Approved 4-7-83
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin Littlejohn at
Chairperson

1:30 ~~a.m.~~/p.m. on March 22, 1983 in room 423-S of the Capitol.

All members were present except: Rep. Spaniol, excused

Committee staff present: Emalene Correll, Research Department
Bill Wolff, Research Department
Bruce Hurd, Revisor's Office
Sue Hill, Secretary to Committee

Conferees appearing before the committee:

Visitor's register, see (Attachment No. 1.)

Mr. Dick Morrissey, Health and Environment
Mr. Dick Hummel, Kansas Health Care Association
Ms. Lynelle King, Ks. State Nurses' Association
Ms. Anne Baker, Attorney for Ks. State Nurses' Assoc.
Ms. Lenora Roe, Emporia City Commission and Bd. of Health
Evelyn Smith, Conference Group on Advanced Practice of KSNA
Dr. Lois Scibetta, Executive Administrator of Ks. State Bd. of Nursing
Dr. Josie Norris, practicing physician in Topeka, Ks.
Joan Denny, Certified Nurse Mid-Wife
Ginger Haynes, newly certified Nurse Mid-Wife
Reva C. Friedman, Lawrence, consumer.
Ms. Audrey Kennedy, Health Systems Agency of Northeast Kansas
Jerry Slaughter, Kansas Medical Society
J. A. Gleason, M. D., Topeka, Ks.

Chairman called meeting to order.

Chairman requested Staff to highlight SB 10 for committee. Ms. Correll comprehensively briefed this bill, calling attention to several specifics. i.e.- "persons' is a defined term in lines 33 and 34.

Mr. Dick Morrissey, Department of Health and Environment distributed printed statement, see (Attachment No. 2.) for details. Mr. Morrissey stated there are times that a buy, lease, sub-lease, and other transactions of Nursing Care homes can occur all in the same day, or two or three days, and many many individuals are involved. This is not representative of the majority in this industry, but is a problem, and a ruling on this is needed, and SB 10 addresses itself to this problem.

They are requesting limiting number of ownership operation to three, (3). It is an arbitrary number. This will assist in identifying key decision makers operating a home and will facilitate action to enforce licensing standards when necessary. Mr. Morrissey stated his Department strongly endorses SB 10 and urges committee to report the bill favorably.

Mr. Dick Hummel of Kansas Health Care Association spoke to the concern of the necessity of the bill, and the questions of whether it is necessary, and will it solve problems it is addressing. Feels SB 10 is unnecessary. Feels that if a facility knows and understands its responsibilities, and continues to openly and flagrantly violate standards, enforcement action should be swift and just. (See attachment No. 3.) for details.

Hearings on SB 10 concluded.

Briefing on SB 13 by Emalene Correll to committee members.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on March 22, 1983

Hearings on SB 13 began:

Ms. Lynelle King, Kansas State Nurses' Assoc. presented her printed statement to committee. See (Attachment No. 4.) for details. She gave a lengthy statement on the position of KSNA, urging to strike lines 83 through 87, and then to report SB 13 favorably as amended, thus approving SB 13 in the form it was drafted and approved by the 1982 Interim committee.

Ms. Anne Baker, Attorney for Ks. State Nurses' Association gave printed testimony to committee. See (Attachment No. 5.) for details. Ms. Baker touched on legal issues on SB 13, and some specifics in certain sections. In summary, commented on the proposed amendment in lines 83 through 87 suffer from debilitating ambiguities, and feels this amendment may impede the development of this policy, possibly provoking more litigation.

Ms. Lenora Roe, Emporia City Commission and on City Board of Health there. Stated her interest in containing health care costs. Also favors ARNP's having broader latitutde, and sees a great and growing need for this in rural areas of Kansas.

Ms. Evelyn Smith, Chairperson of Conference Group on Advanced Practice of KSNA, presented testimony to committee, see (Attachment No. 6.) for details. She stated Nurse Practitioners are very anxious to put this issue to rest without further negotiations. Feels SB 13 is a good bill, but recommended passage of it without the amendment.

Dr. Lois Scibetta, see (Attachment No. 7.) for details of her statement. She stated the Board of Nursing supports this bill, but a first choice would have been for the amendment not to be added. However, the State Board of Nursing will not oppose the bill as amended. The Board continues to support the concept of Advanced Practice and would urge the committee to support SB 13 favorably.

(Attachment No. 8.) given to committee by Dr. Scibetta this date as a good document for future reference.

Dr. Josie Norris, practicing physician in Topeka, stated that Kansas is a prototype in many areas in the health field, however, is the very last state to have regulations to qualify Nurse Mid-Wives to practice. She is hoping for acceptable wording to please everyone. Nurse/physician alliance is vital, and she would like to see licensing of practicing nurse mid-wives.

Ms. Joan Denny, Certified Nurse Mid-wife gave printed statement to committee. (See Attachment No. 09.) for details. It is important she stated, to give legal support to all practicing advanced nurse practitioners. Feels the amendment added does nothing to clarify the bill, and requests support of SB 13 without the amendment.

Ms. Ginger Haynes, gave printed testimony but in the interest of time, made only brief comments, and asked the committee please read her statement. She is a newly Certified Nurse Mid-Wife, awaiting being recognized as such by the Kansas State Board of Nursing. See (Attachment No. 10.) for details.

Mrs. Reva C. Friedman testified as a consumer supporting the philosophy that encourages Nurse Mid-Wifery in Kansas. Mrs. Friedman had her infant daughter with her as she spoke.

Ms. Audrey Kennedy, HSANEK, (Health Systems Agency of Northeast Kansas) spoke from printed testimony. See (Attachment No. 11.) for details. Speaking to three specifics, availability of appropriate manpower, quality of health care delivery, and health care costs, Mrs. Kennedy stated the HSANEK strongly supports the passage of SB 13 without any amendments.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m./~~p.m. on March 22, 1983

Hearings continue on SB 13:--

Jerry Slaughter distributed printed testimony to committee. See (Attachment No. 12.) for details. Basic concern is the role of the ARNP in gray areas, between nursing and medicine. Would like this concept clearly stated in the statutes and not delegated to a non-legislative body, i.e.- The Board of Nursing. The Senate amendment is essentially all that is needed, except the Kansas Medical Society wishes to suggest inserting following language in (d); an Advanced Registered Nurse Practitioner may also perform delegated medical functions within the context of a physician-directed health care team, and according to written protocols between a person licensed to practice medicine and surgery and the Advanced Registered Nurse Practitioner. Mr. Slaughter asked committee to support this amendment, further saying, if it stays in the bill the Kansas Medical Society can support its favorable consideration. If not, they must oppose SB 13.

J. A. Gleason, M.D., a Topeka Obstetrician, stated the basic issue here is to have a team approach and work under written protocol situations. We are for ARNP's he said, but are also concerned about gray areas, and feel a position is needed to address this problem.

Printed statement from John E. Harvey, M.D. was handed to members of committee, as Dr. Harvey was unable to present his testimony in person. See (Attachment No. 13.) for details.

Chairman adjourned meeting at 3:15 p.m. Next scheduled meeting will be at 1:00 p.m., rather than usual scheduled time, on March 23, 1983.

Date: 3-22-83

GUEST REGISTER

HOUSE

Please Print

PUBLIC HEALTH AND WELFARE

182

NAME	ORGANIZATION	ADDRESS
Dr. Lois Rich Sibelius	KSBN	503 Kansas Ave.
Evelyn J Smith	KSNA	944 Peterson Wichita Ks 67212
Anne L. Baker	Attorney for KSNA	1300 Merchants Bldg.
Lynne Ley Lagi	KSNA	Topeka
Leonore Lowe	—	828 Market, Emporia.
Ruth Wilbur	S-S	Topeka
Ruth Frederick	American Association of University Professors	Topeka
Guillermo Barreto Vega	HSANEK	Topeka
Audrey H Kennedy	HSANEK -	Topeka -
Keith R Landis	Christian Science Committee on Publication for Kansas	Topeka
Karen Shectman	—	Topeka
Michele Hinds	Legislative Intern	Topeka
Nickie Stein	Ks St. Nurses' Assn.	Topeka
Loretta Teagarden		La Cygne
Hugo Spiker		Chanute
Glen Wicker	Farm Bureau	Chanute Ks.
Josie Norris, MD	Holistic Birth + Growth Center	Topeka, Ks
Margo Haynes cnm	"	"
Jean Denney cnm	"	"
Harold Lienow	Ks Assn Osteopathic Med	"

(attachment no. 1.)

Date: 3-22-83

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE

NAME	ORGANIZATION	ADDRESS
Ken Schafermeyer	KS Pharmacists Association	Topeka
Dick Hummel	KS Health Care Assn	Topeka
[illegible]	KMS	Topeka
J. A. Pearson MD	KMS	
Heather L Hull	Nursing + Junior Longmont Wichita	Wichita
Cathy Beham	AP	
Rena C. Friedman	—	Lawrence

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KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON SENATE BILL NO. 10

PRESENTED MARCH 22, 1983

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

This is the official position taken by the Kansas Department of Health and Environment on Senate Bill No. 10.

NEED FOR:

This bill constitutes a key step in assuring that the persons (as defined in KSA 39-923(a)(12)) who own and operate adult care homes are concerned and accountable with how those homes are operated. Last year the legislature passed Senate Bill No. 902 specifying that persons who own, lease, establish, maintain, conduct the affairs of or manage an adult care home are engaged in operating the home and thus must be parties to the license. Where numerous persons are involved in the operation of the home, it may still be difficult to hold them accountable for the quality of care provided in the home.

STRENGTHS:

Senate Bill No. 10 would limit the number of persons who may be licensed to operate an adult care home to three. This will assist the department in identifying the key decision makers concerning the operation of a home and will facilitate action to enforce licensing standards when necessary. Since existing arrangements with more than three persons involved are grandfathered by the bill, their economic and contractual interests are protected.

WEAKNESSES:

The department sees no apparent weaknesses in the bill.

DEPARTMENT'S POSITION:

The Department of Health and Environment strongly endorses Senate Bill No. 10 and urges the committee to report the bill favorably.

PRESENTED BY: Richard J. Morrissey, Director
Office of Health Facilities
Department of Health and Environment

(attachment no. 2.)

Kansas Health Care Association
Member of ahca

TESTIMONY BEFORE THE HOUSE COMMITTEE
ON PUBLIC HEALTH AND WELFARE

By
Dick Hummel, Executive Director

March 22, 1983

SB 10 AMENDED

"AN ACT concerning adult care homes; limiting the number of persons licensed to operate certain adult care homes."

Mr. Chairman and Committee Members:

On behalf of the Kansas Health Care Association; a voluntary, non-profit organization representing over 200 licensed adult care homes as well as hospital based long term care units in Kansas, both proprietary and non-proprietary, thank you for this opportunity to appear on SB 10.

We have concern both with its necessity and its implications and question whether or not the bill will actually solve the limited problem it is addressing.

The purpose of SB 10 is to afford the agency a greater handle of accountability on a random few nursing home owners and operators. We understand that the agency has had a problem, limited in scope, in this area recently.

We neither quibble with accountability, nor that nursing homes be held responsible for providing safe, comfortable and appropriate care to our state's 26,000 nursing home residents.

The department has had for sometime now in its enforcement arsenal police power sanctions which can be applied against any recalcitrant nursing home: the issuance of correction orders and assessment of monetary fines, receivership authority to actually take over the operation of a facility, and the power to deny or revoke a license.

It is argued that the bill is needed because the department has had, again in isolated instances, difficulty in identifying the various parties in the nursing home ownership-management hierarchy.

Note that the provisions of SB 902, requested last year by the department which became effective January 1, 1983, require all persons involved with the operation of an adult care home to be identified and to be a signator

(Attachment No. 3.)

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on the adult care home licensure application.

Based upon these two points alone we don't believe the bill is necessary.

The broad implications and questionable constitutionality of the bill are also of concern. Why were three persons, not four or five chosen? Can the government limit the rights of individuals to own and hold property?

Our premise is that SB 10 is unnecessary; if accountability is the issue, hold the agency responsible for the proper exercise of its enforcement duties. Our position has been that if a facility knows and understands its responsibilities, and continues to openly and flagrantly violate the standards, enforcement action should be swift and just.

I would be happy to respond to any questions at this time.

KSNA

the voice of Nursing in Kansas

Statement of Kansas State Nurses' Association
by Lynelle King, R.N., M.S., Executive Director
before the House Public Health and Welfare Committee
March 22, 1983

In support of S.B. 13 ARNPs as Approved by Interim Committee - Opposing Amendment

Mr. Chairman and members of the Committee, S.B. 13 simply authorizes in law what has been the accepted practice of advanced nurses in Kansas and the U.S. for many years (see list on page 2)

S.B. 13 was developed by the 1982 interim Public Health and Welfare Committee to take care of the constitutional issue identified by the district court, which had pointed out a flaw in the 1978 ARNP statute. Our attorney assures us that S.B. 13 does take care of the constitutional issue, and she will speak to that in a few moments.

To summarize KSNA's position: we urgently request that this committee: strike lines 83-87 and then report S.B. 13 favorably as amended, thus approving S.B. 13 in the form it was drafted and approved by the 1982 interim Public Health and Welfare Committee.

To make that decision you need some information. Mrs. Correll is incomparable in outlining this issue thoroughly but succinctly. Absent her excellent verbal explanation I will give a capsule update to the best of my ability in the few moments we have.

In the past fifty years the health care needs of consumers have changed. At the turn of the century, doctors and nurses devoted their energies to treating and containing communicable diseases. Improved public health measures and the discovery of antibiotics drastically changed the character of disease in our country. The leading causes of illness and death today, which include heart attack, cancer, stroke, hypertension, diabetes, and auto accidents, are directly related to life style. Many of these illnesses can be prevented and/or controlled by health education, a role which nurses have always assumed, and which ARNP have advanced skills in.

A maldistribution of health care providers exists and access to health care is limited in rural and urban inner city areas. One solution has been the increased use of ARNPs in those underserved areas.

The escalating cost of health care demands a change of focus in the entire system. Nursing, which has a focus of health and wellness, is in a key position to facilitate the change and has always been willing to adapt its role to society's changing needs and demands.

More than 600 studies have shown the beneficial health effects of ARNPs. They have been shown to reduce as much as 50% the patient's need for hospitalization and to most successfully assist in controlling chronic illness such as diabetes and high blood pressure. (Journal of the American Medical Association, January 20, 1975) Good physician acceptance and patient acceptance of ARNP, health effectiveness and cost effectiveness were shown by a study reported in the Journal of the Kansas Medical Society, December, 1976 (See attached)

(attachment no. 4.)

Kansas State Nurses Association • 820 Quincy • Topeka, Kansas 66612 • (913) 233-8638
Carolyn K. Vath, R.N., M.S. — *President* • Lynelle King, R.N., M.S. — *Executive Director*

Two brief examples of ARNP functioning in Kansas:

- In Larned at the Pawnee County Health Department, Director of Nursing Barbara Hammond felt the need of further education so she could better help with the clinical care of patients who look to the health department for their service. (She reports that physicians are at the health department approximately 1 day a month.) She attended the nurse practitioner program at Hays, which is an outreach of K.U. Now she is back at the Larned Health Department, and with the back-up of the local health officer who is available by phone, she follows the progress of well children, conducts a V.D. clinic and goes out into the homes - in the home care program - to assess the health problems of people as needed. She says that her visits are very cost-effective because otherwise the home health service would have had to send the patient by ambulance to an emergency room for an assessment of their problem. They often won't have to go to the hospital, can be taken care of at home, after Barbara's assessment.

- At KUMC Clinical Nurse Specialist Joyce Olson, R.N., M.S. functions as coordinator of care of children born with the complex, crippling birth defect called Myelomeningocele. Many physicians are involved in managing multiple medical problems of these children, she says, thus "care becomes fragmented as 'parts of problems' are managed and the child and family are lost in the maze of the health care system." As the nurse coordinator of the team she interprets the many aspects of the care to the family and answers questions and coordinates care as the child grows. "It is a process of helping the child and family live with the disability and function maximally," she says. She also provides such coordination and teaching to diabetic children and their families.

Advanced Registered Nurse Practitioners include the following categories in Kansas, which are listed according to the approximate time they began functioning in Kansas:

1940s - Certified Nurse Anesthetist - (R.N.s with advanced education/training in anesthesia)
1960s - Clinical Nurse Specialists - (R.N.s with Masters Degrees, specialization and advanced expertise in a clinical specialty - e.g. gerontology)
1971 - Nurse Practitioner - (also known as nurse clinician) - R.N. with experience in nursing before taking advanced education/training in assessing and managing health problems) Subcategories include: pediatric nurse Pract., Family nurse practitioner, etc
1981 - Certified Nurse Midwife - (R.N. with advanced education/training - often Masters Degree - who specializes in the management of normal pregnancy, normal labor and delivery and follow-up)(Nurse Midwives have been functioning in some parts of the U.S. for more than 50 years - including, Kentucky, New York, Massachusetts, Maryland)

Where They Are Educated in Kansas (Note: they are all at state-supported universities)

Certified Nurse Anesthesists - K.U. Medical Center
Clinical Nurse Specialists - Wichita State University and K.U. Medical Center
Nurse Practitioners/Nurse Clinicians - K.U. Outreach at Hays, K.U.M.C., W.S.U.
Nurse Midwife - no program in Kansas although WSU requested to have such a program some years ago. Geographically nearest program to prepare Nurse Midwives include: University of Colorado, St. Louis University, University of Illinois. There are about 24 such programs in the U.S.

Where they are working:

- Community Health Clinics, especially rural and inner city
- Hospitals and Nursing Homes
- Private offices with a physician or a group of physicians
- Home health
- Clinics and out-patient departments and emergency rooms
- 50% of the anesthesia given in Kansas is given by nurse anesthesists, both in rural and urban hospitals.

The Federal government has long urged education and further use of ARNPs as a cost-effective and health-effective measure. Beginning in the Nixon administration funds for the education of ARNPs have been appropriated yearly. Beginning in 1981, the federal government gives priority to nurse-midwife students when awarding nursing traineeships. The Federal government has taken its own advice: the Air Force, and most other branches of the military and the Indian Health Service make extensive use of ARNPs. The Federal Employee Health Benefits Program and CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) encourage their use.

Nationwide, more than 35 states have enacted statutes to authorize ARNPs and we know of no state in which they are not practicing. In fact Kansas is the only state in the U.S. where Nurse Midwives presently cannot practice (they were able to work in Kansas only due to the former statute and regulations which were struck down on a technicality)

Some chronology of the Kansas ARNP legislation

1977 - an interim committee of the legislature recommended that a statute be enacted to authorize in law the ARNP.
1978 - the ARNP statute was passed by the Kansas legislature - the vote was unanimous in the House.
- there began a long process of drafting regulations for the ARNP
1980 - temporary regulations were promulgated by the Board of Nursing.
1981 - Amended regulations for the ARNP became permanent on May 1, 1981. Through the regs. process the legislature had been involved, and changes in the regs were made by the Board of Nursing at the direction of the legislature.
1982 - June, the Shawnee District Court found the 1978 statute unconstitutional, due to its not giving sufficient guidelines to the Board of Nursing (our attorney will report on this.)

As a result of the court action, the Legislative Coordinating Council in the summer of 1982 assigned to the interim Public Health and Welfare Committee Proposal No. 37, directing that they develop a new ARNP statute to satisfy the constitutional issue.

November, 1982 the interim PH&W Committee drafted S.B. 13 and made the following recommendation, found on page 569 of the 1982 Interim Studies:

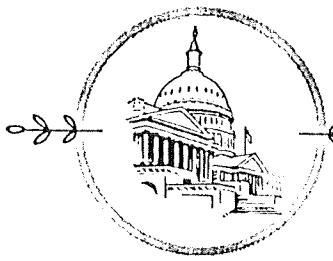
> "The Committee recommends that the 1983 Legislature enact S.B. 13 in order that those registered nurses who have received advanced education or training may be restored to practice as ARNPs and the constitutional issue identified by the district court may be resolved. In making this recommendation the Committee is aware that S.B. 13 does not resolve the position of the Kansas Medical Society that the advanced registered nurse statutes should clarify the relationship between physicians and the practice of advanced registered nurse practitioners. However, this issue, which has reoccurred in the years since 1978 when the ARNP statutes were first enacted, is one which representatives of the Medical Society the Kansas State Nurses' Association, and the Board of Nursing were unable to resolve in a manner satisfactory to all parties and to the Committee."

Why KSNA supports S.B. 13 but opposes the amendment (lines 83-87): Our Attorney will speak more in depth to the legal issues. Practical issues include:

1. It contains several inflammatory phrases and undefined terms which will just continue the unfortunate controversy for more years - involving the legislature again - in the regulations process.
2. Nurse midwives have lost their jobs or left the state due to not being able to practice. So long as the controversy goes on - through this amendment - they will not be able to practice in this state.
3. Places a cloud over the ARNP training programs in Kansas (see list above)
4. Places a cloud over the practice of ARNPs in Kansas - so long as the controversy continues and regulations are not finalized.
5. Places additional unnecessary complicated regulation over the ARNP. The ARNP role is already controlled and standards assured in the following ways if SB13 passes
   a. must be a licensed R.N. in Kansas
   b. must have completed a course at an approved school for ARNPs
   c. must have passed national examinations and become nationally certified (e.g. Certified Nurse Midwife - certified by the American College of Nurse Midwives, etc)
   d. must practice within appropriate scope of practice and other standards of R.N.s - KAR 60-3-110 - cause for discipline or loss of license if go beyond scope as appropriate to training etc.
   e. regulations for ARNPs will (ones in the past did) spell out training, certification, scope of practice, etc
   f. must meet continuing education requirements every two years as approved by SBN
   g. Healing Arts Board already has authority to prosecute anyone who practices medicine without a license
   h. Healing Arts Act already allows M.D.s to delegate to RNs or others
   i. current Nurse Practice Act allows RNs (which of course includes ARNPs) to execute the medical regimen as prescribed by a physician (KSA 65-1113 (d)(1).

The interim public health and welfare committee had many more hours than this committee has to consider this issue. They met on several occasions and had many hours of testimony and discussion. In the end, they rejected language very similar to what is in the amendment on lines 83-87.

We urge you to concur with the Interim PH&W Committee and pass S.B. 13 after striking the amendment on lines 83-87. Thank you for your patience and consideration. We will be happy to answer any questions.



Socio-
ECONOMICS

Nurse Clinician

GERALDINE C. HOLMES, Ph.D. *and*
RITA E. BASSETT, *Kansas City, Kansas*

Results of 1973 and 1975 interview studies of participants in the nurse clinician training program at the Wichita State University-KUMC Branch are reported. Findings from literature reviews and the first productivity case studies are summarized.

SHORTAGE of primary care physicians in rural Kansas and the uneven access to primary care services throughout the state was one of the problems identified by the Kansas Regional Medical Program during its early years of operation. This problem was studied, and several projects were initiated to remedy it. One of the most successful has been the use of physician extenders in private office practices which are located in medically underserved areas.

In 1971, primary care physicians in Kansas were asked if they would be willing to employ a physician extender in their practice, and if so, what type of training these individuals would need in order to work effectively in a new role.[1] On the basis of information received from this survey and consultation with many people in medicine and nursing, a program was developed for training experienced nurses to work as primary care nurse clinicians in ambulatory health care settings. The program was reviewed and approved by a committee of professional experts, by the Regional Advisory Council of the Kansas Regional Medical Program, and by the Division of Regional Medical Programs in Washington.

The Nurse Clinician Training Program was started in January 1972, in Kansas City, at the University of Kansas Medical Center. However, following core training for the first class, the program was transferred to the Wichita State University Branch of KUMC, because an alternative training program for nurse clinicians was developed at KUMC.

The course includes a two-month didactic phase, during which time students reside in Wichita, followed by a ten-month preceptorship with a sponsoring physician. By November 1975, 72 nurse clinicians had completed the program and 34 others were in various stages of training. Of the total, 49 are employed in medically underserved areas of Kansas, 30 are employed in Wichita or other urban areas of the state, 27 are working in other states. Eighty per cent of those employed in Kansas serve in private group or solo practices.

There has been a great deal of interest in the state and nationally in learning more about the participants in the program and the experiences of nurse clinicians in private practice settings. Therefore, the staff of the Kansas Regional Medical Program (KRMP) has conducted a series of studies to evaluate the effectiveness of the program. In spring 1973, a study of the working roles of the first 21 participants in this program was conducted. The motivation of nurses and physicians who had participated, the working roles of clinicians, and the perceived problems and benefits associated with their employment were studied. Concurrently, a systematic review of professional literature was initiated which has

From the Department of Planning and Evaluation, Kansas Regional Medical Program.

focused on the utilization and productivity of physician extenders, the content of primary care practices, and the delivery of primary care services in the office practice setting. On the basis of these findings, a series of case studies to determine the impact of nurse clinicians on the productivity of office practices was initiated during summer of 1974. These case studies have been conducted in Kansas in two rural solo practices, a rural two-physician group practice, and a suburban solo practice.

Professional literature provides extensive evidence that patient acceptance of physician extenders has not been a significant problem. Ten studies conducted since 1967, demonstrate that physician extenders can manage selected types of patient problems equally well with physicians. Three studies indicate that the range of profit to physician employers of pediatric nurse practitioners is $2,500-$17,000 during the first year of employment.[2-4] A recent study of MEDEX shows a range of profit to physician employers of $12,840-$39,210 a year.[5] A 1972 study by Pondy[6] suggests that the role definition of a physician extender has substantial influence on productivity, and this study cites an actual increase of 9 per cent in the number of patient visits processed after the introduction of a physician assistant into a solo practice in North Carolina. The first productivity case study of a solo practice in Kansas indicates that 20 per cent of patient visits which would normally require the attention of a physician are being managed successfully by a nurse clinician, and she allows the physician to increase his productivity by approximately 12 per cent.

Nurse Clinicians in Kansas

Research evidence to date documents and describes some of the problems associated with being a nurse clinician and with employing one. It also provides a very strong argument that such individuals can and generally do make a very significant contribution to the practices and communities in which they are employed.

Interviews were conducted in April and May 1972, with the first 21 nurses who entered the program and their preceptors, or employers. In fall 1975, interviews were conducted with 44 more recent graduates and preceptees and 30 of their employers.

The 65 nurse clinicians interviewed ranged in age from 21 to 57 years (median age, 34). Prior to entering the program, they worked in nursing, 10 months to 33 years. The majority of the early graduates were employed as a nurse in private practice before entering the program, and were employed as nurse clinicians in the same practice following preceptorship. However, 20 of the more recent graduates were employed by hospitals before they entered the program. Most of the former hospital nurses are now employed in group or solo practices. At the time they were interviewed, 45 clinicians were employed in private medical practice, 10 in public health departments, 7 in hospital settings, and 2 in university health centers. One was not employed.

Two clinicians serve their communities from offices in which the physician is no longer present. One physician died, the other retired at the age of 70. Both of these clinicians work with sponsoring physicians located in towns about 20 miles distant. They work from standing orders, consult by telephone with the physicians, and refer patients whose problems are too complex for the clinicians to handle alone.

The first 21 graduates of the program were employed in Kansas after their preceptorship, and 16 of them have been working in small towns and communities which can be described as medically underserved. Many of the more recent graduates are also employed in rural Kansas communities. However, a sizable number of the more recent graduates have come from and returned to Wichita for employment.

The increase in students from Wichita has a direct relationship to the announced termination of the Regional Medical Programs by the federal government on June 30, 1976. The RMP staff in Kansas was reduced by 88 per cent in 1973. Since that time, it has not been possible for the staff to help significantly with the time-consuming and important task of recruiting qualified nurses and preceptors from medically underserved areas in Kansas. KRMP has funded the Nurse Clinician Training Program since its inception in 1972. In 1975, the State of Kansas assumed fiscal responsibility for core training in Wichita, and KRMP provided funds for the preceptorship phase. The program, in its present form, will require additional state funding to continue beyond 1976.

Interviews have been conducted with 49 Kansas physicians who have served as preceptors, and several of these individuals have participated in the training of more than one nurse clinician. All but two are in family practice, internal medicine, pediatrics, or general practice. One is a nephrologist at KUMC, who served as preceptor for a nurse nephrologist. The second is director of the Institute of Logopedics in Wichita. Preceptors have ranged in age from 30 to 57 years. However, most are between 40 and 55 years of age, and have been practicing medicine 10-20 years.

Role of Nurse Clinician

The role of the nurse clinician is varied, and is unique in some respect. However, a number of common tasks are carried out by most clinicians who work in primary care settings. The definition of a particular nurse clini-

cian's role appears to depend upon four factors: (1) the type of practice in which she is employed; (2) the philosophy and preferences of her employing physician; (3) her own abilities and wishes; and (4) the nature of patient care needs.

In the two-month didactic and clinical program at Wichita, nurse clinicians have received training relevant to the performance of 56 health care tasks. Fifty-two nurse clinicians have participated in the study of working roles and role change in relation to these tasks. This study revealed that all of the nurse clinicians working in a private practice perform physical assessments, determine the need for and order basic diagnostic tests on urine, make preliminary interpretation of basic diagnostic tests, and engage in patient education. About half are supervised to some extent when making preliminary interpretations of basic diagnostic tests. Otherwise, these tasks are performed independently by clinicians.

Most clinicians (75-98%) also perform the following tasks independently: (1) obtain and record patient histories; (2) conduct adult and child well-care physical examinations, including gynecological and breast examinations on women; (3) organize information for presentation to the physician; (4) make initial assessment of emergency cases; (5) educate patients in nutrition, special diets, and preventive and emergency measures for high-risk conditions; (6) determine the need for and order throat cultures as well as perform them; (7) perform visual screening procedures and immunizations; and (8) conduct pre and postnatal checkups, well-baby physicals, and child care education.

No direct supervision is required for the 40 per cent of the clinicians who perform audiometries, tonometries, and EKGs; 36 per cent apply casts; and 31 per cent report assisting in the operating room. As in the case of those doing minor suturing, most of these clinicians were formerly hospital nurses.

The other tasks that most clinicians perform (but in which more than 25% have supervision) are determining the need for and ordering x-rays, blood tests, assessing cardiac functions and venereal diseases. Most clinicians monitor and manage chronic problems such as diabetes, hypertension, obstructive lung disease, and arthritis. Approximately one half manage renal insufficiency with some physician supervision.

Between 50 and 75 per cent of the clinicians take histories, give physicals, and write progress reports on hospitalized patients; two thirds of the clinicians performing these tasks do so independently. Fifty-one per cent of the clinicians do minor suturing; fewer than 15 per cent of the clinicians administer anesthetics, manage uncomplicated deliveries, perform circumcisions, insert IUDs, or perform routine laboratory procedures.

Seventy-two per cent of the clinicians make house calls; 68 per cent make nursing home visits; 59 per cent make hospital visits with the physician, and most of these nurses also make rounds unaccompanied.

There are some tasks that clinicians are capable of performing but do not perform. Half of the physicians report that clinicians do not perform male genital examinations, do no suturing, and do not remove growths because of a fear that patients may not accept this service from anyone but a physician.

When comparing the group of nurse clinicians interviewed in 1973 with those interviewed in 1975, a shift in the percentage of clinicians performing certain kinds of tasks was observed. The more recently trained clinicians are taking more responsibility for monitoring and managing chronic illnesses. They are doing fewer of the time-consuming diagnostic tests *(i.e.,* x-rays, Denver Developmental Screening Tests, and EKGs) and less routine laboratory work. Pre and postnatal checkups are being done by 20 per cent fewer of the more recent graduates.

Most tasks presently performed by clinicians are tasks which they did not perform as registered nurses, and a majority perform at least 25 new health care duties. Most clinicians report that prior to training they did not take complete histories, perform physical examinations, make physical assessments, secure Pap smears, or order basic diagnostic tests. Such tasks now comprise a staple part of their responsibilities.

Some tasks nurse clinicians perform are not new; they are ordinarily assigned to registered nurses. For example, a majority of clinicians did and still do take x-rays, give immunizations, and provide education for patients in the use of prescribed medications. Only a few clinicians view patient education as a new function, but they have expanded the scope and depth of the education they provide.

Seventeen clinicians have reported a reduction in the kinds of routine nursing tasks they perform. Those most frequently deleted from the roles of nurse clinicians are taking routine temperatures and blood pressures, administering medications, and performing routine laboratory tests.

The nurse clinicians in this study provide many services to patients which previously required the attention of a physician. Some of these are provided independently, while others are provided with supervision and consultation of the physician. However, the amount of physician supervision required is reduced during the course of preceptorship and, therefore, the physician's time is freed for other patient care responsibilities. Frequently, performed tasks tend to be those which require less physician supervision. This finding is consistent with re-

sults of a study of physician's assistants in other states.[7]

The 65 nurse clinicians and 49 physicians interviewed were asked to state their reasons for participating in the program. Nurse clinicians gave six basic responses: (1) to acquire a more interesting and satisfying professional role; (2) to learn more about patient care; (3) to enhance professional status; (4) to comply with the request of an employing physician; (5) to meet a need for health care in a particular community; and (6) to make more money. The reasons most frequently cited were to engage in more interesting work and to learn more about patient care. A desire to increase income was given as a primary or secondary reason for entering the program by only 12 per cent of the clinicians interviewed.

Physicians gave three primary reasons for agreeing to serve as preceptors: (1) to provide better care for patients already served; (2) to reduce working hours; and (3) to serve a larger number of patients. Most physicians who have trained or employed nurse clinicians have done so to provide a better quality of care to their patients, whether by increasing services, out-of-office visits, or concentration on serious problems. Some have felt a need to provide health care services to new patients who were without a physician.

Twenty-two physicians cited a need to reduce their own working hours as a central reason for training and employing a nurse clinician. Even when this reason was the sole one, the implication was clear that physicians felt unable to reduce time spent in patient care unless a satisfactory alternative existed for providing such care. Three physicians agreed to serve as preceptors primarily because they were asked to do so.

All of the clinicians interviewed felt an increased sense of professional competency, and 86 per cent reported a significant increase in their job satisfaction. Most enjoyed feelings of greater professional challenge and fulfillment in their new roles. They recognized that they were making a more significant contribution to patients now than they were able to in their previous role.

However, there are aspects of their new role that some clinicians do not enjoy. Ten experienced some insecurity in performing certain tasks, and six were uncomfortable with the vagueness of their role. Four clinicians have found that they miss another type of nursing in a hospital environment, and ten objected to increased paperwork at the expense of patient contact. A few have become concerned about the increasing length of their work day. Although a desire to make more money was not a primary reason given by most clinicians for seeking additional training, the issue of appropriate compensation became a concern for many as they have become experienced and established in a new role. In 1973, 13 of 16 clinicians employed in private practice felt that they were receiving an adequate salary for their services. However, the interviews conducted in 1975 revealed that half the nurse clinicians in this group felt that they were not receiving appropriate compensation for their added responsibilities. Eleven of these clinicians have received a salary increase since entering nurse clinician training, and eleven have not.

Although no information was sought on the salaries paid to clinicians, 63 clinicians provided information on the raises they have received since the completion of their preceptorship. *Table I* shows the distribution of salary change that accompanied the change in role from registered nurse to nurse clinician for this group of individuals.

The Physician's View

Kansas physicians who employ nurse clinicians report several types of benefits, including a significant reduction in work-related stress and fatigue. This benefit is cited as a crucial factor in the decision of a few physicians to continue practice in rural Kansas communities. Several physicians comment that the work day is less stressful when a clinician is present, because patients do not have to wait so long to receive attention. In some overburdened practices, long waiting periods for patients have caused a deterioration in doctor-patient relationships.

Twenty-three of 31 physicians who gave "a desire to reduce working hours" as one reason for employing a nurse clinician have attained that objective. The reduction has averaged 10-14 hours per week. However, five physicians report reductions of only 3-6 hours per week. Some of those who report a significant reduction in working hours are still investing 10-12 hours per day in patient care.

Between 1969 and 1971, surveys were conducted in four states to determine physician attitudes toward the use of physician extenders. In those states, the following percentage of physicians surveyed indicated that they would or could profitably employ a physician extender:

TABLE I

MONTHLY SALARY CHANGE FOR NURSE CLINICIANS AFTER TRAINING (N = 63)

Decrease*	2	$201-$300	7
No increase	16	$301-$400	0
Expecting increase	9	$401-$500	3
$100 or less	11	$501-$600	3
$101-$200	12		3

* Both clinicians experiencing salary decreases were previously in hospital settings and are now in group practice.

Kansas, 56 per cent; Pennsylvania, 70 per cent; Wisconsin, 42 per cent; and Kentucky, 75 per cent.[8] One barrier to the utilization of physician extenders uncovered by these surveys was a perception on the part of some physicians that the employment of such an individual would constitute a considerable financial risk. However, studies available on the financial benefits to physicians who employ a physician extender indicate that there is some degree of profit to most of these employers.

Interviews with physicians in Kansas who employ nurse clinicians reveal that the patient charge is generally the same whether the patient is seen by the physician or by the nurse clinician. This policy seems appropriate since nurse clinicians manage independently many patient visits which formerly required the attention of the physician. Patients with problems which are too complex for the clinician are seen by the physician alone or in collaboration with the clinician.

Case studies being conducted in Kansas regarding the impact of nurse clinicians on the productivity of an office practice indicate that clinicians can and sometimes do make a financial contribution to a practice through the patient visits they manage independently and by enabling the physician to make more productive use of his own time.

Physicians serving as preceptors or employers, when asked to identify problems relative to utilizing nurse clinicians, said the greatest difficulty is in defining the clinician's role in a way that maximizes benefits and prevents problems. In several practice settings, working out an operational role has required experience and adjustment. Judgments of physicians vary on what a nurse clinician should do; decisions are based on their perception of the abilities of the clinician, what patients will accept, the needs of their practice, and risks associated with medical-legal liability. Sixteen physicians indicated that the initial difficulties they experienced in creating an appropriate role for the clinician were due to other personnel in the office. Nine cited vague laws or fears of malpractice suits as a factor influencing the role of the clinician.

The cost of malpractice insurance has not increased in Kansas for physicians because they employ nurse clinicians. However, the legal status of clinicians is vague and, as a result, relatively conservative use is being made of their abilities in some situations. In many practices, patients have a choice of seeing the physician or the nurse clinician. In others, the physician sees each patient who has already been seen by the clinician, even if only for a moment.

Difficulties experienced by most physicians have been minimal, but concern about potential problems persists in the minds of a few. Generally, acceptance of the nurse clinician by patients and by other professional persons has not been a problem. Most physicians report positive or enthusiastic acceptance of the nurse clinician. A few noted mixed responses initially, but patient resistance was overcome quickly. Irritants such as jealously exhibited by other employees in the office have been limited.

Others in the health professions seem more reluctant to accept the nurse clinician role than the general patient population. Forty-five per cent of the clinicians reported positive reactions from other nurses, but 75 per cent reported neutral or negative responses from those in other health professions. Ten negative responses were from other physicians in the communities, and eight were from hospitals. In only a few instances, however, were responses serious enough to limit the clinician's function.

Acceptance of nurse clinicians did not come about automatically. Most physicians prepared their patients and office staff for the nurse clinician by personally explaining her role and expressing confidence in her competence. Another factor contributing to positive acceptance is that many clinicians have been well known to patients prior to training for the new role.

Benefits to Patients

Improved access to health care services has been identified by most physicians and nurse clinicians in this study as the most significant benefit to patients. In practices in which the clinician sees patients independently, most average nine or ten patient visits each day; some see fewer than five patients a day, and others average more than 20 patient visits per day. Ten physicians gave estimates of additional patient visits made possible by the assistance of the clinician, and these estimates ranged from 5 to 30 patient visits per day.

Most physicians and clinicians feel that patient waiting time for service has been reduced and that quality of care and patient education have improved. The frequency with which these and other patient benefits have been identified is summarized in *Table II*.

Although patient charges are not generally reduced when a patient sees a nurse clinician rather than a physician, patients often receive more professional attention and more comprehensive care without any additional charge. For this reason, some clinicians and physicians feel it appropriate to say that the cost of health care services to some patients is reduced when a nurse clinician is utilized. Some feel also that improved care can reduce the number of return visits and the cost of hospitalization, and this perception has received some support from other studies.[9]

TABLE II

BENEFITS TO PATIENTS RESULTING FROM NURSE CLINICIAN UTILIZATION

Patient Benefit	*% Citing Benefit* PHYSICIANS (N = 49)	CLINICIANS (N = 65)
1. Reduction in waiting time for care	100	89
2. Increase in time spent with patients	91	76
3. Increase in number of patients seen	85	100
4. Patient education has been improved	83	72
5. Saved time and travel expense for patients by home visits and new practice sites	51	69
6. Improved quality of care	40	23
7. Increased availability of care at night and on weekends	38	43
8. Reduction in incidence of hospitalization	4	0
9. Improved communications	2	3
10. Increased emotional support for patients	0	1

Two physicians in Kansas reported an increase in cost to the patient as a result of utilizing a nurse clinician. However, both indicated that the clinician obtained more information and provided more services. Therefore, this increase in cost is related to increased service. Most physicians and nurse clinicians in the study felt that the patient benefits cited could not have been realized without the nurse clinician training program or the recruitment of another physician to the practice or community.

Summary

The utilization of nurse clinicians in practices studied has produced advantages for patients, the clinicians, and their employing physicians. The type of benefit derived is closely related to the physician's reason for employing a clinician. For the most part, physicians who wished to provide more comprehensive care, to serve more patients, or to reduce their own workload have achieved the desired results. Nurse clinicians have contributed to the productivity of physicians and have provided expanded services to patients. They are generally well accepted.

Nurse clinicians in medically underserved communities in Kansas are improving access to needed health care services. They are helping retain some physicians in rural communities, and they are providing services which would not be available otherwise. Therefore, it seems important that the problems which do exist in regard to the training and employment of nurse clinicians in Kansas be resolved.

Adequate financial support for the nurse clinician training program after 1976 is needed. The legal status of nurse clinicians requires further clarification. Some problems related to third party payment for services provided by nurse clinicians need to be resolved. The issue of appropriate compensation for the services of a nurse clinician deserves attention; it could be addressed through a study of salary scales of physician extenders to supply an external perspective to those who are concerned about this matter.

At the time of this study, the 49 graduates of the Wichita based program who are employed in medically underserved areas of Kansas are managing, or enabling their employing physician to manage, an additional 1,078 patient visits a day. This figure is based on an average of ten patients/day seen independently by clinicians and 12 additional patients seen on the average by physicians. The projected annual figure of an increase in patient visits by 25,872 (5,280 per practice) is based on 240 eight-hour work days/year. These patient visits occur in communities which experience difficulty recruiting the additional physicians they need. This benefit alone seems worth the total investment required to maintain the program which has trained these individuals.

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TESTIMONY REGARDING SENATE BILL NO. 13
March 22, 1983

Prepared by Anne L. Baker
Attorney for Kansas State Nurses Association

I. PURPOSE OF TESTIMONY

On behalf of the Kansas State Nurses Association I welcome this opportunity share with you some concerns regarding the legal ramifications of Senate Bill No. 13, as amended by the senate committee. The Kansas State Nurses Association supports Senate Bill No. 13 as proposed by the Special Committee on Public Health and Welfare as reported by the Legislative Interim Studies to the 1983 Legislature. The concerns of the Association with respect to Senate Bill No. 13 as before this committee center upon the senate committee's amendments found in new section 2(d) on the top of page 3 of the bill, lines 83 through 87.

II. BRIEF HISTORY.

Although I am confident that you are all aware of the history of legislation regarding advance registered nurse practitioners in the State of Kansas, some review of that history puts the present issue in perspective. The Special Committee on Public Health and Welfare presented an interim study to the 1978 Legislature which concluded that the Nurse Practice Act should be revised to recognize the expanded role of nursing. That report states that in 1977, 30 states had revised their nurse practice acts to reflect changes in nursing practice and the expanded role of nursing in the health care system. At that time, the Kansas definition of nursing was not among those which had been revised. The 1978 Legislature responded by adopting House Bill No. 2720 which provided for the licensing and regulation of advanced registered nurse practitioners. Regulations under the 1978 bill, after considerable controversy, were adopted, and by May of 1981 there were 141 licensed ARNPs and 25 other registered nurses who had applied for certification.

The impetus for the 1983 amendments to the Advanced Registered Nurse Practitioner Act arises from litigation filed in Shawnee County District Court, Case No. 81-CV-647 in 1981. In that litigation, Judge Allen held that K.S.A. 65-1113(g), which defined an advanced registered nurse practitioner, was unconstitutional because the statute did not specify the expanded roles in which such nurses could perform. In the view of the court, the act permitted the board in its discretion to either expand or limit the role of ARNPs without adequate legislative direction. Because of the absence of legislative guidelines, the court declared that there was an unlawful delegation of legislative authority to the Kansas State Board of Nursing.

(Attachment No. 5.)

III. REPORT OF SPECIAL COMMITTEE OF PUBLIC HEALTH AND WELFARE TO THE 1983 LEGISLATURE.

In response to Judge Allen's decision, a Special Committee on Public Health and Welfare was assigned last August. The proposal "directed the Special Committee on Public Health and Welfare to develop statutory standards to be followed by the State Board of Nursing in defining the scope of practice of advanced registered nurse practitioners." After hearing testimony from numerous individuals and groups, and after considering approximately seven alternatives, the committee developed Senate Bill No. 13. That bill implements the committee's conclusion and recommendation that the Advanced Registered Nurse Practitioner Act should be reenacted by the 1983 Legislature and that the statute should include the constitutionally required guidelines to assist the State Board of Nursing.

The standard to be met when determining the sufficiency of agency guidelines is that adopted by Judge Allen in his 1982 opinion. It is permissible for the legislature to enact general legislative guidelines setting state policy and then to delegate the agencies' discretion in filling in the details and fixing reasonable and definite standards. Gumbhir v. Kansas State Board of Pharmacy, 228 Kan. 579, 584, ___ P.2d ___ (1980). Senate Bill No. 13 as proposed by the Special Committee on Health and Welfare satisfies that test. In particular, new section 2, subsection c, provides guidelines under which the agency may carry forth the legislative purpose. The bill directs the board to establish categories of advanced registered nurse practitioners which "are consistent with nursing practice specialties and recognized by the nursing profession." In addition, subsection 2 provides that the board shall establish the education, training and qualifications necessary for a certification of each category so as to "assure competent performance by advanced registered nurse practitioners."

The precise deficiency identified by Judge Allen, the failure of the legislature to define the term "expanded role," is very adequately addressed by subsection 3 of new section 2(c), lines 61 to 72. The bill directs the agency to adopt a definition of expanded role under which is

> "consistent with the education, training and qualifications required to obtain a certificate of qualification as an advanced registered nurse practitioner, which protects the public from persons performing functions and procedures as advanced registered nurse practitioners for which they lack adequate education, training and qualifications and

which authorizes advanced registered nurse practitioners to perform acts generally recognized by the profession of nursing as capable of being performed, in a manner consistent with the public health and safety, by persons with post basic education in nursing...."

Further, Senate Bill No. 13, new section 2(c)(3), as proposed by the committee, enumerates four factors which the Board must consider when defining the expanded role. These factors are the following:

(1) the training and education required for a certificate of qualification as an advanced registered nurse practitioner;

(2) the type of nursing practice and preparation in specialized practitioner skills involved in each category of advanced registered nurse practitioner established by the board;

(3) the scope of practice of nursing specialties and limitations thereon prescribed by national organizations which certify nursing specialties; and

(4) acts recognized by the nursing profession as appropriate to be performed by persons with postbasic education and training in nursing.

Most certainly, this bill fixes reasonable and definite standards which will control the board's adoption of licensing regulations.

IV. OBJECTIONS TO PROPOSED NEW SECTION 2(d).

Given the fact that new section 2(c) fulfills the purpose of providing reasonable and definite standards, the Kansas State Nurses Association opposes the inclusion of subsection (d) to new section 2. That proposal is found at the top of page 3 of the bill on lines 83 to 87. The Special Committee on Public Health and Welfare which reported to the 1983 legislature considered and rejected a very similar amendment to the act. The proposal rejected by the special committee, like the senate committee amendment, would have incorporated the standard of performing functions within the framework of an established protocol. The Kansas State Nurses Association agrees that the committee acted wisely when rejecting that proposal. In view of the precise

standards incorporated in the bill, the additional requirement of a written protocol would have been superfluous.

Further, the proposed Senate amendment to S.B. 13 includes illegal delegation infirmities like those which were struck by Judge Allen in the prior version of the Nurse Practice Act. The proposed amendment uses the term "medical functions". Neither the bill nor other Kansas statutes define the term. The absence of precise guidelines may also arise when the agency attempts to define "physican-directed health care team" and "protocols" which also are not defined by Senate Bill No. 13 or other Kansas statutes.

In addition, the proposed amendment (lines 83 through 87) suffers from debilitating ambiguities. First, it is not clear when a protocol would be required. It is well recognized that ARNPs practice in many different contexts. Although a protocol may be a convenient and natural method to define a nursing role when an ARNP is practicing in a physician's office, such protocols may not be the preferred method to address the definition of roles when ARNPs are practicing in other settings, such as community health departments and educational institutions. Another ambiguity of the proposed amendment arises by the inclusion of the word "and" on line 85. May an ARNP perform medical functions only within the context of a physician-directed health care team when a protocol between the physician and nurse has been established? Or, may an ARNP perform medical functions in either of these situations? If this is the intent, then the amendment allows an ARNP to perform medical functions in two contexts: first, within the context of a physician-directed health care team, and second pursuant to an existing protocol established between a physician and an ARNP.

V. SUMMARY.

In summary, the Kansas Nurses Association supports S.B. 13 as proposed by the Special Committee on Public Health and Welfare. In 1978 the Kansas legislature made the policy decision to update the Kansas definition of nursing to include ARNPs. Although a technical infirmity in Senate Bill No. 2720 to the 1978 legislature has clouded the implementation of this Kansas policy, we urge the adoption of Senate Bill No. 13 restore full legality of the policy by the 1978 legislature. It is the view of the Association that the amendment to Senate Bill No. 13 may again impede the development of this Kansas policy, possibly provoking more litigation and more uncertainity among the health care professions.

6

My name is Evelyn Smith. I am Chairperson of the Conference Group on Advanced Practice of KSNA. I am an educator of advanced practitioners at Wichita State University. I am also ANA certified as a Family Nurse Practitioner and practice part time in Wichita.

I would like to thank the interim health and welfare committee members and staff who gave considerable time and thought to the ARNP legislative issue this past summer which culminated in SB 13.

Senate Bill 13 as it came from that committee was agreeable to the nurse practitioners and KSNA. Since that time KMS has continuted to push for an amendment to the statute. Now nurses have the decision to make as to whether or not the amendment is detrimental to nursing as a profession as well as to nurse practitioners. There have been no cases brought to court concerning the practice of an ARNP in KS. The court ruled on the constitutionality of the legislative action giving the State Board of Nursing authority to define the role. The bill as it reads without the amendment has corrected the language which was found to be unconstitutional.

Nurse practitioners are very anxious to put this issue to rest without further negotations so that their energies may be directed to health care. The amendment introduces more controversy about what "medical functions" means. Over 135 ARNPs have been practicing in this State since 1972. From evaluation studies of what graduates are doing and feedback from their employers, I can say that the working relationship between advanced practitioners, physicians and consumers has been a positive one. Team efforts are essential to optimal health care. The profession of nursing is a licensed profession qualified and willing to take responsibility for their own actions. We have no problem working with other health professionals including physicians.

The nurses in the State of Kansas are very proud of SB 13. It is an excellent document. We commend all the effort that has been made in the past to bring the statute to this point. I recommend passage of SB 13 without amendment.

(attachment No. 6.)

4

KANSAS STATE BOARD OF NURSING

BOX 1098, 503 KANSAS AVENUE, SUITE 330
TOPEKA, KANSAS 66601
Telephone 913/296-4929

TO: The Honorable Marvin Littlejohn, Chairman, and Members of the House Public Health and Welfare Committee

FROM: Dr. Lois Rich Scibetta, LRS Executive Administrator

RE: Senate Bill 13 - Advanced Registered Nurse Practitioners

DATE: March 22, 1983

Mister Chairman, and members of the Committee, my name is Dr. Lois Rich Scibetta and I am the Executive Administrator of the State Board of Nursing. I am speaking in support of Senate Bill 13. For several years, the Board of Nursing has supported the concept of advanced nursing practice and for a short time certified Advanced Registered Nurse Practitioners.

In all candor, the Board's first choice would have been that the amendment not be added. The Board's preference would be that the aspects raised by the amendment appear in the regulations, however, the Board will not oppose the Bill, as amended.

The Board continues to support the concept of advanced practice and would urge that the Committee report Senate Bill 13 out favorably. The public has a right to choose the type and extent of health care which they want and are willing to pay for.

Thank you. I will be happy to answer any questions which the Committee may have.

(Attachment No 7.)

8

Advanced Registered Nurse Practitioner
KSBN

1977 Legislature Coordinating Council directed the special committe on PH & W to conduct a study of physician extenders. The committe focused on the physician assistant and the expanded role nurse.

After extensive study, the 1977 Special Committe on Public Health and Welfare concluded that Kansas laws should be amended to allow those registered nurses who had completed advanced training to function in an expanded role. The Committee further concluded that the statutory definition of nursing should be updated and brought into the line with the changed role of nurses in the health care system.

In its report to the 1978 Legislature on Proposal No. 60, the Special Committee on Public Health and Welfare gave the following explanation of the members' view of the practice of expanded role nurses:

> "The expanded role nurse has acquired advanced nursing skills which enable the practitioner to assess the health status of an individual or family, to screen for health problems that need to be referred to a physician or other health care provider, to manage acute or episodic illness, to manage stable chronic illnesses, to teach health maintenance, and to counsel with patients about health problems. While these functions are all a part of modern nursing, the expanded role nurse is able to carry out nursing responsiblities in a less structured setting than the nurse who does not have advanced training.
>
> "While to some degree all nursing practice ranges from those functions which are strictly a nursing function to those which overlap with medical functions, the practice of the expanded role nurse may include responsibilities which are traditionally thought of as medical, i.e., well baby checkups, pre and post partum care, provision of family planning services. In those areas in which there is an overlap between nursing care and medical care, the expanded role nurse frequently functions under protocols or written agreements with a physician."

The Special Committe and the 1978 standing committees which worked with the interim bill, 1978 H.B. 2720, based their concept of the advanced registered nurse practitioner on the two expanded role training programs then in operation in the state - the nurse clinician program conducted by the College of Helath Related Professions at Wichita State University and the Nurse Practiontioner Program offered at the University of Kansas College of Health Sciences. Both programs were one-year expanded role training programs involving didactic study and preceptorships.

One issue considered by both the interim and standing committees of the Legislature was that of the relationship of the expanded role nurse and the physician. After careful consideration, the several committees rejected recommendations that (1) would have required advanced registered nurse practiontioners (ARNP's) to pratice under the direction of a physician: (2) would

(Attachment No. 8.)

have rules and regulations relating to ARNP's adopted jointly by the Boards of Healing Arts and Nursing; (3) would have defined "expanded role" by statute in order to give medicine an input unto the definition; and (4) would have created an advisory committee of nurses and physicians with which the Board of Nursing would have been required to consult when writing rules and regulations relating to the scope of practice of ARNP's.

1980 Legislation

The 1980 Legislature, in Senate Bill No. 566, amended three of the nursing statutes which relate to the advanced registered nurse practitioner. The amendments to K.S.A. 1979 Supp. 65-1113 amended the definition of advanced registered nurse practitioner to make it clear that the ARNP functions in an expanded role.

The amendments to K.S.A. 1979 Supp. 65-1119 to add "training" to the references to educational programs for ARNP's to make it clear that such programs are not limited to those which lead to advanced degrees and that they are to emphasize preparation for patient care in an expanded role.

ug. 1977 KSNA wrote a position - paper defining and supporting the concepts of ARNP to be included in the Nursing Practice Act. ARNP was defined as a "registered nurse who is certified by the board to function in an expanded role."

ct. 1978 The KSBN prepared their first draft of the Rules and Regulations for ARNP. This draft included:

- A long list of Categories of ARNP.
- Requirements for Certification.
  1) Active license as a RN in Kansas.
  2) Documentation of one or more of the following:
     a.) Satisfactory completion of a formal educational program.
     b.) Certification by a specialty board or equivalent.
     c.) M.S.N., in clinical specialty area.
  3) Evidence of current clinical competencies if more than one year since completion of Nurse practitioner program.
  4) After July, 1985 new applicants must have BS.
  5) After July, 1990 new applicants must have MSN.

ec. 1978 Open forum held on proposed Rules and Regulations.

eb. 1979 A staff member of the Board of Nursing prepared a draft of proposed Rules and Regulations for the ARNP which listed an MSN as the required credential. (This paper also required a BSN for entry into practice to be effective Jan. 1985)

une 1979 Revised draft of proposed regulations from KSBN. The academic credentials for an ARNP was MSN with major in a clinical specialty. The characteristics listed were taken from "Characteristics of Graduate Education in Nursing Leading to the Master's Degree," NLN, 1979.

uly 1979 The June draft of the regulation was accepted by the KSBN and sent to the Department of Administration for approval.

Memo from Ray Showalter, July 23, 1979 stated (in-part) - Carolyn Rampy, staff of the 1202 Commission called to inquire (about R & R) as she had received complaints.

ug. 1979 The Board was asked to meet with PH & W committe. The committee discussed "advanced" and felt anything beyond "basic" (RN) education should be included, eg. CRNA's, nurse clinic with BS, community health nurse with CE, etc.

pt. 1979 Board meeting - (see minutes Sept. 5-6). Board adopted definition of ARNP and established categories. Board also approved academic credential for ARNP to be BSN after July '83 and MS after July '86.

t. 1979 Attorney said could not "grandfather" and could not set standards on a progressively higher scale. (BS→MS)

c. 1979 Open hearing on proposed R & R.

Dec. 17, Board met to make recommended revisions (see Board minutes for Dec. 17). ARNP Regulations adopted by Board and sent to Department of Administration.

n. 1980 Memo from Sandy Duncan, Vice Chair for JCARR expressing concern about the Rules and Regulations that were published Decemeber 18, 1979.

eg. - Delete suturing.
- Change wording of introductory statements or write different statements of functions (to differentiate ARNP from other practicing nurses,)

eb. 1980 Met to revise R & R (again) as directed by Legislative committees. (Midnight meeting of the Board after Exams.)

pril 1980 Letter to Sr. Mary Carol from Steven Carr Re: Adopting Temporary Rules and Regulations affecting A.R.N.P.'s..

"As I indicated, I am advised that Senate Concurrent Resolution No. 1676 will likely be adopted, thus revoking or rejecting the permanent ARNP regulations adopted in December, 1979. It is important to note that the legislature passed House Bill No. 2811, which legislation amends K.S.A. 1979 Supp. 77-416 (c) and 77-422 and permits state agencies to adopt rules and regulations rejected or revoked by the legislature. If the governor signs this bill, which is to become effective upon its publication in the official state newspaper, the previously troublesome limitations on adoption of rules after revocation by the legislature (in 77-416 and 77-422, before their amendment in this bill) will be eliminated. The only difficulty remaining is to make a showing that the temporary rules are not "substantially identical" to the rejected permanent rules.

I propose that the Board schedule a public hearing on April 30 or May 1, 1980 for adoption of ARNP regulation as temporary rules and regulations.

"At the public meeting, the Board may make any additional changes or revisions, and any corresponding changes in the fiscal impact statement, and may adopt the rules and regulations as temporary rules and regulations, by a roll call vote of a majority of the total membership. The Board should make a list of all persons attending the hearing.

If the rules and regulations are adopted, the Board should then submit them to the revisor's office on or before May 9, 1980 in order to be placed on the State Rules and Regulations Board's agenda for its meeting May 14, 1980. The Board should submit the rules and regulations, as amended, if any amendments are made at the meeting, together with the

fiscal impact statement, a statement indicating the results of the roll call vote, and a list of persons in attendance at the hearing.

Therefore, the State Rules and Regulations Board will consider the proposed rules and regulations and will decide whether they should be adopted "in order to comply with the requirements of the statute authorizing the same." See Section 4 of House Bill No. 2811, amending K.S.A. 1979 Supp. 77-421.

May 1980 Open Forum on R & R for ARNP. KMS (Dr. Brunner) spoke to physicians being supportive of ARNP and the "Team concept" of care delivery. - But he felt the team concept/approach had not been defined in the R & R.

Section 2 under 60-10-101 was added to read. "ARNP's function as members of a physician directed health care team and within the framework of medically approved criteria, policies and standing orders.

June 1980 Pat Diamond represented KSBN before the JCARR.
Concern raised by the committee included:

1.) The role of the nurse in the Nurse practitioner category.
2.) Is the statement, "ARNP's function as members of a physician - directed health care team," consistant with the role of ARNP and the language of 60-10-101 and with legislative intent?
3.) All sections speaking to written protocols should be consistant.
4.) Questioned some functions that were listed.

Generally speaking the committee expressed concern that the regulations in toto should reflect the interdependent nature of the ARNP status, that is, the advanced or "expanded role" practice in a less structured setting.

Board testimony suggested 60-10-101 (b) Reworded to read "an ARNP functioning in the expanded role performs in an interdependent role as a member of a physician - directed health care team and within the framework of medically approved criteria, policies and standing orders."

Sept. 1980 The Board responded to legislative and Nursing concerns and revised R & R again. 60-10-101(b) was rewritten to read "ARNP's functioning in the expanded role perform in an interdependent role as a member of a physician - directed health care team in the execution of the medical regimen."
(See minutes for Board meeting September 4, 1980.)

Nov. 1980 Hearing held on ARNP Rules and Regulations. The Board, in afternoon session, voted that the Regs, be permanent. (With minor changes in 60-10-102, 60-10-103, 60-10-104, 60-10-106) See Board minutes for Nov. 24.

Jan. 1981 ARNP Rules and Regs. presented before JCARR by Emaline Correll. Pat Diamond represented the Board of Nursing, Melodie Woerman, KSNA, asked that 60-10-101 (4) (b) be deleted. Several KMS members testified, asking that the entire set of regulations be rejected.

JCARR voted to add the word "training" before program in 60-10-101 (a) (1)

From the Jan. KMS Legislative Bulletin "The KMS met with representatives of the KSNA to discuss the proposed regulation for ARNP. No general agreement came out of the meeting. As a consequence, the KMS will continue to vigorously oppose the regulations while awaiting consideration by the Senate PH & W Committee."

. 1981 SCR 1607 to modify the Board of Nursing Regs. regarding ARNP educational programs, to include "training."

KSBN testimony stated 1) the intent of SCR 1607 had already been met in 1980, SB 566 and 2) SCR would open up the entire ARNP issue for ammendment and the Board wanted the R & R to become permanent as written. SCR 1607 defeated. Regs. to become permanent May 1, 1981.

1981 KMS filed for declaratory judgement. The KSBN was requested by KMS to formally review ARNP R & R's to determine their validity as provided by KSA 77-434.

e 1981 All Board Members subpoenaed.

June 1981

Resolved, That the results of this study be presented to the KMS at its 1982 Annual Meeting and made available to the Kansas Legislature and the Department of Health and Environment.

RESOLUTION NO. 81-8

Nursing Education

WHEREAS, The Kansas Medical Society supports all forms of nursing education including baccalaureate, diploma, and associate degree programs; and

WHEREAS, There is a critical shortage of nurses currently available to provide direct patient care in hospitals and medical office settings; therefore be it

Resolved, That the Kansas Medical Society favor increased development of associate degree and diploma school nursing programs to provide more nurses for direct patient care in hospitals and medical offices; and be it further

Resolved, That a copy of this resolution be forwarded to the Governor, members of the Kansas Legislature, the Kansas State Board of Nursing, and the Kansas State Nurses Association.

RESOLUTION NO. 81-9

Advanced Registered Nurse Practitioner Regulations

WHEREAS, The permanent Advanced Registered Nurse Practitioner regulations have taken effect in spite of the continued opposition of the KMS; and

WHEREAS, These ARNP regulations are ambiguous, vague, and a blur of the distinction between physician and nurse; and

WHEREAS, The KMS believes the ARNP regulations go far beyond what the Legislature originally intended for the expanded role nurse; therefore be it

Resolved, That the KMS Executive Committee be directed to take appropriate legal action to prevent implementation of the permanent ARNP regulations.

RESOLUTION NO. 81-10

Health Planning — KMS Active Involvement

WHEREAS, The Kansas Department of Health and Environment and the Health Systems Agencies are developing statistics on health manpower to be utilized in facility and training program planning; and

WHEREAS, The Kansas Medical Society does not have an adequate mechanism for monitoring and verifying these various statistics; therefore be it

Resolved, That the Executive Committee be directed to study the development of an aggressive, workable system for the active monitoring of the health planning system, including additional funding and staff, if necessary; and be it further

Resolved, That the resulting proposal be referred to the Council for appropriate action.

RESOLUTION NO. 81-11

Kansas University Medical Center

Not adopted.

RESOLUTION NO. 81-12

Home Deliveries

Resolved, That the Kansas Medical Society endorse the following statement on home deliveries:

Labor and delivery, while a physiologic process, clearly present potential hazards to both mother and fetus before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation.

We recognize, however, the legitimacy of the concern of many that the events surrounding birth be an emotionally satisfying experience for the family. The Kansas Medical Society supports those actions that improve the experience of the family while continuing to provide the mother and her infant with accepted standards of safety available only in the hospital.

RESOLUTION NO. 81-13

Responsibilities of the Health Care Team in Maternity Care

Resolved, That the Kansas Medical Society adopt the following policy statement on the responsibilities of midwifery in the health care team of maternity care:

The Kansas Medical Society reaffirms its policy that the health care team necessary to provide optimal maternity care must be directed by a qualified physician. Fully recognized in this policy is the possible role of the certified nurse-midwife who, as a member of this team, may assume responsibility for the management of an uncomplicated labor and delivery of a hospitalized pregnant woman. While recognizing the role of the certified nurse-midwife as a

member of this team, there appears to be no pressing need for certified nurse-midwives in Kansas at this time.

Midwives should have a minimum of three years of formal training, including at least one year of nursing. For those midwives who have already completed nursing education, two years of midwifery education should be the minimum requirement. The certified nurse-midwife should meet these standards; lower standards are unacceptable.

The KMS supports actions and programs that encourage family-centered maternity care while continuing to provide the mother and her infant with the accepted standards of safety available only in hospital setting.

RESOLUTION NO. 81-14

Periodic Cancer Screening for Women

WHEREAS, The American Cancer Society has recommended that cytologic screening for cervical neoplasia would have a multi-year interval; and

WHEREAS, the Kansas Medical Society does not agree with the American Cancer Society's recommendation; therefore be it

Resolved, That the Kansas Medical Society recommend annual cytologic screening for cervical neoplasia for most women; and be it further

Resolved, That extending the screening interval in the low-risk group should be an informed choice arrived at by the patient and her physician.

RESOLUTION NO. 81-15

Recommendations of the Graduate Medical Education National Advisory Council

WHEREAS, The Graduate Medical Education National Advisory Council offers as one of its major recommendations a decrease of 17 per cent from current levels in the U.S. medical school enrollment, predicting a surplus of physicians by 1990; and

WHEREAS, The number of Kansas communities seeking physicians, particularly in rural areas, has not been reduced substantially as indicated by records at the University of Kansas School of Medicine and the results of a study by the Kansas Department of Health and Environment; and

WHEREAS, There was no representation from rural America on the Graduate Medical Education National Advisory Council, thus disenfranchising one-third of the nation's population in the need of medical care; and

WHEREAS, The Kansas Legislature is considering a comprehensive interim study of the University of Kansas School of Medicine, its facilities, size, and operation; therefore be it

Resolved, That the Kansas Medical Society encourage the University of Kansas School of Medicine to delay any action on the recommendations of GMENAC until such time as a committee of the Medical Society has made an indepth study of the recommendations as they apply to Kansas; and be it further

Resolved, That all legislators at both the state and national level be notified of this action.

RESOLUTION NO. 81-16

PSRO

Not adopted.

RESOLUTION NO. 81-17

Malpractice Insurance

Not adopted.

RESOLUTION NO. 81-18

Automobile Safety Restraint Devices for Children

WHEREAS, The leading cause of death in children over one year of age is automobile accident; and

WHEREAS, The incidence of mortality and morbidity of children in such accidents can be reduced as much as 80 per cent by the use of proper restraint devices; and

WHEREAS, The use of such restraint devices could be greatly increased by the implementation of a statewide "First Ride a Safe Ride" program to encourage the use of safety restraints for newborns when they go home from the hospital; and

WHEREAS, The Kansas Medical Society was a key sponsoring organization of legislation requiring the use of such devices; therefore be it

Resolved, That the Kansas Medical Society demonstrate its strong support for implementation of a program to promote the use of safety restraint devices by children riding in automobiles by:

1. Co-sponsoring educational programs in Kansas communities for professionals and others about the importance of the use of child safety restraints in automobiles.

Honorable Chairman and Members of the Committee:

I appreciate the opportunity to speak in behalf of my chosen profession, nurse-midwifery.

Senate Bill 13 is important to give legal support to all practicing advanced nurse practitioners. As a Certified Nurse-Midwife this bill is especially important to me and my profession as the regulations under this statue are the only place in Kansas law that addresses nurse-midwifery.

The title, "midwife", often conjures up images of little old ladies trudging down dirt roads, black bag in hand. But today's Certified Nurse-Midwife is an "individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives." Often this education is on a Master's level. The nurse-midwife is prepared to care for healthy women throughout the pregnancy, labor and delivery, and postpartal period as well as immediate care of the newborn and well women gynecology. The nurse-midwife is educated to assess the normal, anticipate problems, and deal with emergencies until help arrives, or the appropriate transfer is made.

Certified nurse-midwives are employed in health departments, public and private hospitals, are employed by or in partnership with Obstetricians or Family Practice physicians around the country. In some cases a group of nurse-midwives employ an obstetrician. But no matter what the administrative structure every practicing nurse-midwife must, according to our professional standards, have a clear relationship, in writing, with an M.D. who provides advice, consultation, is available for complications and emergencies, and will accept referrals.

The American College of Obstetricians and Gynecologist has issued a statement regarding "the deficits in availability and quality maternity care" which could "best be corrected by the cooperative effort of teams of physicians, nurse-midwives, obstetric registered nurses and other health personnel". Yet, Kansas is the only state that does not allow for the practice of the certified nurse-midwife and other advanced registered nurse practicitioners.

After I obtained my M.S. at Columbia University in New York City, I worked as a CNM for 6½ uears at the Medical University of South Carolina. I was on the staff of the nurse-midwifery service as well as on the faculty of the education program. Some of my collegues were on the faculty of the School of Medicine and as time allowed we supervised medical students in normal obstetrics.

(Attachment No. 9.)

I moved to Kansas almost two years ago and enjoyed one year of practicing my profession in an idealistic setting. Then the successful suit of the Kansas Medical Society against the State Board of Nursing removed my legal basis for practice and subsequently has caused me to lose considerable income and eventually contributed to the loss of my position. All this trauma was caused, not on the basis of incompent or unsafe practices, but due to a legal technicality. Senate Bill 13 has been drafted to correct the legal deficit.

The amendment that was added does nothing to clarify the bill, because as I pointed out any conscientious CNM works within protocols, mutually agreed upon by the CNM and the physician on the health care team.

I request your support of Senate Bill 13 without the amendment.

Thank you!

Sincerely,

Joan Denny, CNM

Joan Denny, CNM
2105 NW Lyman Rd.
Topeka, Ks. 66608

913-357-4356

10

March 21,1983

TO: Representatives of the House
Public Health and Welfare Committee

Dear Representatives,

I am here as a newly Certified Nurse-Midwife who is at this time unable to be recognized as such by the Kansas State Board of Nursing.

In all other 49 States, qualified Nurse-Midwives can practice legally. In Kansas, Nurse-Midwifery as a recognized practicing profession existed under earlier Advanced Registered Nurse Practitioner statutes. In June of 1982, the Kansas Medical Societies successful suit against the State Board of Nursing lead to the specific practice of Nurse-Midwifery to become void and to halt any further licensing of ARNP's. At that time there were only two practicing Nurse-Midwives in Kansas, both in Topeka. Although there are not large numbers of CNM's in our state, without the revisions brought forth in SB #13, the growth of the profession would be severely restricted, and the people will be limited in their freedom of choice for alternative individualized maternity health care.

A CNM, is a Registered Nurse who after gaining experience in obstetrical nursing, completes an educational program leading to a certificate or Master of Science Degree in nursing. An individual must pass a national certification exam, governed by the American College of Nurse-Midwives. He/She is then prepared to provide independent management of care to essentially normal newborns and women, antepartally, intrapartally, postpartally, and/orgynecologically, occurring within a health care system which provides for medical consultation, collaborative management, or referral. A CNM would provide these services only with appropriate established protocols with a physician.

In a Joint Statement by the American College of Obstetrics and Gynecology and the American College of Nurse-Midwives, in Aug.1975, the following principles were agreed upon:

(1) That in medically directed teams, qualified Nurse-Midwives may assume responsibility for the complete care and management of uncomplicated maternity patients and,

(2) The logistics of consultations and referral may vary with

(Attachment No. 10.)

geographic and climatic conditions therefore there should be a written agreement among members of the team clearly specifying consultation and referral policies and standing orders. The representatives of each practice discipline should participate in the development of and be signatory to the agreement.

It is my impression the definition of protocols will be established by practicing physician and Advanced practitioner.

I believe the bill as originally drafted clearly defines the proper constitutional, legal, and appropriate language to give ARNP's a legal basis for practice. The attached amendment adds terminology that is subject to uncertain and debatable interpretation. This includes:

(1) Who will define, "...which restricts advanced registered nurse practitioners in the performance of medical functions"?

(2) What does "...physician-directed health care team," mean? In many states, CNM's employ physicians for consultation and referral services.

With the attached amendment, the future of ARNP's may once again be plagued by vague and unclear wording which may lead to yet another round of legal suits for interpretation. After legislative efforts have been demonstrated in the past weeks to provide accurrate constitutional language for the legal practice of ARNP's in all areas of advanced practice, I contend SB#13 unamended version to be the most workable solution for physicians, nurse practitioners, and most importantly, the consumers who at this time have limited choices in their own health care.

Respectfully Submitted,

Ginger Haynes

Ginger Haynes, RN, BS, CNM
303 S. 10th
St. Marys, Kansas

HEALTH SYSTEMS AGENCY

OF NORTHEAST KANSAS

TESTIMONY ON

SENATE BILL 13

PRESENTED TO THE

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

STATE CAPITOL, ROOM 423 S

MARCH 22, 1983

(attachment No. 11.)

Good Afternoon, Mr. Chairperson Littlejohn, and members of the House Public Health and Welfare Committee. My name is Audrey Kennedy. I hold a diploma in Nursing, a Bachelor of Science Degree in Nursing, a Master of Science Degree in Nursing and earned a Certificate as a Nurse Practitioner from the University of Massachusetts, at Amherst. I am testifying today as a member of the Board of Directors of the Health Systems Agency of Northeast Kansas (HSANEK). The HSANEK is non-profit organization with a 50 member volunteer Board of Directors that serves the health plan development needs of a twenty-five county area in Northeast Kansas. The volunteer Board of Directors has 25 representatives appointed by each County Commission and the remaining Board members come from a wide range of rural and urban community groups and organizations.

The health planning function of the HSANEK is to guide the development of the health care delivery system in such a manner that appropriate manpower, quality health care and affordable health care services are available to the residents of Northeast Kansas.

In view of the primary concerns of the HSANEK, which are the availability of appropriate manpower, the quality of health care delivery, and heath care cost containment, I appreciate this opportunity to present the following testimony on S.B. 13, concerning the Advanced Registered Nurse Practitioner (ARNP).

This testimony will be three fold:

First, I will address the availability of appropriate manpower. The 1982 State Plan for the Health of Kansans and the 1982-83 HSANEK Health Systems Plan identify the need for more primary care providers. Twenty-two of the twenty-five counties in the health service area in Northeast Kansas are designated as primary care shortage areas by the Kansas Department of Health and Environment. In addition, six counties and parts of two other counties in

Northeast Kansas are designated by the Federal Government as Health Manpower Shortage Areas, which are in need of primary health care services. A major resource to fill this need in Kansas is the ARNP. These ARNPs have expanded their skills for assessing and treating patients through advanced formal education and clinical practice. The ARNPs can serve as "primary health providers", are often the first health provider to see the patient, provides preventive health care, and/or contributes to the maintenance of the patient's health.

The Federal Government, as well as other State Governments encourage the use of ARNPs as primary health providers. One health goal of the United States is to increase the number of Nurse Practitioners (NP) available across the Nation. The passage of S.B. #13 will allow Kansas ARNPs the same right to practice in the expanded role that exists for ARNPs in 49 other states.

Second, I will address the quality of health care delivery. The quality of care that a patient receives is directly related to the professional education and experience of the provider. The ARNPs have educational background and experience, which provides them with the broad base of knowledge from which to draw in providing nursing care to patients. The ARNP is competent to make nursing assessments and therefore is capable of directing the patients to the appropriate level of health care when indicated. K.S.A. 65-113 Sec. 6 (g) of the proposed bill clearly defines the qualifications for the ARNP and therefore, I support the qualifications stated therein.

Third, I will address the issue of health care costs. Governor Carlin and Kansas Insurance Commissioner Bell have stated that health care costs in Kansas must be contained. Consequently, innovative, cost effective and proven methods of primary care delivery must be implemented in order to reduce health care costs for Kansans. The use of the ARNP is a proven method of

primary care delivery and based on other states and national experiences is cost effective. In the arena of health care, the greater the degree of specialization the higher the cost. Cost effectiveness is attained when the appropriate health care professional is providing the appropriate level of care. When a patient needs nursing care, a nurse is the appropriate provider. When a patient needs specialty care, a specialist is the appropriate provider. The average salary cost per year for an ARNP is approximately $22,000. The average cost per year for specialty primary care providers is approximately $60,000. Where appropriate, the use of the ARNP is a cost effective method of primary health care delivery.

In summary, Kansans especially those in rural areas as well as inner-city areas, where primary care resources are scarce will benefit by the increase availability of ARNPs. ARNPs will guarantee these persons access to quality health care at an affordable cost.

The passage of this bill will be beneficial to Kansans by providing available, affordable and quality health care. Therefore, the HSANEK strongly supports the passage of S.B. #13 without any amendments.

I would like to thank you for the opportunity to provide this testimony. I will be happy to respond to any questions that you may have.

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Kansas Medical Society

Incorporated 1859

March 22, 1983

TO: House Public Health and Welfare Committee

FROM: Jerry Slaughter
Director of Governmental Affairs

SUBJECT: SB 13; Concerning Nurse Practitioners

The Kansas Medical Society appreciates the opportunity to appear today as you continue consideration of Senate Bill 13.

At the outset, let me restate the position of the Kansas Medical Society on the concept of the "expanded role" nurse. This position was adopted in May, 1980:

> The Kansas Medical Society supports the basic concept of the ARNP and recognizes that an appropriately educated nurse can competently perform selected, delegated medical tasks traditionally performed personally by the physician. However, the provision of these services remains the responsibility of the physician, and the ARNP should function as a member of a physician-directed health care team.

Our continued involvement in this issue is based on our fundamental belief that the law and regulations which outline the role of nurse practitioners should be clear, concise and easily understood by all those affected. The previous law and the regulations were ambiguous and vague. They raised more questions than they answered. The amendments in SB 13 which you are currently considering in effect again delegate considerable authority to the Board of Nursing to define a scope of practice for the ARNP. Based on the regulations which were adopted last year, and the limited guidelines in SB 13, we cannot support the bill unless the Senate amendment relating to the ARNP's scope of practice is maintained.

(attachment no. 12.)

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

First, let me explain our concept of the role of the ARNP in greater detail. A nurse with specialized, additional training will be working at an advanced level of nursing, and to a certain extent that role will include the "gray areas" between nursing and medicine. We do not believe such nurses were intended to be primary, independent practitioners, who fulfill the same role as physicians. Increased medical school enrollments and this state's program to encourage physicians to practice in underserved areas were designed to assure an abundance of physicians for the entire state. Although more autonomous than a traditional nurse, the ARNP should not be independent, nor outside of appropriate contact with a physician, especially since such nurses will be working in that gray area between nursing and medicine. We are not suggesting that there should be personal, on site supervision of the ARNP. However, appropriate agreements or written protocols are all that are necessary to assure good continuity and quality of patient care.

In fact, in 1978 the special committee on Public Health and Welfare, in describing the expanded role nurse referred to this concept:

> "In those areas in which there is an overlap between nursing care and medical care, the expanded role nurse frequently functions under protocols or written agreements with a physician."

Our sole interest is to see that this concept is clearly stated in the statute, and not delegated to a non-legislative body, the Board of Nursing. The senate amendment is essentially all that is needed, except we would like to suggest inserting the following words in (d):

> An advanced registered nurse practitioner may also perform delegated medical functions within the context of a physician-directed health care team, and according to written protocols between a person licensed to practice medicine and surgery and the advanced registered nurse practitioner.

This language does not restrict the role of a nurse practitioner. Nor does it prohibit innovative and unique practioner is working in the gray area between nursing and medicine, that there will be some physician input in the form of protocols or agreements. Most nurses agree that the use of protocols and

agreements is consistent with the training and education of nurse practitioners. In the Senate hearings a certified nurse midwife, stated that a compentent nurse midwife always practices in conjunction with a physician, according to written protocols. She went on to state that written protocols are essential to her practice and required by standards of her profession. It is this very concept that we would like spelled out in the law.

We ask your consideration and support of the senate amendment. If it stays in the bill, we can support its favorable consideration. If not, we must oppose SB 13. Thank you for your patience and consideration of our comments.

13

JOHN E. HARVEY MD, FACOG
Obstetrics & Gynecology
2506 W. 15th EMPORIA, KANSAS 66801
(316) 343-7650

MAR 2 1 1983

I am Dr. John E. Harvey from Emporia, Kansas. I am originally from Salina. I attended and graduated from K.U. School of Medicine, was in the Army for 13 years. I am also a fellow of the American College of Obstretricians and Gynecologists. I am presently in private practice as an obstetrician in Emporia.

I am speaking in favor of SB13. I have worked with nurse practitioners in the capacity of providing supervision at Lyon County Family Planning Clinic, providing preceptorships in my office for nurse practitioners, and acting in an advisory capacity to the nurse practitioners at the Lyon County Health Department.

I also have a certified nurse practitioner working with me in my practice and because of her advanced practice status, we have been able to offer patients the advantage of her nursing expertise. This is especially true in the aresa of pre-op teaching, contraceptive counseling and prenatal education--areas where I sometimes do not have the time to cover myself.

In working with nurse practitioners, I have found that they do offer a high quality of nursing care to their clients, as well as being able to offer them the benefits of their advanced training and knowledge. They do have protocols, which they follow responsibly. I have never encountered any problem with these nurses failing to follow such protocols, nor do they hesitate to refer patients with medical problems they are not qualified to deal with.

Thank you for this opportunity to present my viewpoint and personal experiences with you regarding this important issue.

J. Harvey MD

(attachment no. 13.)