M I N U T E S

SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

September 20-21, 1977
Room 527 - State House

Members Present

Representative Michael G. Johnson, Chairman
Senator Wesley H. Sowers, Vice-Chairman
Senator John E. Chandler
Senator Mike Johnston
Representative Theo Cribbs
Representative Kenneth Francisco
Representative Sharon Hess
Representative Marvin 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

John Peterson, Kansas Speech and Hearing Association, Topeka, Kansas
Doug Johnson, Kansas Pharmaceutical Association, Topeka, Kansas
Gary Robbins, Kansas State Nurses Association, Topeka, Kansas
Jeff Wampler, Kansas Farm Bureau, Manhattan, Kansas
Elizabeth Carlson, State Board of Healing Arts, Topeka, Kansas
Jerry Slaughter, Kansas Medical Society, Topeka, Kansas
G. Derril Gwinner, O.D. Kansas Optometric Association, Ellsworth, Kansas
Jack Milligan, Kansas Optometric Association, Topeka, Kansas
Marc Dickey, Wichita State University, PA Program, Wichita, Kansas
V. Gary Anderson, Wichita State University, PA Program, Wichita, Kansas
Jack Roberts, Blue Cross-Blue Shield, Topeka, Kansas
Bill Roy, M.D., St. Francis Hospital and Medical Center, Topeka, Kansas
Terry Whelan, Kansas Association of Osteopathy, Topeka, Kansas
Dr. Robert Harder, Department of Social and Rehabilitation Services, Topeka, Kansas
Al Jarvis, Statewide Health Coordinating Council, Wichita, Kansas
Joe Harkins, Kansas Department of Health and Environment, Topeka, Kansas
Dorothy Woodin, Kansas Department of Health and Environment, Topeka, Kansas
Ray E. Showalter, Kansas State Board of Nursing, Topeka, Kansas
Florence Nelson, Kansas State Nurses Association, Topeka, Kansas
Roberta Thiry, Kansas State Nurses Association, Lawrence, Kansas
Joyce Olson, Kansas State Nurses Association, Shawnee, Kansas
Elaine Dohmeier, R.N., Wesley School of Nursing, Wichita, Kansas
Marguerite Coleman, R.N., Newman Hospital School of Nursing, Emporia, Kansas
Robert R. Snook, M.D., McLouth, Kansas
Jeanene Brown, Kansas University School of Nursing, Colby, Kansas
Marilyn Chard, Kansas University School of Nursing, Mission, Kansas
Doris A. Geitgey, Kansas University School of Nursing, Leawood, Kansas
Ruth C. Dickinson, State Planning and Research, Topeka, Kansas
James W. Wilson, M.D., Kansas Department of Health and Environment, Topeka, Kansas
Bonnie L. Ranson, Health Planning Consultant, Topeka, Kansas
Martha Shawver, Wichita State University, Wichita, Kansas
Carla Lee, Wichita State University, Wichita, Kansas
Jo Spangler, R.N., Leavenworth County Health Department, Leavenworth, Kansas
Virginia Will, Kansas Hospital Association, Topeka, Kansas

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

Proposal No. 60 - Physician Extenders

Revised Draft on Physicians' Assistants. The Chairman read a letter from the Kansas Pharmaceutical Association (Attachment A) stating their comments on the bill draft would not be ready until after September 28.

Staff noted Proposed Draft No. 1 (Attachment B) was the one sent to interested persons and groups. Proposed Draft No. 2 (Attachment C) incorporated the following additional changes: page 5, line 13 simplifies the reference to the D.E.A. number; page 3, lines 9 and 10 limits a physician to two physician's assistants; and, page 4, line 21 adds the use of the abbreviation "P.A."

The Committee then discussed the following comments submitted by individuals and groups:

Referring to Dr. Cramer Reed's recommendation (Attachment D) that a PA not have his own federal drug enforcement registration number, staff noted the Drug Enforcement Agency had stated the PA could have his own number which would be a restricted number.

Staff stated that after Mr. Snyder, Drug Enforcement Agency, learned the Committee had not accepted his earlier suggestion to split Schedule III drugs for the purpose of limiting prescribing to nonnarcotic substances, he stated the proposed bill was satisfactory.

The Physician's Assistant Program, Wichita State University had no additional recommendations (Attachment E).

During the Committee's review of the comments of the Kansas Academy of Physician's Assistants (Attachment F), Ms. Carlson, State Board of Healing Arts, stated in response to a question that the Board has now approved a list of physicians' assistants training programs approved by the American Medical Association. Staff noted the other two suggestions would write specific requirements into the law rather than leaving this determination up to the licensing board as is done in other licensure acts. Consensus was that specifics are to be left up to the licensing board since rules and regulations are more flexible.

In answer to a question relating to the first recommendation of the Kansas Medical Society (Attachment G), Jerry Slaughter, Executive Director, stated this would emphasize the intent that a PA can function only under the supervision of a physician. Staff noted the first sentence of New Section 6 was necessary to meet the federal requirements for hospital certification under Medicare and Medicaid. A general statement was drafted since the Committee had stated they did not want to develop a list of acts a PA could perform. In answer to a question, it was noted this bill does not affect the authority of a hospital staff to determine staff privileges for a physician or a physician's assistant.

Noting this recommendation would be further clarification of the intent stated in the definition of "physicians' assistant," a motion was made and seconded to amend the proposed draft, (Attachment C) page 4, line 29 by inserting "only" before "under." Motion carried. Staff is to determine if the commas should be deleted.

In discussion of the second recommendation, the following points were made: making it difficult or impossible for a doctor to have the PA for whom he is responsible do what he wants him to do would destroy the concept of the physician's assistant; others such as hospitals, dentists, veterinarians, and researchers have D.E.A. numbers; the PA's D.E.A. number would be restricted and the number is coded in a way that tells the pharmacist what the restriction is; registration is both state and federal so the Board of Pharmacy can revoke a state registration. Mr. Slaughter stated the problem does not lie with the PA but with the doctor who may not provide enough supervision. No action was taken on the recommendation.

After consideration of Kansas Optometric Association statement (Attachment H), staff read K.S.A. 1977 Supp. 65-1508 which delineates what a physician can do, what an assistant can do and what a physician can delegate. The proposed amendment (Attachment H, page 2) would seem to make it impractical for an ophthalmologist to hire a PA. It was also noted this might prohibit a PA from administering the vision testing which a nurse can do.

In answer to a question, Jack Milligan, Executive Director, Kansas Optometric Association, stated under present law a physician can do anything but an assistant to the physician can do only those things listed in the Optometry Act. The proposed amendment would mean a physician's assistant could do only what an assistant can do. There is some fear that a general practitioner might go into eye care.

A Committee member noted he did not see how the "assistant" in the Optometry Act trained to do mechanical things, and the PA defined as a legal extension of a physician could be confused in interpreting the statutes.

In discussion of the proposed amendment relating to the grandfather clause (page 6) it was noted this would not require all PA's to pass the exam stipulated by the Board of Healing Arts since graduation from an approved program was an optional way to be registered.

No action was taken on either recommendation.

Based on the Committee's concept of physician responsibility, a conceptual motion was made and seconded to amend Section 3(a)(3) to make the responsible physician responsible for reporting the PA is no longer in his employ and the physician hiring a PA responsible for reporting hiring. The motion carried.

Consideration was given to amending Section 4 to include the disciplinary section from H.B. 2417. Staff pointed out the alternatives are to list reasons for removal from the registry in the statute or to leave it up to the Board of Healing Arts to determine causes for removal in rules and regulations. Licensing acts list specific acts for which disciplinary action can be taken. In answer to a question, it was noted an irresponsible PA could go beyond the authority given him by his responsible physician.

A motion was made and seconded to add a subsection under Section 4 using the language in H.B. 2417.

In answer to a question, it was pointed out that since continuing education is a requirement for renewal, the name of anyone not meeting this requirement would be automatically removed from the register.

Suggestions were made to make noncompliance on the part of a PA a reason for revoking or suspending the responsible physician's license. It was noted, however, this would not remove the PA's name from the registry or prevent the PA from continuing to practice. The feeling was expressed that if a PA commits an act such as fraud, the PA, not the responsible physician, should be disciplined. Staff noted that if a PA acts outside the scope of his authority, such act constitutes a severing of the relationship. If the PA is within the scope of his authority the physician is responsible; if the PA is acting outside the scope of his authority the PA is responsible. The point at issue is whether or not the PA is acting within the scope of his authority.

The motion and second were withdrawn.

Staff noted there is nothing in the bill providing a penalty for violating the provisions of the act. An example given was a physician's assistant writing a prescription after termination of employment. The physician is not responsible and there is no recourse against the physician's assistant. A Committee member noted that if a physician's assistant exceeds the limits of written protocols, he would subject himself to practicing medicine and surgery without a license.

Staff noted discussion was basically about discovery after the act. If a physician finds the physician's assistant is exceeding the authority given him, the physician can fire him. But no provision is made to take action to have the physician's assistant's name removed from the registry. In other statutes, provision is made to report violations to the appropriate licensing board.

Staff was requested to report at the October meeting on what other states have done in this area.

Removing a PA's name at the time he is no longer employed was suggested. It was noted that if a person moved and his name was removed because he was unemployed, he would be unable to look for another job.

Doug Johnson, Kansas Pharmaceutical Association, noted there needs to be a system for notifying pharmacists a PA is terminated. Requiring the Board of Healing Arts to notify the Board of Pharmacy was suggested. Elizabeth Carlson, Board of Healing Arts, stated they do notify other appropriate boards of action taken against a physician as a matter of courtesy. To avoid a time delay, requiring the physician to report the termination to the Board of Pharmacy was suggested. Mr. Johnson noted

one state requires sequential numbering of the PA's prescription pads, which can be related to a termination date. Also, the D.E.A. may consider the PA's D.E.A. number invalid as of the date of termination and issue another number at the time of re-employment.

A motion was made and seconded to amend the proposed draft to require the physician terminating or hiring a PA to notifv the Board of Healing Arts, the Board of Pharmacy and the Federal Drug Enforcement Administration of such termination and hiring. Motion carried.

A motion was made and seconded to instruct staff to prepare another draft of the physicians' assistant bill incorporating amendments adopted for Committee consideration at the next meeting. The motion carried.

Proposal No. 59 - Credentialing of Health Care Personnel

Bill Roy, M.D., Director of Continuing Education, St. Francis Hospital and Medical Center, Topeka, presented a statement (Attachment I).

In answer to questions, Dr. Roy stated licensure leads to exclusivity and lessens the potential for flexibility and mobility. These affect cost adversely. Dr. Leonard Cronkite has stated there are 158 different kinds of health personnel licensed or certified. Each group says only members of their group should do certain procedures. So a hospital should have at least one of each of these groups on each shift. This is expensive.

Dr. Roy stated that mobility and saturation of credentialed personnel are dependent on whether members of the group practice on their own or in a licensed facility.

Responding to a question, Dr. Roy stated an advantage of licensure is measurement of the potential licensee's skills through an exam. This examination, however, measures skills only at a certain point in time. There are questions about what this means five years later. The burden of proving that licensure will improve the quality of care should rest with those licensing or those asking to be licensed. He stated he is suspicious that little has been done to assure quality simply by the licensure of personnel. For example, in the decade 1965-1975 only 2,000 actions were taken nationwide to remove physicians' licenses. Given about 300,000 physicians nationwide there are many reasons the rate for suspending or revoking licenses should be greater than one out of 1,500. He emphasized the importance of a moratorium on licensure although there might need to be a few exceptions.

Dr. Roy, in answer to questions, stated that once a group is licensed, the tendency is for it to go to direct third party payments with an increase in fees. He noted that once contact is made with a physician, the number of exams, procedures, etc., is determined by the physician and not the patient, expecially if the patient does not have to pay for the procedures at the time they are rendered. How many and how often appointments are made may depend on when the physician has a time available not on need. Medical science is not specific enough to say a patient has to come back on a certain day for best care. These are all factors which subtly affect costs.

In answer to a question, Dr. Roy stated there is a great deal of concern about availability of services. If there is to be financial access to services then it is fraudulent not to provide physical accessibility. There is a vacuum in primary care personnel. Whether this need will be met by physicians meeting this need or through the further development and use of physicians' assistants and nurse practitioners will depend not only on licensure but to some extent on who can be paid.

Dr. Roy, in answer to a question, stated the more services provided, the more people will utilize them and the cost will increase. The present system of fee for service, has a positive impact on providers' income and zero marginal impact on consumers because it does not cost them at the point where services are rendered. At the other end is prospective capitation which coupled with co-payment has a negative marginal impact on the consumer. The first system leads to providng more service at more cost and the latter leads to skimping on services. Dr. Roy outlined the following alternatives for limiting service and limiting cost:

(1) Placing a cap on the total amount of money available in any given year;

(2) Process regulation somewhat like Medicare and Medicaid in which it is determined certain services are necessary and can be paid and certain services are not necessary and cannot be paid;

(3) Limit the number of facilities and the number of health care personnel in a given category through a certificate of need system. This is not too satisfactory an alternative.

E.A. Jarvis, Chairman, Statewide Health Coordinating Council, presented a written statement (Attachment J). In answer to a question, Mr. Jarvis stated his reference to the sunset law concept applied to new licensure laws. He did not know what the potential was for adding this feature to present licensure statutes.

Mr. Jarvis, in answer to questions, stated employment of health care personnel is dependent on the number of positions available and the need for the services being offered. He noted the questions implied that if groups were not licensed they could not perform what they were trained to do which he hoped was not true. Licensure may affect employment negatively since it may curtail mobility.

Responding to a question, Mr. Jarvis stated only the Southeast Kansas HSA, which looked at the number of primary care providers, has addressed manpower specifically. He expressed the hope that supply and the need for numbers of health care professionals would be looked at by the other HSA's.

Mr. Jarvis, in answer to a question, stated another criteria to consider for licensure is whether or not a person must go through another health care provider to get a service. If a physician refers the patient, he has confidence the physician has checked the qualifications of the person to whom he is referring. If one goes directly to a provider, he is not so confident unless the person is licensed.

Jack Roberts, Blue Cross-Blue Shield, presented a written statement (Attachment K). In answer to a question, Mr. Roberts stated they had not seen any significant increase in demand for service in the case of psychologists who had previously been covered through a psychiatrist's billing. Pressure to include a service or a profession may come from the medical community which feels it is of value or from the public because of the extent to which it is being used or because they feel it would be worthwhile and should be available with no financial barrier.

Dr. Robert Harder, Secretary, Department of Social and Rehabilitation Services, stated he could not give a fiscal note on the impact of broadening the types of providers given a provider number under Title XIX, but there is a domino effect. He noted that prior to the last session, psychologists billed the Department of Social and Rehabilitation Services through a physician provider number. In many cases the physician was used only as a conduit for billing so the Department was not in a position to police the services of the psychologist. Since this was a service already being provided, it was better from the Department's standpoint to give the psychologist a provider number so he could be monitored and the type service being provided could be determined. This change went into effect on July 1 and last week an attorney called requesting provider numbers for psychiatric social workers. He stated if an agreement could not be reached, his client would sue. There have also been overtures from physical therapists wanting individual provider numbers. The impact on the budget of adding these groups may not be significant compared to other provider services, however, when some legislators want the medical budget brought in at the same figure as last year, perhaps thought ought to be given to dropping provider groups rather than adding groups. If groups are to be added, an unlimited commitment to medical costs needs to be made.

In answer to a question. Dr. Harder used mental health centers to illustrate cost escalation when a new service is added. These centers have had about a 40 percent increase and next year it will be a little over 50 percent increase in use. Counseling and therapy services provide more opportunity for continuing service and are difficult to monitor. In the last three years payments to mental health centers under Title XIX have increased from about $800,000 to approximately $2.1 million. At the same time substantial increases were made in state grants to these centers.

Dr. Harder, in answer to a question, stated a provider under Title XIX must be licensed or certified. Certification can be by a national group. For the rest of this year, alcoholism counselors in a treatment program are paid through Title XX; in a mental health center, payment is through Title XIX. Payments are not made to a person hanging out a shingle as an alcoholism counselor. However, if they are licensed, the Department will probably hear from them or their attorney requesting provider numbers. Licensure does not mean a provider number will automatically be granted but it does provide the advantage of saying they want to be treated like other licensed persons.

Responding to questions, Dr. Harder stated that if a physician determines he needs a social worker in his practice, he would include this in his cost and there would be no way for the Department to get at the additional cost. If a nurse practitioner makes some routine calls for the physician and the physician bills the Department on his own number and says he provided the service, the Department would pay. However, HEW disallowed a case where a nurse practitioner made calls in a nursing home on the basis of finding there was no way the physician could be providing direct supervision. If the federal law is amended to allow payments for physician extenders if services are provided through a rural clinic or its equivalent, the state would comply. There should be a way to provide for extending services of the physician which is different than opening the door for ancillary services.

In answer to a question, Dr. Harder stated when he talked about dropping provider groups, he was referring to provider groups under Title XIX but perhaps dropping the licensure or certification of some provider groups might also be considered. He stated he felt a good case could be made for saying only a few provider groups should be licensed. For example, he was not sure licensure is a guarantee of quality service. Questions should be raised about licensing ancillary groups. It becomes a question of cost effectiveness. He emphasized he was not saying ancillary groups should not be trained. Training is essential and training programs are more useful than licensing in determining quality care.

In answer to a question, Jerry Slaughter, Kansas Medical Society, stated the federal government has authorized funds to look at the viability of paying physicians' assistants working away from the responsible physician. These are short term pilot projects and will be used as a basis for recommending whether direct payment should be made to physicians' assistants.

The meeting was adjourned at 4:30 p.m.

September 21, 1977

The meeting was called to order at 9:10 a.m. by the Chairman, Representative Michael G. Johnson.

Proposal No. 60 - Physician Extenders

Ray Showalter, Kansas State Board of Nursing, presented a written statement (Attachment L).

In answer to a question, Mr. Showalter stated some states use standards for nursing specialities developed by national organizations and some states have developed their own. The Kansas State Board of Nursing keeps track of National League of Nursing standards for schools of nursing but adopts its own standards. In some cases they are the same, in some cases they are less stringent and in some cases they are more stringent. Nurse practitioners, certified in another state, coming to Kansas are told Kansas does not have certification and they are given guidelines for practice with emphasis on the need for protocols in any gray areas.

The feeling was expressed that if the Board of Nursing feels the present definition of nursing is inadequate, they should be taking a lead role in developing a definition and in working with nurses and other health care professions to get a consensus. Mr. Showalter stated the Board and staff have worked on suggested changes. However, they have not presented these as the Board's changes because they have looked to the professional organization to take the lead as do other health professional groups. If the feeling is that the Board should be doing this, consideration will need to be given to approving adequate staff to carry out this responsibility.

Dr. Roberta Thiry, Kansas State Nurses Association, presented a written statement (Attachment M). Referring to the discussion of the Board of Nursing's responsibility in recommending changes in the definition of nursing Dr. Thiry stated that when she served on the Board the message from above was that the Board should not make recommendations for changes in statutes.

In answer to questions, Dr. Thiry stated 28 states speak to an R.N. practicing as nurse midwives. However, she could not speak to whether the proposed changes would allow an R.N. in Kansas to practice as a midwife.

Referring to the deletion of "professional" in 65-1113(b), staff noted that a previous interim committee had specifically rejected a proposal to take this word out of the statute. Also, if it is deleted in the definition, it would need to be deleted throughout the act.

Dr. Thiry, responding to a question, stated nurses have seven functions only one of which is dependent on a physician. Therefore she sees the relationship as a diagonal one rather than either horizontal or vertical.

In answer to questions, Dr. Thiry stated the groups meeting together (page 2, last paragraph, Attachment M) agreed some changes were needed in the definition and a revised definition should be ready for the 1978 Session of the Legislature. Attempts were made to have another meeting to work out differences on changes recommended but members have been too busy. The Master Planning Committee for Nursing referred to is composed of representatives selected by the Kansas Hospital Association, Kansas Health Care Association, Kansas State Nurses Association, Kansas League for Nursing, State Board of Nursing and the Kansas Medical Society and includes disciplines other than nursing. The Kansas State Nurses Association has 2,375 members. District meetings were publicized through announcements to hospitals and the media, and were attended by nurses not belonging to the Association. Also proposed changes have been sent out for posting to places such as hospitals.

After Dr. Thiry explained the Assoication's concern relative to the achievement of a dignified death as what happens when a person is dying, it was suggested a less active term such as "support of dignified death" be used.

In answer to a question, Dr. Thiry stated their preference is one title to cover all groups. She noted that not all specialties in other professions are specifically listed in statutes pertaining to those professions. The Association is questioning how much should be included in the statute and how much should be left to rules and regulations. She pointed out some nursing titles are comparable to specialties in medicine but they may also be used to denote where a nurse works in the hospital. It was pointed out that if titles for specialties are used, a definition for each would be needed.

Responding to a question about examples of what nurses are doing now that are a problem under the present definition, Dr. Thiry gave the following example: A public health nurse in a VD clinic takes a culture, determines what organism is present and then follows the protocol for treating that organism. Technically this is making a diagnosis and initiating treatment. The Kansas Medical Society has expressed some concerns, i.e., protocols written some time ago.

Such practices of nurses have been challenged by physicians, not necessarily on whether nurses are functioning outside their authority even though there is a protocol, but also on the basis that the nurse should be sending this business to the physician.

Dr. Thiry gave the following examples of things nurses should be permitted to do that they do not presently do under existing statutes: midwivery; psychiatric nurse counseling; administering and initiating routine medication for an illness and writing prescriptions under an arrangement with a physician.

The feeling was expressed that some distinction needs to be made since the definition speaks only to registered nurses and not all RNs would be qualified to provide such services. Also, it is difficult to determine what is "recognized by the nursing profession" since no single group speaks for nursing. Leaving so much to be determined by rules and regulations presents problems since no framework is provided in the act within which rules and regulations can be developed.

In answer to a question, Dr. Thiry stated they had looked at Florida's rules and regulations but they did not have a copy of the law to determine how authority for developing them was granted. These rules and regulations use the term "advanced practitioner" and then list who can use this title and spell out the qualifications the licensing board is to use. Optional ways of meeting the qualifications are provided.

Joe Harkins, State Department of Health and Environment, introduced Dorothy Woodin, who presented a written statement for the Department (Attachment N). She stated 30 states have passed some legislation relative to nurse practitioners and an additional 10 states do not have restrictions in the definition as Kansas does.

In answer to a question, Ms. Woodin stated there are over 300 public health nurses in Kansas. Those employed by the Department of Health and Environment and local health departments which have federal funds are under the state civil service. Following are the classifications and the criteria: Public Health Nurse I - graduate of a nursing education program; Public Health Nurse II - graduate of a baccalaureate program or experience as a public health nurse; Public Health Nurse III - baccalaureate program graduate and experience; Public Health Nurse IV - increased experience; Public Health Nurse V - increased experience. There is not a classification for nurse practitioners although the Department does have an approval procedure for nurses to

operate in an expanded role. This is done under an agreement with the Department of Social and Rehabilitation Services to do screening programs required by federal law. Before going into this program, the Department of Health and Environment checked with the Attorney General and the attorney for the State Board of Nursing. The decision was that the public health nurses would be covered by common practice concepts not by specific authority under the nurse practices act. It would be a more comfortable position if they were covered by the statute.

Responding to a question, Ms. Woodin stated some situations should be handled through physician delegation to a nurse. However, some things public health nurses are doing are good nursing, not the practice of medicine, so they should not have to be physician delegated.

Ms. Woodin, in answer to a question, stated protocols for public health nurses are written by the local health officer if he is a physician. The State Department also furnishes guidelines.

It was noted the only limitation on the word "treatment" in the proposed definition is "substantial knowledge" which is to be determined by the Board of Nursing. However, when the expanded nurse role overlaps a field normally belonging to another profession a more specific limitation agreed to by the boards of both professions could be developed.

The feeling was expressed that if certain privileges were to be granted, the privileges should be limited to those having specified qualifications. Different classifications should be delineated with qualifications established for each.

Ms. Woodin agreed, but stated she felt it was preferable to have this done by rules and regulations as in other states having laws similar to what is being proposed.

Staff noted some states have used the modifier "medical" or "nursing" before "treatment, diagnosis and prescription." Ms. Woodin stated this would be a satisfactory approach. There is a clear area at each end of the continuum of care with areas in the middle that need collaboration between medicine and nursing.

In answer to a question, Ms. Woodin stated anything a nurse is doing which is considered the practice of medicine is being done under the supervision of or through a protocal with a doctor. Under the practice of nursing, nurses are doing more comprehensive assessments and evaluations so better referrals can be made. The problem with the existing law is the term "diagnosis," a term nurses use too. Restrictions on safe nursing need to be removed. If the professions of nursing and medicine could learn to collaborate, communicate and understand each other, it would help. However, the statute would still need to be changed to comply with what is common practice.

Robert N. Snook, M.D., private physician and part-time county health officer, stated health care has changed and we are now talking about skilled public health nurses with special training. They are trained to do some things, such as heart monitoring, that he would hesitate to do as a general practitioner. Because of the training of these nurses, patients can come home from the hospital sooner and can have better follow-up care. He noted physicians are now referring patients to nurses in home health agencies.

In answer to a question, Dr. Snook stated that in the realm of nursing, nurses are making decisions about patient care when they see a patient and conferring with a physician if necessary. Nurses also carry on clinics in communities and refer problems to the local physician. He stated he felt that he and the nurses working with him had a common understanding of what is nursing care and what is medical care although it would be difficult to give specific answers to questions in this area. A nurse does not diagnose and prescribe in the same sense a physician does. However, she does make an assessment and determines if some treatment or referral is needed. He noted he did not think these public health nurses were taking money out of a physician's pocket and he questioned physicians who are criticizing them.

Jo Spangler, R.N., Leavenworth County Health Department, outlined the programs conducted by the department: multi-phase screening which has developed into an entire assessment program for all ages; geriatric clinics in senior citizen housing complexes; blood pressure clinics; family planning programs, including VD clinics; well baby clinics; and the home health services agency. In these programs, the public health nurse who is trained to know what normal is, can make assessments, help people with their own care and make appropriate referrals. These nurses are finding illnesses such as hypertension which the person is not aware of and are finding those not following through on prescribed care. In the family planning program, the public health nurse,

under a protocol, is doing physicals, is doing blood work-ups, handles infection problems and gives birth control pills referring anything she cannot handle. She noted that if sticking a finger for a test or taking a blood pressure is practicing medicine, then nurses are guilty of practicing medicine. She noted that in some areas public health nurses are being criticized when they take a blood pressure the second time although it is alright for them to do it the first time.

Referring to earlier questions, Ms. Spangler stated levels of nursing education need to be considered in amending the Nurse Practices Act. In answer to a question, she stated she felt delineating levels of nursing related to level of education was a rational approach. She suggested an internship and examination as requirements for performing in an expanded role.

In answer to a question, Ms. Spangler stated every nurse, including those in hospitals, is accountable for his or her actions and should carry his or her own medical malpractice insurance.

Doris A. Geitgey, R.N., Kansas University School of Nursing, stated the law needs to be changed to alleviate the possibility of nursing appearing to be a profession which has to take orders from another profession relative to functions of nursing. Referring to her experience working in an office with an orthopedist, she emphasized the role of the nurse in support, in teaching, in encouragement and in helping people deal with their own strengths. This is nursing and does not involve medications. In answer to a question, she stated that when a regimen involved medical treatment, i.e., medications, it is the nurse's responsibility to carry out the physician's orders. However, it is inappropriate for nurses to be ordered when to turn a patient, or to teach people to protect themselves. Nurses should be able to prescribe in the areas of nursing intervention, comfort, teaching, encouragement. Many things nurses could not do previously, i.e., taking of blood pressure, are now common practice. Nursing needs the support of the law for those things being done as common practice.

Marilyn Chard, R.N., Director of the Nurse Practitioner Program, University of Kansas, College of Health Sciences, presented a written statement (Attachment O). In answer to a question, Ms. Chard gave examples of nursing diagnosis and nursing treatment. A nurse with training can make an assessment and prescribe treatment (devise a plan to alleviate the problem) or refer. Using an example from her own practice, Dr. Chard used the example of a baby whose ear is red and bulging internally. She would call the physician in and after a diagnosis was made and the physician had determined the medication to be given, she whould figure out the dosage based on the baby's weight and write the prescription for the physician's signature. In answer to an additional question, she stated that nurses are capable of working both for and with physicians but physicians are concerned about the "with" relationship because of the Nurse Practices Act.

In answer to questions about the current nurse practitioner training program, Dr. Chard stated the one-year program includes eight subject areas and a preceptorship. In the beginning the student works under instructors; during the preceptorship there is a physician available to them. They accept any level of registered nurse in the program and have found the success of the person in the program is more dependent on the person than on the previous level of training. Referring to a doctoral study she had done, she stated the only difference she found was that those with a masters degree in nursing collaborated more with others on the health team, i.e., physician, social worker, dietitian.

Dr. Chard, in response to questions, stated about 10 percent of their graduates say they are using all of the skills they learned. She noted the department was aware from the beginning that graduates could not practice to the extent of their training because of statutory restraints but they had hope for the future. Students are made aware of the restraints but they also know this will vary from physician-to-physician. She stated she was not opposed to outlining functions nurses could carry out in relation to educational levels although she does have concerns about the degree of specificity which should be included in the law. She expressed her willingness to work with others in developing language which would speak to the concerns expressed.

Martha Shawver, R.N., Chairperson, Department of Nursing, College of Health Related Professions, Wichita State University, presented a written statement (Attachment P).

Virginia Will, R.N., Kansas Hospital Association, presented a memorandum (Attachment Q) which stated the Association would not have an official statement until the latter part of November. In answer to a question she stated the impact upon hospitals mentioned in the memorandum referred to costs and how nurses are utilized. It was noted that if nurses are already doing the things included in the proposed changes, further impact on the hospitals was questionable.

Carla Lee, R.N., Director, Nurse Practitioner Program, Wichita State University, presented a written statement (Attachment R).

Jerry Slaughter, Kansas Medical Society, stated they do not have a position on the proposed changes but the changes and concerns about some of the words and phrases will be discussed by the Society's Executive Committee in about 30 days. The Medical Society has in the past opted for the status quo as being adequate to provide health care but this position needs to be reconsidered. Speaking to questions raised earlier, he stated that in the past the Kansas Medical Society has been lax in not making more effort to meet with the other interested groups to try to reach a consensus in this area. As individuals, more physicians are becoming advocates of the expanded role in nursing.

In answer to a question, Mr. Slaughter stated the Society has received a call from a physician about the multi-phasic clinic in Emporia but it was more for information than to register a complaint. Responding to a question, he stated there are some legitimate differences of opinion but he does not think there are areas of wide disagreement.

Mr. Slaughter, in answer to questions, stated there is a Joint Practice Committee. It has met but no organized attempts have been made to develop a joint practice statement as have joint committees in other states. The last two meetings of the joint committee have been devoted to a discussion of the Nurse Practices Act.

Terry Whelan, Kansas Association of Osteopathic Medicine, stated the Association's executive group had discussed the issue addressed by the proposed changes and recommended the definition be left as it now appears in the statute. The definition needs to be strengthened by tightening it up not by making it more open ended. In answer to a question, she stated that nurse practitioners should be under a physician. However, they are aware that nurses are now functioning in clinics without direct supervision.

Minutes

The minutes of the August 23-24, 1977 meeting are to be amended on page 6 to reflect that Dr. Nyle Diefenbacher did not appear but his statement was submitted by the Kansas State Dental Association as a part of their presentation. A motion was made and seconded to approve the minutes as amended. Motion carried.

Next Meeting

The next meeting will be October 18-19, 1977. Agenda items are to include action on the proposed physicians' assistants bill; review of the HEW report; further consideration of amendments to the Nurse Practices Act; review of suggestions by conferees and what other states have done relative to criteria for credentialing of health care personnel; development of recommendations for criteria for credentialing and application of those criteria to groups that appeared before the Committee; direction to staff for the drafting of Committee reports.

The Chairman reported that the Legislative Coordinating Council had denied the Committee's request for two additional meeting days to hold hearings on the laetrile issue. The basis for the denial was that several requests for bills have been submitted so the issue will be considered during the session without an interim Committee report or recommendation.

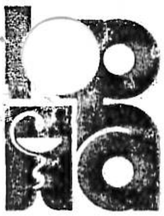
The meeting was adjourned at 3:15 p.m.

Prepared by Emalene Correll

Approved by Committee on:

10-18-77
Date

Attachment A



THE KANSAS PHARMACEUTICAL ASSOCIATION
1308 WEST 10TH
P. O. BOX 4218, GAGE CENTER STATION
PHONE (913) 232-0439
TOPEKA, KANSAS 66604

DOUGLAS P. JOHNSON, R. PH.
EXECUTIVE DIRECTOR

September 14, 1977

Michael Johnson, D.D.S.
Chairman
Special Committee on Public Health & Welfare
1111 Brady
Abilene, Kansas 67410

Dear Chairman Johnson:

The Kansas Pharmaceutical Association is in receipt of the latest draft of the Physician Assistant bill. However, I regret that we are unable to offer written comments on the draft bill, prior to your September 20-21, 1977 Committee meeting.

The Governmental Affairs Committee and our Board of Trustees will be meeting September 28-29, 1977 to discuss amony other items the draft P.A. Bill. We will forward our comments to you for distribution to the committee, after our 28th-29th meeting.

I apologize for not forwarding our comments to you earlier, and hope that this will not cause any inconvenience.

Sincerely,

Doug

Douglas P. Johnson, R.Ph.
Executive Director

DPJ:cs
cc: Sen. Wesley Sowers
Vice Chairman

Atch. A

Attachment B

7 RS 1602

#1

PROPOSED DRAFT

____ BILL NO. ____

By Special Committee on Public Health and Welfare

1 AN ACT concerning physicians' assistants; providing for the
2 registration thereof; granting certain powers, duties and
3 functions to the state board of healing arts; amending
4 K.S.A. 1977 Supp. 65-2896, 65-2896a, 65-2896b and 65-2896c
5 and repealing the existing sections; and also repealing
6 K.S.A. 1977 Supp. 65-2897.

7 Be it enacted by the Legislature of the State of Kansas:

8 New Section 1. The following words and phrases when used in
9 this act shall for the purpose of this act, have the meanings
10 respectively ascribed to them in this section.
11 (a) "Direction and supervision" means the guidance,
12 direction and coordination of activities of a physicians'
13 assistant by his or her responsible physician, whether written or
14 verbal, whether immediate or by prior arrangement, but does not
15 necessarily mean that the continuous, immediate, or physical
16 presence of the responsible physician is required during the
17 performance of the assistant.
18 (b) "Physician" means any person licensed by the state
19 board of healing arts to practice medicine and surgery.
20 (c) "Physicians' assistant" means a skilled person
21 qualified by academic training to provide patient services under
22 the direction and supervision of a physician licensed to practice
23 medicine and surgery who is responsible for the performance of
24 that assistant.
25 (d) "Responsible physician" means a physician who has
26 accepted the ultimate responsibility for the actions of the

Atch. B

1 physicians' assistant under his or her direction and supervision.
2 Sec. 2. K.S.A. 1977 Supp. 65-2896 is hereby amended to read
3 as follows: 65-2896. The state board of healing arts shall
4 maintain a register of the names of physicians' assistants who
5 ~~request to have their names placed on the register showing the~~
6 ~~record of training held by each person so registered and such~~
7 ~~person's current address~~ registered in accordance with the
8 provisions of K.S.A. 1977 Supp. 65-2896a, as amended. A fee of
9 fifteen dollars ($15) shall be charged for the initial
10 registration. All registrations shall be renewed annually and
11 any renewal thereof shall not be more than ten dollars ($10).
12 The executive secretary of the state board of healing arts shall
13 remit all moneys received by or for him or her from the
14 provisions of this act in accordance with K.S.A. 1977 Supp.
15 65-2855. The state board of healing arts may adopt rules and
16 regulations necessary to carry out the provisions of this act and
17 the act of which this section is amendatory. ~~As used in this act~~
18 ~~the term "physicians' assistant" shall mean a skilled person~~
19 ~~qualified by academic training to provide patient services under~~
20 ~~the direction and supervision of a physician licensed to practice~~
21 ~~medicine and surgery who is responsible for the performance of~~
22 ~~that assistant.~~
23 Sec. 3. K.S.A. 1977 Supp. 65-2896a is hereby amended to
24 read as follows: 65-2896a. ~~From and after the effective date of~~
25 ~~this act,~~ (a) No person's name shall be entered on the register
26 of physicians' assistants by the state board of healing arts
27 unless such person shall have:
28 ~~(a)~~ (1) Presented to the state board of healing arts proof
29 of graduation from an accredited high school or the equivalent
30 thereof; and
31 ~~(b)~~ (2) presented to the state board of healing arts proof
32 that the applicant has successfully completed a course of
33 education and training approved by the state board of healing
34 arts for the education and training of physicians' assistants.
35 Such course of education and training shall be substantially in

1 conformity with educational and training programs for physicians'
2 assistants approved by the state board of regents; or
3 ~~(c)~~ (3) passed an examination ~~prescribed~~ approved by the
4 state board of healing arts covering subjects incident to the
5 education and training of physicians' assistants.
6 (b) A physicians' assistant shall at the time of initial
7 registration and any renewal thereof present to the state board
8 of healing arts the name and address of his or her responsible
9 physician. Whenever a physician's assistant shall cease to be
10 employed by his or her responsible physician, such responsible
11 physician shall notify the state board of healing arts of such
12 termination. Whenever a physicians' assistant shall be employed
13 by another responsible physician, prior to renewal of his or her
14 registration, such physician's assistant shall provide to the
15 state board of healing arts the name and address of his or her
16 new responsible physician. Such notification shall be given to
17 the state board of healing arts as soon as practicable but not to
18 exceed a period of ten (10) days.
19 (c) On and after July 1, 1979, the state board of healing
20 arts shall require every physician's assistant to submit with the
21 renewal application evidence of satisfactory completion of a
22 program of continuing education required by the state board of
23 healing arts. The state board of healing arts by duly adopted
24 rules and regulations shall establish the requirements for such
25 program of continuing education as soon as possible after the
26 effective date of this act. In establishing such requirements
27 the state board of healing arts shall consider any existing
28 programs of continuing education currently being offered to
29 physician's assistants.
30 (d) A person whose name has been entered on the register of
31 physicians' assistants prior to the effective date of this act
32 shall not be subject to the provisions of subsection (a) of this
33 section, unless such person's name has been removed from the
34 register of physicians' assistants pursuant to the provisions of
35 K.S.A. ~~1975~~ 1977 Supp. 65-2896b, as amended.

1 Sec. 4. K.S.A. 1977 Supp. 65-2896b is hereby amended to
2 read as follows: 65-2896b. The board of healing arts may remove
3 a person's name from the register of physicians' assistants for
4 any of the following reasons:
5 (a) The person whose name is entered on the register of
6 physicians' assistants requests or consents to the removal
7 thereof; or
8 (b) the board of healing arts determines that the person
9 whose name is entered on the register of physicians' assistants
10 has not been employed as a physicians' assistant or as a teacher
11 or instructor of persons being educated and trained ~~as~~ to become
12 a physicians' assistant in a course of education and training
13 approved by the state board of healing arts under K.S.A. ~~1975~~
14 1977 Supp. 65-2896a, as amended, at some time during the five
15 years immediately preceding the date of such determination.
16 Sec. 5. K.S.A. 1977 Supp. 65-2896c is hereby amended to
17 read as follows: 65-2896c. (a) ~~From-and-after-the-effective~~
18 ~~date-of-this-act,~~ No person shall use the title physician's
19 assistant or words of like effect nor shall any person represent
20 himself or herself to be a physician's assistant unless such
21 person's name is entered on the register of the names of
22 physician's assistants in accordance with the provisions of this
23 act.
24 (b) Any person violating the provisions of this section
25 shall be guilty of a class C misdemeanor.
26 New Sec. 6. A person whose name has been entered on the
27 register of physicians' assistants may perform, under the
28 direction and supervision of a physician, acts which constitute
29 the practice of medicine and surgery to the extent and in the
30 manner authorized by the physician responsible for the
31 physicians' assistant. Before a physicians' assistant shall
32 perform under the direction and supervision of a physician, such
33 physicians' assistant shall be identified to the patient and
34 others involved in providing the patient services as being a
35 physicians' assistant to the responsible physician.

1 New Sec. 7. Prescriptions may be written by physicians'
2 assistants as provided in this section when authorized by the
3 responsible physician except for those controlled substances that
4 are listed on schedule II under federal and Kansas uniform
5 controlled substances acts. The prescription shall include the
6 name, address and telephone number of the responsible physician.
7 The prescription shall also bear the name and the address of the
8 patient and the date on which the prescription was written. The
9 physicians' assistant shall sign his or her name to such
10 prescription followed by the letters P.A. and his or her D.E.A.
11 (Drug Enforcement Administration, of the United States Department
12 of Justice) registration number.
13 Sec. 8. K.S.A. 1977 Supp. 65-2896, 65-2896a, 65-2896b,
14 65-2896c and 65-2897 are hereby repealed.
15 Sec. 9. This act shall take effect and be in force from and
16 after its publication in the statute book.

Attachment C

#2

7 RS 1602

PROPOSED DRAFT

_____ BILL NO. _____

By Special Committee on Public Health and Welfare

1 AN ACT concerning physicians' assistants; providing for the
2 registration thereof; granting certain powers, duties and
3 functions to the state board of healing arts; amending
4 K.S.A. 1977 Supp. 65-2896, 65-2896a, 65-2896b and 65-2896c
5 and repealing the existing sections; and also repealing
6 K.S.A. 1977 Supp. 65-2897.

7 Be it enacted by the Legislature of the State of Kansas:

8 New Section 1. The following words and phrases when used in
9 this act shall for the purpose of this act, have the meanings
10 respectively ascribed to them in this section.
11 (a) "Direction and supervision" means the guidance,
12 direction and coordination of activities of a physicians'
13 assistant by his or her responsible physician, whether written or
14 verbal, whether immediate or by prior arrangement, but does not
15 necessarily mean that the continuous, immediate, or physical
16 presence of the responsible physician is required during the
17 performance of the assistant.
18 (b) "Physician" means any person licensed by the state
19 board of healing arts to practice medicine and surgery.
20 (c) "Physicians' assistant" means a skilled person
21 qualified by academic training to provide patient services under
22 the direction and supervision of a physician licensed to practice
23 medicine and surgery who is responsible for the performance of
24 that assistant.
25 (d) "Responsible physician" means a physician who has
26 accepted the ultimate responsibility for the actions of the

Atch. c

1 physicians' assistant under his or her direction and supervision.

2 Sec. 2. K.S.A. 1977 Supp. 65-2896 is hereby amended to read
3 as follows: 65-2896. The state board of healing arts shall
4 maintain a register of the names of physicians' assistants ~~who~~
5 ~~request--to--have--their-names-placed-on-the-register-showing-the~~
6 ~~record-of-training-held-by-each-person--so--registered--and--such~~
7 ~~person's--current--address~~ registered in accordance with the
8 provisions of K.S.A. 1977 Supp. 65-2896a, as amended. A fee of
9 fifteen dollars ($15) shall be charged for the initial
10 registration. All registrations shall be renewed annually and
11 any renewal thereof shall not be more than ten dollars ($10).
12 The executive secretary of the state board of healing arts shall
13 remit all moneys received by or for him or her from the
14 provisions of this act in accordance with K.S.A. 1977 Supp.
15 65-2855. The state board of healing arts may adopt rules and
16 regulations necessary to carry out the provisions of this act and
17 the act of which this section is amendatory. ~~As-used-in-this-act~~
18 ~~the-term-"physicians'-assistant"--shall--mean--a--skilled--person~~
19 ~~qualified--by-academic-training-to-provide-patient-services-under~~
20 ~~the-direction-and-supervision-of-a-physician-licensed-to-practice~~
21 ~~medicine-and-surgery-who-is-responsible-for--the--performance--of~~
22 ~~that-assistant.~~

23 Sec. 3. K.S.A. 1977 Supp. 65-2896a is hereby amended to
24 read as follows: 65-2896a. ~~From-and-after-the-effective-date-of~~
25 ~~this-act,~~ (a) No person's name shall be entered on the register
26 of physicians' assistants by the state board of healing arts
27 unless such person shall have:

28 ~~(a)~~ (1) Presented to the state board of healing arts proof
29 of graduation from an accredited high school or the equivalent
30 thereof; and

31 ~~(b)~~ (2) presented to the state board of healing arts proof
32 that the applicant has successfully completed a course of
33 education and training approved by the state board of healing
34 arts for the education and training of physicians' assistants.
35 Such course of education and training shall be substantially in

conformity with educational and training programs for physicians' assistants approved by the state board of regents; or

~~(c)~~ (3) passed an examination ~~prescribed~~ approved by the state board of healing arts covering subjects incident to the education and training of physicians' assistants.

(b) A physicians' assistant shall at the time of initial registration and any renewal thereof present to the state board of healing arts the name and address of his or her responsible physician. No more than two (2) physicians' assistants shall be currently registered for any physician at any one time. Whenever a physician's assistant shall cease to be employed by his or her responsible physician, such responsible physician shall notify the state board of healing arts of such termination. Whenever a physicians' assistant shall be employed by another responsible physician, prior to renewal of his or her registration, such physician's assistant shall provide to the state board of healing arts the name and address of his or her new responsible physician. Such notification shall be given to the state board of healing arts as soon as practicable but not to exceed a period of ten (10) days.

(c) On and after July 1, 1979, the state board of healing arts shall require every physician's assistant to submit with the renewal application evidence of satisfactory completion of a program of continuing education required by the state board of healing arts. The state board of healing arts by duly adopted rules and regulations shall establish the requirements for such program of continuing education as soon as possible after the effective date of this act. In establishing such requirements the state board of healing arts shall consider any existing programs of continuing education currently being offered to physician's assistants.

(d) A person whose name has been entered on the register of physicians' assistants prior to the effective date of this act shall not be subject to the provisions of subsection (a) of this section, unless such person's name has been removed from the

1 register of physicians' assistants pursuant to the provisions of
2 K.S.A. ~~1975~~ 1977 Supp. 65-2896b, as amended.
3 Sec. 4. K.S.A. 1977 Supp. 65-2896b is hereby amended to
4 read as follows: 65-2896b. The board of healing arts may remove
5 a person's name from the register of physicians' assistants for
6 any of the following reasons:
7 (a) The person whose name is entered on the register of
8 physicians' assistants requests or consents to the removal
9 thereof; or
10 (b) the board of healing arts determines that the person
11 whose name is entered on the register of physicians' assistants
12 has not been employed as a physicians' assistant or as a teacher
13 or instructor of persons being educated and trained ~~as~~ to become
14 a physicians' assistant in a course of education and training
15 approved by the state board of healing arts under K.S.A. ~~1975~~
16 1977 Supp. 65-2896a, as amended, at some time during the five
17 years immediately preceding the date of such determination.
18 Sec. 5. K.S.A. 1977 Supp. 65-2896c is hereby amended to
19 read as follows: 65-2896c. (a) ~~From--and--after--the--effective~~
20 ~~date--of--this--act,~~ No person shall use the title physician's
21 assistant or words of like effect or the abbreviation "P.A." nor
22 shall any person represent himself or herself to be a physician's
23 assistant unless such person's name is entered on the register of
24 the names of physician's assistants in accordance with the
25 provisions of this act.
26 (b) Any person violating the provisions of this section
27 shall be guilty of a class C misdemeanor.
28 New Sec. 6. A person whose name has been entered on the
29 register of physicians' assistants may perform, under the
30 direction and supervision of a physician, acts which constitute
31 the practice of medicine and surgery to the extent and in the
32 manner authorized by the physician responsible for the
33 physicians' assistant. Before a physicians' assistant shall
34 perform under the direction and supervision of a physician, such
35 physicians' assistant shall be identified to the patient and

1 others involved in providing the patient services as being a
2 physicians' assistant to the responsible physician.
3 New Sec. 7. Prescriptions may be written by physicians'
4 assistants as provided in this section when authorized by the
5 responsible physician except for those controlled substances that
6 are listed on schedule II under federal and Kansas uniform
7 controlled substances acts. The prescription shall include the
8 name, address and telephone number of the responsible physician.
9 The prescription shall also bear the name and the address of the
10 patient and the date on which the prescription was written. The
11 physicians' assistant shall sign his or her name to such
12 prescription followed by the letters "P.A." and his or her
13 federal drug enforcement administration registration number.
14 Sec. 8. K.S.A. 1977 Supp. 65-2896, 65-2896a, 65-2896b,
15 65-2896c and 65-2897 are hereby repealed.
16 Sec. 9. This act shall take effect and be in force from and
17 after its publication in the statute book.

Attachment D

THE UNIVERSITY OF KANSAS

Office of the Vice Chancellor
University of Kansas School of Medicine — Wichita
1001 N. Minneapolis
Wichita, Kansas 67214
(316) 268-8221

September 16, 1977

Ms. Emalene Correll
Legislative Research Department
State Capitol Building
Topeka, KS 66612

Dear Emalene:

I'm responding to the September 13 letter of Sherman Parks regarding the upcoming Special Committee on Public Health and Welfare hearing relating to the physician's assistants bill, a copy of which was attached to Sherman's letter.

I had previously indicated to Elmira that I did not consider it propitious for me to attend this hearing since I am no longer formally affiliated with the Wichita Physician's Assistants program, however, I do appreciate the opportunity of commenting on the proposed draft.

By way of introduction I would like to say that generally speaking, the draft encompasses most all of the points that I felt were significant, and which should be considered for inclusion in any state legislation dealing with this subject. Basically, I am sure that those concerned with the physician's assistants movement will be generally pleased with the principles embodied in the proposed bill draft.

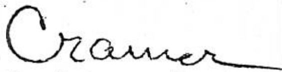
Having commented as above, I feel it equally important that those who are not supportive of the concept will find two sections or portions thereof to be of questionable acceptance. The first of these relates to New Section 6 beginning on line 26 of page 4. This statement may well come under criticism by the Kansas State Board of Healing Arts and/or other members of the medical profession because it provides broad performance coverage by the supervising physician, and eliminates the matter of whether or not such physician authorized services must be performed under direct or some other type of specified supervision. My personal feeling is that if the concept is to have merit, and to justify continued support of the educational process, the end product, the Registered Physician's Assistant must be able to perform health and/or medically related functions in a manner that will not necessitate immediate and direct supervision by the supervising physician. Others will undoubtedly question this philosophy.

Atch. D

The second area that I feel may only represent a typographical area, relates to New Section 7, line 10 on page 5. Here it states, "The physician's assistant shall sign his or her name to such prescription followed by the letters P.A. and his or her D.E.A. Actually the P.A. will not be given a D.E.A. number by the Department of Justice, so I'm sure the intent of the draft was to insert the word "physician's" before the D.E.A. on line 10. With this proposed change, line 10 would then read, "--- prescription followed by letters P.A., and his or her physician's D.E.A. Almost certainly, members of the pharmacy board will point out this discrepancy if the phrasing is not modified.

Many thanks, Emalene, for permitting me to respond to the proposed bill. You and other members of the Legislative Research Department are deserving of a great deal of credit for having worked so well to develop the present proposal. If you feel that I can be of any further assistance, do afford me that opportunity.

Sincerely yours,



D. Cramer Reed, M.D.
Vice Chancellor

DCR:bh

cc: Representative Mike Hayden
Senator Wes Sowers

Attachment E

PHYSICIAN'S ASSISTANT PROGRAM
College of Health Related Professions
VA Center, 5500 E. Kellogg Wichita, Kansas 67218
Area Code (316) 685-0249

September 16, 1977

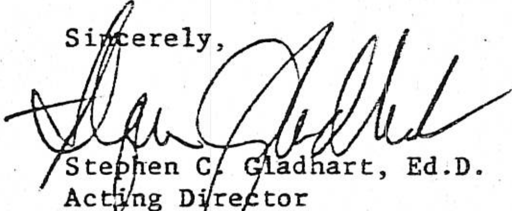
Ms. Emalene Correll
Legislative Research Dept.
State Capitol Building
Topeka, KS 66612

Dear Ms. Correll:

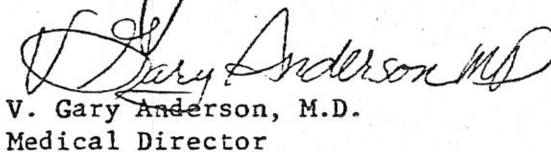
We are writing in support of the Proposed Legislation for Physician's Assistants as drafted by the Special Committee on Public Health and Welfare. As written, the proposed legislation will clarify several important legal areas which are currently a matter of confusion. The sections defining supervision and prescriptive practice are particularly relevant to the utilization of Physician's Assistants in the State of Kansas.

As representatives of the training institution for PA's in the State, we are especially pleased with the concern of the Committee for developing appropriate guidelines for PA practice. The Health Care system in Kansas will benefit from your actions. Representatives from the Program will be present for the public hearings. We would appreciate being kept informed of the progress of the Proposed Legislation and will be happy to offer any assistance possible.

Sincerely,



Stephen C. Gladhart, Ed.D.
Acting Director



V. Gary Anderson, M.D.
Medical Director

SCG/VGA/hs

Atch. E

Attachment F

Kansas Academy of Physicians' Assistants

9203 LINCOLN CT. WICHITA, KANSAS 67207
810 lawrence lane, 67206

KAPA

Pres., Elizabeth Sheldon, P.A.
Pres.-Elect, James Sommers, P.A.
Vice Pres., Phillip Metzer, P.A.
Sec., Marvis Goostree, P.A.
Treas., Val Valgora, P.A.

BOARD MEMBERS
Rebecca Ediger, P.A.
Sandra Summers, P.A.
Richard Hamaker, P.A.

Dear Ms. Sorrell;

Thank you for the latest proposed draft of 7 RS 1602 regarding Physicians Assistants Legislation.

We would like to make the following additions and changes.

Page2 Sec. 3 Lines 31--34
(2) presented to the board of healing arts proof that the applicant has successfully graduated from an A.M.A. accredited Physicians Assistant Program, approved by the state board of healing arts or:

Page 3 Lines 3---5
(3) passed the National Physicians Assistants Certification Exam.

Lines 19---23
(C) On and after July 1,1979, the State Board of Healing Arts shall require every Pysicians Assitant to submit with their renewal application evidence of satisfactory completion of 100 hrs. Category 1 each two years of continuing education, as requird by the National Certification Board of Healing Arts.

Sincerely yours,

Elizabeth J. Sheldon
President K.A.P.A.

Atch. F

Attachment 6

J. D. HUFF, M.D., KANSAS CITY, PRESIDENT
W. [illegible]YER, M.D., WICHITA, PRESIDENT-ELECT
D. [illegible]ERING, M.D., SALINA, FIRST VICE PRESIDENT
P. [illegible]DWIN, M.D., LAWRENCE, SECOND VICE PRESIDENT

J. R. COOPER, M.D., SHAWNEE MISSION, SECR[illegible]
W. K. WALKER, M.D., SEDAN, TREASURER
C. C. CONARD, M.D., DODGE CITY, AMA DELE[illegible]
ALEX SCOTT, M.D., JUNCTION CITY, AMA DELEGA[illegible]

THE KANSAS MEDICAL SOCIETY

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

JERRY SLAUGHTER, EXECUTIVE DIRECTOR
GARY CARUTHERS, EXECUTIVE ASSISTANT
VAL BRAUN, EXECUTIVE ASSISTANT

September 20, 1977

The Honorable Michael G. Johnson, Chairman
Interim Committee on Public Health and Welfare
State Capitol Building
Topeka, Kansas 66612

Dear Representative Johnson:

We appreciate the opportunity to comment on the proposed draft bill relating to physician's assistants. Generally, we would like to commend the entire committee on their diligent efforts in drafting much needed changes to the physician's assistant law, especially in the area of clarifying the credentialing resquisites for registration.

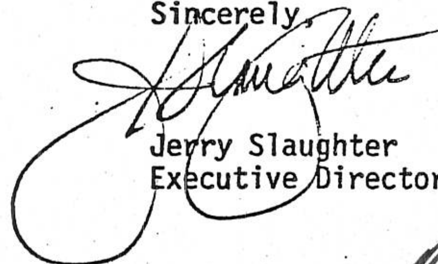
We have two primary concerns with the bill as it is now drafted:

1) New Section 6 could be strengthened on line 27 by deleting the comma after "perform" and inserting the word "only" therein. We feel the addition of the word "only" will make it absolutely clear that a physician's assistant cannot work except under the direction and supervision of a physician.

2) New Section 7 specifically authorizes physician's assistants to write prescriptions independently of any countersignature or initialing by the responsible physician. We cannot support this proposed concept for a variety of reasons. First of all, it is simply not needed in the vast majority of medical practices which employ a P. A. Secondly, we feel there is an added potential for abuse, especially in view of the fact that a P. A. may change employers many times, creating even more problems. Finally, current drug laws in Kansas are satisfactory, and a stricter enforcement of the existing laws, not a liberalization of them, is all that is both needed and appropriate at this time.

I appreciate the opportunity to comment on the draft bill, and trust that you will contact me if you have any questions or if I can assist you in any way.

Sincerely,



Jerry Slaughter
Executive Director

JS:sm

Atch. G

Attachment "

STATEMENT TO JOINT COMMITTEE ON

PUBLIC HEALTH & WELFARE

Proposal #60 - Physicians' Assistants

September 20, 1977

Mr. Chairman and members of the committee, the Kansas Optometric Association wishes to take this opportunity to comment on and in some instances raise questions about the proposed draft of the physician's assistants bill that is being considered by the Special Committee on Public Health & Welfare.

I shall preface my comments by stating that Kansas Optometry has in the past and will in the future continue to achieve the highest level of health care possible for all Kansans. However, we would be remiss if we did not raise the questions we feel are pertinent to proper optometric care.

As the proposed draft is written, any physician who wishes to employ a registered physician's assistant for the purpose of performing vision examinations may do so. It is the broad power of delegation in this area that concerns Kansas Optometry.

If you recall Senate Bill 126 from the 1977 Legislative session or more specifically K.S.A. 65-1501 which defines the practice of

Atch. H

optometry, language was inserted that would allow optometrists to employ the use of topical pharmacological agents for the purpose of diagnosing the refractive, muscular, or pathological condition of the vision system. Language was also inserted in Section 2 of that same bill or more specifically K.S.A. 1976 Supp. 65-1508 that limits examination procedures performed by assistants to optometrists or ophthalmologists to data gathering at the direct request of the optometrists and ophthalmologists and to those examination procedures which do not require professional interpretation or professional judgement.

The Kansas Optometric Association can foresee an inconsistency in the law if the proposed draft was to become law as written. We suggest however, that such an inconsistency could be avoided by simply inserting the following language as the last sentence in Section 6.

> A registered physician's assistant may not perform any act or procedure performed in the practice of optometry except as provided in K.S.A. 1977 Supp. 65-1508.

The proposed language above is conceptually the same language that has appeared in past

physicians' assistants proposals and certainly the language that the Kansas Optometric Association feels is necessary to insure that all Kansans will receive quality vision care.

At the initial hearings on this subject at Wichita State University and throughout subsequent hearings in Topeka, it was repeated time and time again that physician's assistants should and in most instances would be utilized in the underserved rural areas where the real shortage of physicians exists. If in fact the impetus for the physician's assistants concept is to distribute proper health care to the underserved rural areas, we submit that optometry has already more than adequately served these areas for years.

One cannot ignore the fact that there are more than twenty thousand (20,000) optometrists practicing in the United States today. In Kansas alone, there are more than two hundred and sixty (260) optometrists practicing in eighty five of our one hundred and five Kansas counties. More than seventy percent (70%) practice outside Kansas City, Wichita and Topeka with eighty (80) practicing in fifty (50) communities on or west of 81 highway, excluding Wichita. There are seventy-eight (78) ophthalmologists in Kansas with fifty-two percent (52%) practicing in

Kansas City, Wichita and Topeka. There are eighteen (18) ophthalmologists in ten (10) communities on or west of 81 highway, excluding Wichita. It is obvious from this data that a majority of the citizens of Kansas receive their initial or total eye care from optometrists in the State of Kansas.

In light of the statistics above it seems redundant and needless to register an additional provider with much less training that could only provide eye care of lesser quality.

We feel it is important that you as committee members are aware of optometry as it is defined in K.S.A. 65-1501 and what is required to become an optometrist. We think you will agree that vision care should be left to optometrists and physicians, particularly when proper and comprehensive vision care is currently being provided throughout Kansas, both urban and rural.

Just a brief overview of optometric education will give you an idea of the extensive training an optometrist receives. For example, an optometric student receives approximately 30 lecture hours and 17 laboratory hours in physics and mathematics. These include calculus and visual optics. The student is also required to study anatomy and physiology. Some of these

courses are: Inorganic and Organic Chemistry, Biology, Anatomy of the Eye, including neuro anatomy, Biochemistry and Mammalian Physiology. These courses total 50 hours of lecture and 22 hours of laboratory. The optometric student also must successfully complete 32 hours of lecture and 29 hours of laboratory work directly concerning the diseases of the eye. There are of course extensive courses designed to help teach the student doctor in examination, diagnosis and treatment of the non-diseased eyes. These courses are Clinical Examination of the Visual System, Eye Movement Mechanisms, Normal Binocular Vision and Anomalies, Visual Perception, Psychophysics of Vision Tests and Measures, Visual Rehabilitation and Geriatric and Pediatric Optometry. These courses total 58 hours of lecture and 208 hours of clinical experience.

It's difficult to imagine why a physician's assistant with a very limited knowledge in vision care would be needed to supplement proper and comprehensive vision care in any geographical region of Kansas.

Mr. Chairman, the Kansas Optometric Association feels this issue was addressed and resolved last year in Senate Bill 126 when the House and Senate Public Health and Welfare Committees and the balance

of the Legislature saw fit to include the language that limited examination procedures performed by assistants to ophthalmologists and optometrists to data gathering at the direct request of the optometrist and ophthalmologist and to those procedures which do not require professional interpretation or professional judgement. The absence of similar language in the physicians' assistants proposal would present an inconsistency.

For the above reasons, we would respectfully request that the language alluded to earlier on page 2 be incorporated in this proposal.

Our only other concern pertains to Section three, subsection 3d. Subsection 3d exempts any physician's assistant whose name was entered on the register of physicians' assistants prior to the effective date of this act from the requirements set forth in subsection (a) of Section three. We suggest that this exemption be omitted thus requiring all physicians' assistants to successfully complete an examination approved by the Board of Healing Arts.

Mr. Chairman and members of the committee, we conclude by stating that the Kansas Optometric Association's posture concerning this issue is certainly not an attempt to discredit the services

performed by physicians' assistants nor the physicians' assistants concept in general, we simply feel that proper and comprehensive vision care has long existed in both urban and rural Kansas and will continue to do so in the future.

Thank you.

Respectfully submitted,

Jack Milligan
Executive Director

Attachment I

Special Committee on Public Health and Welfare
September 20, 1977
(Excerpts from a speech given at the 2nd Annual Meeting, FAHRB in 1975)

First, let me review three areas of major impact on personnel licensure, all of which have an economic component although this economic component is somewhat remote and indirect and not entirely of recent origin.

The economic value of the right to practice a health profession or vocation has resulted recently in quick recourse to the courts to secure and protect that property right. As a result, there have been increasing court-imposed requirements of due process for licentiates with particular attention to the possible conflicts of interest of board members and to procedural due process.

A second factor, also economically related, has impacted on health regulatory boards and that is the phenomenon called consumerism. The public is demanding accountability--a praiseworthy concept and one of the "in" or "buzz" words of our time. Health care costs are so great and potential health care benefits are also so great--that people are rightfully demanding a dollar's worth of quality health care for a dollar spent. There is an increasingly high index of suspicion by the public that they are being ripped off by practitioners who are granted an exclusive right to practice by state mandatory licensure laws.

Third, there is the impact on state licensing boards of the demand for relicensure determined by either continuing education or reexamination. The knowledge explosion of our time has resulted in the half life of medical knowledge being reduced to an estimated three years to seven years. This explosion of knowledge is inextricably and directly related to the costs of health care as I will discuss later.

Dr. Frank E. Ellis has defined a regulation as "a principle or rule designed to govern behavior" adding "as our society becomes more complex, the need for regulation becomes more intense and compelling."

I will not differ with him, but I would like to observe that the converse also appears to be true, that as regulation becomes more intense and compelling, our society becomes more complex.

As a result there is more public disillusionment with regulation, especially federal regulation, and politicians and lawmakers of all persuasions confess great doubts about the benefits and advisability of regulation.

And yet, while legislators individually express these reservations, collectively they pass more and more laws regulating nearly all facets of American economic life. There are some signs of lessened regulation in some areas, but certainly not in the area of health care.

Atch. I

If the current of opinion and action is running against regulation, the health care industry is directed upstream.

From this introduction, I hope to make three points from a political/ legislative perspective.

First, the motivating force for increased federal legislation and regulation of health care is greatly increasing expenditures--i.e., the runaway costs of health care.

Second, regulations of the health care industry include many regulatory mechanisms and personnel licensure is one part of the regulatory bag and closely related to and bound to the other forms of health industry regulation.

Third, regardless of the form of national health insurance, the federal government already has the power--jurisdiction--muscle to regulate nearly all aspects of health care delivery.

Turning back to the driving force bringing about changes in health care, it is impossible in my opinion to overplay the seriousness of increasing health care expenditures. Simply put--these increased expenditures are pricing many Americans out of the health care market and threaten to price the nation out of the health care market. Ten years ago, 1965, we spent 38.9 billion for health care. In 1975 this was 118 billion. . . a greater than 300% increase in one decade.

Why are health costs exploding at this time? Because knowledge is exploding. The health sciences are the cutting edge of a scientific and technologic revolution that is profoundly affecting all aspects of our personal and national lives.

We can do more things--many more things for more people than we could do last week, last month, or certainly one or five years ago. And it all costs money--it all requires human and material resources. In health care, as in so many other areas, we have outstripped our resources.

As a result there is an allocation or rationing system for health care. National health insurance will merely establish a new rationing system for health care which would not be based on the ability to pay and in this sense should be more equirable. But resources will still be limited--there will not be enough for everyone everywhere--and this will require a new rationing or allocation system. So predictable reaction to runaway health care costs are national health insurance and regulation to hold down costs and distribute services.

Dr. Patrick O'Donoghue has done an excellent job of categorizing health care industry regulation in a book entitled "Evidence About Effects of Health Care Regulation." Let me run through these.

1) Cost and Price Regulation - This includes wage and price controls such as federally imposed under the ESP. You'll recall that the Nixon Administration, usually categorized as conservative, wanted to continue controls in the construction and health industries. Also in this category are state hospital cost commissions and prospective reimbursement programs.

2) Regulation of Capital Expenditures - This includes state certificate of need laws, now required by federal law, and certainly the new Health Planning and Resources Development Law.

3) Regulation of Professional Performance - This includes utilization review, medical audit, PSRO, and institutional privileges.

4) Regulation of Institutional Quality - Accreditation of institutions, certification and state licensure of institutions are examples of this type of regulation.

5) Personnel licensure

6) Regulation of Health Professional Education, including accreditation of schools and recognition of postgraduate training programs and certification, and finally,

7) The Regulation of Private Interests.

<u>Purposes of Regulation</u>:

To control costs
To make necessary services available and accessible
To assure quality care or to equitably allocate health services.

<u>Undergirding entire concept</u> in several regulatory categories, it is the generally accepted premise that services of poor quality and unnecessary services cost money that should be spent for necessary services of reasonable quality.

By the way, everyone cannot have better than average health care.

<u>Personnel Licensing</u> is one of the older regulatory mechanisms now under examination. I will not generalize broadly except to say that licensure establishes minimum standards of competence at time of entry into practice of health care profession or vocation. It also provides for suspension or revocation of license under police power of the state. This is infrequent. Less than 2,000 such actions were brought against all this country's physicians in a ten year period, and rarely are such actions based on the finding of professional incompetence. It unquestionably brings some order to the entire process of personnel licensure.

What are the effects of the regulatory requirement of personnel licensure on the cost, quality and availability of health care services? Again to O'Donoghue. He presents a number of criteria questions:

a) Has personnel licensure succeeded in placing a floor on the quality of health care practitioners?

b) Has personnel licensure reduced the supply of health care practitioners?

c) Is there evidence to indicate that increases in costs are related to manpower shortages, and that such manpower shortages are in turn in part caused by personnel licensure practices?

d) What are the effects of licensing laws on the utilization and mix ofprofessionals in health care settings?

e) Have state licensing practices contributed to the maldistribution of health professionals by restricting mobility of health care personnel?

Other pertinent questions may be added to Dr. O'Donoghue's questions that are directed toward determining the effects of health care regulation. Some of these are:

--Is there evidence of increased costs due to an excessive number of health professionals in an area? Are there benefits commensurate with such increased expenditures? Who defines benefits commensurate with?

--What will be the quality and cost effects of a physician population 237:100,000 projected for 1990? What are the implications for physician licensure?

--Will there be state or federal requirements for the granting of a certificate of need before permitting a health professional to practice in a given geographic area?

--Will personnel licensure be the effecting mechanism of distribution of health professionals?

Health care costs are greatly out of control. As a result you who are involved must prove that personnel licensure has beneficial rather than deleterious effects on the cost and quality of health care services. Most of us believe this is so. All of us hope this is so. There is little evidence that this is so.

It is not enough that the police power of the state is used to bring a degree of order to the practice of the health care professions and vocations within the several jurisdictions. It is mandatory that other important socioeconomic effects of personnel legislature, especially the effects on the cost and quality of health care be measured--to the degree possible--and related to other present and possible health care problems and mechanisms, especially other regulatory mechanisms.

For better or for worse, so it is.

Attachment J

TESTIMONY

By: E. A. Jarvis, Chairman
Statewide Health Coordinating Council

on

Proposal No. 59 - Credentialing of Health Care Personnel

The Kansas Statewide Health Coordinating Council, in fulfilling its role in developing a State Health Plan, reviewed health problems presented by the general public through a public opinion poll, the local health systems agencies, the Department of Health and Environment and the National Health Planning Priorities. In an effort to focus the council's attention on priority problems, the council considered each problem for condition prevalence, severity, duration and public dissatisfaction and concluded that improvement in the health care delivery system is a major goal in Kansas and that improvement should:

(1) provide a better balance in the delivery of health promotion services and the traditional medical care services;

(2) provide equitable access to primary care services, particularly to those populations presently underserved; and

(3) restrain health care costs.

Competent health care personnel is one ingredient to attain these goals and credentialing is one method used for quality assurance. While health manpower credentialing*, particularly the licensure and certification of individuals, has

*Credentialing: The formal recognition of professional or technical competence.

Certification: The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Licensure: The process by which an agency of government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety and welfare will be reasonably well protected.

Att. J

received increased attention in recent years as an important issue that has an impact on health care delivery, it did not surface as a priority for action in our first State Health Plan. This means that the issue of credentialing will not receive a priority for problem research, analysis and recommendations. With that qualifier in mind, I would like to provide my comments on health manpower credentialing.

Professional licensure has its roots in the protection of public health and safety. In the HEW Report on Licensure and Related Health Personnel Credentialing, 1971, state licensure programs were reviewed and it was found that licensure had evolved into a system of varying requirements, responsibilities and controls that tend, in many instances, to impede effective utilization of health personnel, to inhibit geographic and career mobility and to foster variable licensure standards and procedures in different regions of the country. Furthermore, licensing agencies often tend to emphasize formal education and other requirements for entry into a profession but devote much less attention to assuring the continued competence of those who are licensed. Since that 1971 report, significant activity in the states has occurred around the continuing education requirement for relicensure, however, there are few agreements among states on what is appropriate. Consequently the inconsistent continuing education requirements may further exacerbate the problem of mobility.

Compounding the problem of licensure is the growing number of health occupations seeking licensure. This poses two more problems: (1) a general proliferation of occupations and roles that is likely to contribute to inefficiencies in the health system; and (2) the adoption of arbitrary scopes of practice in fields that will be

undergoing substantial evolution over the next five to ten years.

The conditions I just described prompted the Department of HEW and the American Hospital Association to call for a national moratorium on any new legislation to license additional health occupations. The purpose of the moratorium was to provide an opportunity to examine other alternatives for credentialing health manpower and to begin a fundamental reassessment of licensure as a primary method of quality assurance in the field of health manpower. During the moratorium professions, states and the federal government conducted experiments and studies on alternatives.

Since one issue was the proliferation of licensed health occupations, a recommended set of criteria for future state licensure decisions was developed. I think these criteria are pertinent to the Kansas situation.

States should entertain proposals to license additional categories of health personnel with caution and deliberation. Before enacting any legislation that would license additional categories of health manpower, states should consider the following:

(1) In what way will the unregulated practice clearly endanger the health, safety and welfare of the public, and is the potential for harm easily recognizable and not remote or dependent on tenuous argument?

(2) How will the public benefit by an assurance of initial and continuing professional competence?

(3) Can the public be effectively protected by means other than licensure?

(4) Why is licensure the most appropriate form of regulation?

(5) How will the newly licensed category impact upon the statutory and administrative authority and scopes of practice of previously licensed categories in the state?

This approach was first articulated in the "New Jersey Bateman Commission Report" in 1971, and more recently was incorporated in the 1974 Virginia Statute (Code of Va. 54-1.1) that created an administrative agency to review all petitions for state licensure and to convey to the legislature its findings and recommendations. In utilizing these criteria, Kansas should be able to integrate their licensure decisions into broader manpower planning decisions, particularly in examining the mutual responsibilities and scopes of practice among the various health categories, and in projecting the impact that a newly licensed category would have upon the authority, responsibility and scopes of work of existing licensed categories.

Another possibility is the concept of "sunset" statutes whereby regulatory agencies are sanctioned for a specific period of time, e.g., five years, after which the agency must justify the need for renewal of the authorizing legislation. This type of self-limiting statutory authority may give the legislature the opportunity and incentive to review the need for continued licensure of various occupations as well as a chance to review the activity of the licensure board or agency. The constant evolution of new manpower categories and the concomitant changes in roles and functions of established occupations would appear to justify further consideration of the "sunset" concept.

Finally, I do not have specific recommendations concerning any particular health occupation, but I would recommend careful deliberation on any proposal for licensure using the criteria I mentioned earlier as guidelines for that deliberation.

Attachment K

SUMMARY OF TESTIMONY BY BLUE CROSS AND BLUE SHIELD BEFORE SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE, SEPTEMBER 19, 1977 ON PROPOSAL 59 - CREDENTIALING OF HEALTH CARE PERSONNEL

Since others have already eloquently addressed themselves to the issue of licensure of health care personnel, we will address ourselves to the inadvisability of mandating health care personnel into the third party payment mechanism.

In order to do so we should first review the myriad of factors which affect health care costs.

Often, in the legislative setting, a committee is dealing with a factor which affects health care costs, but because they are dealing with it in isolation from the other factors, it does not appear to have much significance.

The legislative body, by not mandating benefits of health care personnel into third party payor mechanisms has the opportunity to positively affect the efforts to curtail escalating costs.

The Kansas Legislature has a remarkably good record, and is to be commended, in not excessively mandating either benefits or health care personnel into third party payment mechanisms.

Some factors which affect health care costs:

(1) Inflation (50% of increase).

(2) Medical Malpractice (This promotes the practice of "defensive medicine".).

(3) Price Freeze (lifted in 1974 triggering an upward surge to "catch up").

(4) Advances in medical technology (CAT; open heart surgery; replacement of knees, hips, etc.; pacemakers).

(5) Empty Hospital Beds (What is the proper ratio of beds per thousand population?).

(6) Duplication of Services (CAT scanners, OB services, etc.).

(7) Maldistribution of Physicians (This is not only geographical, but there is also maldistribution by specialties.).

(8) Research and Training (We spent 27 million in 1947 and 2.4 billion in 1974. However, this is where many of the marvelous advances are made.).

(9) Composition of Population - (6.8% of population over 65 in 1940 --- today, 10.3% is over 65).

(10) Demand for best medical care (Almost anyone seeking medical care will demand the best.).

(11) Mandating Benefits - (If nervous and mental bill proposed last session had passed, it would have cost our subscribers an additional $7,000,000.)

Atch. K

(12) Mandating Health Care Personnel -

The following have been mandated into the third party payment mechanism:

Psychologists (7-1-74) - Pay out in 1977 was $44,581

Podiatrists (7-1-73) - Pay out in 1977 was $437,846

Dentists (7-1-73) - Pay out in 1977 was $660,125

(This was not additional cost as we already provided coverage, but it would constitute an increase to any third party payor who had not previously provided coverage for these practitioners.)

Optometrists (7-1-73) - Pay out in 1977 was $43,113. This is a new expense not previously covered.

Chiropractors (7-1-73) - Pay out in 1977 was $617,011. This is a new expense not previously covered.

Mandating health care personnel into third party payor mechanism will affect:

(1) Costs - In each case cited above it created a cost increase.

(2) It negates the opportunity for third party payors to negotiate with practitioners on reimbursement schedules as well as types of services to be covered.

(3) It disregards public demand. Almost any group of practitioners can make a "good case" before the legislative body, but they may not have any real relationship to what subscribers may desire to have included or excluded in their programs.

We may also be encountering the same problem in terms of facilities being licensed. Serious questions can be raised as to what a third party payor is "paying for" in a "halfway house", should it be mandated that they make payment to such facilities.

JR/lc

Attachment 2

STATE OF KANSAS

BOARD OF NURSING

TESTIMONY BEFORE THE SPECIAL COMMITTEE ON
PUBLIC HEALTH AND WELFARE
REGARDING PROPOSAL NO. 60

September 21, 1977

Ray E. Showalter, R.N., M.S.
Executive Administrator

Mr. Chairman and Members of the Committee:

For a number of years the nurses in Kansas have identified the need to have the definition of registered nursing as it appears in K.S.A. 65-1113 (b) (1) changed to more adequately reflect the current practice of those nurses who are providing primary health care to the Citizens of Kansas. Although practice usually leads the law, the Board of Nursing believes that it is urgent that appropriate legislation be drafted and introduced to provide for the required changes. Therefore, the Board is pleased to know that your committee is once again addressing this issue.

Many jurisdictions have made changes in their definitions of nursing in order to legalize the practice of nurses functioning in expanded roles. Probably the most common change has been to incorporate language about the performance of "additional acts." Preparation for

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The Kansas Board of Nursing believes that the profession of nursing must be practiced in collaboration with all other health care providers; however, the Board believes that the authority for nursing practice must remain under the Board of Nursing. Therefore, the Board of Nursing would support an "additional acts" amendment which gives the authority for its implementation to the Board of Nursing. The Board could then develop the appropriate administrative regulations, subject to legislative review, that provide for implementation. The regulations would need to speak to functions, educational requirements, and program approval. Legislative review insures proper administrative regulations within the intent of the statutory authority.

Thank you for this opportunity to make this presentation.

these "additional acts" has been provided through on the job training, special courses of varing lengths, and through graduate programs leading to the masters degree. Usually the nurse is prepared in one specialized field in regard to the expanded role being performed.

The nurses coming through the various preparatory programs have assumed titles indicating their area of specialization. Some of these are Certified Registered Nurse Anesthetist, Certified Registered Nurse Midwife, Family Nurse Practitioner, Family Planning Nurse Practitioner, Geriatric Nurse Practitioner, Pediatric Nurse Practitioner, Adult Nurse Practitioner, Occupational Health Nurse Practitioner, Community Health Nurse Practitioner, School Nurse Practitioner, and Critical Care Nurse Practitioner.

Certification in these areas is available through such national associations as the American College of Nurse Midwives, National Association of Pediatric Nurse Associates and Practitioners, American Association of Nurse Anesthetists, and the American Nurses' Association. These certification programs are quite stringent and provide a mark of excellence for those achieving certification through this process.

The "additional acts" amendments have been implemented variously through administrative regulations developed jointly by boards of nursing and medicine, through committees which are advisory to boards of nursing, and through administrative regulations developed solely by boards of nursing.

Reports about the implementation of the legislation providing for the "additional acts" indicate some difficulties. The greatest difficulty seems to arise when joint promulgation by the boards of nursing and medicine is required.

Attachment M

KANSAS STATE NURSES' ASSOCIATION

PRESENTATION TO

SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

September 21, 1977

Mr. Chairman and Members of the Committee:

My name is Roberta Thiry. I am representing the Kansas State Nurses' Association.

I will be presenting rationale for a change in the definition of nursing as found in the Nurse Practice Act and then briefly discuss the specific changes embodied in the draft submitted to you.

Consumers have demonstrated concern over the availability, accessibility, and cost of health care. The restrictive language of the present definition of nursing prohibits nurse mid-wives from practicing in Kansas and seriously limits the practice of other nurse specialists. These restrictions certainly compromise the availability and perhaps accessibility of health care for consumers.

A number of studies have shown that nurse management of certain patient populations can help control or substantially reduce health care costs with no reduction in quality of care. Komaroff and others compared the care given by nurse practitioners using protocols with that of physicians for the dimensions of safety, effectiveness, efficiency and cost. All patients seen in the out patient department of Beth Israel Hospital by the nurse practitioner over a ten day period with symptoms of respiratory tract, urinary and vaginal infections were evaluated and compared with those seen by the physician during a comparable period. No serious illnesses were overlooked in either case. Eighty-six per cent of patients in the nurse-protocol mode and 73 per cent in the traditional situation reported good relief of symptoms. Patient satisfaction was equivalent in both groups, while physician time involvement was reduced by 91 per cent. In addition, the costs of laboratory tests and medications ordered were 27 per cent less in the nurse-protocol mode. No difference in personnel costs would have occurred with residents or interns, but for a staff physician, the cost in salary would have doubled.

At a nursing conference on Quality of Care held at the University of Kansas early in 1975, Mary Woody reported that when nurses assumed responsibility for the diabetic clinics at a major medical center in the South, the number of hopital readmissions for this population was reduced 30-40 per cent. She attributed this to support and teaching of patients, thus improving their self management and reducing complications. The reduction in health care costs was substantial.

There are different ways to view savings in health care costs. Besides comparing the cost of delivery by physicians and nurses, one must also consider the savings to society through prevention or early referral. Nurses in community settings, such as schools, industry and public health clinics provide health education and counseling to promote health maintenance. In addition, they administer immunizations, treat common ailments by protocol, and screen for specific health problems. In the school system, nurses screen for vision or hearing impairment, developmental problems, and common disease conditions. Nurses in industry may perform similar functions, but with a different age group. The well baby, family planning,

Atch. M

V.D., weight-control, and other public health clinics operated by nurses contribute significantly to health maintenance. How does one determine the savings when illness does not occur or when it is identified and treated early?

Nurses in expanded roles are prepared to do research related to patient care. Research helps improve quality while reducing or maintaining costs. A study by Voshall demonstrated that by instructing patients pre-operatively about how to control their pain, the experimental group took less analgesics, and on the average, went home one day earlier than the control group. The reduction of cost related to one hospital day is economically significant.

Other studies have shown that when nurses provide support, counseling, and/or information, the client's compliance with the medical regimen will improve. Fiorella documented such improved compliance through the use of laboratory tests and clinical assessments with a group of patients on dialysis. Improved compliance tends to reduce the number of complications and hospital admissions for persons with chronic illnesses, thus keeping costs down. Nurses have been credited with having greater psycho-social skills than most other health workers. Such studies document their value.

It should be apparent that the areas where nurses are most effective in providing services and in cost containment are areas that are not in competition with the physician, but support or complement the physician's role. The expanded role of nursing can improve case finding and referral services, expedite treatment of common and relatively simple conditions, assist in the management of chronic health problems, and provide elements of care that are more common to nursing than to medicine. Early referrals would allow physicians to care for the acute and complex conditions which require their expertise. Early diagnosis and treatment have also been shown to reduce health care costs.

The improvement of health care in Kansas can be achieved by recognizing and maximizing the contributions of both the medical and nursing professions. It cannot be achieved by making one profession subservient to another. Collaborative relationships will allow both physicians and nurses to share their knowledge and experience, make referrals in either direction, and free the client to assume responsibility for his own health.

Kansas nurses have made several attempts over the past few years to change the definition of nursing. The basic reason for seeking such a change is to provide for the expanded role of the nurse. Any new definition must meet two criteria. First, it must legitimize current nursing practice; and, secondly, it must provide for the future growth and development of the nursing profession. A majority of the fifty states have found it necessary to revise their Nurse Practice Acts to provide for expanded roles either by removing restrictive language or by redefining nursing.

Efforts have been made to arrive at a definition that could be supported jointly by medicine and nursing. The Kansas Medical Society, Kansas State Nurses' Association, and the Department of Health and Environment have each hosted meetings for this purpose; however, no decisions were reached. The Master Planning Committee for Nursing released a position paper on "The Expanded Role of the Nurse" in February, 1977, to stimulate interest in legislation. In July, 1977, the Kansas State Nurses' Association also published a position paper supporting legislation to provide for the expanded role.

Since the first of September several Districts of KSNA have held forums to discuss the proposed changes in the definition of nursing. Some non-members, citizens, and legislators attended as well as members of the organization. The response has been overwhelmingly in support of the intent of the changes. Other districts will hold forums prior to our state convention which will be held in mid-October. Representatives of Kansas State Nurses' Association met with representatives of the Kansas Medical Society on September 15, 1977, to share the concepts and rationale for the proposed change in definition of nursing.

The committee that prepared the present draft reviewed the practice acts of a number of other states and the model practice act proposed by the American Nurses' Association. An attempt was made to avoid the problem areas reported by other states and in the literature. The changes suggested in our proposal are designed to express the intent of Kansas nurses. We recognize that a draft suitable for submission to the legislature would need to be prepared by experts. Perhaps the rationale for the various alterations is in order at this point.

Deletion of the word, "professional," was suggested by the model practice act. Registered nurse is the only title protected by the law. However, nurses generally objected to its removal. The description of nursing as a process delineates various aspects of the nursing role. "Treatment" was added to the functions, but is limited by the context in which it appears. Some concern has been expressed that the phrase, "achievement of a dignified death," might stir up bio-ethical issues. It would be better to delete it if that concern is generalized.

The phrase regarding "execution of the medical regimen as prescribed by a person licensed to practice medicine and surgery or a person licensed to practice dentistry," was chosen to replace "the administration of medicines and treatments" and the disclaimer clause. This statement would permit nurses to function using protocols as well as specific physician or dentist's orders.

The position of the provision for administration, supervision, and teaching was changed rather than the content. Some provision for "additional acts" is essential to allow for change in the nursing role over time. Concern has been expressed that "acts recognized by the nursing profession" was a self-serving statement. In court cases, however, nurses are usually judged according to practices common to the profession. Protection for the public is provided in the next phrase allowing for "such further functions as may be defined in the rules and regulations of the board not inconsistent with the provisions of this act." The board usually has an advisory committee to develop new rules and regulations, then public hearings are held, and finally, the rules and regulations must be approved by the legislature. These procedures provide ample opportunity for input from interested parties. It is essential that all nursing practice be regulated by the Board of Nursing.

Although we would like to have time to deal with the issue of entry into practice before defining an advanced level of practice in the law, we would not oppose the use of Advanced Registered Nurse Practitioner if it should be found necessary to provide control through the Board of Nursing.

Thank you for the opportunity to present the views of our organization. I will be happy to answer any questions you may have or refer them to other nurses in the audience.

PROPOSED CHANGES
IN THE
KANSAS NURSE PRACTICE ACT

Article 11. Examination, Licensure and Regulation of Nursing

K.S.A. Chapter 65, Article 11

65-1113. Definitions. When used in this act: (a) "Board" means the board of nursing.

(b) *Practice of nursing.* (1) the practice of ~~professional~~ nursing ~~means the performance~~ as performed by a registered nurse for compensation or gratuitously, except as permitted by K.S.A. 65-1124 and amendments thereto, ~~of any act in the observation,~~ is a process in which substantial specialized knowledge derived from the biological, physical, and behavioral sciences is applied to: the care, treatment, ~~and~~ counsel, ~~of the ill, injured, -or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision~~ and health teaching of ~~other personnel,~~ persons who are experiencing changes in the normal health processes; or who require assistance in the maintenance of health or the prevention or management of illness, injury or infirmity or in the achievement of a dignified death; the execution of the medical regimen ~~or the administration of medicines and treatments~~ as prescribed by a person licensed to practice medicine and surgery or a person licensed to practice dentistry; the administration, supervision or teaching of nursing; the performance of additional acts requiring education and training which are recognized by the nursing profession as proper to be performed by a registered nurse, and such further functions as may be defined in the rules and regulations of the board not inconsistent with the provisions of this act. ~~requiring substantial specialized judgement and skill, and based on knowledge and application of the principles of biological, physical, and social science. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures.~~

(c) A "~~professional~~ registered nurse" means a person who is licensed to practice ~~professional~~ nursing as defined in paragraph (b) (1) of this section.

Attachment N

TESTIMONY ON PROPOSAL 60

21 September 1977

By: The Department of Health and Environment

Atch. N

Thank you for the opportunity to speak on the position of the Department of Health and Environment regarding the subject of Health Professionals -- specifically the expanded role of the nurse.

Over the past several years what was viewed as the traditional role of the nurse by some has been in a state of constant change. At present there are some 200 programs training approximately 7,000 nurses for expanded roles annually. The N.P. training programs vary widely in format, curriculum, and clinical training requirements. These variations reflect, in part, different areas of specialization for which students are being prepared such as pediatrics, family and public health.

To date, regulation and standardization of the training program has come about slowly. That which is occurring is being developed by the profession in the form of self-regulation. It has been enough, so fairly consistent in objectives and context, and in some cases just better articulation of existing practice. Since the expanded role concept has been an evolutionary one with many experimental approaches, there has been no rigid regulation.

Regulation and definition of nurses practicing expanded roles has also come about slowly, although the pace has quickened during the last several years (30 states have revised their Nurse Practice Acts since 1972).

Now, with several thousand nurses active in expanded roles and many more to come in the future, it is desirable to modify the Nurse Practice Act in Kansas and empower the Board of Nursing to set standards for nurses entering such practices in this state.

This is not, we must emphasize, a proposal to remove the legal limits on nurses. It is an effort to provide adequate definition and regulation to activities which are becoming, or have become, commonplace throughout the country, and Kansas is no exception.

Proposals to change the Nurse Practice Act have met strong opposition in the past from many physicians. We think this opposition is based on a genuine concern for public safety. Physicians know better than anyone how complex and potentially hazardous the practice of medicine can be for even well trained physicians. They do not want people not trained in medicine to be allowed to do so. We agree completely with this point of view, but this is not the purpose, nor would be the result of a change in the Nurse Practice Act which would provide regulation for nurses in expanded roles -- performing acts which are not in the exclusive domain of medicine, which are indeed nursing.

The Kansas Healing Arts Act expressly prohibits anyone, and specifically nurses, from performing medical acts of diagnosis, treatment, and

prescribing. This law would remain unchanged and the deterrent against non physicians practicing medicine will remain as effective as ever. This is appropriate since we are not asking or desiring for nurses to practice medicine.

The type of change we advocate will allow for the safe administration of professional nursing care and treatment which would follow rules and regulations prescribed by the Board of Nursing consistent with the level of knowledge and skills of the professional nurse. We recommend the Nursing Board be specifically empowered to:

1) Develop definitions for different classes of nursing practice.
2) Adopt educational standards and criteria for nurses to be admitted to the various classes.
3) Administer a program which would define and regulate examination and licensure for the various appropriate classes of nursing.

We want to emphasize that this approach would not create a "new profession" but would facilitate the logical growth and development of one of the most essential professions in our health system for meeting the primary care needs of our people.

Attachment O

PRESENTATION BEFORE THE INTERIM
COMMITTEE ON PUBLIC HEALTH AND WELFARE
CONCERNING THE
PROPOSED CHANGES IN THE KANSAS NURSE PRACTICE
ACT

Mr. Chairman and Members of the Committee, my name is Marilyn A. Chard. I am a registered nurse and have a doctorate in education. I am Director of the Nurse Practitioner Program at the University of Kansas, College of Health Sciences, School of Nursing. I hold joint faculty appointments in the School of Nursing, Department of Pediatric Nursing, and the School of Medicine, Department of Pediatrics. In addition, I am a member of the University Pediatric Group, a corporation which offers health care, provided by nurse practitioner physician teams, to pediatric patients from birth through adolescence. I wish to speak to the Proposed Changes in the Kansas Nurse Practice Act amending the definition of the practice of nursing.

Ivan Illich, a well known humanist, believes that optimal health care prevails when human beings are allowed to be autonomous and responsible in coping with their internal and external environments. He notes that, currently, health care is planned and engineered by those who provide care, while those who seek it take little or no responsibility for their own health or cure.[1] Health care today denies its consumers the right to cope with their internal and external environments. Large populations are controlled and regulated in the name of health care.[2] Their members, oriented toward open-ended enrichment in all spheres of life, believe that technology alone can change the human condition.[3] With technology held in such high esteem, a technocracy has been created. Its members eagerly bow before the power of expertise and descend to a state of dependency to have their needs met. In the realm of health,

Atch. O

intervention is engineered by specialists who fail to foster self-care and autonomy in recipients.[4] Illich has not denigrated technology per se. When self care and autonomy are fostered, then freedom in the use of technology will pertain. Allowing people the means and responsibility for coping with illness can raise the level of health.[5]

Lysaught has written that greater than 88 percent of health care needs fall under health education, periodic examinations, dietary education, and chronic care, yet resources are directed toward acute care.[6] The Cambridge Research Institute found that the spectrum of the health care system has its weakest point in health education and prevention of illness.[7]

I believe that Illich's concepts of autonomy and responsibility can supply the ingredients necessary to strengthen health education and to prevent illness. Furthermore, I believe that the Proposed Changes in the Kansas Nurse Practice Act acknowledge the client's autonomy and responsibility with the following words:

> the practice of nursing as performed by a registered nurse... is a process in which substantial specialized knowledge derived from the biological, physical, and behavioral sciences is applied to: the care, treatment, counsel, and health teaching of persons who are experiencing changes in the normal health processes; or who require assistance in the maintenance of health or the prevention or management of illness, injury or infirmity or in the achievement of a dignified death....

The words "counsel" and "teaching" in their truest meaning imply a reciprocal relationship between client and registered nurse. A reciprocal relationship acknowledges both the client's and the registered nurse's autonomy and their responsibility to one another. The word "assistance" also implies a reciprocal relationship.

Health care is not the province of one profession. Although members of several

health-related professions may be involved in the provision of health care, entry into the health care system is generally sought through registered nurses and/or physicians. It is imperative that members of the professions of nursing, medicine, and dentistry work collaboratively. The words

> the practice of nursing as performed by a registered nurse...is a process in which substantial specialized knowledge...is applied to: ...the execution of the medical regimen as prescribed by a person licensed to practice medicine and surgery or a person licensed to practice dentistry....

acknowledge this need. The "execution of the medical regimen" may be accomplished collaboratively either in person, when a joint practice exists, or through protocols when the registered nurse and the physician are in separate locations.

Nurse mid-wives have been in existence in this country (the Frontier Nursing Service in Kentucky) since the mid 1920s. The nurse practitioner movement as we know it today was inaugurated by Lewis and Resnick in 1963 at the University of Kansas. Fourteen years have passed. A plethora of programs preparing nurse practitioners have arisen. Numerous studies have shown that nurse practitioners are well accepted by both physicians and clients. It is time to legitimize the role in this state. The words

> the practice of nursing as performed by a registered nurse... is a process in which substantial specialized knowledge...is applied to: ...the performance of additional acts requiring education and training which are recognized by the nursing profession as proper to be performed by a registered nurse, and such further functions as may be defined in the rules and regulations of the board not inconsistent with the provision of this act.

acknowledge the role as legitimate.

The purpose of a practice act is simply to protect the consumer; that is, to

give reasonable assurance that only properly qualified persons will provide the service in question. The proposed revisions supply such assurance.

A nurse practitioner program has existed at the University of Kansas since 1972. The majority of its graduates are practicing in the State of Kansas. The legislators in this state have supported the development of a Rural Nurse Practitioner Program in Hays under the auspices of the University of Kansas, School of Nursing. The Program is now in the planning stages and will be inaugurated in January 1978. Several registered nurses have already applied to the program. They are committed, dedicated people who wish to provide quality health care to consumers in rural Kansas.

In teaching nurse practitioner students at the Kansas City Campus, I emphasize the concepts of autonomy, responsibility, and collaboration. Additionally, students are exposed to these concepts in their clinical practice at the University. Once they have completed the program, many discover that constraints are placed upon practice because of the existing nurse practice act. The proposed revisions can alleviate this dilemma. As a practitioner and an educator, I heartily support the Proposed Changes in the Kansas Nurse Practice Act.

Respectfully submitted,

Marilyn A. Chard, R.N., B.S., Ed.M., M.S., Ed.D.
Associate Professor, School of Nursing
Assistant Professor, School of Medicine
Director of the Nurse Practitioner Program
University of Kansas, College of Health Sciences

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[1]Ivan Illich. Medical Nemesis: _The Expropriation of Health_ (New York: Pantheon Books, 1976), p. 7.

[2]_Ibid._, pp. 41-42.

[3]_Ibid._, p. 73.

[4]_Ibid._, pp. 219-220.

[5]_Ibid._, pp. 274-275.

[6]Jerome P. Lysaught. "Distributive Health Care Needs and the Occupational Health Nurse," _Occupational Health Nursing_, XX (November 1972), 8-9.

[7]Cambridge Research Institute for U.S. Department of Health, Education, and Welfare. _Trends Affecting the U.S. Health Care System_, Washington, D.C.: U.S. Government Printing Office, 1976, p. 263.

Attachment P

Martha Shawver, R.N.
College of Health Related Professions
Wichita State University

I am pleased to have been asked to speak before this committee as a representative from the College of Health Related Professions at Wichita State University and more specifically as a representative from one of the state's largest baccaleaureate and masters nursing programs.

Our efforts to academically prepare students to meet the health needs of people in Kansas is not a task that we can perform independently. We must be in continuous dialogue, seeking mutual support from our colleagues and from our legislators. To prepare students in such a way that they meet the needs of the people and remain within the confines of the law sometimes is very difficult. Change does not come easy. But neither should change for the sake of the good of the people be stifled by outdated laws, as I am sure you will all agree. Someone has said that laws follow the changes in practice. In other words, practice proceeds law. This fact bears true again as we look at the current Nurse Practices Act.

The current Nurse Practices Act could best be described as fragmented and incomplete in its definition of nursing practice. It does not describe "who the nurse is" - except through registration - nor does it cover the scope of nursing practice as has been established by the national accrediting agency, National League of Nursing. It uses terms such as "diagnosis and prescription of corrective treatment" to describe what nursing is not, when in actuality nursing does these things.

I recognize that describing "who the nurse is" in Kansas might be quite difficult. For some reason, we have a difficult time getting away from the notion that "a nurse is a nurse is a nurse". In practice we are just beginning to recognize the differences in nursing preparation. We may have not advanced so far as to recognize this with dollars, but we do recognize it in the types of positions and advancement opportunities that are offered to nurses with bachelors or masters preparation. Should the Nurse Practices Act distinguish in any way those nurses who are prepared on a technical and professional level basically as well as those who receive advanced preparation, i.e. on a masters level? Certainly preparation and function are different. The deliberate omission of these distinctions may be necessary because nurses themselves have perhaps a great deal of difficulty in identifying the differences. However, I personally would support the inclusion of differences in training and educational preparation.

My second criticism is that the Nurse Practices Act does not describe the scope in which nurses perform or practice. I thought perhaps it would be useful to this committee to describe what the graduate from any baccalaureate program should be able to do. (See attachment 1)

Atch. P

If Kansas nurses were to follow the present Nurse Practices Act, it is not difficult to see that baccalaureate and masters prepared nurses, if practicing in a manner in which they are prepared, would obviously be quite unlawful. "The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or correctional measures" would negate a large portion of nursing practice.

Nurses make diagnoses continuously. We teach students to assess and then prescribe nursing measures. For example: A postoperative cholecystectomy patient complains of pain and asks for medication. The nurse goes into the room and assesses the patient to determine the nature of the pain and finds that the pain is in the calf of the right leg. She touches the leg and finds it is warm to touch and very tender. She instructs the patient to remain in bed with the leg flat or slightly elevated and explains why. She calls the physician immediately. She has diagnosed according to Webster's definition of diagnosis - tenderness, pain and redness in leg. She has prescribed - stay in bed with leg flat or elevated. Under the current Nurse Practices Act she would be allowed to do little more than observe the problem and give pain medication that was prescribed by the physician.

The proposed changes are, I believe, an attempt to "clean up" the previous act. I can live with the proposed changes. I believe it has at least deleted a very obvious erroneous or obsolete statement and has relocated or rephrased some rather clumsily written statements.

I would suggest the following wording or concept: "a process in which knowledge which has been derived from the biological, physical and behavioral sciences is synthesized and used to develop nursing knowledge which is then applied to:". I would also suggest the inclusion of the concept that the services listed are provided to individuals, families and communities.

I support dropping "professional" until such time as we may wish to make a distinction in the law between technical and professional nurses and until such time as we have separate licensing exams to aid us eliminate the confusion that currently exists in our practice discipline.

Attachment 1

CHARACTERISTICS OF BACCALAUREATE EDUCATION IN NURSING

The baccalaureate program in nursing, which is offered by an institution of higher education, provides students with an opportunity to acquire (1) knowledge of the developing theories and practices of nursing; (2) knowledge of the broad function the profession is expected to perform in society; (3) competency in selecting, synthesizing, and applying relevant information from various disciplines; (4) competency in collaborating with members of other disciplines and with consumers; (5) ability to assess nursing needs and provide nursing intervention; (6) ability to evaluate current practices and try new approaches; and (7) a foundation for graduate study in nursing.

The structure of the baccalaureate degree in nursing usually follows the same pattern as that of baccalaureate education in general. It is characterized by two divisions of knowledge: lower division and upper division. The lower division consists of basic first-level courses that require no previous study. The upper division is reserved for concentrated study in the professional nursing major. Upper division also includes courses that complement nursing or increase the depth of general education.

In line with the above, the graduate of a baccalaureate program in nursing will be able to:

1. Assess health status and health potential; plan, implement, and evaluate nursing care in concert with clients–individuals, families, and communities.
2. Utilize theoretical and empirical knowledge from the physical and behavioral sciences and the humanities as a source for making nursing practice decisions.
3. Utilize decision-making theories in determining care plans, designs, or interventions for achieving comprehensive nursing goals.
4. Utilize nursing interventions as hypotheses to be tested; anticipate a variety of consequences and make predictions; and select and evaluate the effectiveness of alternative approaches.
5. Accept individual responsibility and accountability for nursing interventions and their results.
6. Use nursing practice as a means of gathering data for refining and extending nursing science.
7. Share in the responsibility for the health and welfare of all people with citizens and colleagues on the interdisciplinary health team by collaborating, coordinating, and consulting with them.
8. Assist in implementing change to improve delivery of health care.
9. Understand present and emerging roles of the professional nurse.

Nurses prepared at the baccalaureate level provide within the health care system a vital, dynamic, evolving service that maintains and promotes the health of individuals and groups. Nurses prepared at the baccalaureate level are progressing toward acceptance of a greater share of responsibility in the provision of health care services, toward development of more productive methods of working interdependently with other health care professionals, toward realizing a broadened scope of practice, toward greater independence as practitioners, and toward acceptance of the advocacy role in relation to clients. They practice in a variety of health care settings and emphasize comprehensive health care, including preventive and rehabilitative services, health counseling and education, and care in acute and long-term illness, in culturally acceptable ways.

Professional nursing programs provide the general and professional education essential for understanding man and his environment and for promoting self-understanding, personal fulfillment, and motivation for continual learning.

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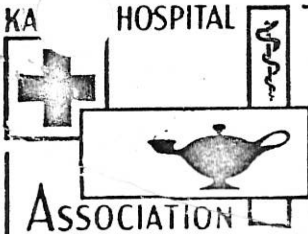
Attachment Q



MEMORANDUM

Frank L. Gentry
President

September 21, 1977

TO: Special Committee on Public Health & Welfare

FROM: Virginia C. Will, R.N., Assoc. Director of Education, Kansas Hospital Association

SUBJECT: PROPOSED CHANGES IN THE KANSAS NURSE PRACTICE ACT

We received a copy of the proposed changes in the Kansas Nurse Practice Act last week. This brief period of time has not permitted us to conduct a thorough review of the proposed changes.

Since over one-half of the registered nurses currently licensed in Kansas are employed by hospitals,* the proposed changes within the Nurse Practice Act may have a decided impact upon hospitals.

We plan to have the proposed changes in the Kansas Nurse Practice Act reviewed by two of our allied organizations, i.e., Kansas Society of Nursing Service Directors and the Kansas Association of Hospital Schools of Nursing, in October and possibly present recommendations to the Kansas Hospital Association Board of Directors in November. Consequently, we do not have an official response at this time, but will be able to present an official KHA statement the latter part of November.

VCW:dh

* 15,007 - Currently licensed in Kansas
7,722 - employed by hospitals

Source: June 30, 1977, statistics from the Kansas State Board of Nursing

1263 Topeka Ave. • Box 417 • Topeka, Ks. 66601 • 913/233-7436

Atch. Q

Attachment R

21/77

WICHITA STATE UNIVERSITY
(316) 689-3605
WICHITA, KANSAS 67208

NURSE CLINICIAN PROGRAM
COLLEGE OF HEALTH RELATED PROFESSIONS
BOX 43

Chairman and members of the committee:

Thank you for this opportunity to present to the ~~Interim~~ Special Committee on Public Health and Welfare with regard to the proposed legislation concerning the Kansas Nurse Practice Act. My name is Carla Lee and I am the Chairperson of the Nurse Clinician Department of the College of Health Related Professions at the Wichita State University.

As you all know, nursing has historically been expanding its role in service to society and especially when there has been a time of crisis. History is replete with examples, such as the creation of the Nurse Corps with national wars. Earlier examples before the specific use of the term "Nurse Practitioner" in the 1960's and 1970's have been nurses in the Frontier Nursing Service, providing health care when there were no physicians, nurse midwives; and community health nurses, the latter two at various stages being certified.

The creation of the first nurse practitioner program in Colorada and the first physician's assistant program in North Carolina in the mid-60's were both respones to a national maldistribution crisis of physician supply as well as the lack of sufficient availabilty and accessibility of primary health care services.

Thus states in which this was a particular problem, such as Kansas, through the Kansas Regional Medical Program the Nurse Clinician Program was instituted to enhance the availability of primary care servies and to extend the services being provided by the health teamin an interdependent way. This concept included building upon the registered professional nurses' knowledges and skills to expand as well as extend such to provide additional services in a complementary, collaborative way to those of the medical team as well as selected assistance in designated extended tasks.
Examples of the expanded skills include health histories, client teaching, health maintenance and continuity of care programs, of course not limited to these.
Examples of extended functions, as currently being utilized, include physical examinations making initial assessments, ordering selected diagnostic tests, managing patients with selected medical and nursing problems by the use of collaboratively-developed protocol.

The expanded services are the responsibility of the registered professional nurse as a part of being accountable in professional practice. The extended services are provided under the direction of a physician by established protocol.

Thus, as many of us know, the current Nurse Practice Act and the definitionof professional nursing lacks conteet dealing with expanded practice and actually possesses a deterant in terms of the use of the disclaimer, "the foregoing shall not be deemed to include acts of diagnosis or prescription of therapuetic or corrective measures." The understanding of this has been interpreted to mean acts of medical diagnosis and prescription. Nurses have historically, as does the lay public, practice forms of diagnosis (not medical). With the statement earlier in the act that speaks to administration of medications and treatments as prescribed by a person liscensed to practice medicine and surgery or a person licensed to practice dentistry, it seems reasonable to support the proposed new definition with regard to the removal of the disclaimer or at least specification of medical diagnosis and treatment.

Atch. R

I also find it reasonable to incorporate the use of the "additional acts" amendment. These additional acts must of course be based upon formal educational preparation and agree upon formally by the profession. Thus I would support this section, "the performance of additional acts requiring education ~~and training~~ which are recognized by the nursing profession as proper to be performed by registered nurses. I would suggest the following: further functions related to expanded functions as shall be defined in the rules and regulations of the board not inconsistent with the provisions of this act.

The additional acts amendment has been adopted by 17 states and has generally been added to the traditional form of the definition of nursing. This technique has then typically allowed other sources, such as the rules and regulations, to be issued by the designated administrative boards, preferably the board of nursing.

This entire amendment is generally made applicable only to nurses with "education and training", presumably in addition to that required for all professional nurses. I would support such an approach for Kansas in that for future use, it would not require revising the nurse practice act as practice evolves. It would also add protection for the public in that specific rules and regulations can be weitten that deal with accreditation of expanded role programs, such as midwifery, nurse anethesists, nurse practitioner/ clinician and clinical nurse specialists (master's -prepared). Also, specific rules and regulations can be developed as to the formal credentialling of expanded role nurses, such as by graduation from a formal nurse practitioner program or its equivalent, certification, or testing), whatever systems are found most applicable to the situation both in preparation for functioning and the specific roles and functions. Of the latter, the most fruitful approach according to Kissam (University of Kansas), has been not to attempt to deal substantively with the content of nursing practice, but to incorporate a criterion of legality, such as professional opinion, which can be relied upon to delimit the scope of nursing practice (expanded and extended--my parenthesis) in a meaningful, responsible way.

I hope this information provided will prove helpful. It is essential that the nurse pract act, from my perspective, be updated to be in pace with the practice, and particular with expanded role nurses and nursing, with the knowledge that expanded role nurses have been being prepared formally in this state for at least 7 years. The nurses have been supported in such growth by themselves, physicians, and others to provide both increased quality and quantity of services delivered in particularly rural settings. Research out of the Wichita program and also that conducted nationally show much support to the expansion of nurses'roles in order that more comprehensive care (all levels) can be rendered by an efficiently and effectively-functioning health team.

Again, thank you for this opportunity to present my beliefs on this important matter to this important committee that can very much determine the future functioning of professional nurses.