Kansas Legislative Research Department August 15, 1977

M I N U T E S

SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

July 19-20, 1977

Room 527-S

Members Present

Representative Michael G. Johnson, Chairman
Senator Wesley H. Sowers, Vice-Chairman
Senator John E. Chandler
Senator Bert Chaney
Senator Mike Johnston
Representative Theo Cribbs
Representative Kenneth Francisco
Representative Sharon Hess
Representative Marvin L. Littlejohn
Representative Pascal A. Roniger
Representative Larry F. Turnquist

Staff Present

Emalene Correll, Kansas Legislative Research Department
Bill Wolff, Kansas Legislative Research Department
Sherman Parks, Revisor of Statutes Office

Others Present

Carl C. Schmitthenner, Kansas State Dental Association, Topeka, Kansas
Jack Milligan, Kansas Optometric Association, Topeka, Kansas
Doug Johnson, Kansas Pharmaceutical Association, Topeka, Kansas
Bill Kimble, Wesley Medical Center, Wichita, Kansas
Frank L. Gentry, Kansas Hospital Association, Topeka, Kansas
Katie Pyle, Kansans for the Improvement of Nursing Homes, Topeka, Kansas
John C. Peterson, Kansas Speech and Hearing Association, Topeka, Kansas
Joe Harkins, Department of Health and Environment, Topeka, Kansas
Ruth C. Dickinson, Division of Planning and Research, Topeka, Kansas
Elizabeth Carlson, State Board of Healing Arts, Topeka, Kansas
Paul Bratsman, School of Social Welfare, University of Kansas, Lawrence, Kansas
Harriet Nehring, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Murray Brown, Neosho Memorial Hospital, Chanute, Kansas
Robert E. Jacoby II, M.D., Family Practice Group, Topeka, Kansas
Robert C. Harder, Department of Social and Rehabilitation Services, Topeka, Kansas
Margaret Buis, Public Health Service, Region VII, Kansas City, Missouri
V.J. Valgora, PA Program, Wichita State University, Wichita, Kansas
Jerry Slaughter, Kansas Medical Society, Topeka, Kansas
Marc T. Dicker, PA Program, Wichita State University, Wichita, Kansas
James E. Hill, M.D., State Board of Healing Arts, Arkansas City, Kansas
Rosemary Waddell, Kansas Chapter National Association of Social Workers, Topeka, Kansas
Mary J. Wiersma, Kansas Farm Bureau, Manhattan, Kansas
Gary Robbins, Kansas State Nurses Association, Topeka, Kansas
Terry Whelan, Kansas Association of Osteopathic Medicine, Topeka, Kansas
Homer Cowan, The Western Insurance Company, Fort Scott, Kansas

The meeting was called to order at 10:00 a.m. by the Chairman, Representative Michael G. Johnson.

Proposal No. 59 - Credentialing of Health Care Personnel

After the Chairman noted that a bill relating to naturopaths had been held in Committee last session, Committee consensus was to added this group to the list of professions to be considered by the Committee. Copies of "Practice of Naturopathy", a report by the 1975 Special Committee on Public Health and Welfare was distributed. This report is available in the Kansas Legislative Research Department.

Staff reviewed pertinent sections of 1971, 1973, and 1976 HEW reports on the credentialing of health manpower. (These reports are on file in the Kansas Legislative Research Department.)

The 1971 report lists three forms of credentialing of health manpower: (1) accreditation of an institution or a program by a nationally recognized accrediting agency; (2) licensure by a governmental agency which administers an examination, issues the license and enforces the licensure statutes; (3) certification or registration by a nongovernmental agency or association.

Noting that accreditation is frequently done by an arm of a professional organization, a question was raised as to whether this protects the public or the people practicing. Staff stated the HEW report raises this same question. Doug Johnson, Kansas Pharmaceutical Association, in answer to a question, stated accreditation of schools of pharmacy is done by a separate body, not an arm of the American Pharmaceutical Association, composed mostly of educators in the field and a few pharmacists.

Licensure can be compulsory (a person cannot practice without a license) or voluntary (only a person holding a license can use the title but others may practice in the field). In some professions a person who is licensed may, after meeting additional qualifications, be certified in a specialty. Specialty certification is usually done by a specialty board of a professional organization.

Staff noted that groups appearing before the Legislature do not always distinguish between certification and licensure or clearly state what certification means in relation to their group. Also, in Kansas statutes credentialing terms are used interchangeably. For example, by statute pharmacists are "registered", but in fact they are licensed since a governmental body determines who may practice and may suspend, revoke, or restrict the right of a registered person to practice. A physician's assistant by statute is also "registered" which means only that he has met the qualification to have his name on a registry.

Staff called attention to three other points raised in the 1971 Report: whether academic requirements should be the only way to enter the developing allied health professions; whether licensing is based on political pressure rather than on an analysis of whether it is needed to protect the public; whether state licensing agencies are effectively enforcing present licensure statutes.

Referring to the recommendations to states in the 1971 Report, staff stated most health professions boards in Kansas are using national or regional exams for licensure: public members serve on the regulatory boards; and Kansas licensure acts have been amended to require continuing education for relicensure.

In the 1973 Report staff called attention to the criteria for licensing groups developed by the New Jersey Professional and Occupational Licensing Study Commission. These criteria appear in the final HEW recommendations and have been incorporated into the laws of some states.

The 1973 Report makes a strong case for the negative effect of state licensure on mobility of health care personnel but notes the lack of supporting evidence for this conclusion; raises questions about the relationship of continuing education to continuing competence; and notes the trend toward proficiency and equivalency testing. This report continues the discussion of institutional licensure and notes some current studies. However, the 1976 Report states this is not a viable alternative at the present time.

Staff reviewed the recommendations in the 1976 Preliminary Report and discussed major changes made in the final report.

In answer to a question, staff stated HEW initiated these studies because of the shortage of traditional health care personnel and the proliferation of new types of allied health care personnel. There was national concern that state licensing laws have an adverse effect on the mobility of health care professionals and that the inflexibility of state licensing policies tends to prevent persons from doing what they are qualified to do.

Staff noted there were mixed reactions to these reports, including criticism of the trend toward a national system.

Staff reviewed Virginia and Minnesota statutes pertaining to credentialing of health care personnel. The statutes list criteria to be used by the Legislature in determining if an occupation is to be regulated and list modes of regulation.

After discussion, staff was asked to compile a report for five states including Kansas, Minnesota, and Virginia listing health groups which are credentialted by type of credentialing -- registered, certified, licensed.

Proposal No. 60 - Physician Extenders

Staff reviewed the guidelines for physicians' assistants suggested by the American Hospital Association. Attention was called to guidelines developed by three Kansas hospitals and a checklist used by another hospital.

The Committee recessed for lunch at 11:55 a.m. and reconvened at 1:35 p.m.

Proposal No. 59 - Credentialing of Health Care Personnel

It was noted that a bill relating to chiropractors and their scope of practice was held in the House Public Health and Welfare Committee with a request it be referred for interim study. The Legislative Coordinating Council did not include this request in Proposal No. 59 but the Committee's policy decision was to include all bills held in a standing committee. A motion was made and seconded to include the scope of chiropractic for consideration. Motion carried.

Proposal No. 60 - Physician Extenders

Robert Jacoby, M.D., member of a family practice group in Topeka which has received a grant from the Robert Wood Johnson Foundation, stated the nurse clinician and the physicians' assistant may do some of the same things but their training is different. The physicians' assistant's training is in the medical model and is primarily in a clinical setting; the nurse clinician comes from a hospital orientation and the training is nurse-oriented.

In his remarks and in answer to questions, Dr. Jacoby stated he employs one physician's assistant who works primarily within the office. The PA is identified to patients who may choose whom they see. He sees about 25 patients per day and the PA sees about 10 or 15. He is also identified and his role is explained to other health care providers. Based on their close working relationship and the training of the PA, Dr. Jacoby determines what the PA can do. His PA may write prescriptions, except for Schedule II drugs, on presigned prescription forms and keeps him informed of all that are written.

Dr. Jacoby stated he felt a PA should have the equivalent of a college education, be a graduate of an approved program, and be Board certified or Board eligible. Legislation should be primarily to prevent abuse. It should ensure physicians' assistants are qualified, ensure physician back-up, stress the physicians' responsibility for the PA, and limit the number of PAs a physician can employ. He stated he had not thought about issuing an additional license to physicians authorizing them to employ PAs as a safeguard to abuse. He wished the medical profession policed itself better than it did. Everyone practicing should be qualified to employ a PA.

Frank Gentry, Kansas Hospital Association, stated the Association's survey showed seven hospitals employed PAs -- three proprietary (Cedar Vale, Gardner Community, Dechairo), three military (Irwin, McConnell, VA Med Center in Wichita), and Neosho Memorial. He introduced Murray Brown, Administrator, Neosho Memorial Hospital.

Mr. Brown, in his presentation and in answer to questions, stated Neosho is a 97-bed hospital which employs PAs in the emergency room and is also used as a rotation for students in the Wichita State University Program. The PA is registered to a staff physician, is paid by the hospital, and is responsible to the doctor on emergency call which may be any one of 12 physicians. When a patient enters the emergency room, the PA calls the family physician or the physician on call. If the physician feels the PA can perform the needed services, the patient is informed this is a PA. The patient may go elsewhere or request that the physician be called in. All orders the PA carries out must be from a physician. There is variation in what each doctor will let the PA do. PAs also oversee the County Ambulance Service and provide coordination between the Wichita Program and the students on rotation.

Most of their PAs have military background and training; one is a graduate of the WSU Program; one has taken the national exam; and all are registered by the Board of Healing Arts.

The major problem is payment for the PA services since the hospital cannot and the doctors usually do not bill patients for the PA services. In their situation having one PA work for several physicians works fairly well. However, this might not be true in other situations.

Richard Walsh, M.D., Acting Dean, Wichita Branch, University of Kansas School of Medicine, presented a statement outlining the type of meaningful supervision for physicians' assistants which will lead to a good quality of patient care. (Attachment A)

In answer to questions, Dr. Walsh emphasized that supervision should be based on quality and not on time or distance. The New Mexico statute establishes the responsibility of the physician and requires that the PA graduate from an approved program and pass the national exam before employment. Rules and Regulations stipulate the supervising physician must be within 40 miles or 60 minutes but provides a procedure for requesting exemptions which are usually granted. He stated he favors using the words "direction and supervision" but does not agree with defining them in terms of time and distance. He recommended limiting a physician to two PAs and requiring continuing education for the PA but questioned the validity of requiring re-examination every six years.

Valgene Valgora, Wichita State University Physicians' Assistants Program, stated that to take the exam, a person must graduate from an AMA approved program or have five continuous years experience, documented by a physician, in work comparable to that of a PA. Dr. Walsh stated he favors a cut-off for the experience provision which was for military people with extensive experience and would favor requiring both graduation and the exam to practice.

Dr. Walsh, in answer to a question, stated if a PA works for several doctors it would be difficult for him to learn procedures for each physician. Also if the physician's assistant is registered to one physician and another physician tells him what to do, the physician to whom he is registered may be held legally responsible for something he did not know was ordered. He stated he did not think PAs were used sufficiently in state institutions, in adult care homes and to handle routine care such as diabetes.

Margaret Buis, Regional Physician Assistant Coordinator, Health Manpower, HEW, presented a statement about Medicare reimbursement to physicians utilizing physicians' assistants and two bills, pending in Congress, relating to this issue. (Attachment B)

In answer to questions, Ms. Buis stated Nebraska statutes relative to what a PA can do are both delegatory and regulatory but the regulations are not very restrictive; Iowa statutes are regulatory and somewhat delegatory; Missouri has no PA statutes so PAs function under the general delegatory authority of the physician. She gave New York as an example of statutes relating to the prescription problem.

Referring to the increased Medicare costs if physician extenders are included, Ms. Buis stated this needs to be weighed against the alternative of no medical services at all.

Dr. Robert Harder, Secretary, Department of Social and Rehabilitation Services, stated the Department pays for physician extenders through a physician with a provider number. The Department is interested in the PA concept as a way to improve the quality of health care, for example in a nursing home, but is concerned about extending the concept because of the fiscal impact.

In answer to questions, Dr. Harder stated that when a new type provider is licensed and entitled to an individual provider number, there is a fiscal impact. The total impact and rate of impact depend on how many qualify, how quickly they qualify, how quickly people become aware of the service, and how many Medicaid recipients use the service. There can also be a multiplier effect, i.e. license the alcoholism counselor and other type counselors ask to be licensed, or a service rather than a group is approved for payment and other groups offering that service demand payment. Expanding the scope of practice of a licensed group also has an impact, i.e., allowing chiropractors to draw blood involves them in lab procedures which opens the door to more billing in the Title XIX program. There is also the problem of duplication of billing, i.e., a person seeing a psychiatrist, psychologist, physician, and alcoholism counselor. A rule has been adopted that if payment is made for seeing a psychiatrist, payment cannot be made for seeing a psychologist unless it is for testing.

In answer to a question, Dr. Harder stated that when a group is credentialed, it feels it is sanctioned by the Legislature as a health care provider and therefore should be eligible for Title XIX payments.

If the Department could start over, it would define medical services more conservatively; establish that credentialing did not automatically entitle one to payment for services rendered; create a state body, like those for utilities, to systematically review fee structure and cost reimbursement.

The meeting was adjourned at 4:00 p.m.

July 20, 1977

The meeting was called to order by the Vice-Chairman, Senator Wesley H. Sowers.

Staff reviewed Attorney General Opinion 77-186. It was noted the Attorney General appears to be reverting to the agent relationship. The PA is an individual agent of the physican and can act for him within the scope of what the physician is qualified to do and authorizes him to do.

Referring to the term "continuous inspection" used in the opinion, Mr. Valgora, Wichita State University Program, stated 23 states have adopted a disclaimer clause stating supervision is not to be considered to require the physical presence of the physician.

James Hill, M.D., Secretary, State Board of Healing Arts, apologized for his letter of July 11 relating to direct supervision and stated the Board is willing to be flexible on defining supervision. Their consern is redress for infractions of the law and the three percent who will cause trouble. Answering a question, he stated he could not say how the Board would interpret the law relative to supervision until after its meeting Saturday. He was asked to inform the Committee as soon as possible of any action taken at this meeting.

In answer to a question, Dr. Hill stated the Board feels it has the authority under the Healing Arts Act to control the PA and to determine how, when and where the physician can use a PA. It was noted the Attorney General does not feel it has this authority.

Dr. Hill stated the Board is not opposed to physicians' assistants but is opposed to their use in certain cases. The Board feels the law does not and should not allow a satellite arrangement and is not willing to extend the geographic limits very far unless such limits are specifically stated in the law.

Responding to questions, Dr. Hill stated he would prefer the matter of supervision be left up to the physician if the physician would be responsible and if the Board was given statutory authority to enforce the law. It is difficult to take disciplinary action against a physician because of community reaction and court procedure. It was pointed out the physician, by law, has to be responsible. Also, by law, the Board can revoke, suspend or restrict a physician's license. In answer to what additional authority the Board needed, Dr. Hill stated he would have to talk to their attorney about this.

Dr. Hill, in answer to a question, stated there are three classifications of physicians' assistants to be considered in developing statutes pertaining to registration and scope of practice. It was noted by a reference to the present statutes, that physician's assistant is a statutorily defined term and there is no provision for classes of physicians' assistants.

Noting there are no laws or rules and regulations about how a PA can be used, Dr. Hill was asked what he meant when he used the term "infractions of the law" and how a physician would know what an infraction was. Dr. Hill stated perhaps it was not an infraction of the law but the Board's interpretation of what an infraction would be. The purpose of the directive, mailed at the request of the Board, relating to direct supervision was to inform licensees what an infraction would be. The Board considered this a legitimate procedure and might call a physician in for questioning but would not take disciplinary action based on a directive.

Dr. Hill stated the Board feels that allowing a physician to have more than two PAs is undesirable.

Staff noted an October 30, 1973, Attorney General's Opinion which stated the Board of Healing Arts could write rules and regulations only on those subjects which were a part of the Physicians' Assistants Act. Staff then reviewed the rules and regulations submitted by the Board of Healing Arts for approval in 1973 and in 1975. These give some idea of the Board's thinking in the past and what the Board might do if allowed to write rules and regulations governing what a PA can do. Both sets of rules and regulations were rejected by the Attorney General as being outside the authority of the statute. Staff noted the similarities in the two sets of rules and regulations.

Staff reviewed the federal and state laws pertaining to who can write prescriptions, a letter to Dr. Hill from the Drug Enforcement Authority dated April, 1976, and the letter from Dr. Hill to Mr. Shalinsky and licensees discussed at the last meeting. It would appear that a practitioner, by law, may direct his PA to phone in a prescription or write a prescription for the practitioner's signature or to be signed by the PA. It was noted that in practice, a PA seems to have more authority on the phone than in writing a prescription.

Doug Johnson, Kansas Pharmaceutical Association, stated their concern is that the pharmacist know the chaim of command and who is responsible for what. The pharmacist is comfortable filling a prescription phoned in by an employee because the law speaks to this specifically or in accepting a prescription written by the PA if it is signed at some time by the physician which puts the responbility on the physician. At the federal level, the DEA feels it would be a violation of the Controlled Substances Act if a PA writes and signs prescriptions for controlled drugs if he would be using the physician's DEA number. Such prescriptions must be signed by the person to whom the number is issued. If the PA were specifically included in the state statutory definition of practitioner, the DEA could issue the PA a separate number which could be restricted as to what controlled drugs the holder could prescribe.

Staff reviewed policy questions raised about state compliance with federal regulations relative to the use of physicians' assistants in hospitals certified as Medicare/Medicaid providers. This does not relate to payments but rather to whether or not a hospital can be certified.

Staff reviewed rules and regulations from New Mexico, North Carolina, and Nebraska pertaining to physicians' assistants to highlight how some states have responded to policy questions and to point out that statutory language similar to that in Kansas has been interpreted differently by other states. For example, direction and supervision.

Staff reviewed the policy questions which had been raised for Committee consideration; registration or licensure of the PA's authority to prescribe; definition of direction and supervision; limitation of the number of PAs a physician may employ; scope of practice; fees, educational and testing requirements.

In answer to a question, staff reviewed the statutory requirements for a PA to be registered by the Board of Healing Arts and the requirements to be certified by their own national organization. In answer to a question, Elizabeth Carlson, Board of Healing Arts, stated the Board does not have a list of approved PA programs. It was noted this is required by law.

Concern was expressed over the broad delegation of authority under the Healing Arts Act. Limiting the delegation of authority only to credentialed personnel was suggested. It was noted there does not seem to be any problems with the broad delegation and limiting it might prevent utilization of an employee's capabilities in health care.

The meeting was recessed for lunch at 11:25 a.m. and was reconvened by the Vice-Chairman at 12:35 p.m.

After a brief discussion of the bills relating to physician's assistants held over by the Legislature, a motion was made and seconded that the Committee draft its own bill. Motion carried.

Registration - Licensure. A motion was made and seconded to require a physician's assistant to register annually with the Board of Healing Arts, such registration to include the name of the employing physician, and to require the physician's assistant to notify the Board when the employing physician changes. Motion carried.

Requiring a person to have graduated from an approved program and to have passed the exam before being registered was considered. In discussion the following points were made: people with experience who can pass the exam should not be excluded; there is an obligation to protect the public; quality control is the responsibility of the physician; reciprocity is not a problem as in licensure; a physician can hire anyone to do what a PA is doing as long as he does not call them a physician's assistant. The consensus was to take no action leaving the statute as presently written.

Continuing Education. In answer to a question, Mr. Valgora stated the Kansas Academy of Physicians' Assistants provides continuing education courses in various areas of the state. Credit is also given for physician and family practitioner seminars and other approved seminars or workshops. Consensus was to include the terminology used in other licensing acts - "continuing education as established by the regulatory board."

Scope of Practice. General consensus was that what a PA can or cannot do should be left up to the physician. Reference was made to the five specific areas listed in the letter to Dr. Hill from the Department of Health and Environment. Adding a section relating specifically to hospitals and listing the items in this letter with the phrase "including but not limited to" was suggested. It was noted that with this phrase a separate section would not be needed. Leaving it up to the physician and then specifying the items in the letter with the phrase "including but not limited to" was suggested. Noting the listing was only to meet HEW requirements for certification and these could change every year necessitating changes in the statute, it was suggested that including any list be done only as a last resort.

Mr. Valgora stated that HEW's interpretation as of last week was that they would allow those things listed in the letter only if they were specifically stated in the law. A general delegation was not acceptable. About four small rural hospitals have been disapproved for certification because PAs were doing some of these things.

Staff is to contact the HEW Regional Office to see if a general delegation of authority is acceptable. If not, the five items listed in the letter are to be included in the bill draft in as broad wording as possible to still be acceptable to HEW.

Prescribing. Adopting the approach used in New York, Nebraska or North Carolina was considered. It was noted that all of these involve lists; there are problems in interpreting the Nebraska statute; following the North Carolina approach would cause confusion and possibly be too limiting.

Amending the definition of practitioner in the Pharmacy Act to include physicians' assistants was considered. The PA would then have, under DEA regulations, his own DEA number and could prescribe on his own authority. Mr. Valgora stated the latter would not be true since by Kansas statutes the PA cannot do anything without the physician's authorization.

Amending the Physicians' Assistants Act to authorize PAs to prescribe all drugs except Schedules I, II, and III under the physicians's supervision was considered. It was noted excluding Schedule III would eliminate most drugs used for pain. Also "under the physician's supervision" would be redundant.

Consensus was to amend the PA Act to authorize PAs to prescribe all drugs (legend and controlled) except Schedule I and II drugs. In answer to a question, it was noted the assumption could be that the PA could write and sign the prescription. Staff pointed out this might mean the PA would have to have his own DEA number to prescribe controlled drugs. Staff is to check with the DEA to see if this amendment would comply with their regulations or what changes would be necessary for compliance.

In answer to a question, Jerry Slaughter, Kansas Medical Society, stated its philosophy is that a physician should be responsible for precribing drugs. He may delegate this authority to an agent or employee as long as there is a protocol or the physician is close enough for some communication. However, the physician should always sign or countersign the prescription.

A question was raised about how the pharmacist would know the PA was acting under the authority of a physician. It was noted a change to be proposed in the definition of PA will speak to this point. If it is felt a more definite mechanism needs to be included in the statute, this can be considered at a later meeting.

Identification of PA. The importance of identifying the PA to patients and the problems that have arisen because other health care providers did not know who the PA was and what his authority was were noted. Consensus was to amend the definition of PA to require that the PA be identified to patients and to other health care providers involved in patient care.

Supervision. By consensus a disclaimer is to be added after supervision to clarify that it does not mean the physical presence of the physician. Consensus seemed to be that any rules and regulations developed relative to supervision should not consider distance as a controlling criteria.

Limit on Number. Testimony recommending a physician be limited to two PAs was noted. It was pointed out no limits are prescribed in the present statute and there does not seem to be any abuse. Consensus was to take no action leaving the statute as presently written.

Limiting the number of physicians for whom a PA can work was discussed with particular reference to the Neosho Memorial Hospital. It was noted that anyone comfortable with this situation could continue the practice by calling the person something else and taking him off the register. It was also noted that this practice may work well in an emergency room setting but not in an office setting. No action was taken.

Fees. Noting that the changes to the PA Act recommended by the Committee will increase the workload of the Board of Healing Arts, consensus was to authorize the Board to establish the fees set out in the 1975 proposed rules and regulations ($15 for initial registration, not more than $10 for annual renewal, and $100 for the examination). By consensus these fees are to go into the Healing Arts Fund, since a separate fund would be costly to administer, with the usual percentage going to the State General Fund.

It was noted that the $100 examination fee was irrelevant since the national exam in used, the applicant pays a fee direct to the National Board and the Board of Healing Arts does not administer the exam. Dr. Hill stated the Board should not have a fee for the exam. Staff stated the present statute says, "exam prescribed by the Board of Healing Arts", which implies the Board is to give an exam. By consensus this wording is to be changed to "exam approved by the Board of Healing Arts" and the examination fee is to be deleted.

Rules and Regulations. Staff noted that many of the proposed rules and regulations the Attorney General objected to pertained to things that were not a part of the PA Act. Changes being recommended by the Committee would include some of these

areas (i.e., prescribing, definition of supervision) in the Board's authority to develop rules and regulations. Also, under the new system of looking at rules and regulations, broad delegation of authority for developing rules and regulations is being questioned. Specifying the areas of authority was suggested. Consensus was to take no action leaving the broad delegation of authority.

Minutes. A motion was made and seconded to approve the minutes as distributed. Motion carried.

Next Meeting. The next meeting of the Committee will be August 23 and 24. The agenda is to include staff review of S.B. 90, S.B. 218, S.B. 257, H.B. 2284, and H.B. 2422, testimony on these bills, and time for Committee discussion.

Prepared by Emalene Correll

Approved by the Committee on:

Aug. 24, 1977
(Date)

Attachment A

Presentation
Special Committee on Public
Health and Welfare
June 19, 1977

Chairman Johnson, Senators and Representatives, my name is Richard A. Walsh. I am Acting Dean, Wichita Branch, University of Kansas School of Medicine. I have been associated with the use of physicians' assistants in New Mexico rural area for the past four years.

I am sure you have heard extensive testimony on the use and regulation of physicians' assistants. Therefore, I wish to limit my remarks to three statements and then respond to any questions you might have.

First, from my personal experience and observation, I feel physicians' assistants can and do supply much needed good quality care and have much to contribute to the health care delivery system particularly in rural areas.

Second, they may function adequately at distances of forty to one hundred forty miles from their supervising physician provided there are meaningful supervisory requirements.

Third, the key to their successful use lies in a meaningful definition of supervision which I do not believe has any relation to time of travel or distance. Rather supervision should be based on such factors as:

Systematic review of the physician's assistant's work on a regular basis

Signing of all prescriptions by the physician within forty-eight hours

A definition of the physician's assistant's responsibilities in the hospital, clinic and office with a clear means of rapid communication - telephone, radio, TV system - for urgent consultation

On site visits at least two times a week by the physician to review charts, sign prescriptions and see problem cases

Documentation of supervision in the daily logs of the physician's assistant's activities

Having the physician's assistant return to the physician's office periodically to work under direct supervision to insure a close understanding of accepted procedures

Making clear that at all times the physician has complete responsbility and liability for the delegated responsibility.

This is a brief outline of the type of meaningful supervision which can and will lead to a good quality of patient care.

Atch. A

In closing, there are over four hundred fifty communities of less than one thousand people in Kansas. If some of these communities go together,they may pool resources and share the services of several physicians or a combination of physicians and physicians' assistants. However, many of the more isolated communities cannot support a physician or keep a physician busy. People in such communities will be able to have a large amount of their routine health needs met by the physician's assistant under the physician's supervision.

My own personal observations have convinced me of the effectiveness of these resources, if properly handled, in the health care delivery system.

Attachment B

Thank you for inviting me to appear today. Ms. Emaline Correll has requested that I speak about Federal Regulation regarding 3rd party reimbursement under Medicare PE services.

On the national level, the Department has testified before Congressional Committee's to the fact that there is a discrepancy between rendering professional respect to P.A.'s for quality health care services and then denying Medicare reimbursement to physicians who utilize those services. Non-reimbursement has negatively influenced health care practice in rural areas with physicians cutting back on P.A. employment or Medicare recipients covering medical care cost themselves.

There is a marked dichotomy between PHS support for PE training and SSA denial of Medicare Part B reimbursement for their services. Basically, however, this dichotomy is but one aspect of two larger conflicting policy goals--the desire to increase access to health services on the one hand and the need to contain health care costs on the other. Thus PHS, as the major Departmental agency addressing access issues, would tend to favor reimbursement policies that enhance the employment and utilization of PEs. Inasmuch as it has reimbursement responsibilities and must be concerned with the level of Federal medical care expenditures, SSA would tend to take a cautious approach to the PE reimbursement issue.

Atch. B

At the present time, there are two bills pending, HR 2504 sponsored by Rostenkowsky and Senate Bill 708 sponsored by Senator Clark of Iowa and presently co-sponsored by 53 other members of the Senate.

HR 2504 hearings were held July 18th (basically this bill will allow for 3rd party reimbursement for physician extenders services on a cost related basis to clinics that meet the criteria established for Rural Health Clinics). An amendment to this bill was made by Martha Keys of Kansas, to expand this Rural Health Clinic reimbursement to include Physician Directed Clinics in rural areas for reimbursement on a cost related basis. This was accepted by the committee. She also proposed to change the term PE to "Primary Care Provider". This term was adopted in the bill

The Department of Health would like to have expanded this bill to cover urban underserved areas as well. This was not accompolished. Instead, an amendment was adopted that would require the Secretary to fund demonstration projects in urban clinics to determine patient cost, utilization factors and the feasibility of this type of funding.

HR 2504 will become a "clean bill" which means it will be rewritten in accordance with the committee recommendations and also assigned a new number.

Senate Bill 704 and the House 2504 as amended now are essentially the same,

1. Both provide for 3rd party reimbursement on a cost related basis for PE services to clinics meeting the definition of rural health clinics and

2. Both provide for 3rd party reimbursement on a cost related basis to physician directed clinics (this could mean physicians in solo practice meeting the definition of clinic criteria could receive reimbursement on a cost related basis for their Medicare patients.

It is my understanding that both these bills will be presented to the Finance Committee on Thursday, July 20th (approval by the Finance Committee is mandated before bills can progress legislatively).

Bill Fullerton, the new Deputy Administrator of the Health Care Finance Agency (formerally SSA) was present at these hearings and was in accord with the Department's stand on these issues.

It is a feeling of the Department people working with this legislation that it will become a law this year. We would like to see these bills further expanded to include urban clinic 3rd party reimbursement instead of authority to fund demonstration projects in urban areas. We feel, however, that expanding reimbursement to rural health clinics and physician directed clinics in rural areas will indeed support access to quality care for Medicare recipients in most rural communities in this region.

Denturists

No. 48,265

IN THE COURT OF APPEALS OF THE STATE OF KANSAS

DR. LEO V. BONGERS, DR. DOUGLAS T. McCALL
and DR. ROBERT E. STROUD, in their capacity
as members of the Kansas Dental Board,
Appellees,

v.

DAVID A. MADRIGAL, SR.,
Appellant.

SYLLABUS BY THE COURT

1.

Once a party accused of contempt for violating an injunction is properly before the court, the merits of the original suit are not involved and the sole question for determination is whether such injunction has been violated.

2.

The practice of dentistry is a proper subject for state regulation.

3.

The provisions of K.S.A. 65-1438 (C) (2) which require unlicensed persons to retain the original prescription for two years, which records are open to inspection by the dental board, or its agent, do not violate the constitutional privilege against self-incrimination under the Fifth Amendment to the United States Constitution.

4.

Where a party has acted in willful and deliberate disregard of reasonable and necessary orders of the court, the application of a stringent sanction is fully justified and should not be disturbed.

Appeal from Sedgwick district court, division No. 9; DAVID P. CALVERT, judge. Opinion filed April 15, 1977. Affirmed.

Michael D. Gragert, of Hiebsch, Robbins & Tinker, of Wichita, for the appellant.

Richard C. Hite, special assistant attorney general, of Kahrs, Nelson, Fanning, Hite & Kellogg, of Wichita, and Curt T. Schneider, attorney general, for the appellees.

Before FOTH, P.J., ABBOTT and PARKS, JJ.

PARKS, J.:

This is an appeal from a conviction of indirect criminal contempt for violation of an order of permanent injunction issued by the district court of Sedgwick County, Kansas. The injunction, filed June 12, 1959, prohibited the defendant from violating the provisions of the Kansas Dental Act (K.S.A. 65-1421 et seq. [then G.S. 1949 65-1421]) and in particular enjoined the defendant, David A. Madrigal, Sr., from:

> " . . .the direct or indirect, by any means or method, taking of impressions of the human tooth, teeth, jaws. . .; or the supplying of artificial substitutes for the natural teeth, or furnishing, supplying, constructing, reproducing or repairing any prosthetic denture, bridge, appliance or any other structure to be worn in the human mouth, EXCEPT ON THE WRITTEN PRESCRIPTION OF A DULY LICENSED AND REGISTERED DENTIST; the placing of such appliance or structure in the human mouth, or adjustment or attempts to adjust the same; THE DELIVERY OF THE SAME TO ANY PERSON OTHER THAN THE DENTIST UPON WHOSE PRESCRIPTION THE WORK WAS PERFORMED. . . ." (Emphasis by the Court)

It is uncontroverted that the defendant was served with a copy of the order of permanent injunction and that he understood that he was prohibited from making dentures, fitting teeth, or related activities except on the written prescription of a licensed and registered dentist. No appeal was taken from

the order of permanent injunction or from Madrigal's three previous convictions of indirect contempt of court for violation of such order. The order of the court had not been reversed, modified or set aside and was in full force and effect at the time of filing the motion for contempt and accusation in this case.

The proceedings leading to this appeal were commenced on September 12, 1974, when defendant was accused of violating the order of permanent injunction and ordered to show cause why he should not be found in contempt. The affidavit of John D. Dickey, an investigator with the Consumer Protection Division of the district attorney's office for Sedgwick County, Kansas, was attached to the accusation in contempt. The affidavit recited that defendant had repaired dentures for Dickey without a dentist's prescription and that Dickey had talked to other persons for whom Madrigal had made dentures without a prescription.

Defendant filed an answer to the motion for contempt citation. He admitted the entry of the order of permanent injunction but raised various issues concerning the validity of the order.

The trial court found that the defendant had violated the order of permanent injunction and that he should be confined in the Sedgwick County jail for a period of 18 months and fined the sum of $10,000. Execution of the sentence was stayed pending appeal upon posting a $2,500 appeal bond, subject to certain conditions imposed by the court. During oral argument before this court, it was disclosed that the defendant had violated the conditions of his bond, and after serving 100 days in jail, he was paroled from the balance of the 18 months' sentence.

The first point raised is whether an order of permanent injunction is subject to collateral attack during indirect contempt proceedings.

Whether the court had authority to issue its order of permanent injunction is not an issue in this case. Such a decision is not necessary to vest jurisdiction in the trial court over its own order, which is in full force and effect, and is being violated. The violation need only be brought to the attention of the court.

In Horn v. Seeger, 174 Kan. 194, 198, 255 P. 2d 997, the court approvingly cited City of Wichita v. Wright, 169 Kan. 268, 219 P. 2d 350, where the court said:

> "'We have repeatedly held that once parties accused of contempt are properly before the court, the merits of the original suit are not involved, and the sole question for determination is whether the permanent injunction order and judgment has been violated by them.'"

Here we have the testimony of Mr. Dickey, and of witnesses called on behalf of Mr. Madrigal, which establishes that Mr. Madrigal had taken impressions of their teeth or jaws and had made or repaired dentures without prescriptions from dentists. Such activities are clear violations of the order.

We hold that the evidence adduced at the trial was sufficient to justify the finding of the court that the defendant had knowingly violated its order and was guilty of indirect contempt.

Defendant argues that the Kansas Dental Act constitutes unreasonable, discriminatory and oppressive interference with his right to earn a living and is violative of the anti-trust laws of the United States.

Defendant concedes in his brief that the practice of dentistry is a proper subject for state regulation. But then he proceeds to argue that denturism is not a profession but a trade, and involves working in inert material which has no more relation to health than fitting a shoe to a foot. We cannot uphold this argument.

In Thrasher v. Board of Governors, 359 P. 2d 717, 722 (Okla. 1961), the court said:

> "We know, as a matter of rather common knowledge, that mastication of food by chewing with the teeth is an integral part of, or related to, the human body's digestive process. We also know that the malformation, maladjustment and ill-fitting of false teeth may not only result in poor digestion but may cause physical discomfort, nervousness, and mental anguish, or even disturbance, generally, and specifically cause lesions in the mouth and gums that may lead to infection and serious bodily illness. . . ."

We are convinced that there is sufficient relation between the work of a dental technician and the public health and welfare that the legislature can prohibit the repair of dentures to be worn in the mouth except on the written prescription of a duly licensed and registered dentist.

Defendant contends that the information which he was compelled to give concerning the prescription files was

erroneously received by the court and was privileged testimony under K.S.A. 65-1454. K.S.A. 65-1438 (C) (2) requires unlicensed persons to retain the original prescription for two years.

The privilege against self-incrimination does not extend to records required by statute which are pertinent to appropriate subjects of governmental regulations. (State v. Braun, 209 Kan. 181, 495 P. 2d 1000, cert. denied, 409 U. S. 991, 34 L.Ed.2d 258, 93 S.Ct. 334; Shapiro v. United States, 335 U. S. 1, 92 L.Ed. 1787, 68 S.Ct. 1375 [1948].)

Defendant further contends that it was error for the plaintiffs to allege transactions with 63 persons whose identities were never discovered, and end up proving their case relative to transactions with a dozen other persons never included in the accusation.

It appears that it was Madrigal who instituted and was permitted to pursue discovery proceedings; he submitted interrogatories to the plaintiffs; he moved for production of documents; he deposed witnesses who were to testify for the plaintiffs; and he participated in the preparation of the pretrial order in this case.

We find that it was not necessary to amend the accusation in this instance when the names of the proposed witnesses were available to defendant by means of the discovery procedure employed by him.

Defendant also complains that he was entrapped by investigator John Dickey. K.S.A. 21-3210 provides two

exceptions to entrapment: (a) if the public officer merely afforded an opportunity or facility for committing the crime, and (b) the crime was of a type which is likely to occur and recur in the course of such person's business. The matter here need not be labored. There was direct evidence that defendant was previously involved in the repair of dentures without a prescription. His three previous convictions clearly demonstrated this fact. Defendant's argument fails because the activities fall within the exceptions of K.S.A. 21-3210.

The defendant argues that the sentence imposed upon him exceeded the penalties prescribed by K.S.A. 65-1460 for a misdemeanor prosecution. We would point out that in 1959 the dental board initiated these proceedings under the injunction procedure authorized by K.S.A. 65-1451 instead of instituting a criminal action under K.S.A. 65-1460. Therefore, the court was not limited to the penalties prescribed for a misdemeanor.

Defendant next argues that the trial court abused its discretion when it imposed penalties of 18 months' confinement and a $10,000 fine. We note that the defendant in this case has been convicted on four separate occasions of indirect contempt for violating the order of permanent injunction, and was "taking in" approximately $4,000 a month by continuing to make dentures in violation of the injunction.

Where a party has acted in willful and deliberate disregard of reasonable and necessary orders of the court, the application of a stringent sanction is fully justified and should not be disturbed. (Williams v. Consolidated Investors, Inc., 205 Kan. 728, 733, 472 P.2d 248; Ronnau v. Caravan International Corporation, 205 Kan. 154, 468 P.2d 118.)

We find nothing to justify a conclusion that the trial court abused its judicial discretion in imposing its sentence and fine on the defendant.

Other points raised by the defendant have been examined and found to be without merit.

Under all the facts and circumstances of this case, there was sufficient evidence to warrant a finding that the defendant violated the order of permanent injunction.

Judgment is affirmed.

A true copy ATTEST:
Lewis C Carter
Clerk Supreme Court