate to the surgical technologists, makes  
7 a little bit more sense, especially since the Board of  
8 Nursing is most familiar with registries, as they're the  
9 ones who currently regulate medication aides as well as  
10 nurse's aides through registries. I think that it's more --  
11 most appropriate to have the particular occupation that is  
12 supervising those roles and overseeing those roles to be the  
13 ones who are regulating those positions.

14 MR. KINNEY: Okay. Thank you.

15 CHAIRPERSON JACKSON: Any other questions?

16 (No response.)

17 Next for the applicant group. I'll have you state  
18 your name and spell it for us.

19 LINDA SHOEMAKER

20 MS. SHOEMAKER: Linda Shoemaker, L-i-n-d-a,  
21 S-h-o-e-m-a-k-e-r. Good afternoon, Chair Diane Jackson and  
22 Committee. I am currently a registered nurse in the state  
23 of Nebraska and have been for 46 years. I also serve Sidney  
24 Regional Medical Center currently as the Corporate  
25 Compliance Officer and the Risk Manager. And I am going to

1 talk about the pathway for the certified surgical  
2 technologist to obtain surgical first assist.

3 The surgical technologist must apply and take an  
4 exam through the national accredited certifying agency, the  
5 National Board, Surgical Technology and Surgical Assisting.  
6 Upon successful completion of the exam, the surgical  
7 technologist will attain certification.

8 So, the pathway for the surgical technologist to  
9 become a certifi- -- or, excuse me, a surgical first assist,  
10 you must have a qualifying facility sponsor for experience;  
11 training; submit a notarized, pre-authorized form signed by  
12 the facility director of surgery; document 200 surgical  
13 first assist cases that meet the case experience  
14 requirements with notarized verificati- -- with a notarized  
15 verification form; apply for and pass the surgical first  
16 assist exam through the NBSTSA, which I just talked about,  
17 the nationally accredited agency.

18 There are two pathways for the certified surgical  
19 technologist to obtain becoming a surgical first assist.  
20 You can attend an accredited program, or you can apply for  
21 the way I just talked about and have actual, hands-on  
22 experience and clinical time. This education and training  
23 is acquired through classroom instruction or hands-on, as I  
24 just mentioned.

25 The personal supervision that has been requested

1 in the application means having the physical attendance of  
2 the physician in the room during the performance of a  
3 service or a procedure. And this is for patient safety,  
4 which is the utmost point that we're driving at.

5 I do want to refer to question -- or the comment  
6 eight about the medication aide in the State of Nebraska.  
7 Currently, I also serve as the consulting RN for our  
8 assisted-living facility. And when it comes time for our  
9 medication aides to re-certify, I physically watch the  
10 medication aide administer the medication and go through all  
11 of the processes that is required before I sign the  
12 attestation form for them to submit for their  
13 recertification, for that clarity that Elisabeth talked  
14 about.

15 Do you have any questions? Casey Glassburner will  
16 talk about the front part of this, the surgical  
17 technologist, to the point that I began talking.

18 CHAIRPERSON JACKSON: You mentioned they could  
19 attend a program. Where's the nearest program available?

20 MS. SHOEMAKER: Bruce?

21 MS. HURST: For surgical assisting?

22 MS. SHOEMAKER: Uh-huh.

23 CHAIRPERSON JACKSON: No, surgical first assist.

24 MS. SHOEMAKER: Surgical first assisting.

25 MS. GLASSBURNER: Colorado.

1 MS. SHOEMAKER: Colorado would be the closest to  
2 us.

3 CHAIRPERSON JACKSON: Okay.

4 MS. GLASSBURNER: Well, there's two that are  
5 online. There are two that are offered distance learning.  
6 So, potentially, they could access that here, and then they  
7 have to travel to do an intense one-week lab.

8 CHAIRPERSON JACKSON: Is that through Colorado?

9 MS. GLASSBURNER: No, it's through the Meridian  
10 Institute through -- out of Nashville, Tennessee.

11 CHAIRPERSON JACKSON: Okay. But you don't  
12 necessarily have to attend one of those programs. You could  
13 do on-the-job training? Is that --

14 MS. SHOEMAKER: Yes, with the qualifications that  
15 are established in the proposal.

16 CHAIRPERSON JACKSON: Does anybody else have any  
17 questions of Linda?

18 (No response.)

19 Okay.

20 MS. SHOEMAKER: Thank you.

21 CHAIRPERSON JACKSON: Next for the applicant  
22 group.

23 CHRIS WILSON

24 MR. WILSON: Good afternoon. My name is Chris  
25 Wilson, C-h-r-i-s, W-i-l-s-o-n. I'm a surgical assistant

1 for a private orthopedic group in Omaha, Nebraska, GIKK  
2 Ortho Specialists. I'm here today to talk to the panel  
3 about surgical assisting, more importantly, the scope of  
4 practice, as we -- Elisabeth had previously covered.

5 According to the American College of Surgeons, the  
6 surgical first assistant participates during a surgical  
7 operation, and is a trained individual who is able to  
8 participate in and actively assist the surgeon in completing  
9 the operation safely and expeditiously by helping to provide  
10 exposure, maintain hemostasis, and serve other technical  
11 functions. The surgical first assistant works under the  
12 personal supervision of a physician as an allied health care  
13 provider providing quality health care services.

14 Hence, why we're here working for a licensure. I  
15 believe it's important for patient safety, as opposed to  
16 just anybody being able to do assisting, that we make sure  
17 everybody's qualified accordingly. And then, have a scope  
18 of practice to be able to follow, to be adhered to.

19 Hence, where we come up with the scope of  
20 practice, as follows, under Part A:

21 Number one, assisting the surgical team in the  
22 operative care of a surgical patient;

23 Two, positioning the patient;

24 Three, preparing and draping the patient for the  
25 operative procedure;

1           Four, providing visualization of the operative  
2 site;

3           Five, assist with hemostasis;

4           Six, assist with closure of body planes with  
5 subsets of (a) utilizing running or interrupted subcutaneous  
6 sutures with absorbable or non-absorbable material, (b)  
7 utilizing subcuticular closure technique with or without  
8 adhesive skin closure strips, (c) closing skin with method  
9 indicated by surgeon, i.e. sutures, staples, et cetera, (d)  
10 postoperative subcutaneous injection of local anesthetic  
11 agent as directed by the surgeon;

12           Seven, applying appropriate wound dressings;

13           Eight, providing assistance in securing drainage  
14 systems to the tissue;

15           Nine, preparing specimens, such as grafts; and,

16           Ten, performing surgical -- excuse me, performing  
17 tasks during a surgical procedure delegatable under the  
18 personal supervision of a licensed physician appropriate to  
19 the level of competence of the surgical first assistant.

20           I believe we had talked about, originally, on the  
21 closure of body planes, hence, we have answered the question  
22 to that from our previous meeting and had created the subset  
23 of closures that I believe was adequate for everyone's  
24 approval.

25           With that said, then I want to move on to working

1 with what Linda had talked about in the training of surgical  
2 first assistants in the state. Since it's not been a  
3 recognized practice of the years that I have been a part of  
4 it, I want to touch base on making sure that the applicants  
5 who want to become surgical first assistants have the  
6 ability to do so. And, under that part of our application,  
7 we wanted to require, or have the State require, that  
8 trainees are allowed under State law to perform tasks  
9 integral to the accredited program in which he or she is  
10 enrolled while unlicensed. Under the proposal, the  
11 applicant's requesting that the statutory language would be  
12 similar to that of the physician's assistant under Nebraska  
13 Revision (sic) Statute 38-2048 is developed and included in  
14 the legislative proposal to facilitate training of the  
15 surgical first assistants in the state.

16 And this will also pave the way for the  
17 development of any accredited program in Nebraska's  
18 educational institutions. And I think something will  
19 eventually arise if we do do a licensure. I'm sure that the  
20 institutions -- and Casey will probably touch on this a  
21 little bit more -- I'm sure some of the surgical technology  
22 institutions will probably work toward first assistant  
23 programs. I would assume that's going to be the case.

24 And I'm open to any questions that the panel might  
25 have.

1 MR. KINNEY: The hands-on, the on-the-job  
2 training, is one of the alternatives to qualify.

3 MR. WILSON: Yes.

4 MR. KINNEY: Of those surgical techs that we have  
5 at this point, how many of them do you think possess that  
6 experience? Just ballpark, percentage-wise.

7 MR. WILSON: It would be difficult to assess. I  
8 really wouldn't even start to try to guess how many would be  
9 out there. You know, since this isn't -- this has not been  
10 something that the State has wanted to keep track of, I --  
11 there's no way to know the numbers out there. There's no  
12 registry, there's never been any kind of registry involved  
13 with that, so I -- it would be difficult to even come up  
14 with a ballpark in my head.

15 MR. KINNEY: Can the surgical tech come up with  
16 his or her own estimate? I mean, do they keep track of it  
17 as they go?

18 MR. WILSON: I would imagine that would be the  
19 case, yes. Yes.

20 MR. KINNEY: Do you have any -- and I suppose the  
21 answer to this question is it depends on where they're  
22 working -- but how long does it take to obtain the necessary  
23 on-the-job experience?

24 MR. WILSON: Oh, I would say a course of several  
25 years. I don't think anything -- you know, formal training

1 is a year within itself. With the requirement of additional  
2 cases and the amount of cases that are required on their  
3 formal training is at least a year's worth of cases to be  
4 assumed. So, I'm going to state that, probably, the minimal  
5 of two years would be the acceptable amount of anybody being  
6 grandfathered under the clause to be allowed to be able to  
7 do that.

8 MR. KINNEY: Okay. Thanks, Chris.

9 MR. WILSON: Yeah, you bet.

10 Any other questions I can answer?

11 CHAIRPERSON JACKSON: How long have you worked for  
12 the ortho group?

13 MR. WILSON: It will be 20 years in September.  
14 I'm not as young as I appear.

15 (Laughter.)

16 CHAIRPERSON JACKSON: So, did most of your- -- was  
17 most of yours on-the-job training?

18 MR. WILSON: Yes, ma'am. I have had some formal  
19 training, but, yes.

20 DR. BALDWIN: I guess I have a question. And it  
21 may be that I just don't understand something. How do you  
22 get -- how will, going forward, people get this training if  
23 it's outside of the scope of practice of a surgical  
24 technologist?

25 MR. WILSON: Well, I think what you're asking is,

1       how will people get education without formal education? And  
2       I believe that the answer to that is they won't. There'll  
3       be -- formal education will be necessary, moving forward,  
4       once the licensing process happens.

5                 DR. BALDWIN: I think that's what you're backing  
6       people into a corner. And I'm not saying that that's  
7       necessarily bad. But you need to realize that, technically,  
8       asking somebody to close a -- prove that they can close a  
9       wound, to allow them to close a wound, they have to close a  
10      wound, and to close a wound, you have to be within the scope  
11      of your responsibilities, so we may have a catch-22 here.

12                CHAIRPERSON JACKSON: But that's what they talked  
13      about.

14                MR. WILSON: It's -- to answer part of that is, I  
15      work very closely with a registered nurse first assist who  
16      teaches suturing courses. And the interesting aspect of  
17      that, Doctor, is that he is now training nurse practitioners  
18      and physician's assistants, who are required by their  
19      program, to come for a week suturing class. So, I think the  
20      answer to your question is that, even if a person's trained  
21      on the job, they can still attend these courses, suturing  
22      courses, to be able to become educated in that portion. So,  
23      it's not just something that would be educated -- unedu- --  
24      you know, not through some kind of training program. There  
25      are training programs out there available for people.

1                   CHAIRPERSON JACKSON: Well, and didn't you mention  
2 that part of the education process would allow them to do --  
3 practice some of those techniques through their training?

4                   MR. WILSON: That's absolutely correct.  
5 Absolutely correct.

6                   CHAIRPERSON JACKSON: So, they -- like nurses,  
7 nurse practitioners, PAs, who take care of patients while  
8 they're going to school --

9                   MR. WILSON: Are allowed to --

10                  CHAIRPERSON JACKSON: -- under the supervision of  
11 another?

12                  MR. WILSON: -- practice accordingly. That's  
13 exactly right. That would be stating that a nurse wouldn't  
14 be able to work with a patient, voluntarily, through their  
15 education because they haven't been educated to do so  
16 accordingly. So, it's a catch-22, and I would agree. But  
17 that's why there has to be an educational program or, at  
18 least, an allowance.

19                  MS. SNECKENBERG: So, who would approve those  
20 courses? Would it be the Board of Surgery and Medicine  
21 would approve the courses?

22                  MR. WILSON: I believe Casey Glassburner is going  
23 to touch on that a little bit better, but I believe that the  
24 national board is going to -- no? Is NBS --

25                  MS. GLASSBURNER: Approve, I'm sorry, approve the

1 courses, the surgical assisting programs, who accredits  
2 those programs?

3 MR. WILSON: Correct. Correct.

4 MS. GLASSBURNER: It is CAAHEP. I don't know if  
5 you're familiar with them, but they're the Commission on  
6 Accreditation of Allied Health Education Programs. They're  
7 a national accreditation agency that accredits surgical  
8 assisting programs as well.

9 MS. SNECKENBERG: But wouldn't the Board of  
10 Surgery and Medicine still have to approve that  
11 organization?

12 MS. GLASSBURNER: That school --

13 MS. SNECKENBERG: That school.

14 MS. GLASSBURNER: -- that they were enrolled in,  
15 yes, I think that's the idea, is that, as long as they prove  
16 that they're enrolled in that accredited school, then, yes,  
17 there would be some type of, like, an affiliation agreement,  
18 somewhat similar to what we have, such as, at Southeast  
19 Community College. When I have a surgical technology  
20 student that's in Alliance, we have an affiliation agreement  
21 with that hospital that allows our student to come in and  
22 work in the surgical procedures while they're still a  
23 student. So, it would just be some type of an affiliation  
24 agreement or a temporary license, if you want to say  
25 something like that, that would allow that person who's

1 enrolled in that accredited program to gain that clinical  
2 experience that's required for graduation from the program.

3 MS. SNECKENBERG: And that would be approved by  
4 the Board of Medicine and Surgery if they're overseeing the  
5 licensure?

6 MS. GLASSBURNER: I would assume. I'm not sure  
7 how the applicant group --

8 MR. WILSON: The medical association.

9 MS. GLASSBURNER: -- wanted to do that, but I  
10 would assume that that would be how that lines up, --

11 MR. WILSON: Fall under the NMA.

12 MS. GLASSBURNER: -- because that's how the  
13 license is administered.

14 CHAIRPERSON JACKSON: Any other questions for  
15 Chris.

16 (No response.)

17 Okay.

18 MR. WILSON: Okay. Thank you.

19 CASEY GLASSBURNER

20 MS. GLASSBURNER: I am Casey Glassburner,  
21 C-a-s-e-y, G-l-a-s-s-b-u-r-n-e-r. And I -- actually, before  
22 I do my testimony, I would like to answer the question that  
23 was just asked about the on-the-job training and how that  
24 happens for -- currently, for -- as a pathway to sit for the  
25 CFSA exam. As Linda originally talked about, there has to

1 be an authorization by an OR director that says, yes, this  
2 surgical technologist who currently works in my facility can  
3 log those cases in my facility. I'm signing off on that as  
4 the OR director. And then, that person has two years,  
5 there's only a two-year time window, for them to log the 200  
6 cases that are required in the specific specialties that are  
7 required. And then, they take that notarized form of the  
8 cases that they log, they submit it to the NBSTSA, and then  
9 they sign off on those cases and say that this person is  
10 eligible to sit for that national certifying exam in  
11 surgical assisting.

12 I will tell you that the National Board of  
13 Surgical Technology and Surgical Assisting is planning to  
14 get rid of that pathway. They are moving towards only  
15 having the pathway of having everybody graduate from an  
16 accredited surgical-assisting program to be allowed to sit  
17 for that national certifying exam.

18 So, does that answer your question about how that  
19 pathway works?

20 MR. KINNEY: I think so. Yeah.

21 MS. GLASSBURNER: Okay. Perfect. All right.

22 So, I will go on, then, with my testimony related  
23 to the educational pathway for and supervision of surgical  
24 technologists in the State of Nebraska and, also,  
25 nationally, as well as the benefit of establishing a

1 surgical technologist registry here in the state.

2 Currently, here in the state of Nebraska, as well  
3 as across the country, surgical technologists are educated  
4 in surgical technology programs that are accredited by  
5 either CAAHEP, which is the Commission on Accreditation of  
6 Allied Health Education Programs, or ABHES, which is the  
7 Accrediting Bureau of Health Education Schools. There are  
8 over 500 accredited surgical technology programs across the  
9 country, and most of them result with a graduate receiving  
10 an Associate's of Applied Science in Surgical Technology  
11 upon completion. By 2021, all accredited surgical  
12 technology programs are required to be associate degree  
13 programs, as they are currently phasing out all diploma  
14 programs in order to create uniformity among the education  
15 of all graduates of accredited surgical technology programs.

16 There are two CAAHEP-accredited surgical  
17 technology programs in the state of Nebraska, one, in Omaha  
18 at Nebraska Methodist College, and one here in Lincoln at  
19 Southeast Community College, which also offers their program  
20 online to serve the western part of the state. I am also an  
21 instructor in that program. Both of these programs are  
22 associate degree programs and include several months of  
23 clinical education in order to prepare graduates for success  
24 in the field following completion of that program. Students  
25 in the surgical technology program at Southeast Community

1 College spend 700 hours in the actual operating room and  
2 scrub around 150 to 200 cases prior to graduation.

3 Surgical technologists are allied health  
4 professionals who play an integral role as a member of the  
5 operating room team. They work under the direction of  
6 hospital and clinic policies and under the supervision of  
7 the independent licensed practitioner and the registered  
8 nurse throughout the preparation, performance, and clean up  
9 of a surgical procedure. Their main focus is assisting the  
10 surgical team to ensure the procedure is performed as  
11 efficiently as possible by anticipating the needs of the  
12 team and maintaining the highest level of aseptic or sterile  
13 technique to ensure that the patient does not acquire a  
14 surgical-site infection. Surgical technologists are the  
15 only member of the operating room team that are specifically  
16 trained in the procedures that should be utilized to  
17 minimize the patient's risk of contracting a postoperative  
18 wound infection. Their attention to making sure that all  
19 the instruments and supplies are sterile during the  
20 preparation and throughout the case directly affect the  
21 outcomes upon completion for the patients. Surgical site  
22 infections can cause a case that would have otherwise been  
23 considered a success to be seen as a failure by a patient  
24 and their family.

25 Creation of a mandatory surgical technologist

1 registry with a competency assessment requirement is an  
2 essential step that must be taken to improve surgical  
3 patient care, as well as ensure that surgical patients  
4 throughout the state are being protected from the potential  
5 harm that can result from unqualified members of the team  
6 being present during a procedure. Surgical patients do not  
7 have the ability to choose their team like they have the  
8 ability to chose their surgeon. These patients deserve to  
9 know that everyone in their operating room has, at least, a  
10 minimum level of competency for the role they are serving  
11 in. And, currently, the surgical technologist is the only  
12 member of the immediate operating room team that does not  
13 have education or competency requirements.

14 Surgical patients are in their most vulnerable  
15 state where they do not have a voice to speak up for  
16 themselves. They are trusting that every member of the team  
17 has their best interest at heart at every step of their  
18 care. By establishing this mandatory registry, we can help  
19 give every surgical patient this peace of mind.

20 I'm available for any questions that you may have.

21 CHAIRPERSON JACKSON: The Southeast Community  
22 College offers an online program?

23 MS. GLASSBURNER: Yes.

24 CHAIRPERSON JACKSON: And then, do you ha- -- you  
25 talked about having affiliated agreements with different

1 hospitals --

2 MS. GLASSBURNER: Uh-huh.

3 CHAIRPERSON JACKSON: -- where students can  
4 practice?

5 MS. GLASSBURNER: Yeah, that's where they perform  
6 their clinical education. They do come to us for a lot of  
7 the formalized lab work in the beginning to make sure that  
8 they have that base foundation. We try to consolidate it  
9 into eight-hour labs every other week. But they do travel  
10 to us, so they are getting the same base foundation that the  
11 students do face-to-face. And then, they do perform, then,  
12 their clinical procedures or the clinical experience within  
13 the hospital. And, hopefully, it's a win-win for the  
14 hospital as well, because, hopefully, that student will then  
15 stay there and be employed in the hospital. So, it helps to  
16 serve the need of the hospitals in the western part of the  
17 state as well.

18 CHAIRPERSON JACKSON: How long has -- the program  
19 at Southeast and the program at Methodist, how long have  
20 they been in operation? Any idea?

21 MS. GLASSBURNER: The program at Southeast, I  
22 know, has been around, I think, about 40 years. Don't quote  
23 me on the exact date, but it's been a very long time. They  
24 have been associate degree less than that. They were  
25 diploma in the beginning, but then, they did move to an

1 associate degree program.

2 It is important to note, too, that all graduates  
3 of accredited surgical technology programs sit for the  
4 national certifying exam prior to graduation. So, the  
5 majority of students that are coming out of these programs  
6 are certified, and, for our two past classes at Southeast,  
7 we have had a hundred percent pass rate of that national  
8 exam.

9 CHAIRPERSON JACKSON: But certification is not  
10 required?

11 MS. GLASSBURNER: It is not required. There are,  
12 however, a few hospitals in the state that do require  
13 certification, such as the Lincoln Surgical Hospital here in  
14 Lincoln; York General Hospital in York does require  
15 certification; Norfolk, Faith Regional, they require  
16 certification, as a condition of employment for surgical  
17 technologists in those facilities.

18 MR. KINNEY: And I apologize if you addressed this  
19 in your remarks, but you're recommending registry with  
20 competency assessment for --

21 MS. GLASSBURNER: Right.

22 MR. KINNEY: -- surgical techs.

23 MS. GLASSBURNER: Yes.

24 MR. KINNEY: Assuming there's 300 -- I'm pulling  
25 it out of the air -- does that apply to the current 300 as

1 well as all future surgical techs?

2 MS. GLASSBURNER: Yes, absolutely. Yes.

3 MR. KINNEY: So, the ones who are currently  
4 certified, you would have to go through additional training  
5 under this, or --

6 MS. GLASSBURNER: No, absolutely not. Elisabeth  
7 did speak to that in the amendment. That we did meet with  
8 the Department of Health and Human Services, members of the  
9 Nebraska State Assembly did. And anyone who is currently a  
10 CST, all they would have to do is show their certification  
11 card, and that would serve as their proof of competence to  
12 say, yes, I've passed this national certifying exam, and  
13 this proves that I'm competent.

14 MR. KINNEY: Okay.

15 MS. GLASSBURNER: Because I've graduated from an  
16 accredited school, I've passed the national exam, and I  
17 maintain current through my continuing education that's  
18 required.

19 MR. KINNEY: What if they don't have the  
20 certification, then --

21 MS. GLASSBURNER: Then, they would just go through  
22 that competency assessment that they described earlier. So,  
23 they would just need to have those skills that were listed  
24 in the amendment, observed by a licensed health care  
25 professional, to determine that they're competent.

1 MR. KINNEY: All right. Thank you.

2 CHAIRPERSON JACKSON: It's probably been mentioned  
3 and I just can't remember. How often would you have to show  
4 competency?

5 MS. GLASSBURNER: I'm not sure that that was  
6 mentioned. I think, originally, we talked about, possibly,  
7 two years. The certification is on a four-year cycle, so I  
8 think the recommendation would be either two to four years  
9 so that you line up with that certification cycle.

10 MS. SHOEMAKER: The current medication aide  
11 recertification is every two years.

12 CHAIRPERSON JACKSON: Any other questions?

13 MS. GLASSBURNER: Thank you. Anybody else?

14 (No response.)

15 CHAIRPERSON JACKSON: Okay. Next for the  
16 applicant group.

17 DR. ERIK OTTERBERG

18 Good afternoon. I'm Dr. Erik, E-r-i-k, Otterberg,  
19 O-t-t-e-r-b-e-r-g. I'm an orthopedic surgeon in Omaha,  
20 Nebraska. Also, currently, the chief of staff at Lakeside  
21 Hospital, and I sit on the Systems Credentialing Committee  
22 for the system. I'm here on behalf of the NMA to lead -- to  
23 support this amendment.

24 I have worked with surgical first assistants.  
25 I've had quite a bit of experience with them. As a surgeon,

1 I find them to be extremely valuable as team members. To  
2 make it simple, they make my life easier. They make me more  
3 efficient, which makes my patient outcomes better. The way  
4 they do so is because, once you begin to work with an  
5 assistant and you've worked with them a while, they, like  
6 other people who you guys really works with well, know what  
7 you want. This retractor goes here, this retractor goes  
8 here. I can see what I need to see. I don't have to put it  
9 in somebody's hand and say, "Hold here." Put another in his  
10 hand and say, "Hold here."

11 Making me more efficient actually decreases  
12 operating room time, which has several consequences. First  
13 and foremost, it keeps people -- it gives people shorter  
14 surgical time, less anesthesia. Also, in our times of  
15 heightened infections, decreased operating room times,  
16 particularly in my field, which is total hip and knee  
17 replacements, are associated with lower infection rates.  
18 Critical, both from a patient's point of view, because an  
19 infected total joint is an extremely -- significantly  
20 affects their quality of life, and by a cost view, an  
21 infected total joint costs the system about \$150,000 for  
22 that.

23 I don't want to take a lot of your time, but some  
24 of the questions that were brought up that I thought I might  
25 address while I was here. Mr. Kinney, I think you said

1 about how many surgical assistants would you possibly see in  
2 the future. Looking at that, as surgeons get to work with  
3 surgical assistants more, I think what they will find is  
4 that this will be a cost-effective and -- surgical  
5 assistants are very much part of the health care team and  
6 they find it very rewarding. So, I think, as this  
7 opportunity becomes available, there'll be a lot of people  
8 who look at this as a great opportunity.

9 In terms of credentialing at the hospital system,  
10 currently, our surgical assistants are credentialed through  
11 our Medical Executive Committee and through the system's  
12 Credentialing Committee. So, they're not separated  
13 separately. They go through our system.

14 And then, I think another point you brought up was  
15 how long does it take to become competent or good, which is  
16 interesting. We address that in our residency program right  
17 now. You know, we have a residency program. It's five  
18 years of orthopedic surgery resident, and then you're out.  
19 Is everybody competent in five years? Some might be  
20 competent in four and some may be competent in six. And I  
21 think that the time where any of us feel like we're  
22 completely competent and don't need to learn anymore, we  
23 should stop working, because that's not the -- we need to be  
24 continually educating ourselves. My personal experience is  
25 I think, as people -- when I've worked with our surgical

1 assistants, as people's competency improves, their duties --  
2 their scope of practice widens, under supervision. So, my  
3 guess is, I think, to really become somebody who becomes  
4 competent, in my mind, it's probably a two- to five-year  
5 period, depending on the individual.

6 Other questions from the Committee for me?

7 DR. BALDWIN: Do you think that the 200 cases is  
8 adequate?

9 DR. OTTERBERG: Yeah, I think 200 is a good  
10 number. Again, I think, I put it, as myself, as a surgeon,  
11 if I had a surgical assistant and if I'm working on training  
12 somebody, 200 is adeq- -- is a good number. But, again, not  
13 everybody necessarily falls into that. Some people may  
14 require additional training. We find ourselves doing that  
15 in residency, where we will have someone stay another year.  
16 And, again, I think you have to have a rough number. But I  
17 would always say, holding fast to a number is -- can always  
18 be dangerous. As a physician, it wouldn't make a difference  
19 if they had 2000 or 200, it's under my supervision, what  
20 I've seen them do, and what I think they're competent at,  
21 which is what would be their level of scope of practice,  
22 based on working with me.

23 DR. BALDWIN: Within this proposal, then, is there  
24 some demonstration of competence that must mandatorily go  
25 along with the acquisition of those 200 cases?

1 DR. OTTERBERG: I think, when you have those 200  
2 cases, my thought, and correct me if I'm wrong, there will  
3 be evaluations of the cases, is that correct?

4 (No audible response.)

5 DR. OTTERBERG: Yeah. So, there will be  
6 evaluations of those cases. So, just having the number  
7 itself, I would say, is not -- you have to have someone sign  
8 off on the cases and say you are appropriate.

9 DR. BALDWIN: So, it's not just a matter of  
10 numbers, it's a matter of quality as well.

11 DR. OTTERBERG: It's my understanding that is  
12 correct.

13 MR. WILSON: Each case has to be approved, Doctor,  
14 by the facility's person who's in charge of watching over  
15 those cases, so each case has to be approved.

16 CHAIRPERSON JACKSON: That's part of the log that  
17 they have to keep?

18 MR. WILSON: Part of the log, yes, ma'am.

19 DR. BALDWIN: Thank you.

20 MS. GLASSBURNER: And then, they have to sit for  
21 and pass the certification exam, the national certifying  
22 exam. So, the certifying exam, I guess, is your level of  
23 competence.

24 DR. BALDWIN: Okay. Thank you.

25 DR. OTTERBERG: Any other questions or concerns?

1 (No response.)

2 DR. OTTERBERG: Appreciate your time. Thank you  
3 very much.

4 DR. BALDWIN: Thank you.

5 CHAIRPERSON JACKSON: Next member of the applicant  
6 group.

7 MELISSA FLORELL

8 MS. FLORELL: I'm Melissa Florell, M-e-l-i-s-s-a,  
9 F-l-o-r-e-l-l. I'm here on behalf of the Nebraska Nurses  
10 Association, and I'll be very, very brief.

11 I want to just restate our support of the work of  
12 the applicant committee in the pursuit of licensure for  
13 certified first surgical assists and then, also, for the  
14 registry for surgical technologists. We believe that it's  
15 essential to begin to identify the people that are in the  
16 operating room caring for the patients and to give the  
17 benefits that are put forth in this proposal to the care of  
18 the patient. And that is a scope of competency -- or a  
19 scope of practice for the certified surgical first assist  
20 and a level of competency that is verified for surgical  
21 technologists. And we submitted that in our written  
22 statement. I believe it came forward in the main meetings.

23 Do you have any additional questions for me?

24 (No response.)

25 CHAIRPERSON JACKSON: Thank you.

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BRUCE RIEKER

MR. RIEKER: Chairwoman Jackson, Members of the Committee, my name is Bruce Rieker. It's B-r-u-c-e, R-i-e-k-e-r. And I will be here testifying with regard to the applicability of the application to the four criteria by which this application will be measured.

To aid the Technical Review Committee's review of the surgical first assistant credentialing proposal, Sidney Regional Medical Center and the Nebraska Hospital Association have applied proposal components to each of the four criteria on which the review is based. Criterion number one, the unregulated practice can clearly harm or endanger the health, safety, or welfare of the public. In the comments that I will share with you, we broke this out for the licensure of the surgical first assists, and then how the criteria applies to the surgical technologists, so we broke it out.

So, with regard to the first criterion and how that applies to the licensure of surgical first assistants, the role of the surgical first assistant is specific to surgical techniques and procedures that require high-level training and competency to meet the safety needs of patients. Surgical first assistants must possess education and training, examination, and experience to function in and foster a safe surgical environment. The continuing

1 education requirements that will be in place as part of the  
2 regulation will further ensure safety of the patient.

3 As far as the criteria of the unregulated practice  
4 could clearly harm or endanger the health, safety, or  
5 welfare of the public for surgical technologists, we submit  
6 that, currently, health care facilities can employ surgical  
7 technologists with little or no experience in surgical  
8 technology. Creation of a mandatory registry for surgical  
9 technologists that is a requirement for employment within  
10 Nebraska will aid the State in regulating the surgical  
11 technology field, strengthening patient safety, and  
12 safeguarding against employment of inexperienced allied  
13 health professionals. Requiring a competency assessment, as  
14 has already been discussed, for surgical technologists as  
15 part of the mandatory registry ensures that only surgical  
16 technologists with prior experience, whether on-the-job  
17 training or formal education, can be employed in Nebraska,  
18 and that surgical technologists must exhibit basic  
19 principles of surgical technology as part of the registry  
20 application process to be eligible for the registry.

21 As far as criterion number two, the regulation of  
22 the profession does not impose significant new economic  
23 hardship on the public, significantly diminish the supply of  
24 qualified practitioners, or otherwise create barriers to  
25 service that are not consistent with the public welfare and

1 interest. As that pertains to surgical first assistants,  
2 licensure of surgical first assistants will not impose a  
3 significant economic hardship on the public as licensure  
4 fees will offset the expense to the State to implement and  
5 maintain licensure of the occupation, and the credentialing  
6 requirement will not increase the cost of the services a  
7 surgical first assistant provides to a patient, as those  
8 fees are included under global billing for surgical  
9 procedures.

10 Currently, surgical first assistants cannot  
11 function in Nebraska within the role of surgical assisting.  
12 Regulation of surgical first assistants will not diminish  
13 the supply of qualified practitioners, but, rather, allow  
14 those who meet the licensure requirements to practice in  
15 Nebraska. The ability to practice will logically encourage  
16 other allied health professionals in Nebraska to obtain  
17 education and training required for such licensure, which  
18 will, in turn, encourage development of training programs in  
19 the state.

20 Appropriate utilization of surgical first  
21 assistants helps increase access to care locally while  
22 controlling the cost of health care. Engaging surgical  
23 first assistants in surgical procedures is more cost  
24 effective than utilizing mid-level practitioners to carry  
25 out the role of the assistant to the surgeon, reducing the

1 cost of service while maintaining patient safety through  
2 specialized care.

3 As the second criterion applies to surgical  
4 technologists, implementation of a mandatory registry for  
5 surgical technologists will not impose a significant  
6 hardship on the public. Registry fees will offset the  
7 expense to the State to implement and maintain the registry.

8 The third criterion of the four by which this will  
9 be judged, the public needs assurance from the State of  
10 initial and continuing professional ability. I think that a  
11 great deal of that has already been discussed by previous  
12 testifiers.

13 As it applies to surgical first assistants, under  
14 this proposal, only those surgical assistants who have met  
15 the new licensure standard of appropriate education,  
16 training, and examination are eligible for licensure. The  
17 Nebraska Department of Health and Human Services will  
18 develop and approve these initial requirements. The  
19 surgical first assistant occupation has its own specific  
20 educational standards, as well as private certification  
21 requirements. Under this proposal, the Department would  
22 collaborate with private, certifying bodies, issuing  
23 certification for surgical first assistants to facilitate  
24 the State of Nebraska's endorsement of the education,  
25 training, and testing upon which the private credential is

1 based. These standards would become part of the new  
2 licensure standard for surgical first assistants in  
3 Nebraska.

4 Additionally, the proposal requires a continuing  
5 education component in line with national standards to aid  
6 in ensuring continuing competence. As with other  
7 occupations in the state, this component will be mandatory  
8 and rigorous to bolster patient safety.

9 As this criterion applies to surgical  
10 technologists, the mandatory registry for surgical  
11 technologists will include a competency assessment  
12 requirement that will require applicants and those renewing  
13 their registration to exhibit basic principles of surgical  
14 technology. This is an indicator of both initial and  
15 continued ability, providing public assurance of the  
16 applicant's competency.

17 The last criterion, the public cannot be protected  
18 by a more effective alternative. As that pertains to  
19 surgical first assistants, surgical first assistants are  
20 trained to perform very specific functions during surgical  
21 procedures, to participate in and actively assist the  
22 surgeon in completing the operation safely and  
23 expeditiously, as pointed out by the American College of  
24 Surgeons. As surgical first assistants are trained in both  
25 surgical technology and surgical assisting, they are the

1 most qualified individual to assist the surgeon in this very  
2 specialized field. While mid-level practitioners can carry  
3 out the functions of a surgical first assistant, surgical  
4 first assistants receive more focused training, as this is  
5 their specialty area, garnering more expertise and  
6 experience in assisting the surgeon.

7 As this pertains to surgical technologists, once  
8 again, the competency assessments as requirements for the  
9 registry eligibility are an established best practice for  
10 protecting the public's best interest.

11 That is the conclusion of my formal comments. Are  
12 there any questions?

13 (No response.)

14 CHAIRPERSON JACKSON: No. Thank you.

15 MR. RIEKER: Thank you.

16 MR. GELVIN: Madame Chair, there are three more  
17 people. A Catherine Sparkman, I believe? Is Catherine  
18 here?

19 MS. GLASSBURNER: Matt, can I testify again, since  
20 I -- as, yeah, as a proponent, not with the applicant group?

21 MR. GELVIN: That's fine.

22 MS. GLASSBURNER: Okay. I'm back.

23 CHAIRPERSON JACKSON: You'll have to state your  
24 name again.

25 CASEY GLASSBURNER

1 MS. GLASSBURNER: Okay. I'm Casey Glassburner,  
2 C-a-s-e-y, G-l-a-s-s-s-b-u-r-n-e-r. I think I put too many  
3 Ss in that. Sorry.

4 (Laughter.)

5 Spelled it too many times.

6 So, I am a certified surgical technologist. I'm  
7 also currently the president of the Nebraska State Assembly  
8 of the Association of Surgical Technologists. And this  
9 testimony is going to be on behalf of that organization, as  
10 well as our national organization, the Association of  
11 Surgical Technologists, which is AST, and, also, the  
12 Association of Surgical Assistants, which is ASA.

13 In relation to our recommendations to your  
14 questions and issues that were posted to the credentialing  
15 review website, that you wanted specifically addressed at  
16 this public hearing. First, I'd like to comment on the  
17 duties of positioning the patient, draping the patient,  
18 holding retractors, and applying dressings not being  
19 included in the surgical assistant scope of practice. The  
20 American College of Surgeons and AST have a nationally  
21 approved job description for surgical technologists that  
22 includes these specific tasks. Including these tasks in the  
23 surgical assistant scope of practice would prevent surgical  
24 techs from performing these functions that are historically  
25 and currently part of their job. Therefore, we would

1 recommend that these items be included in the surgical  
2 technologist range of functions and that the scope of  
3 practice read as you will see in your copy.

4 I'd like to specifically draw attention to number  
5 two, which has, "Providing visualization of the operative  
6 site through the placement of retractors, which is an  
7 advanced skill beyond just holding retractors after they  
8 have already been placed," by the surgeon, which was  
9 referenced by the surgeon that made comments earlier. And  
10 then, also, number five, "Applying appropriate immobilizing  
11 wound dressings, which includes casts and splints that a  
12 surgical technologist is not trained to apply." So, these  
13 would be advanced skills that are performed by the surgical  
14 assistant, but are not performed by the surgical  
15 technologist. So, this would be our recommended scope of  
16 practice, as you will see.

17 It should also be noted that the American College  
18 of Surgeons, ASA, and AST have a nationally approved job  
19 description for surgical assistants that includes the task  
20 of postoperative subcutaneous injection of local anesthetic  
21 under the direction of the surgeon. It is our  
22 recommendation that this task be included in the surgical  
23 assistant scope of practice as well.

24 Next, I'd like to comment on the role of the first  
25 assistant in the closure of body planes. Again, this

1 nationally approved job description for surgical assistants  
2 that I just referenced does include information related to  
3 closure of body planes that describes only closure of the  
4 subcutaneous and skin layer by various means. Therefore, it  
5 is our recommendation that we utilize this nationally  
6 approved job description to restrict the closure to just the  
7 subcutaneous and skin layer.

8 We would also recommend that the wording of this  
9 skill within the scope be switched from "assisting with  
10 closure" to "performing closure," as there have been  
11 surgical assistants in other states that have encountered  
12 issues with their ability to actually apply sutures, because  
13 it has been interpreted that "assisting with closure" does  
14 not actually mean placing the suture in the tissue. So, we  
15 would like to make sure that that is worded appropriately to  
16 try to avoid that concern.

17 We would like to comment on the role of the  
18 surgical first assistant in preparing grafts. In order to  
19 remove the concern expressed by the Committee related to the  
20 potential of having a surgical assistant remove a graft from  
21 a patient, we would recommend that the scope of practice  
22 include the task of preparing, but not procuring, grafts  
23 after they have been removed from the patient by the  
24 surgeon. The Core Curriculum for Surgical Assisting, which  
25 is taught in surgical assisting programs, includes graft

1 care, which would provide them this base information to  
2 perform this skill.

3 We would also like to ensure that the word  
4 "specimen" is removed from the skill in the wording in the  
5 scope of practice, as specimen care is already included in  
6 the surgical technologist range of functions, which the  
7 surgical technologi- -- or which, excuse me, the surgical  
8 assistant will be allowed to perform in its entirety. Also,  
9 including the word "specimen" in this section could allow  
10 for interpretation preventing the surgical assistant from  
11 removing a specimen from a patient after it has already been  
12 removed from all of its internal attachments by the surgeon,  
13 such as taking the gallbladder out of an abdomen after a  
14 surgeon has already resected it from the liver, which is  
15 often a duty of a surgical assistant.

16 Next, I would like to comment on which potential  
17 registrants should or should not be required to undergo the  
18 surgical technologist competency, which we have talked about  
19 quite a bit already today. I just wanted to reiterate that  
20 members of the Nebraska State Assembly did meet with the  
21 Department of Health and Human Services of June 30<sup>th</sup> to  
22 discuss the potential of recognizing the National Surgical  
23 Technologist certifying exam as a method of establishing  
24 competence for surgical technologists seeking registration.  
25 We were assured that this was an acceptable pathway to

1 establish the potential registrants' competence, as the  
2 method of recognizing a national exam, but not a private  
3 agency, is utilized by other professions in the state to  
4 establish a minimum level of competence.

5 In relation to which health professionals should  
6 administer this competency, we would recommend that wording  
7 be included to reflect a "qualified licensed health care  
8 professional with at least two years of operating room  
9 experience." The operating room is a unique environment,  
10 one in which many licensed health care professionals do not  
11 practice in, making them ill-equipped to properly determine  
12 if a surgical technologist seeking to be on the registry is  
13 competent in the tasks that are required to be assessed.  
14 Prior operating room experience is essential to establish  
15 the base knowledge for a licensed health care professional  
16 to adequately assess the competence of a surgical  
17 technologist seeking registration. We would also like to  
18 ensure that an LPN is not allowed to administer this  
19 competency assessment, as we feel their educational  
20 background does not provide them the knowledge to adequately  
21 assess the competence of a surgical technologist registrant.

22 In reference to our recommendation of the nature  
23 of the competency assessment, we would endorse that it does  
24 need to be a demonstration of the skills, as you can see  
25 listed in your copy, because they are very complex and they

1 do include many intricacies. Rather than having the  
2 potential registrant sit for an exam, we would endorse that  
3 they do need to actually demonstrate the skills in order to  
4 have their competency assessed.

5 And, finally, I would like to comment on the idea  
6 of defining a scope of practice for surgical first  
7 assistants and a range of functions for surgical  
8 technologists. Our organizations completely endorse the  
9 definition of a range of functions for the surgical tech and  
10 a scope of practice for the surgical assistant that includes  
11 a clause that states that the surgical assistant can perform  
12 everything that's included within the surgical tech range of  
13 functions, as well as the tasks that are included within the  
14 scope of practice for the surgical assistant. Included in  
15 your copy you will find our recommendation of the range of  
16 functions, as well as the scope of practice, that would  
17 achieve this situation.

18 Thank you for the ability to provide you these  
19 recommendations today, and I'm available for any questions  
20 that you may have.

21 MR. KINNEY: That's a lot.

22 MS. GLASSBURNER: Yeah, sorry.

23 MR. KINNEY: Maybe what you just said goes back to  
24 the beginning of where I had a question. And maybe I  
25 misunderstood. But I thought your first suggestion was that

1 certain items, maybe four, not be included in the scope of  
2 practice, if you will, of a surgical assistant, because a  
3 surgical tech does do that.

4 MS. GLASSBURNER: Yes.

5 MR. KINNEY: What is wrong with it being listed in  
6 both scopes of practice?

7 MS. GLASSBURNER: I think the interpretation is  
8 that, if it's in the license, you have to have the license  
9 to be able to do it, and that has been the interpretation  
10 nationally. Unless you have a license. But, currently, the  
11 surgical technologist isn't -- we're not seeking licensure,  
12 so the surgical technologists will only be registered, they  
13 will not be licensed. And, therefore, because they don't  
14 have a license, they can't perform licensed duties.

15 CHAIRPERSON JACKSON: But the Department --

16 MS. GLASSBURNER: But they're different. I guess,  
17 a lot of where the confusion has come here is that, in that  
18 nationally approved job description, it had the bulleted,  
19 you know, of holding retractors. But then, underneath it,  
20 it had additional description that said "placement of  
21 retractors," which further defined how the assistant  
22 practice is different than the surgical technologist  
23 practice. So, I think what we've done is, kind of, we're  
24 trying to not step on the toes of another profession while  
25 trying to regulate this profession when there are such small

1 words of placement that really makes it very different from  
2 one profession to another. So, we really want to make sure  
3 that there -- it really is clearly defined as to the skills  
4 that are being performed by the assistant compared to what  
5 the surgical technologist does.

6 Now, you were going to make the comment that the  
7 Department said that it would not preclude them --

8 CHAIRPERSON JACKSON: That, if we had a statement  
9 that said surgical assists can perform all the tasks  
10 included in the surgical technologist range of functions as  
11 well as the tasks included in the scope of practice, then  
12 that would allow them to do everything that a surgical  
13 technologist does, but -- and they'd have additional --

14 MS. GLASSBURNER: Yes, exactly. Yes. And that's  
15 exactly what we're seeking.

16 CHAIRPERSON JACKSON: And the -- it wouldn't make  
17 it so that surgical technologists couldn't their job.

18 MS. GLASSBURNER: Exactly. And we find it  
19 redundant to list it in both places. I mean, if both people  
20 are performing it, obviously, a surgical assistant spends  
21 some of their day functioning as a surgical technologist, so  
22 it would be redundant to list those duties in the scope if  
23 they are in the range of functions already, because there is  
24 that clause that states that they are able to do everything  
25 that's included in the range of functions.

1           MR. KINNEY: Will we have an opportunity for the  
2 applicant to respond to all that we just hearing that's  
3 contained in these suggestions? I mean, is there a --

4           CHAIRPERSON JACKSON: A lot of it has already  
5 been, just looking through this. But there's a few things,  
6 like perform closure of body planes versus assist and  
7 prepare the specimen thing. So, that would be something,  
8 then, that the applicant group would respond to us at the  
9 next meeting or --

10          MR. GELVIN: Yeah, they can, or they can use their  
11 summary time.

12          CHAIRPERSON JACKSON: Okay. Yes.

13          MR. KINNEY: And I don't know if they're prepared  
14 to do that today or not. I mean, there's a lot here --

15          MS. GLASSBURNER: Yeah.

16          MR. KINNEY: -- in what you put in there, Casey.  
17 And I don't want to spend the Board's time talking about  
18 things if everybody in the room agrees.

19          MS. GLASSBURNER: Absolutely.

20          MR. KINNEY: That's kind of silly to go -- to  
21 spend time on that. So, I guess, if there's another meeting  
22 and the applicant has the opportunity to point-by-point go  
23 through these and say we agree with the first three, we  
24 don't agree with the last four, then we should be addressing  
25 the last four at that point.

1 CHAIRPERSON JACKSON: Any other questions of  
2 Casey?

3 (No response.)

4 MS. GLASSBURNER: Okay. Thank you.

5 CHAIRPERSON JACKSON: Two other proponents?

6 MR. GELVIN: Charles?

7 CHARLES SCHOLTES

8 MR. SCHOLTES: Good afternoon. I'm Charles  
9 Scholtes, C-h-a-r-l-e-s, S-c-h-o-l-t-e-s. I'm a PA. I  
10 represent the Nebraska Academy of Physician Assistants in  
11 Nebraska, in the absence of Kurt Schmeckpeper, who's our  
12 Chair of our Legislative Committee.

13 We're in support of the statements that Casey just  
14 read for surgical technologists. So, obviously, there's  
15 been a lot of changes and a lot of things I've seen in the  
16 30 years I've been doing this, that were assumed that  
17 surgical technologists could do all along that, apparently,  
18 there's been things that haven't been. And we think that  
19 bringing this to a more concise, consistent thing, to have  
20 for the public, it makes sense in terms of its safety.

21 I have one question for the Board. Has there ever  
22 been any other medical profession that's been licensed by  
23 on-the-job training, that you know?

24 CHAIRPERSON JACKSON: Yes, dental assistants.

25 MR. SCHOLTES: Dental assistants. Okay.

1                   CHAIRPERSON JACKSON: We just went through a big  
2 review for them.

3                   MR. SCHOLTES: Review, yeah.

4                   Otherwise, we appreciate Elisabeth's conversations  
5 with us, with the Nebraska Academy, and addressing some of  
6 our concerns regarding some of the verbiage in their scope  
7 of practice and would like to see things move forward. I  
8 think it's been a very good experience. We've learned a  
9 lot, and I've learned a lot. But, surely, we don't want to  
10 continue with things the way they are, because the  
11 technology in the operating room is changing a lot. We're  
12 just getting into -- Dr. Otterberg, with orthopedics -- a  
13 lot more electronic components that involve navigation and  
14 many other things in the operating room, so the skills that  
15 the people in the operating room are going to have to be way  
16 different than just passing, handing sutures, and doing  
17 things. Because those machines and things take more  
18 knowledge as we get into more consistency with some of our  
19 surgical techniques.

20                   Thank you. Short.

21                   CHAIRPERSON JACKSON: And questions of Charles?

22                   (No response.)

23                   MR. SCHOLTES: Thank you.

24                   MR. GELVIN: And a Vonderschmidt. Vonderschmidt?

25                   MR. VONDERSCHMIDT: I have no comment.

1 MR. GELVIN: No comments? Okay. Catherine  
2 Sparkman, is she still in the room?

3 MS. SPARKMAN: I am.

4 MR. GELVIN: Oh, come on up.

5 CATHERINE SPARKMAN

6 MS. SPARKMAN: Good afternoon, Chairwoman Jackson,  
7 Members of the Committee. My name is Catherine Sparkman,  
8 C-a-t-h-e-r-i-n-e, S-p-a-r-k-m-a-n. One S. I am the  
9 Director of Government and Public Affairs for the National  
10 Association of Surgical Technologists and the National  
11 Association of Surgical Assistants, both of which are  
12 headquartered in Denver, Colorado. Together, these  
13 organizations constitute approximately 38,000 members  
14 nationwide and represent the interests of approximately  
15 75,000 surgical technologists and surgical assistants  
16 nationwide, including approximately 750 in the state of  
17 Nebraska.

18 Together with our sister organizations, which are  
19 independent -- I'd just like to identify them, although I do  
20 not speak for them or am I an employee or representative of  
21 them. NBSTSA, the National Board of Surgical Technology and  
22 Surgical Assisting, which is the organization tasked with  
23 administering certification exams for both surgical  
24 assistants and surgical technologists, and the ARCSTSA,  
25 which is the advisory organization to CAAHEP, which Ms.

1 Glassburner talked about, which is the accrediting  
2 organization for the -- some 450 of the 500 surgical  
3 technology and surgical assisting programs in the United  
4 States.

5 I am formerly the Director of Government and  
6 Public Affairs for the Association of Operating Room Nurses.  
7 Earlier in this decade, I am also a recovering lawyer. I  
8 say that only because, for 35 years, I specialized in  
9 medical malpractice defense representing facilities,  
10 hospitals, ambulatory surgical centers, for whom surgical  
11 technologists pretty much all work, and surgical assistants  
12 are credentialed and perform services there.

13 And, from that, I offer the following comments on  
14 this process. I will not presume in any way to add any  
15 professional medical expertise to the wealth of information  
16 presented today. I'm -- and, certainly, throughout the  
17 process. I'm present today, basically, to address the  
18 professional mechanics of what this organ- -- what this  
19 Committee and, eventually, what the legislation will be  
20 crafted to reflect, the regulation and oversight of surgical  
21 assistants and, in this case particularly, surgical  
22 technologists.

23 Starting about a decade ago, a little less than  
24 that, about eight years ago, the Association of Surgical  
25 Technologists undertook an initiative to require competency

1 for surgical technologists and licensure for surgical  
2 assistants nationwide. Since it is a state regulatory  
3 issue, this meant being what I often call the Johnny  
4 Appleseed approach. We have filed and passed legislation  
5 state-by-state. And since 2000 and -- approximately 2007,  
6 surgical technologists and surgical assistants are currently  
7 regulated, or their competencies are addressed, in 14 states  
8 and the District of Columbia. Legislation is currently  
9 pending in five other states today.

10 Some nine of these states require surgical  
11 technologists to be certified, and they obligate health care  
12 facilities to hire and retain certified surgical  
13 technologists, including continuing education, and these  
14 laws provide oversight of this requirement through their  
15 respective departments of public health or health care  
16 facilities licensing agencies or a combination. Those  
17 states are, without boring everyone, Oregon, Texas,  
18 Tennessee, South Carolina, New Jersey, Massachusetts, New  
19 York, Indiana, and Idaho.

20 Still other states provide licensure or  
21 registration of surgical technologists and surgical  
22 assistants. Those states are Colorado, Illinois, Kentucky,  
23 Texas, Virginia, Washington, and the District of Columbia.

24 All these states are -- or, excuse me, all these  
25 professions are regulated either by the board of medicine or

1 a designated state professional agency, such as the  
2 department -- the Colorado Department of Regulatory Agencies  
3 or the Illinois Department of Finance and Professional  
4 Regulations. In Washington state, it's the Department of  
5 Health, and they -- the non-board of medicine oversight,  
6 registration, or licensing authorities have a distinct sub-  
7 regulatory oversight board for each of these professions.  
8 None are reg- -- no state -- in no state are these  
9 professions regulated under the board of nursing.

10 So, the appropriate and consistent locus for  
11 regulating surgical technologists is the board of medicine  
12 or the state health authority or by a separate  
13 professionally dedicated regulatory agency. I think when we  
14 discussed this with various state legislatures nationally,  
15 we reflect on the fact that the surgical technology  
16 profession has undergone a sea change in the last three  
17 decades. In the '80s, 85 percent of the persons serving in  
18 the scrub role were nurses. We all know Hot Lips Houlihan.  
19 We all know how that was constructed. The operating room  
20 and surgical procedures were taught in nursing schools.  
21 There were 25 to 40 instruments used in a regular, ordinary  
22 surgery. There were no robotics, there were no  
23 technologies, there were no electronics, as we've heard, and  
24 there were about 40 to 50 surgical technology schools  
25 nationwide. And none of them -- and not all of them were

1 necessarily accredited at that time either.

2 Today, 85 percent of the scrub role are surgical  
3 technologists, are not nurses. The primary role for the  
4 registered nurse, and it is a critical one, is as the  
5 circulating role outside the sterile field. Inside the  
6 sterile field, at the table, that profession is by a  
7 surgical technologist. Today, a total knee replacement, in  
8 comparison to the number of instruments, takes approximately  
9 1100 separate instruments laying out on a field. It is an  
10 extraordinarily complicated and intensive procedure.  
11 Surgical technology in the operating room, surgical  
12 procedures, is no longer taught in nursing school, and there  
13 are now 500 accredited schools for surgical technology in  
14 the United States, accredited by CAAHEP and through the  
15 advice of the ARCSTSA.

16 The regulation and oversight of surgical  
17 technologists, therefore, seems most particularly  
18 appropriate to the medical functions that the surgical  
19 technologist now performs almost exclusively inside the  
20 sterile field, and it's the position of the Association of  
21 Surgical Technologists that that is the appropriate registry  
22 for those similarly -- similar to the registries and  
23 oversight authorities in other states -- in all other  
24 states. I'd be happy to share copies of these applicable  
25 laws, which reflects this, and, also, to answer any

1 questions you might have about those laws, supervisory  
2 issues under law, and the legal liabilities that go with the  
3 surgical technologist performing in the operating room.

4 Thank you.

5 CHAIRPERSON JACKSON: Questions?

6 MR. KINNEY: Well, I have one. I just don't know  
7 how to ask it.

8 (Laughter.)

9 MS. SPARKMAN: Well, as a lawyer, I'm sure I don't  
10 know how to respond.

11 (Laughter.)

12 MR. KINNEY: You are suggesting that the surgical  
13 techs be governed by, if you would, that might not be the  
14 appropriate word, under the auspices of the Board of  
15 Medicine as opposed to the Board of Nursing?

16 MS. SPARKMAN: Yes. Actually, I do think that  
17 would be the most appropriate place. Virginia just passed a  
18 law, this last year it went into effect, in 2015, where  
19 surgical technologists and surgical assistants are both  
20 licensed and registered in the board of medicine.

21 MR. KINNEY: Did the AST address that at all in  
22 their --

23 MS. GLASSBURNER: We did not, because we were  
24 allowing Cathy to make that comment as a national  
25 standpoint. Because it is a national position as to where

1 those should be regulated.

2 MR. KINNEY: All right. And we -- the question  
3 was raised earlier, when Ms. Hurst was up here, about that.  
4 And, as I recall, I don't want to misquote you, it was your  
5 thought that surgical techs did -- had more of a nursing job  
6 description, so to speak, and surgical assistants had more  
7 of a physician job description, more closely aligned.

8 MS. HURST: It's more central to the supervision  
9 that's involved with the particular occupation. So, for  
10 example, the surgical technologist is supervised primarily  
11 by the circulating RN. Therefore, it makes sense for them  
12 to be the ones doing the regulation of the role.

13 MS. SNECKENBERG: Then why do other states differ?  
14 Why are -- why is your opinion that they should not be  
15 supervised by nursing, because --

16 MS. SPARKMAN: Because, at least, the legislatures  
17 in the 14 states in which I went and proposed this law,  
18 there was considerable debate. And they determined that  
19 there are, certainly, -- and there are, actually,  
20 supervisory -- there's some supervisory language in some of  
21 the bills. None of the -- excuse me, the laws. They were  
22 bills at one time. In the laws. The supervisory language  
23 varies from supervised by a physician within the sterile  
24 field, to supervised according to hospital policy, to  
25 supervised by a licensed practitioner. And we recognize and

1 acknowledge that, in some aspects, the surgical  
2 technologist, you know, is under the supervisory direction  
3 of a registered nurse in, perhaps, setting the room,  
4 obtaining supplies. Once that person steps inside the  
5 sterile field, it is a completely different supervisory  
6 chain and which -- with attendant liability, as well, for a  
7 surgeon who is responsible for the actions of the surgical  
8 technologist performing surgical technology tasks and  
9 functions in that surgical procedure. And, from that, I  
10 speak as an attorney as well as a legislative advocate.

11 And so, in Texas, for example, it is very specific  
12 -- the law is very specific that says, "Nothing in this law  
13 shall affect how surgical technologists are supervised." In  
14 Massachusetts, it says, "by a licensed practitioner." In  
15 another state, it says, "inside the sterile field, by a  
16 surgeon, and outside the sterile field, by a -- by a -- the  
17 circulat- -- by a registered nurse." But in terms of the  
18 critical functions that the surgical technologists are now  
19 educated, trained, skilled, and performing, those are  
20 functions more appropriately overseen by the board of  
21 medicine or, in some cases, a specific board dedicated to  
22 registration and oversight of surgical technologists, itself  
23 separate from the board of nursing. And it is the long-  
24 established policy and position of AST, as the national  
25 organization, that that is the appropriate oversight for

1 state legislation, and we take that position, firmly and  
2 deliberately, in all states in which we advance legislation.  
3 It ain't over 'til it's over, but in Minnesota, Michigan,  
4 Ohio, Florida, all of those states, currently have  
5 legislation pending that proposes exactly the regulation and  
6 oversight of surgical technologists outside of the board of  
7 nursing.

8 MS. HURST: And, Mr. Kinney, where Nebraska  
9 differs from all of those states that have been named, the  
10 case law from 1998 states that a physician cannot delegate  
11 to an unlicensed individual. Therefore, there's a  
12 separation there that the nurses are delegating to the  
13 unlicensed allied health professionals, whereas the doctor  
14 is delegating to the surgical first assistant.

15 MS. SPARKMAN: Depending on -- well, we can debate  
16 this a long time, but --

17 MR. KINNEY: I think I understood what you said,  
18 but I'm not sure I understood its applicability. That's  
19 what started this whole process.

20 MS. HURST: Right. So, whereas in other states, a  
21 physician could potentially delegate to a surgical  
22 technologist, in Nebraska, he cannot.

23 MR. KINNEY: Nor can he or she to a surgical  
24 assistant without us going forward.

25 CHAIRPERSON JACKSON: Unless they're licensed.

1 MS. HURST: Right. And under this proposal, it  
2 would remain that the physician could delegate to the  
3 surgical first assistant, which we would prefer to see  
4 regulated under the Board of Medicine and Surgery, and the  
5 physician could not delegate to a surgical technologist as a  
6 member of the registry, which we recommend is supervised  
7 under the Board of Nursing.

8 MR. KINNEY: Is your concern more the doc or the  
9 board?

10 MS. HURST: The appropriateness of the board under  
11 the law.

12 MR. KINNEY: Whether that board is the proper fit.

13 MS. HURST: Right.

14 DR. BALDWIN: Is not a surgical first assistant  
15 also a technol- -- or a technician?

16 MS. SPARKMAN: A certified surgical technologist?

17 DR. BALDWIN: Yes.

18 MS. SPARKMAN: Sometimes.

19 DR. BALDWIN: Are we creating a -- is a surgical  
20 first assistant a surgical technologist as well?

21 MS. SPARKMAN: That is a pathway, that's true.  
22 That is.

23 DR. BALDWIN: All right, then, you're creating a  
24 system -- you are creating a system whereby they may be  
25 speaking to two masters then.

1 MS. SHOEMAKER: In Nebraska, the state law is very  
2 clear. A physician cannot delegate to an unlicensed  
3 individual. The surgical tech and a certified surgical tech  
4 are unlicensed. The surgical first assist, which is what  
5 we're trying to attain licensure for, the physician can  
6 delegate to that person, but they can't delegate to a  
7 surgical tech or a certified surgical tech in the state of  
8 Nebraska.

9 MR. KINNEY: Until they are licensed. Until that  
10 day comes, if it comes.

11 MS. SHOEMAKER: Correct. That's why we're pushing  
12 the licensure.

13 MS. SNECKENBERG: Okay. This is a really dumb  
14 question, but I want to get it clear. If you're an SFA,  
15 surgical first assistant, could you, at some time in your  
16 hospital, also be functioning in an operating room as a  
17 surgical tech or will you always only be an SFA?

18 MS. SHOEMAKER: No. No. Ye- --

19 MS. SNECKENBERG: You -- no what?

20 MS. SPARKMAN: Yes or no? Yes, you may --

21 CHAIRPERSON JACKSON: Yeah, no what?

22 MS. SNECKENBERG: Whoever wants to answer.

23 CHAIRPERSON JACKSON: Linda.

24 MS. SHOEMAKER: Currently, the certified surgical  
25 first assist who was coming with our orthopedic surgeon from

1 Colorado, he can only work in the role of a certified  
2 surgical technologist at this point, even though he has --  
3 he's not licensed in Colorado, but that's the only way he  
4 can work for us, is in the certified surgical tech position.

5 MS. SNECKENBERG: Well, will it be that way in the  
6 proposal?

7 CHAIRPERSON JACKSON: But if this passes --

8 MS. SHOEMAKER: If it passes, then he will be able  
9 to work as a cert- -- or as a surgical first assist with our  
10 orthopedic surgeon.

11 MS. SNECKENBERG: But could the person -- could  
12 that -- let's take one of our own people here -- that's  
13 here, that's already a certified -- a SFA and is now  
14 functioning as a tech because we don't recognize it. So  
15 then, they become a surgical first assistant. Can they  
16 also, then, revert to their old role as a tech in another  
17 situation?

18 CHAIRPERSON JACKSON: Casey?

19 MS. GLASSBURNER: That's --

20 UNIDENTIFIED VOICE: Can I answer that?

21 MS. SNECKENBERG: So, then, in that case --

22 CHAIRPERSON JACKSON: Casey can. You can't.

23 MS. GLASSBURNER: That's incorporated in the first  
24 element of the scope of practice.

25 MS. SNECKENBERG: Okay. So then, in that case,

1 they would actually be accountable to two different boards,  
2 depending on what they're doing at the moment in time.

3 MS. GLASSBURNER: That's true, because -- okay,  
4 so, if a surgical assistant is employed by a hospital, they  
5 would only function as a surgical assistant if a doc doesn't  
6 already bring a surgical assistant with him. Often, people  
7 like Chuck or any of these other PAs that have spoken, are  
8 employed by a physician, and they come with the physician to  
9 the hospital and they function as a surgical assistant.  
10 Therefore, if that surgical assistant was assigned in that  
11 room, there's no need for them to function as the assistant.  
12 They may be functioning as a surgical technologist in the  
13 first scrub role, handing instruments, doing those kinds of  
14 things.

15 MS. SNECKENBERG: And then, they would be  
16 accountable to the Board of Nursing.

17 MS. GLASSBURNER: Yes.

18 MS. SNECKENBERG: Okay.

19 CHAIRPERSON JACKSON: Chuck?

20 MR. SCHOLTES: I think the PA Academy likes the  
21 wording that, inside the operating room, when the  
22 physician's not there, that the SFA could actually close  
23 with this. Because, right now, if it's -- it has to be  
24 personal insight, often the physician goes outside to talk  
25 to the family. And when that happens, if you don't have

1 that oversight, then that would drop off and they would have  
2 to quit helping close and become a surgical tech.

3 And we often -- the PAs close with -- or they  
4 close -- two people at a time, now, just necessarily one  
5 person close, but -- so, licensed -- another individual  
6 licensed provider is the language that we like, versus, you  
7 know, the physician.

8 MS. FLORELL: Personal supervision was there  
9 initially, included in the application so that the physician  
10 would be in the room with the certified first assist.

11 THE REPORTER: I'm sorry to interrupt, but I  
12 cannot pick up her voice on the recording. She's too far  
13 away.

14 CHAIRPERSON JACKSON: Yes.

15 MS. FLORELL: I was just responding to --

16 THE REPORTER: No. You need to come up here.

17 CHAIRPERSON JACKSON: So, can she respond?

18 MR. GELVIN: She needs to come up to the table.

19 CHAIRPERSON JACKSON: Yeah, she needs -- and  
20 you'll need to state your name again.

21 MS. FLORELL: Well, I didn't want to test- -- I  
22 was just asking if, I mean, I was saying that personal  
23 supervision was very intentionally included in the  
24 application, meaning that the physician would be in the  
25 room.

1 CHAIRPERSON JACKSON: Could you get that?

2 THE REPORTER: I believe so.

3 CHAIRPERSON JACKSON: Okay.

4 MR. KINNEY: Well, obviously, -- excuse me.

5 CHAIRPERSON JACKSON: Go ahead.

6 MR. KINNEY: No, go ahead.

7 CHAIRPERSON JACKSON: No. I was just going to  
8 move this along. But, if you have another question --

9 MR. KINNEY: I'm assuming nobody's advocating that  
10 any one individual be subject to two boards under --

11 DR. BALDWIN: Essentially, that's what's  
12 happening.

13 MS. SNECKENBERG: But you would be.

14 DR. BALDWIN: That's what's happening.

15 MS. SNECKENBERG: What they just described. And  
16 what happens if you forget your role and you overstep? In  
17 this surgery, I'm a tech, and in this one, I'm an SFA.

18 CHAIRPERSON JACKSON: Would surgical first assists  
19 have to be on the registry also? No?

20 MS. SHOEMAKER: The surgical first assist would  
21 not be on the registry because they're licensed. They will  
22 have a scope of practice. The surgical technologist and the  
23 certified surgical technologist will not have a scope of  
24 practice because they're not licensed. They'll be on the  
25 registry.

1                   CHAIRPERSON JACKSON: So, regardless of what -- if  
2 the surgical first assist was actually being the first  
3 assist or acting in the role of a surgical technologist,  
4 they would be supervised by the Board of Medicine, because  
5 that's the governing board that licen- -- so, because -- you  
6 said, in their licensure, you would include that they could  
7 do all the functions of a surgical technologist, plus these  
8 additional steps. So, that means they would only be  
9 governed by the Board of Medicine, not two different boards.  
10 Is that --

11                   MS. SNECKENBERG: Even though they're acting, in  
12 that particular surgery, in the capacity of a tech?

13                   CHAIRPERSON JACKSON: Even though they're acting  
14 in the capacity of a tech, they would still be under the  
15 Board of Medicine, because their license says that they can  
16 function under all those activities, plus these additional  
17 things.

18                   MS. HURST: Right. You aren't demoted simply  
19 because of the functions you're performing.

20                   MS. SPARKMAN: Demoted? Is that what you said?

21                   MS. HURST: Yeah.

22                   MS. SPARKMAN: Oh, okay. Thank you.

23                   CHAIRPERSON JACKSON: So, the surgical first  
24 assist would always be regis- -- governed by the Board of  
25 Medicine, and your proposal is that the surgical

1           technologist would be governed by the Board of Nursing at  
2           this time.

3                   MS. HURST: Right.

4                   CHAIRPERSON JACKSON: Does that make sense?

5                   DR. BALDWIN: Correct me if I'm wrong, but one of  
6           the possible outcomes of this review could possibly be a  
7           recommendation that that statement about the physicians be  
8           changed?

9                   MR. RIEKER: Which statement is that?

10                  DR. BALDWIN: The one that you're quoting about --

11                  CHAIRPERSON JACKSON: The law prohibiting -- that  
12           would be another --

13                  MR. KINNEY: They can't supervise an unlicensed  
14           person.

15                  DR. BALDWIN: That could come, I believe, out of  
16           this group as a recommendation?

17                  MR. GELVIN: It could, if you want to recommend  
18           it.

19                  MR. BALDWIN: Well, if it's causing a problem, and  
20           there's not a good reason.

21                  CHAIRPERSON JACKSON: Any other questions for  
22           Catherine?

23                           (No response.)

24                           Okay. Thank you.

25                           MS. SPARKMAN: Thank you.

1 MR. GELVIN: Okay. We have two more people to  
2 testify. We have a Karen --

3 MS. RUSTERMIER: Me.

4 MR. GELVIN: Karen.

5 CHAIRPERSON JACKSON: What purpose is she signed  
6 up with, Matt?

7 MR. GELVIN: Opponent.

8 KAREN RUSTERMIER

9 MS. RUSTERMIER: My name is Karen Rustermier.  
10 It's K-a-r-e-n, R-u-s-t-e-r-m-i-e-r. And I'm listed as an  
11 opponent primarily because, at our last meeting, it was  
12 going to be concerned parties and proponents. And I  
13 couldn't say I was actually neutral, but I can't say I'm  
14 actually opposed either. So -- nor can I say I'm actually  
15 in agreement. So, I had to put myself in the opposed  
16 category.

17 What -- I went over the list of questions that we  
18 are trying to delineate today, and my -- I have some  
19 concerns. I rep- -- I should say, I represent the  
20 Association of periOperative Registered Nurses. I'm the  
21 State Legislative Coordinator for Nebraska for that  
22 organization, and a member of their National Legislative  
23 Committee.

24 My concern with the graft handling. Specimens,  
25 every tech, whether they're working as a CST or a first

1 assistant, are going to handle specimens. They know how to  
2 do that. They know how to handle them. They're responsible  
3 to get them identified and hand them off to the circulator,  
4 who gets them to the lab where they need to go. And that  
5 part is not an issue to me.

6 The graft handling, I think, when you put a broad  
7 statement into a statute, that somebody can prepare a graft,  
8 all we've talked about is hamstring grafts for the  
9 orthopods, where that might be appropriate. If you give  
10 somebody a license, you can handle grafts, today can you  
11 handle this kidney that's going into somebody else? That's  
12 a graft. Can you handle hair plugs? Can you handle bone  
13 graft? Can you handle vessels that are for coronary artery  
14 bypass? And I'm talking about preparing them, not just  
15 handing them to someone. Actually preparing those grafts.  
16 So, if you're giving them a license, we're talking about  
17 basic preparation here. And, if we put that into statute  
18 that way, boy, I can just see somebody, you know, "Okay, I  
19 have a license. I can do this." And, you know, what is --  
20 some of it may be appropriate, some it I don't think is  
21 appropriate. And kind of like, you know, if you mess up a  
22 couple of hair plugs out of 4000 of them, it's probably not  
23 going to be a problem. But this may be the only vessel that  
24 you have that you -- that we can make into a -- vein graft  
25 into an arterial graft for a patient. I think that, to me,

1 that requires a physician's abilities. I just think there's  
2 a difference. All -- a graft isn't a graft isn't a graft.

3 So, I don't know how you delineate that when you  
4 put that into statute. In their education, are they -- you  
5 know, you may have an idea, when you're in -- taking your  
6 training, you're going to work for an orthopedic doctor.  
7 So, you're getting the most cases that you can in  
8 orthopedics. That may not be what -- the job you get when  
9 you get done. You may have a different -- your employer may  
10 have a different idea of what you're going to do today,  
11 tomorrow, and the next day, unless you're employed  
12 specifically by that doctor. That there, again, if you have  
13 a license, it's just, I think, it's giving carte blanche,  
14 where some judgment needs to come into place. And how we  
15 get that into legislation, that judgment has to be applied,  
16 I'm not too sure. I don't know that I know that answer.  
17 But I think we have to be careful about giving permission to  
18 just do whatever with grafts. That's a big concern for me.

19 I still have basic concerns about the educational  
20 process. On the second page, and we've talked ad nauseum at  
21 different levels of first assisting. CST and RN are  
22 assisting at one level. The PA, NP, the CST/SFA are  
23 assisting; this is an advanced level; it's not this lower  
24 level. We're giving them the ability to do the same thing  
25 as a CRNFA, the PA, and the -- not per- -- I mean, in the

1 operating suite. I'm not talking about prescriptive  
2 authority or writing orders or any of that portion of those  
3 jobs. But, actually, first assisting, hands-on, we're  
4 giving them the same ability. There's the difference, the  
5 CRNFA probably has the least amount of education of those  
6 other-level practitioners. The difference in the CSFA and  
7 the CRNFA, so you can see there's a considerable difference  
8 there in education.

9 I'm not so worried about the CST that becomes an  
10 SFA, because I know they have two years of school. They  
11 have an associates degree in most cases. They have passed a  
12 board and then gone on. So, because some of the schools,  
13 I'm -- that I researched, you just have, they say "operating  
14 room experience." Well, I have some aides, they've got 10  
15 years of experience. They know how to open a sterile  
16 package. They could get into that school without, you know,  
17 with very minimal education. And, when you're setting a law  
18 with licensure, you're talking about the minimum. You're  
19 not talking about what, you know, -- you're still talking  
20 about minimum. You're not talking about what these people  
21 have or these people have. This is the minimum that we're  
22 going to require to license you to do this job. So, I have  
23 concerns about that.

24 In nursing, there's tiers of licensure. The LPN  
25 is at the bottom, the registered nurse is next, the nurse

1 practitioner and the clinical nurse specialists are higher.  
2 It's a tiered licensure that's all nursing, but it's not the  
3 same license. So, I do have concerns about that.

4 What I am excited about is the registry for the  
5 technologists. I think it's an excellent idea for them to  
6 get -- and a way for them to elevate their profession and to  
7 bring up some of the stragglers who were still working on  
8 OJT that have not completed programs. And, you know, just  
9 to have an idea, who do we have in this state, we really  
10 should know. We should know what the education base is. We  
11 should know where we need to go, how to promote that  
12 profession. And I think that the registry is a great idea.

13 Whether they're regulated under the Board of  
14 Nursing or the Board of Medicine, I think there's pros and  
15 cons both ways. I can see your point with the serving two  
16 masters, because, if they're employed, say, employed by a  
17 hospital, they're working as a surgical first assistant, and  
18 they don't really need a first assistant for this case, so  
19 they're actually functioning as a CST, well, that's  
20 delegated by the nurse. Am I going to delegate to another  
21 really -- to another licensed personnel? I'm not so sure  
22 how all of that would work?

23 MS. SNECKENBERG: You're talking about in the  
24 actual operating room at that moment?

25 MS. RUSTERMIER: Uh-huh. Right.

1 MS. SNECKENBERG: Yeah.

2 MS. RUSTERMIER: I'm not so sure how all of that  
3 would work. So, I think there's pros and cons to either  
4 board. You know, and I think that maybe those individual  
5 boards should let us know what they think about this. So,  
6 we might have a better -- might be able to make, maybe, a  
7 better decision.

8 At any rate, I just kind of pulled my things down  
9 to just a couple of things I was concerned about. I am  
10 still concerned that urinary catheterization is still listed  
11 in there as a duty. It's -- that's a complex procedure that  
12 could -- you know, it's the number one cause of nosocomial  
13 infections. And, if I'm going to delegate that, I'm  
14 probably not going to delegate that.

15 CHAIRPERSON JACKSON: I guess, I don't see that in  
16 here.

17 MS. RUSTERMIER: It was on the listing of duties.  
18 There in the range of functions for the CST and the duties  
19 for the -- but that --

20 CHAIRPERSON JACKSON: Okay. From the previous --

21 MS. RUSTERMIER: Pardon me?

22 CHAIRPERSON JACKSON: From previous meetings?

23 MS. RUSTERMIER: Yes. That comes from AST and CS-  
24 -- and SF- -- CSA? CSA, is that --

25 UNIDENTIFIED VOICE: ASA.

1 MS. RUSTERMIER: ASA. Sorry. That comes from  
2 their organization. So, that's the only things that I'm  
3 really concerned about. I know that nursing wants to be  
4 involved, whatever we decide.

5 If anybody has any questions, I'd be happy to  
6 respond.

7 DR. BALDWIN: For approximately what percentage of  
8 surgeries is there a CRNFA present?

9 MS. RUSTERMIER: Depends on where you work. I  
10 mean, --

11 DR. BALDWIN: Okay, Nebraska.

12 MS. RUSTERMIER: I think we probably have --  
13 there's probably about 70 here in this state.

14 DR. BALDWIN: Seventy total?

15 MS. RUSTERMIER: Yeah.

16 DR. BALDWIN: Okay.

17 MS. RUSTERMIER: There's, you know, some -- the  
18 primary reason there aren't more here is because they can't  
19 be reimbursed individually.

20 DR. BALDWIN: Well, my point is that we don't have  
21 a whole lot of these so-credentialed people to be able to  
22 fill that gap, and there obviously is a gap.

23 MS. RUSTERMIER: Well, we only have 20 SFAs, so  
24 that's not exactly a huge number.

25 DR. BALDWIN: No.

1 MS. RUSTERMIER: So, you know, I mean, you can  
2 look at it an- -- you can -- any way you want to slice it.  
3 We have a lot of people that are doing a very similar job.  
4 And, you know, I'm just concerned that, if the indi- --  
5 these individuals are licensed, that we do it appropriately  
6 with the correct oversight and that we're not just, -- like,  
7 I really am concerned about the preparation of grafts, just  
8 to state as one, 'cause we're -- just all we've talked about  
9 is orthopedic grafts. There's a lot of grafts, and, like I  
10 said, that's not -- you know, I think, sometimes, it's  
11 appropriate, sometimes it's not, that a physician should be  
12 doing that.

13 MS. GARRISON: Is there any way I can comment?

14 CHAIRPERSON JACKSON: No. Sorry, you're not on  
15 the --

16 MS. GARRISON: Or do I -- can I come up later?

17 CHAIRPERSON JACKSON: You're not signed in on the  
18 list. Sorry.

19 MS. GARRISON: Okay. That's fine.

20 CHAIRPERSON JACKSON: Is that correct?

21 MR. GELVIN: I mean, at your discretion.

22 CHAIRPERSON JACKSON: At the end, we can allow --

23 MS. GARRISON: Thank you.

24 CHAIRPERSON JACKSON: Okay. So, remember your  
25 comment.

1 UNIDENTIFIED VOICE: I don't think she's going to  
2 forget it.

3 CHAIRPERSON JACKSON: Any other questions?

4 (No response.)

5 MR. RUSTERMIER: Thank you.

6 CHAIRPERSON JACKSON: Okay. Then we have --

7 MR. GELVIN: Dr. Bittles.

8 DR. MICHAEL BITTLES

9 DR. BITTLES: I put it down as neutral. I'm Mike  
10 Bittles, B, as in bravo, i-t-t-l-e-s, a general surgeon.  
11 I'm on the Board of Medicine.

12 We have discussed this at our board meetings, and  
13 the general consensus is that we're in favor of your efforts  
14 and appreciate all the hard work that's going on here. A  
15 couple of questions, and I may have not understood this.  
16 Something about certifying an SFA's abilities in the  
17 operating room being another licensed health care  
18 professional. Was that the wording?

19 MS. SHOEMAKER: Say that again.

20 DR. BITTLES: Who, in the operating room, can  
21 certify to an SFA's ability when they're trying to get  
22 grandfathered or something along those lines? It said any  
23 health care --

24 MS. SHOEMAKER: When they're going through their  
25 education?

1 DR. BITTLES: Right. Correct.

2 MS. SHOEMAKER: The director of surgery would be  
3 the one that would sign off.

4 DR. BITTLES: Okay. I'm not sure that that ought  
5 not to be a physician. Okay. There's some nurses don't  
6 even scrub, you know? So, just a thought.

7 MS. SHOEMAKER: Well, open to discussion.

8 DR. BITTLES: Yeah, just a thought. And, as far  
9 as the talk about who -- which board ought to -- I think,  
10 for the SFAs, they're being licensed. I think it's  
11 appropriate that the Board of Medicine pass judgment, I  
12 guess. But, if you're going to do that, there ought to be a  
13 subcommittee, like there is with the PAs. That, then, you  
14 know, the PAs will arrive at a decision, but then it has to  
15 go to the Board of Medicine. And my recommendation would be  
16 that, if the SFAs have that same type of thing.

17 I think, as far as the surgical technologists, I  
18 think, if they're not being licensed, they're being  
19 registered, I think it's perfectly appropriate that the  
20 Board of Nursing oversee that.

21 And those were my comments.

22 CHAIRPERSON JACKSON: Any questions?

23 (No response.)

24 DR. BITTLES: Thanks.

25 MR. GELVIN: That concludes all the testifiers.

1 CHAIRPERSON JACKSON: Okay.

2 MR. GELVIN: Although, there is a summary period  
3 for the applicant group, neutral, and other, if they wish to  
4 utilize it.

5 CHAIRPERSON JACKSON: We had the people in the  
6 audience that wanted to make comment. Can they make comment  
7 first?

8 MS. SCHEER: I think so.

9 MR. GELVIN: Sure.

10 MS. SCHEER: I'd want her to sign the list,  
11 though.

12 CHAIRPERSON JACKSON: We need to have you come  
13 forward and state your name, and I'm going to have you sign  
14 a list, on a list, one of the lists. Neutral's fine.

15 JENNIE GARRISON

16 MS. GARRISON: Sure. My name is Jennie Garrison,  
17 J-e-n-n-i-e, G-a-r-r-i-s-o-n. I'm currently a certified  
18 surgical technologist and first assistant -- certified first  
19 assistant.

20 With respect to Karen's issues, Casey handed out a  
21 -- the stuff that she handed out about grafts, specifically.  
22 It mentions surgical assisting preparing the grafts, you  
23 know, off -- after they are removed. I work at the Nebraska  
24 Heart Hospital. I deal with vein grafts every day for  
25 coronary bypass. I've been a surgical tech for 24 years now

1 and a first assistant for probably 17 of those. I am one  
2 hundred percent competent in preparing a vein graft after  
3 it's removed. One hundred percent. Knowing I've done it  
4 forever, so, it's, again, it's one of those things that's a  
5 comfort level that I don't think it a problem for a surgeon  
6 saying, "I'm comfortable with you doing this as a first  
7 assistant."

8 So, I don't have a problem with the wording that  
9 Casey gave, as far as a surgeon or, -- and, in our case,  
10 like, a PA removing said graft and then taking care of it  
11 after it is out of the patient.

12 The other thing I wanted to just mention is, you  
13 know, again, with respect to Karen's comments about a --  
14 putting a catheter in. My job is sterile technique. My job  
15 is asepsis. If I can't put in and be responsible for a  
16 urinary catheter insertion, then how can I possibly be  
17 responsible for a table that can contaminate and give  
18 somebody endocarditis and kill them? I mean, it's kind of a  
19 double standard, as far as I'm concerned.

20 But, those are the two things I'd like to say.  
21 Thank you.

22 MR. GELVIN: Let them do their summaries.

23 CHAIRPERSON JACKSON: Okay. We'll have the  
24 applicant group, if you'd like to come up and do a five-  
25 minute summary, you are allowed.

1 MS. SNECKENBERG: There's another question out  
2 there.

3 DR. BALDWIN: You had one other person who --

4 MS. SNECKENBERG: She had a question.

5 MR. RIEKER: She -- there's one more that wanted  
6 to speak.

7 CHAIRPERSON JACKSON: Okay.

8 JEANNE WARDLAW

9 MS. WARDLAW: I'm probably a familiar face. I'm  
10 Jeanne Wardlaw, J-e-a-n-n-e, Wardlaw, W-a-r-d-l-a-w. I know  
11 I probably should have brought this up in previous meetings,  
12 but I agree with the proposition that we should be licensed  
13 as surgical first assistants. But I have a little bit of a  
14 problem with having the nurses supervise the surgical  
15 technologists, because, as --

16 MS. SPARKMAN: Catherine.

17 MS. WARDLAW: -- Catherine -- sorry -- Catherine  
18 spoke, that registered nurses have not been trained in the  
19 operating room for many, many years. And to have them, once  
20 we go into the sterile field, those nurses do not know what  
21 is going on at the table. And they cannot tell us, "Okay,  
22 Joe Blow, you can put that retractor in." You know, I feel  
23 they should not be delegating what a surgical technologist  
24 can do.

25 CHAIRPERSON JACKSON: Who should be?

1 MS. WARDLAW: The surgeon. I feel the Board of  
2 Medicine should be over everybody that is at the surgical  
3 field.

4 MS. SNECKENBERG: So, it's one point of  
5 responsibility.

6 MS. WARDLAW: Yes. Yes.

7 MS. SNECKENBERG: One point.

8 MS. WARDLAW: One board. Uh-huh. You know, just  
9 license surgical technologists and surgical first  
10 assistants. And if you have to tier it, I see no problem  
11 with that. But I have -- you know, most of the time, the  
12 nurse is at the computer doing paperwork. A lot of times,  
13 they do not know what is going on at the table. And very  
14 critical decisions and things are being done at that time.  
15 And they cannot turn around and know what's going on. So,  
16 that's my point.

17 CHAIRPERSON JACKSON: Okay.

18 MS. WARDLAW: Thank you very much. Any questions?

19 (No response.)

20 MS. WARDLAW: Thank you, again.

21 CHAIRPERSON JACKSON: Okay, now, we'll do the  
22 summaries. We'll let the applicant group start. This is a  
23 five-minute limit. Can you talk in five minutes, Bruce?

24 BRUCE RIEKER

25 MR. RIEKER: I can do it, you bet. Apparently, my

1 reputation precedes me here too. My name, again, is Bruce  
2 Rieker, B-r-u-c-e, R-i-e-k-e-r, Vice President of Advocacy  
3 for the Nebraska Hospital Association. Hopefully, my  
4 summary will be very brief.

5 We appreciate all the time and attention that you,  
6 all the members of the Technical Review Committee and the  
7 support staff have put into this. There have been an  
8 excellent discussion, once again, as indicative from all of  
9 the previous meetings as well. We respect the other  
10 opinions that have been shared. Some of those are  
11 incorporated in our revised application. So, we'd hope that  
12 you, the Committee, would take note of that.

13 I think that, sometimes, it gets lost that there's  
14 a fear that, by licensing surgical first assists, that they  
15 will become rogue independent practitioners. However, it  
16 has been the intent all along in this application, and it  
17 states so, that they are under the personal supervision of a  
18 physician, who is ultimately responsible for them and their  
19 competency.

20 We do appreciate Dr. Bittles' comments and,  
21 probably, if there is one area that we would consider  
22 changing is that the competency of these individuals be  
23 determined by a physician. He made a very good point.  
24 That's one that we think that that requires or merits  
25 consideration and modification to our revised application.

1           We hope that you will consider our application in  
2 light of Nebraska law, not other states' laws. If that's  
3 the case, then we're going to have to go through all of the  
4 definitions used in those other states and how they go about  
5 licensing and supervision and the whole gamut of this to  
6 have an accurate assessment or evaluation in light of other  
7 laws.

8           This application does the right thing, and we're  
9 on the right course. It improves access. It's going to  
10 increase the number of people we have to fill those voids.  
11 Can we give you an exact number? No. But, as soon as  
12 they're licensed, there will be an opportunity for those  
13 individuals to pursue that licensure and fill those voids.

14           For all of the reasons that we included in our  
15 application and this summary, we would urge the Committee to  
16 approve our application. We know you have the ability to  
17 offer ancillary recommendations, and that, in the interest  
18 of moving this along, I think that we're at a point that the  
19 next step is to move it to the Board of Medicine, and we can  
20 continue the discussions on some of these matters. But I  
21 think that that is where we are, and we would urge the  
22 Committee to forward it accordingly.

23           CHAIRPERSON JACKSON: Thank you.

24           MR. GELVIN: Other testifiers that want to  
25 summarize can line up.

1 CHAIRPERSON JACKSON: Okay. Any other from the  
2 applicant group? Or from the other three groups?

3 MR. RIEKER: Chris Scott told me I was under five  
4 minutes.

5 (Laughter.)

6 MR. GELVIN: See if there's any other applicant  
7 members that want to --

8 CHAIRPERSON JACKSON: Are there any other  
9 applicant members that want to provide a summary?

10 (No response.)

11 Would a representative from the proponent group  
12 like to give a summary?

13 (No response.)

14 No? Would a member of the neutral group like to  
15 give a summary?

16 (No response.)

17 And the opponent group? Would you like to give a  
18 summary?

19 MS. RUSTERMIER: I have one thing to say about the  
20 grafts.

21 CHAIRPERSON JACKSON: Okay. Please sit at the  
22 table so she can hear you.

23 MS. RUSTERMIER: Sit at the table so that she --  
24 usually -- people don't usually have trouble hearing me.

25 CHAIRPERSON JACKSON: I know, but just in case.

1 KAREN RUSTERMIER

2 MS. RUSTERMIER: I know the lady from Nebraska  
3 Heart is -- feels very comfortable doing vein grafts.  
4 That's where she works. That's what she does every day.  
5 The person that works at ortho, they do those ACL grafts  
6 every day. But, with broad language like that, would that  
7 person who is comfortable doing vein grafts, can you prepare  
8 a bone graft? Can you prepare a kidney for transplantation?  
9 Because you are only saying "prepares grafts."

10 I mean, when you get into specialties, somebody  
11 has taught her how to do that, and she's probably very good  
12 at it because she does it all the time, as is it about any  
13 other technical function, once you've learned to do that and  
14 someone's supervised you and taught you how. But, when you  
15 put broad language into statute, that's license for anybody  
16 to do something they've never seen before. That's what I  
17 have to say about that.

18 MS. SNECKENBERG: I have a clarifying question.

19 MS. RUSTERMIER: Yes.

20 MS. SNECKENBERG: In a large hospital, I  
21 understand specialization. But, if you get out into, like,  
22 a Box Butte or somewhere like that, do -- would the surgical  
23 first assistant, would they be doing multiple types of  
24 surgeries or would they be staying within a specialized --

25 MS. RUSTERMIER: Well, they would probably be

1 doing more than one type of surgery, but they, most likely,  
2 wouldn't be doing any open-heart surgery.

3 MS. SNECKENBERG: Correct. But I'm -- your --

4 MS. RUSTERMIER: They wouldn't probably be doing  
5 any transplantation. Those kinds of cases would be shipped  
6 to Lincoln or Omaha.

7 MS. SNECKENBERG: Right. So, --

8 MS. RUSTERMIER: Or, you know, or some other big  
9 city.

10 MS. SNECKENBERG: I'm not trying to minimize your  
11 concern, --

12 MS. RUSTERMIER: Yeah.

13 MS. SNECKENBERG: -- but is it, I mean, is it kind  
14 of -- does it answer itself? Does the field itself answer  
15 it's own question?

16 MS. RUSTERMIER: I don't think so, --

17 MS. SNECKENBERG: And, again, I'm not minimizing  
18 what you're saying.

19 MS. RUSTERMIER: -- because, then, you're saying  
20 -- because judgment -- this is a judgment call, and you're  
21 putting in broad language. You've given them a license.  
22 Say, they work at Box Butte this week, but next week,  
23 they're working in Omaha. They have a license, then they're  
24 employer thinks, "Okay, they can do this." You know, and  
25 does the person they're working with have judgment enough to

1 say, "I don't think so"? Maybe they do. Maybe they don't.  
2 I mean, that's the facts of life.

3 MS. SNECKENBERG: I would hope that would come out  
4 in the application screening, but --

5 MS. RUSTERMIER: Yeah.

6 MS. SNECKENBERG: -- I understand what you're  
7 saying, though, about broad language. I understand.  
8 Because I'm on the Board of Dentistry, I understand exactly  
9 where you're coming from on that. But, on the other hand --

10 MS. RUSTERMIER: So, I don't know how you can fix  
11 that problem so that the specialty person can continue to do  
12 that specialty thing without jeopardizing safety by, you  
13 know, okay, now, they're working here next week.

14 DR. BALDWIN: How do we avoid psychiatrists doing  
15 appendectomies?

16 (Laughter.)

17 DR. BALDWIN: You know, it's just common sense,  
18 kind of.

19 MS. SNECKENBERG: Maybe they do.

20 MS. RUSTERMIER: Well, I wasn't aware you'd have a  
21 license -- you have a license to practice medicine.

22 DR. BALDWIN: Medicine. Therefore, you can.  
23 There's noth- -- legally, they can.

24 MS. RUSTERMIER: You'd have to, I would suppose --  
25 I don't know.

1 DR. BALDWIN: As I understand it.

2 MS. RUSTERMIER: Well, surgeons and psychiatrists  
3 are very closely related.

4 (Laughter.)

5 CHAIRPERSON JACKSON: So, the wording somehow to  
6 be more specific to their specialty area, including grafts  
7 according to specialty area.

8 MS. RUSTERMIER: Uh-huh.

9 CHAIRPERSON JACKSON: Okay.

10 MR. GELVIN: The next meeting is August 28<sup>th</sup> at  
11 9:00 a.m. In what room? It's at the State Office Building,  
12 somewhere in the basement, and we'll make sure you know.  
13 And at that meeting, we'll have some clarifications, as  
14 needed. The Committee will apply the criteria and start  
15 developing their recommendations for their report.

16 DR. BALDWIN: Matt, will we be getting a combined  
17 recommendation that incorporates all of these, or do we have  
18 to take all of these separate pieces of paper and fit them  
19 back into the proposal?

20 MR. GELVIN: We'll get it all combined into one.

21 DR. BALDWIN: All right.

22 MR. KINNEY: Did you say 9:00 a.m. on the 28<sup>th</sup>?

23 MR. GELVIN: 9:00 a.m. on the 28<sup>th</sup>.

24 MR. KINNEY: And the applicant is going to, as I  
25 understand it, give some type of a point-by-point response

1 to the AST presentation today. Is that --

2 MS. HURST: I submitted it with my testimony at  
3 the beginning. The responses to one through nine?

4 MR. RIEKER: No, you're -- Mr. Kinney, are you  
5 referring to what the national AST organization submitted,  
6 or --

7 MR. KINNEY: Yes, that Casey presented.

8 And then, Elisabeth, are you saying that the July  
9 -- that today item that goes paragraphs one through nine --

10 MS. HURST: Right.

11 MR. KINNEY: -- that tracks those ni- -- the nine  
12 on this one?

13 MS. HURST: It's the same questions, right.

14 MR. KINNEY: All right. I'm sorry.

15 MS. SNECKENBERG: Can we have these more than,  
16 like, the day or a day ahead of time, as far as any  
17 information that's coming out, or does it have to be,  
18 because it's a public meeting, just can it be that same day?  
19 Because it would be nice to be able to have some of this  
20 ahead of time.

21 MR. GELVIN: Everything we have today, we'll put  
22 online.

23 MS. SNECKENBERG: Okay. But last -- like, last  
24 night --

25 MR. GELVIN: Anything new we get --

1 MS. SNECKENBERG: Last night or would it be that  
2 day? Because, with my job, I can't do personal things.

3 MR. GELVIN: Yeah. As we get information in, we  
4 send it as quickly --

5 MS. SNECKENBERG: Okay. But can we request a -- I  
6 mean, everybody's here. Can we request a -- please have it  
7 submitted by?

8 MS. SCHEER: A week before the meeting?

9 MR. GELVIN: How long do you want it?

10 MS. SNECKENBERG: The 26<sup>th</sup> is fine with me. Just  
11 so it's not the night before and the same day, because I  
12 don't feel like I have a chance to prepare.

13 MR. GELVIN: Okay.

14 MS. SNECKENBERG: And that gives you guys over a  
15 month. It's six weeks. For whomever. For anything further  
16 you want to bring forward.

17 CHAIRPERSON JACKSON: By August 26<sup>th</sup>.

18 MS. SNECKENBERG: For example, I asked for the  
19 information on your ballpark of what would be -- and I've  
20 said it before, not home plate, it could be left field --  
21 but how many would be possible surgical first associates --  
22 assistants, excuse me. Could we have that information,  
23 whatever it is you're going to supply, like, by the 26<sup>th</sup>?  
24 Again, that's a long way out.

25 MR. RIEKER: Yeah, we can do that.



The following responses from Sidney Regional Medical Center and the Nebraska Hospital Association address questions and issues members of the Technical Review Committee posed at the June 18<sup>th</sup> meeting.

**Questions and Issues the Committee Members want addressed at their Public Hearing on July 8, 2015:**

**1. Comments regarding the definition of ‘misdemeanors’ being used. What are some examples?**

Please see the document entitled “Examples of DHHS Regulations On ‘Misdemeanor’ & ‘Felony’” dispersed at the June 18<sup>th</sup> meeting of the Technical Review Committee for examples of current professional and occupational licensure regulatory definitions of “misdemeanor” and “felony.”

As discussed at the meeting, the applicant group wants to ensure the absence of subjectivity in interpretation of the reporting requirements in the licensure application process. Requiring reporting of all misdemeanors and felonies while excluding infractions ensures full disclosure on the part of the applicant. Additionally, the applicant group wants to facilitate the Department of Health and Human Services’ (“Department”) efforts to standardize credentialing regulations while maintaining public safety. Recent occupational licensure regulations do not limit the definition of “misdemeanor” and “felony.”

The applicant group recommends that application requirements for both licensure of surgical first assistants and registry of surgical technologists exclude minor traffic violations and do not limit the definition of “misdemeanor” and “felony.”

**2. Comments on ‘due diligence’ pertinent to the following items NOT being included in the SFA scope of practice: a. positioning the patient, b. preparing and draping the patient for the operative procedure, c. providing visualization of the operative site d. applying wound dressings.**

As discussed at the June 18<sup>th</sup> meeting, inclusion of functions within a statutory scope of practice are specific to the occupation addressed and **do not preclude** other allied health care professionals or health care practitioners from performing them. In meeting with the Department, it was recommended that functions integral to an occupation are included in the proposed scope of practice. Based on the Department’s recommendation, these functions will remain in the proposed scope of practice for the surgical first assistant.

**3. Comments on the role of SFAs in the closure of body planes, if any.**

Based on feedback obtained during the June 18<sup>th</sup> meeting and in discussions with individuals trained in surgical assisting, the proposed scope of practice will be amended to include the Association of Surgical Assisting limitations on closure of body planes as indicated below.

Assist with closure of body planes,

- a. Utilizing running or interrupted subcutaneous sutures with absorbable or nonabsorbable material,
- b. Utilizing subcuticular closure technique with or without adhesive skin closure strips,
- c. Closing skin with method indicated by surgeon (suture, staples, etc.),
- d. Postoperative subcutaneous injection of local anesthetic agent as directed by the surgeon

**4. Comments on the role of SFAs in preparing specimens, grafts, etc., if any.**

As indicated in the proposed scope of practice for surgical first assistants, licensed practitioners will be able to prepare specimens, including grafts, which is an accepted function for the occupation. Harvesting of grafts is not included in the proposed scope of practice.

**5. Comments regarding who should or should not be required to sit for the ST assessment procedure.**

The applicant group recommends that proof of current national certification exempts registry applicants from the competency requirement if the Department deems it appropriate.

**6. Comments regarding which board or boards should administer the regulation of STs and SFAs?**

As indicated in the application amendment dated July 8<sup>th</sup>, 2015, the applicant group recommends that the Board of Medicine and Surgery administers licensure of surgical first assistants. As registered nurses are the primary supervisors of surgical technologists and delegate tasks integral to the field of surgical technology, the Board of Nursing is best suited to regulate the registry of surgical technologists.

**7. Comments regarding which health professionals should administer or evaluate the competency assessment for STs?**

Though the Department will determine who the appropriate health care professionals are for evaluating surgical technologists for purposes of the competency assessment, the applicant group recommends that it is in line with the medication aide registry requirements of a licensed health care professional who must indicate his or her occupation and medical license number.

**8. Comment on the nature of the assessment process for STs: Is it a formal examination? Or is it an interview? Or something else?**

As is the case for medication aides in Nebraska, the competency assessment is a demonstration of the registry applicant's ability to perform basic functions of the occupation. The licensed health care professional must observe and certify that s/he witnessed the registry applicant's ability to successfully complete the functions listed. This might occur during the educational process, on-the-job training, or in the course of the applicant's employment.

**9. Comment on the idea of defining a scope of practice for SFAs and a range of functions for STs under the terms of the proposal, with the exception that SFAs would have both a scope of practice and a range of functions, whereas STs would only have a range of functions.**

As licensed health care professionals under this proposal, surgical first assistants will have a scope of practice that dictates the functions an individual can perform under the license. The functions are statutory and limiting.

This proposal creates a mandatory registry for surgical technologists. The proposed registry does not limit the functions of the surgical technology occupation. It simply dictates minimum standards for competencies through a required assessment during the application process. The best model of this type of regulation is in Nebraska's medication aide registry (which can be found [here](#)). Under this proposal, the only limiting factor on the full range of functions of a surgical technologist will be determined through a hospital or clinic's job description and/or competency requirements.

**July 8, 2015**

**Surgical First Assistant Credentialing Review Application  
Amendment**

1. The following will replace the response to Question #4 on the credentialing review application for surgical first assistants submitted on February 23, 2015, as well as the amendment submitted June 18, 2015.

**PART A: Licensure of Surgical First Assistants**

Part A of this proposal seeks to license surgical first assistants that have obtained a level of education, training, and examination as approved by the Nebraska Department of Health and Human Services (hereafter, "the Department"). The surgical first assistant occupation has its own specific educational standards as well as private certification requirements. Under this proposal, the Department would collaborate with the private certifying bodies issuing certification for surgical first assistants to facilitate the State of Nebraska's endorsement of the education, training and testing upon which the private credential is based. These standards would become part of the new licensure standard for surgical first assistants in Nebraska. Under this proposal, only those surgical assistants who have met the new licensure standard of appropriate education, training and examination are eligible for licensure. The applicant group recommends that the Board of Medicine and Surgery oversees this license.

According to The American College of Surgeons, "[t]he [surgical first assistant] participates during a surgical operation and is a trained individual who is able to participate in and actively assist the surgeon in completing the operation safely and expeditiously by helping to provide exposure, maintain hemostasis, and serve other technical functions." The surgical first assistant works under the personal supervision of a physician as an allied health care provider, providing quality health care services.

Under Part A of the application, the proposed scope of practice for a surgical first assistant includes but is not limited to:

1. Assisting the surgical team in the intraoperative care of a surgical patient,
2. Positioning the patient,
3. Preparing and draping the patient for the operative procedure,
4. Providing visualization of the operative site,
5. Assist with hemostasis,
6. Assist with closure of body planes,
  - a. Utilizing running or interrupted subcutaneous sutures with absorbable or nonabsorbable material,
  - b. Utilizing subcuticular closure technique with or without adhesive skin closure strips,
  - c. Closing skin with method indicated by surgeon (suture, staples, etc.),
  - d. Postoperative subcutaneous injection of local anesthetic agent as directed by the surgeon,
7. Applying appropriate wound dressings,
8. Providing assistance in securing drainage systems to tissue,
9. Preparing specimens, such as grafts, and

10. Performing tasks during a surgical procedure delegatable under the personal supervision of a licensed physician appropriate to the level of competence of the surgical first assistant.

The applicants want to ensure that training for surgical first assistants can occur in Nebraska. This requires that trainees are allowed, under state law, to perform tasks integral to the accredited program in which he or she is enrolled while unlicensed. Under this proposal, the applicants are requesting that statutory language similar to that which applies to physician assistants under Neb. Rev. Stat. 38-2048 is developed and included in the legislative proposal to facilitate training of surgical first assistants in the state. This will also pave the way for development of accredited programs in Nebraska's educational institutions.

The proposed language is as follows: Notwithstanding any other provision of law, a trainee may perform medical services when he or she renders such services within the scope of an approved program.

The following health care practitioners will be exempted from the Surgical First Assistant Practice Act: Physician, Nurse Practitioner, Physician Assistant, Registered Nurse and Licensed Practical Nurse.

#### **PART B: Registry for Surgical Technologists**

Part B of this proposal requests creation of a mandatory registry with a competency assessment requirement for surgical technologists. The purpose of this registry is to assist the State of Nebraska in ensuring that individuals functioning in the surgical technology occupation meet the competency requirements necessary to provide quality care in the State. The applicant group recommends that the Board of Nursing oversee the creation and maintenance of the registry.

Completion of an accredited surgical technology program is not a requirement of the registry but a component of the information collected. As a provision of Part B of this proposal, the registry shall include the highest level of education of the registrant. Applicants will be required to provide a copy of his or her transcript in support of an indication that he or she has completed a surgical assisting program. The proposal also requests that the documentation includes an opportunity for the applicant to acknowledge his or her possession of certification in surgical technology from a private certifying board.

A sample proposed model for the mandatory registry qualifications may include:

To qualify for placement on the Registry, the applicant must:

1. Be at least 19 years of age;
2. Be of good moral character; and
3. Be a citizen of the United States, or an alien lawfully admitted into the United States;
4. Submit to the Department:
  - a. A completed application including:
    1. applicant name, address, birth date, last four digits of the applicant's Social Security Number;
    2. identification of any felony or misdemeanor conviction along with date of occurrence and county in which the conviction occurred;
    3. whether or not the applicant has completed an accredited program in surgical technology;

4. whether or not the applicant has obtained private certification in surgical technology; and
  5. certification of competency assessment completed by a licensed health care professional.
- b. All records, documents or information requested by the Department;
  - c. The required non-refundable fee as determined.

Though the Department will develop registry requirements, the following is a potential model based on the Medication Aide Registry (71-6723, 71-6725), including the elements for the competency assessment.

Surgical technologists are allied health professionals who are an integral part of the team of medical practitioners providing surgical care to patients. Surgical technologists work under the direction of hospital and clinic policies to ensure that the operating room environment is safe, equipment functions properly and the operative procedure is conducted under conditions that maximize patient safety.

As part of the registry application, a determination will be made by a licensed health care professional and placed in writing that the surgical technologist is competent to perform the following activities:

1. Checks supplies and equipment needed for surgical procedure,
2. Scrubs, gowns and gloves,
3. Sets up sterile table with instruments, supplies, equipment, and medications/solutions needed for procedure,
4. Performs appropriate counts with circulator prior to the operation and before incision is closed,
5. Gowns and gloves surgeon and assistants,
6. Helps in draping sterile field,
7. Passes instruments, etc., to surgeon during procedure,
8. Maintains highest standard of sterile technique during procedure,
9. Prepares sterile dressings,
10. Cleans and prepares instruments for terminal sterilization,
11. Assists other members of team with terminal cleaning of room,
12. Assists in prepping room for the next patient,
13. Positioning the patient,
14. Preparing and draping the patient for the operative procedure, and
15. Providing visualization of the operative site.

The applicant group recommends that proof of current national certification exempts registry applicants from the competency requirement if the Department deems it appropriate.

2. The following statement found on page 13 of the application is stricken from the response to Question #5: "An ST works under the personal supervision of a registered nurse and the direct supervision of the independent licensed practitioner."





The influential voice of Nebraska's hospitals

**TO:** Diane Jackson, Chair  
Members of the Technical Review Committee

**FROM:** Elisabeth Hurst, Director of Advocacy

**DATE:** July 8, 2015

**SUBJECT:** Public Hearing Testimony

The surgical first assistant credentialing review application stemmed from an August 2013 facility survey at Sidney Regional Medical Center that brought to the forefront a Nebraska law prohibiting physicians from delegating tasks to unlicensed health care practitioners. Soon after, the State of Nebraska issued a cease and desist order informing facilities that it was illegal for a physician to delegate in this manner. Specifically, as identified in the survey, the physician could not delegate surgical tasks to the surgical first assistant.

Linda Shoemaker, the Compliance Officer and Risk Manager at Sidney Regional Medical Center, began researching the role of surgical first assistants in Nebraska. She quickly found that surgical assisting, like many allied health occupations, is not regulated in Nebraska and began the preliminary research for developing licensure of surgical first assistants. Linda drafted a white paper and submitted it the Nebraska Hospital Association's Board of Directors for review.

The NHA Board of Directors voted to sponsor the effort of Sidney Regional Medical Center and to partner through the credentialing review process for surgical first assistants. Shortly after, a stakeholder group was convened to further develop the application. The collaboration resulted in the application submitted on February of this year, and the credentialing review process officially began.

And here we are. We can all agree that this has been a learning experience. Much information has been cast upon you and we all know a lot more about how allied health professionals support the surgical team.

The primary goal of this proposal is patient safety through increased regulation of surgical first assistants and surgical technologists. Licensure of surgical first assistants will ensure that individuals in the field of surgical assisting meet a standard of education and training that the State of Nebraska determines is appropriate for this role. Surgical first assistants possess training specific to the intricacies involved in the surgical first assisting position and licensure will allow them to function as trained under the law.

Licensure will also increase access to services across the state. Surgeons will have greater access to the assistance necessary for providing services to patients in need. A licensed surgical first assistant can increase the availability

of appropriate surgical staff. This will promote cost-effective employment of qualified individuals to assist surgeons, enabling them to provide a higher quality of care while lessening the risk of surgical procedures.

Additionally, licensure of surgical first assistants will boost workforce development as more individuals seek out the training necessary to fulfill licensure requirements. Those functioning as a surgical technologist will realize the benefits of attaining increased education. Increased demand will create new training programs in Nebraska, which will boost the workforce for this occupation.

Finally, creation of a mandatory registry for surgical technologists with a competency assessment requirement will assist the State of Nebraska in ensuring that individuals functioning in the surgical technology occupation meet the competency requirements necessary to provide quality care in the State.

To highlight the application proposal, amended from its original form, there are several individuals who will testify as part of the applicant group.

Linda Shoemaker will review the educational pathway that an individual follows to become a surgical first assistant. She will also discuss the supervision of a licensed practitioner of surgical assisting under this proposal.

Chris Wilson, a surgical first assistant by training, will review the proposed scope of practice for this license and explain the trainee exemption which will facilitate training of surgical first assistants in Nebraska.

Casey Glassburner, a surgical technologist and program educator, will explain the educational pathway of a surgical technologist, the supervision of surgical technologists and the benefits of the registry under this proposal.

Dr. Erik Otterberg, an orthopaedic surgeon, is testifying on behalf of the applicant group and the Nebraska Medical Association in support of this effort.

Finally, Bruce Rieker of the Nebraska Hospital Association will discuss the credentialing review criteria and corresponding elements of the proposal.

We appreciate the many stakeholders who have contributed their expertise, time and resources to bring this proposal to its current form. On behalf of the applicant group, I would like to thank all involved.

Additionally, we would like to thank the Nebraska Medical Association, the Nebraska Nurses Association, and the Nebraska Association of Independent Ambulatory Centers for their letters of support.

To: Members serving on the Surgical First Assistant 407 Review Board

From: Nancy Gondringer, CRNA, Director of Surgical Services, CHI Health St. Elizabeth

Re: CST and CSFA

Date: July 8, 2015

First, I wish to express appreciation to the Nebraska Hospital Association and members of many professional groups who have worked on completing the 407 process on behalf of the Surgical First Assistants. I have been able to be part of the meeting and have found them to focus on providing safe patient care and quality outcomes for all surgical patients in the state of Nebraska.

The 407 process, although very demanding and time consuming, was the appropriate mechanism to allow all interested parties to come together and develop an overdue scope of practice for these health care providers. During the 407 process preparation the CST and CSFA were identified as vital members of the surgical team providing patient care. The committee researched various levels of practice for each provider group with the main objective in providing safe quality of care for all surgical patients in the state of Nebraska. The final product that is being debated today addresses the educational requirements, clinical experiences needed and responsibilities of the CST and CSFA. It also addresses how those roles and responsibilities interact with those of the circulating Registered Nurse and Physician provider for whom they assist during a surgical procedure.

I understand there has been confusion between a Certified Surgical Technologist and a Certified Surgical First Assistant. Both are vital to the team but their functions differ. Like all medicine and nursing some lines seemed to be blurred as both the CST and CSFA could do some of the same activities but the major difference is what activity they are performing and whose license they are functioning. The CST has more limited functions under the Registered Nurse or under the direct supervision of the physician as well as the Registered Nurse, whereas the CSFA has obtained additional education and clinical skills which allow the CSFA to provide a more comprehensive support system to the physician. A simple example would be a surgeon would place a retractor and ask the CST to hold it in place whereas the surgeon may ask the CSFA to place the retractor based on their additional education and experiences with the surgical procedure.

I have heard there has been open discussion regarding who should provide oversight for these two groups of individuals. That will be a decision the group needs to make but someone needs to have oversight into their licensure or registration that provides a mechanism to oversee this group of providers and validate they are providing safe quality of care to the citizens of Nebraska.

I have worked with both CST and CSFAs and believe both groups of allied health professionals and an important part of the surgical team. They are part of the team that cares daily for surgical patients and this legislation provides a means to monitor and have oversight into their scopes of practice. If there are questions regarding my statements please contact me at 402-432-0511.

Thank you

Nancy Gondringer, CRNA

Good afternoon Chair Jackson and Members of the Committee,

My name is Casey Glassburner (spelled) and I am a Certified Surgical Technologist and have been for almost 10 years. I am also currently serving as the President of the Nebraska State Assembly of the Association of Surgical Technologists. Today I will be providing testimony on the Educational Pathway for and Supervision of Surgical Technologists as well as the benefit of establishing a surgical technologist registry.

Currently in the state of Nebraska and across the country, surgical technologists are educated in surgical technology programs that are accredited by either CAAHEP (Commission on Accreditation of Allied Health Education Programs) or ABHES (Accrediting Bureau of Health Education Schools). There are over 500 accredited surgical technology programs across the country ranging in length from 18-24 months with most resulting in graduates receiving an Associate's of Applied Science Degree in Surgical Technology. By 2021 all accredited surgical technology programs are required to be associate degree as all diploma programs are being phased out in an attempt to create uniformity among the education of all graduates from accredited surgical technology programs.

There are 2 CAAHEP accredited surgical technology programs in the state of Nebraska. One is located in Omaha at Nebraska Methodist College and the other is located at Southeast Community College in Lincoln which also offers their program online to serve the western part of the state. Both programs are associate degree programs and include several months of clinical education to adequately prepare graduates for success in the field following graduation. Students in the surgical technology program at Southeast Community College spend 700 hours in the actual operating room setting and scrub around 150-200 cases prior to graduation.

Surgical technologists are allied health professionals who play an integral role as a member of the operating room team. They work under the direction of hospital and clinic policies as well as under the supervision of the independent licensed practitioner and the registered nurse throughout the preparation, performance, and clean up of a surgical procedure. Their main focus is assisting the surgical team to ensure the surgical procedure is performed as efficiently as possible by anticipating the needs of the team while maintaining the highest level of aseptic or sterile technique to ensure the patient does not acquire a surgical site infection. Surgical technologists are the only member of the surgical team that is specifically trained in aseptic technique and the methods that should be utilized to minimize the patient's risk of contracting a postoperative wound infection. Their attention to making sure that all instruments and supplies that are utilized during the procedure are sterile during the preparation for the case and throughout the performance of the procedure directly affects the outcomes upon completion for the patients. Surgical site infections can cause a case that would have otherwise been considered a success to be seen as a failure by the patient and their family.

Creation of a mandatory surgical technologist registry with a competency assessment requirement is an essential step that must be taken to improve surgical patient care as well as ensure that surgical patients throughout the state are being protected from the potential harm that can result from unqualified surgical team members being present during a procedure. Surgical patients do not have the ability to

choose their surgical team like they have the ability to choose their surgeon. These patients deserve to know that everyone in their operating room has at least a minimum level of competency for the role that they are serving in. Currently the surgical technologist is the only member of the immediate operating room team that has no education or competency requirements.

Surgical patients are in their most vulnerable state where they do not have a voice to speak up for themselves. They are trusting that every member of the team has their best interest at heart in every step of their care and that everyone has the base knowledge to provide them with the best outcomes possible. By establishing a mandatory surgical technologist registry we can help give every surgical patient this piece of mind.

Thank you for the opportunity to provide this information to you this afternoon and I am available to answer any questions you may have.

Casey Glassburner, CST, F.A.S.T.

President

Nebraska State Assembly of the Association of Surgical Technologists

Surgical Technology Instructor

Southeast Community College

Good afternoon Chair Jackson and Members of the Committee,

My name is Casey Glassburner (spelled) and I am a Certified Surgical Technologist and have been for almost 10 years. I am also currently serving as the President of the Nebraska State Assembly of the Association of Surgical Technologists. Today I will be providing testimony on behalf of this organization (NE-AST) and our national organizations the Association of Surgical Technologists (AST) and the Association of Surgical Assistants (ASA), related to our recommendations as answers to the specific questions and issues that you have requested to be addressed at this Public Hearing in the document that was posted to the credentialing review website.

**First I would like to comment on the duties of positioning the patient, preparing and draping the patient for the operative procedure, providing visualization of the operative site through holding retractors and applying wound dressings not being included in the surgical assistant licensure scope of practice.**

The American College of Surgeons and AST have nationally-approved a job description for surgical technologists that includes all of these tasks as surgical technology tasks and functions. Including these tasks in the surgical assistant license and scope of practice would prevent surgical technologists from performing these functions that are historically and currently part of their job.

Therefore we would recommend that these items be included in the surgical technologist range of functions and that the surgical assistant license scope of practice read as follows:

1. Performing all tasks included in the surgical technologist range of functions
2. Providing visualization of the operative site through the placement of retractors (which is an advanced skill beyond just holding retractors after they have already been placed)
3. Assisting with hemostasis
4. Performing closure of body planes, including only the subcutaneous and skin layer
5. Applying appropriate immobilizing wound dressings (which includes casts and splints that a surgical technologist is not trained to apply)
6. Providing assistance in securing drainage systems to tissue
7. Preparing but not procuring grafts after they have been removed from the patient by the surgeon
8. Performing tasks delegatable under the personal supervision of a licensed physician

It should also be noted that the American College of Surgeons, ASA and AST have a nationally-approved job description for surgical assistants to include the task of postoperative subcutaneous injection of local anesthetic agent as directed by the surgeon. It is our recommendation that this task be included in the surgical assistant scope of practice as well.

**Next I would like to comment on the role of surgical first assistants in the closure of body planes.**

The American College of Surgeons, ASA and AST have nationally approved a job description for surgical assistants related to closure of body planes that describes only closure of the subcutaneous and skin layer by various means.

Therefore we would recommend utilizing the nationally approved description in restricting the closure of body planes in the surgical assistant scope to just the subcutaneous and skin layer. We would also like to recommended that the wording of this skill in the scope be switched from “assisting with closure” to “performing closure” as surgical assistants in other states have encountered issues with their ability to actually apply sutures as some have claimed that “assisting with closure” doesn’t actually mean placing the sutures in the tissue layers.

**Next I would like to comments on the role of surgical first assistants in preparing grafts.**

In order to remove the concern expressed by the committee related to the potential of allowing surgical assistants in the state to remove grafts from a patient, we would recommend that the scope of practice for the surgical assistants include the task of preparing but not procuring grafts, after they have been removed from the patient by the surgeon. The Core Curriculum for Surgical Assisting, which is taught in accredited surgical assisting programs, includes graft care providing graduates adequate information to perform this skill.

We would also like to ensure that the word specimen is removed from this skill in the surgical assistant scope of practice as specimen care is already included in the surgical technologist range of functions which the surgical assistant will be allowed to perform in its entirety. Also including the word specimen could allow for interpretation preventing the surgical assistant from removing a specimen from a patient after it has already been resected and detached from all of its internal attachments by the surgeon such as removing the gallbladder from the abdomen on a laparoscopic case after it has been resected by the surgeon from the liver bed which is often a skill that is performed by the surgical assistant.

**Next I would like to comment on which potential registrants should or should not be required to undergo the surgical technologist competency assessment procedure and who should administer this assessment.**

While all our organizations agree that the competence of all surgical technologists in the state should be assessed prior to an individual being placed on the surgical technologist registry we continue to recommend that surgical technologists who are currently Certified Surgical Technologists (CSTs) should not go through a competency assessment to be placed on the registry as these individuals have already demonstrated their competency through graduation from an accredited surgical technology program, passage of the national surgical technologist certifying exam, and maintenance of current competency through required continuing education that is currently set at 60 hours in a 4 year period.

The passage of the national surgical technologist certifying exam and maintenance of the Certified Surgical Technologist credential is utilized in several other states as the highest level of competence and is required as a condition of employment.

Members of the Nebraska State Assembly met with members of the Department of Health and Human Services on June 30<sup>th</sup> to discuss the potential of recognizing the national surgical technologist certifying exam as a method of establishing competence for surgical technologists seeking to be placed on the registry. We were assured that this was an acceptable pathway to establish the potential registrant’s competence as the method of recognizing a national exam but not a private agency is utilized by other professions in the state to establish a minimum level of competence.

Therefore, we continue to recommend that two pathways be allowed for potential surgical technologist registrants to establish their competence.

1) If the potential registrant is currently a CST (Certified Surgical Technologist), they would need to provide a copy of their current certification card that will serve as proof of passage of the national surgical technologist certifying exam establishing their competence as a surgical technologist.

OR

2) If the potential registrant is not currently a CST (Certified Surgical Technologist), they would need to submit a certification of competency assessment completed by a qualified licensed health care professional with at least 2 years of operating room experience to establish their competence as surgical technologist.

**In relation to which health professionals should administer or evaluate the competency assessment for surgical technologists seeking to be placed on the registry,**

We recommend that wording be included to reflect a “qualified licensed health care professional with at least two years of operating room experience.” The operating room is a unique environment, one that many licensed health care professionals do not practice in, making them ill-equipped to properly determine if a surgical technologist seeking to be on the registry is competent in the tasks that are required to be assessed. Prior operating room experience is essential to establish the base knowledge for a licensed health care professional to adequately assess the competence of a surgical technologist seeking registration. We would also like to ensure that an LPN is not allowed to administer this competency assessment as we feel their educational background does not provide them the knowledge to adequately assess potential surgical technology registrants.

**In reference to our recommendation of the nature of the competency assessment process for surgical technologists seeking to be on the registry,**

On the copy that you have received you will see the wording from the amendment in reference to the skills that must be assessed by the licensed health care professional to determine the competency of a surgical technologist seeking to be on the registry.

As you can see these skills are complex and include many intricacies. It is the recommendation of the NE-AST that to accurately assess these skills the potential registrant would actually have to demonstrate them and would not be able to simply take an exam to establish their competence.

**Finally I would like to comment on the idea of defining a scope of practice for surgical first assistants and a range of functions for surgical technologists under the terms of the proposal.**

Our organizations completely endorse the definition of a range of functions of the surgical technologist and a scope of practice for the surgical assistant that includes a clause stating that a surgical assistant can perform all of the tasks included in the surgical technologist range of functions as well as the tasks included in the surgical assistant scope of practice. Included in your copy you will find our recommended range of functions for the surgical technologist and our recommended scope of practice for the surgical assistant that will achieve this situation.

Thank you for the opportunity to provide these recommendations to you this afternoon and I am available to answer any questions you may have.

Casey Glassburner, CST, F.A.S.T.

President

Nebraska State Assembly of the Association of Surgical Technologists

Surgical Technology Instructor

Southeast Community College

June 30, 2015

Diane Jackson, APRN (Chair) Members,  
407 Technical Review Committee  
c/o Matt Gelvin  
Administrator, Credentialing Review Program  
Department of Health and Human Services  
Licensure Unit  
P.O. Box 95026  
Lincoln, NE 68509-5026

Dear Ms. Jackson and Members of the Committee:

On behalf of the Nebraska State Assembly of the Association of Surgical Technologists (NE-AST) and our national organizations the Association of Surgical Technologists (AST) and the Association of Surgical Assistants (ASA), we would like to provide you with our recommendations as answers to the following questions and issues that you have requested to be addressed at the Public Hearing on July 8, 2015 in the document that was posted to the credentialing review website.

**Questions and Issues the Committee Members want addressed at their  
Public Hearing on July 8, 2015:**

**1. Comments regarding the definition of 'misdemeanors' being used. What are some examples?**

NE-AST, AST and ASA will not provide a recommendation related to this area as this is not a technical question related to the practice of the professions of surgical technology and surgical assisting.

**2. Comments on 'due diligence' pertinent to the following items NOT being included in the surgical first assistant scope of practice:**

- a. positioning the patient,**
- b. preparing and draping the patient for the operative procedure,**
- c. providing visualization of the operative site**
- d. applying wound dressings**

The American College of Surgeons AST have nationally-approved a job description for surgical technologists that includes all of the tasks listed above as surgical technology tasks and functions. Including these tasks in the surgical assistant license and scope of practice would prevent surgical technologists from performing these functions that are historically and currently part of their job.

NE-AST, AST and ASA would recommend that the above items be included in the surgical technologist range of functions and that the surgical assistant license scope of practice read as follows:

1. Performing all tasks included in the surgical technologist range of functions

2. Providing visualization of the operative site through the placement of retractors
3. Assisting with hemostasis
4. Closure of body planes, including only the subcutaneous and skin layer
5. Applying appropriate immobilizing wound dressings
6. Providing assistance in securing drainage systems to tissue
7. Preparing but not procuring grafts after they have been removed from the patient by the surgeon
8. Performing tasks delegatable under the personal supervision of a licensed physician

It should also be noted that the American College of Surgeons, ASA and AST have a nationally-approved job description for surgical assistants to include the task of postoperative subcutaneous injection of local anesthetic agent as directed by the surgeon. It is our recommendation that this task be included in the surgical assistant scope of practice as well.

### **3. Comments on the role of surgical first assistants in the closure of body planes, if any.**

The American College of Surgeons, ASA and AST have nationally approved the following job description for surgical assistants related to closure of body planes:

5. Utilizing appropriate techniques to assist with closure of body planes
  - A. Utilizing running or interrupted subcutaneous sutures with absorbable or nonabsorbable material
  - B. Utilizing subcuticular closure technique with or without adhesive skin closure strips
  - C. Closing skin with method indicated by surgeon (suture, staples, etc)

NE-AST, AST and ASA would recommend utilizing the nationally approved description in defining "closure of body planes" in the scope of practice for the surgical assistant in Nebraska.

### **4. Comments on the role of surgical first assistants in preparing specimens, grafts, etc., if any.**

Surgical assistants assist in preparing specimens and grafts. This includes handling specimens such as skin grafts and biopsy samples after they have been removed from the patient. Surgical assistants often prepare replacement Anterior Cruciate Ligaments (ACLs) at the backtable. The surgeon removes a hamstring muscle from the patient. Then, at the backtable, the surgical assistant removes the muscle tissue. The remaining tendon is fortified by the surgical assistant. The surgeon then uses the new Anterior Cruciate Ligament and places it in the patient.

NE-AST, AST and ASA would recommend that the scope of practice for the surgical assistant license in the state of Nebraska include the task of preparing grafts, after they have been removed from the patient by the surgeon. The Core Curriculum for Surgical Assisting, which is taught in accredited surgical assisting programs, includes graft care.

### **5. Comments regarding who should or should not be required to sit for the surgical technologist assessment procedure.**

NE-AST, AST and ASA agree that the competence of all surgical technologists in the state should be assessed prior to an individual being placed on the surgical technologist registry and being allowed to function in the surgical technology profession to ensure quality patient care.

Surgical technologists who are currently Certified Surgical Technologists (CSTs) should not go through a competency assessment to be placed on the registry. Certified Surgical Technologists have already demonstrated competency. Surgical technologists who are CST certified have:

1. Graduated from an accredited surgical technology program which are 18-24 months in length with many months of clinical training;

2. Passed the national surgical technologist certifying exam administered by the National Board of Surgical Technology and Surgical Assisting, (a non-profit certifying agency); and
3. Maintain current competency through required continuing education.

Currently Certified Surgical Technologists are required to complete 60 continuing education hours in a four-year period to maintain the CST credential.

The passage of the national surgical technologist certifying exam and maintenance of the Certified Surgical Technologist credential is utilized in several other states as the highest level of competence and is required as a condition of employment.

Members of the Nebraska State Assembly of the Association of Surgical Technologists met with members of the Department of Health and Human Services on June 30<sup>th</sup> to discuss the potential of recognizing the national surgical technologist certifying exam as a method of establishing competence for surgical technologists seeking to be placed on the registry. We were assured that this was an acceptable pathway to establish the potential registrant's competence.

### **Competency Demonstration Proposal**

The NE-AST and AST recommendation remains that two pathways be allowed for potential surgical technologist registrants to establish their competence to be placed on the surgical technologist registry in the state of Nebraska.

1) If the potential registrant is currently a CST (Certified Surgical Technologist), they would need to provide a copy of their current certification card that will serve as proof of passage of the national surgical technologist certifying exam establishing their competence as a surgical technologist.

OR

2) If the potential registrant is not currently a CST (Certified Surgical Technologist), they would need to submit a certification of competency assessment completed by a qualified licensed health care professional with at least 2 years of operating room experience to establish their competence as surgical technologist.

### **6. Comments regarding which board or boards should administer the regulation of surgical technologists and surgical first assistants?**

It was recommended by the applicant group at the technical review committee meeting on June 18<sup>th</sup> that the surgical assistant license would be administered by the Board of Medicine in Surgery and that at the time they were uncertain as to which board would administer the surgical technologist registry.

The Board of Health or the Board of Medicine administers most registries for surgical technologists in other states. It is the opinion of NE-AST and AST that the registry should be administered by the same board as the surgical assistant licensure as the two professions are so closely related and are a stepping stone to one another. Testimony by the Director of Government and Public Affairs from the Association of Surgical Technologists will be made at the public hearing related to this concern.

### **7. Comments regarding which health professionals should administer or evaluate the competency assessment for surgical technologists?**

According to the amendment that was proposed "a determination will be made by a licensed health care professional and placed in writing that the surgical technologist is competent to perform the following tasks...". NE-AST and AST would recommend that the wording be changed to reflect a "qualified licensed health care professional with at least two years of operating room experience." The operating room is a unique environment, one that many licensed health care professionals do not

practice in, making them ill-equipped to properly determine if a surgical technologist seeking to be on the registry is competent in the tasks that are required to be assessed. Prior operating room experience is essential to establish the base knowledge for a licensed health care professional to adequately assess the competence of a surgical technologist seeking registration.

**8. Comment on the nature of the assessment process for surgical technologists: Is it a formal examination? Or is it an interview? Or something else?**

According to the amendment that has been made to the application;

As part of the registry application, a determination will be made by a licensed health care professional and placed in writing that the surgical technologist is competent to perform the following activities:

1. Checks supplies and assess the functionality of equipment needed for surgical procedure,
2. Scrubs, gowns and gloves,
3. Sets up sterile table with instruments, supplies, equipment, and medications/solutions needed for procedure,
4. Performs appropriate counts with circulator prior to the operation and before incision is closed,
5. Gowns and gloves surgeon and assistants,
6. Helps in draping sterile field,
7. Passes instruments, etc., to surgeon during procedure,
8. Maintains highest standard of sterile technique during procedure,
9. Prepares sterile dressings,
10. Cleans and prepares instruments for terminal sterilization,
11. Assists other members of team with terminal cleaning of room, and
12. Assists in prepping room for the next patient.

These skills that are listed are complex and include many intricacies. It is our recommendation that to accurately assess these skills the potential registrant would actually have to demonstrate them and would not be able to simply take an exam to establish their competence.

**9. Comment on the idea of defining a scope of practice for surgical first assistants and a range of functions for surgical technologists under the terms of the proposal, with the exception that surgical first assistants would have both a scope of practice and a range of functions, whereas surgical technologists would only have a range of functions.**

NE-AST, AST and ASA endorse the definition of a range of functions of the surgical technologist and a scope of practice for the surgical assistant that includes a clause stating that a surgical assistant can perform all of the tasks included in the surgical technologist range of functions as well as the tasks included in the surgical assistant scope of practice.

We recommend the following range of functions for the surgical technologist:

Surgical technologists perform the following tasks or functions:

- a) preparing the operating room for surgical procedures by ensuring that surgical equipment is functioning properly and safely;
- b) preparing the operating room and the sterile field for surgical procedures by preparing sterile supplies, instruments, and equipment using sterile technique;
- c) anticipating the needs of the surgical team based on knowledge of human anatomy and pathophysiology and how they relate to the surgical patient and the patient's surgical procedure; and
- d) performing tasks in an operating room setting in the sterile field, including the following:
  - (1) scrubbing, gowning and gloving as required for the procedure being performed;
  - (2) participating in the "Surgical Time Out" to ensure correct patient identification, correct surgery site and correct surgical procedure;

- (3) recognizing and correcting breaks in the sterile field to maintain the highest standard of sterile technique throughout the procedure;
  - (4) passing supplies, equipment or instruments to the surgeon and/or other qualified surgical team members;
  - (5) applying drapes to the patient to create the sterile field;
  - (6) gowning and gloving additional surgical team members;
  - (7) sponging or suctioning an operative site;
  - (8) preparing and cutting suture material;
  - (9) transferring and irrigating with fluids;
  - (10) transferring but not administering medications within the sterile field, according to applicable law following verification and distribution by the registered nurse to the sterile field;
  - (11) handling specimens;
  - (12) holding retractors and other instruments including endoscopes to assist in the visualization of surgical site as directed by a licensed independent practitioner;
  - (13) applying electrocautery to clamps that have been placed by a licensed practitioner on bleeders as directed by a licensed independent practitioner;
  - (14) connecting drains to a suction apparatus under personal supervision by a licensed independent practitioner;
  - (15) applying skin staples and skin adhesive under personal supervision by another licensed health care professional who approximates wound edges;
  - (16) applying dressings to closed wounds;
  - (17) counting sponges, needles, supplies, and instruments as appropriate for the procedure being performed with the registered nurse circulator prior to the operation and before the incision is closed;
  - (18) cleaning and preparing instruments for sterilization on completion of the surgery; and
  - (19) assisting the surgical team with cleaning of the operating room on completion of the surgery.
- e) performing tasks in an operating room setting in the unsterile role as an assistant to and under the supervision of the circulating nurse, including the following:
- (1) Verifying and obtaining appropriate sterile and unsterile items needed for procedure
  - (2) Opening sterile supplies
  - (3) Transferring the patient to operating room table
  - (4) Providing comfort and safety measures as well as verbal and tactile reassurance to the patient
  - (5) Assisting anesthesia personnel
  - (6) Positioning the patient, using appropriate equipment and safety precautions
  - (7) Applying electrosurgical grounding pads, tourniquets, monitors, etc., before the procedure begins
  - (8) Preparing the patient's skin prior to draping by the surgical team by applying the appropriate skin preparation solution and shaving as ordered by the surgeon
  - (9) Performing urinary catheterization when necessary
  - (10) Anticipating additional supplies needed during the procedure
  - (11) Properly caring for specimens
  - (12) Securing dressings after incision closure
  - (13) Assisting in transport of the patient to the recovery room or critical care area
  - (14) Assisting in cleaning of the operating room and preparing for the next surgical procedure

We would recommend the following scope of practice for the surgical assistant:

1. Performing all tasks included in the surgical technologist range of functions
2. Providing visualization of the operative site through the placement of retractors

3. Assisting with hemostasis
4. Assisting with closure of body planes, including only the subcutaneous and skin layer
5. Applying appropriate immobilizing wound dressings
6. Providing assistance in securing drainage systems to tissue
7. Preparing but not procuring specimens, such as grafts after they have been removed from the patient by the surgeon
8. Postoperative subcutaneous injection of local anesthetic agent as directed by the surgeon.
9. Performing tasks delegatable under the personal supervision of a licensed physician

Respectfully,

Casey Glassburner, CST, F.A.S.T.

President

Nebraska State Assembly of the Association of Surgical Technologists

Surgical Technology Instructor

Southeast Community College

## **Questions and Issues the Committee Members want addressed at their Public Hearing on July 8, 2015**

Dear Ms. Jackson and Members of the Committee:

#### **4. *comments on the role of the surgical first assistants in preparing specimens, grafts, etc. if any.***

Surgical technologists handle specimens obtained by the operating surgeon, and are responsible to transfer that specimen to the RN circulator. They are also responsible for handling grafts removed from patients that are intended for re-implantation. Surgical assistants would be responsible for those actions as well.

In the case of the surgical first assistant that is working with an orthopedic surgeon, a surgical first assistant may prepare a hamstring graft at the back table for use in that procedure.

AORN is concerned that it be explicitly clear that the graft is obtained by the surgeon only, as obtaining a graft is a surgical procedure. Our concern over listing graft preparation is in the complexity of graft preparation of various types of grafts, to include vascular grafts for coronary bypass and peripheral bypass, renal grafts for transplantation, skin grafts, hair plugs, bone grafts and the like.

In granting licensure with broad statements regarding scope of practice such as this could become problematic and potentially cause harm to the patient. While some graft preparation may be appropriate, others may not.

AORN has concerns regarding some of the activities listed in the scope of practice for the SFA and the range of function for the CST, most notably the application of a tourniquet and urinary catheterization, as has been listed in #9 of the questions.

Urinary catheterization is an intervention carried out traditionally by the nurse but may be performed by the physician. The number one cause of nosocomial infection is the urinary catheter and should not be delegated. The application of a tourniquet is problematic in that improper fit may cause permanent nerve damage and should not be delegated either. The selection of the appropriate cuff is correlated to the physical assessment of the patient that is performed by the nurse or physician.

AORNs biggest concern in the credentialing of the SFA is the limited amount of post secondary education required. I have included a copy of the requirement for obtaining and maintaining SFA and compared it to the CRNFA, who would be first assisting at the level being requested for these practitioners.

## CRNFA

1. Current, unrestricted nursing license
2. Bachelors Degree
3. Currently hold CNOR certification/APRN certified in the specialty  
Two years employment as a perioperative registered nurse and write and pass the CNOR exam
4. Currently working full or part time as an RNFA
5. Documented 2000 hours of first assisting (not classroom work)
6. 500 of those hours must have been in the previous 2 years
7. Completion of an accredited formal RNFA program  
140 hours online/ home study (35 credit hours)  
60 hour didactic workshop  
Internship of 60 cases
8. Write/Pass CRNFA exam
9. Renews every 5 years  
200 contact hours if 1000 active hours of first assisting is logged  
300 contact hours if 500 active hours of first assisting has been logged

## CSFA

1. Graduate of a SFA program  
(28 credit hour's average)
2. Previous operating room experience such as CST
3. Log 200 cases (75 general surgery, 75 specialty, 50 in another specialty)
4. Write /Pass CSFA exam
5. Renews every 2 years  
50 contact hours  
Log 200 cases verified by 2 different surgeons

**Contact information:**

Karen Rustermier RN BSN CNOR  
8131 S 107 St  
LaVista, NE 68128  
[nurserust@yahoo.com](mailto:nurserust@yahoo.com)

AORN National Legislative Committee Member  
Nebraska State Legislative Coordinator

**SIGN IN SHEET**  
 For Public Testimony on the  
 Surgical First Assistants' Technical Review  
 July 8, 2015 (1:00 p.m. start time)

**TESTIFIERS - Please Print or Write Legibly for the Record**

	<b>PROPONENT'S NAME</b>	<b>REPRESENTING</b>
A 1.	Casey Glassburner <sup>AOP</sup> ✓ <sub>4</sub> x2	Nebraska State Assembly of AST
2.	Catherine Sporkman ✓	Assoc. of Surgical Technologists & Surgical Assistants
3.	Charles Scholtes ✓	Neb. Academy Phys Assistants
4.	Corlan Vonderschmidt <sup>No Comment</sup>	Ne Academy of Physician Assistants.
A 5.	ERIN OTTERBERG MD ✓ <sub>5</sub>	NMA
A 6.	Chris Smith ✓ <sub>3</sub>	CSSA's
A 7.	Elizabeth Jurst ✓ <sub>1</sub>	NHA
A 8.	Heinde <sup>v2</sup> Sprenkle	SKMC.
A 9.	Bowen Kreker ✓ <sub>1</sub>	Nebraska Hospital Association
A 10.	Melissa Florell ✓ <sub>6</sub>	Nebraska Nurses Association
11.	Juan Yari	
12.	Joanne Wardlaw	Lincoln OB/GYN
13.		
14.		
15.		
16.		
17.		

5  $\frac{3}{10}$  7 Applicant Group  
 Proponents

2 1 opponent  
 1 Neutral

**SIGN IN SHEET**  
For Public Testimony on the  
Surgical First Assistants' Technical Review  
July 8, 2015 (1:00 p.m. start time)

**TESTIFIERS - Please Print or Write Legibly for the Record**

*Other*

**OPPOSANT'S NAME**

**REPRESENTING**

1. *Karen Rustermiec RN BSN CNOR* ✓

*AORN*

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**SIGN IN SHEET**  
For Public Testimony on the  
Surgical First Assistants' Technical Review  
July 8, 2015 (1:00 p.m. start time)

**TESTIFIERS - Please Print or Write Legibly for the Record**

<b>NEUTRAL, NAME</b>	<b>REPRESENTING</b>
1. <i>Michael Bittles</i>	<i>State Bd of Med. &amp; Surgery</i>
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