Amended 2/16/8:

Approved: February 10, 19
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Jan Meyers (Chairperson) at

10 a.m./p.m. on February 7, 1983 in room 526-S of the Capitol.

All members were present except:

Senator Bogina

Committee staff present:

Emalene Correll, Norman Furse, and Bill Wolff

Conferees appearing before the committee:

Jerry Slaughter, Kansas Medical Society
Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes office

Others present: see attached list

Senator Meyers announced that the dispensing physicians' act which the committee introduced last month, and which would grandfather permanently 13 physicians in the state who have no pharmacies, would include a cleanup from last session - a section that is included twice in the statutes.

Senator Hayden moved to incorporate into the bill a cleanup of double sections. Senator Ehrlich seconded the motion and it carried.

Jerry Slaughter, Kansas Medical Society, requested that PH&W committee introduce a bill to bring Kansas into compliance with what the Supreme Court has said in relation to advertising and would prohibit false or fraudulent advertising.

Senator Ehrlich moved to introduce this bill which would bring Kansas into compliance with the Supreme Court ruling. Senator Hayden seconded the motion and it carried.

Senator Meyers stated that she had been in touch with the Attorney General on the issue of surrogate motherhood. There is nothing in the statutes that prohibits this practice or provides any guidelines or restraints. She suggested that the committee introduce a bill spelling out rights and responsibilities of parties involved.

Senator Hayden moved that this bill concerning surrogate motherhood be introduced. Senator Francisco seconded the motion and it carried.

SB 13 - providing for issuance of certificates of qualification of advanced registered nurse practitioners

Emalene Correll, Legislative Research Department, reviewed the history of SB 13 and told how it was developed. Her memorandum will be distributed to members of the committee giving the background of the concept of registered nurse practitioners in Kansas. (Attachment #1)

Norman Furse, Revisor of Statutes office, reviewed SB 13. He said this bill was developed by the Interim Committee following a court case in

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

which the judge ruled the legislature had made an unconstitutional delegation of authority to the State Board of Nursing. He reviewed each section of SB 13, noting the major changes relating to each section. Some changes recommended are: adoption of a definition of the expanded role of ARNP; setting standards and guidelines for the Board of Nursing; a grandfather provision regarding certain certification requirements and fees for ARNP's certified prior to the court case; placing all ARNP sections together as new sections; and language and technical changes.

In response to a question, Mr. Furse said that the Board of Nursing has actual accrediting authority, and the Board of Healing Arts does not.

Senator Morris moved that the minutes of February 4, 1983, be approved. Senator Francisco seconded the motion and it carried.

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-7-83

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Lynelle King	Ks State Nurses' Assn.
Lynne Bachman Brown	Ks. Health Care Assn.
Janice Madsen	Assoc. of Operating Room Nurses
Rebecca Kupper	Ks. Hosp. Assoc.
Michele Hinds	Legislative Intern
Sister Lucy Callaghan	U of Ks - School of Nursing
Marilyn A. Chard	U of KS - school of nursing & Univ. Ped. association
Beth Potts	University Ped. Assn. University of Ks. Med. Center
Keith R Landis	Christian Science Committee on Publication for Kansas
[illegible]	KS Medical Society
Donna Howell	Washburn U. Nursing Student
Carole Gonzalez	Girl Scout
Rosemary Smith	Girl Scout
Sherri Santos	Girl Scout
Charlotte Pokorney	Girl Scouts
Nickie Stein	KS St. Nurses Assn.
Ron Daches	KACI

2-7-83 #1
SB 13

MEMORANDUM

October 11, 1982

TO: The Special Committee on Public Health and Welfare

FROM: Kansas Legislative Research Department

RE: Nursing and the Nurse Practitioner

Development of Nursing

In discussing the role of the nurse practitioner in the health care system of the 1980s, it may be helpful to look at the development of nursing laws in the United States since the beginning of the 20th Century and at various factors that have resulted in changes in the legal and practice status of nurses.

Medicine was the first of the professions to establish the legal precedent of licensure of an occupation by the states and to protect the occupation from those who were incompetent or untrained. Texas was the first state to license physicians and to prohibit medical practice by those who were not licensed through the enactment of the first medical practices act in 1973. After the U.S. Supreme Court held that occupational licensing was a valid exercise of the powers of the states in 1888, the licensing of medical practitioners spread rapidly to all the states. Medicine, unlike other professions, also gained control of medical education through the accreditation of medical schools early in the 1900s.

The first national nursing organization was not established until 1894, some 47 years after the American Medical Association was founded. Unlike medicine, nursing did not lobby for nursing practice acts initially, but for the recognition of trained nurses through registration by the states. North Carolina became the first state to enact a nurse registration act in 1903. By 1923, all of the states then in the Union had enacted nurse registration acts. The early nurse registration acts were not analogous to the medical practice acts because they did not include a statement of the scope of practice of registered nurses nor were they mandatory practice acts. Rather, they provided for a registry of those nurses who had completed an accepted nursing program and had passed an examination conducted by a state agency. In other words, the nurse registration laws made it illegal to use the title "registered nurse" without meeting state requirements, but did not make it illegal for an unregistered individual to practice nursing.

New York initiated the second phase of nursing by enacting the first mandatory nurse practice act in 1938. The New York law recognized two levels of nurses — the registered professional nurse and the practical nurse. By the time that nurses began to lobby for mandatory nurse practice acts, the standard training for nurses had become the three-year hospital-based diploma program and nurses were beginning to move from private duty practice to hospital settings. Nursing did not totally control nursing education, as medicine controlled medical education, since three-year diploma programs were operated by hospitals and were influenced by hospital administrators and medical staff.

Atch. 1 SB-13 2-7-83 #1

With the expansion of mandatory licensing acts in the 1940s and 1950s it became necessary to define nursing or the scope of practice of nursing in order that prohibitions against nonlicensed practitioners engaging in nursing could be enforced. It was not, however, until 1955 that the American Nurses Association (ANA) adopted a model definition of nursing practice which was subsequently adopted in toto or substantially by some 21 states, Kansas among them.

The model definition of nursing adopted by the ANA in 1955 contained the following disclaimer. "The foregoing shall not be deemed to include any acts of diagnosis or prescription of thereapeutic or corrective measures." The disclaimer was not found in some of the practice acts passed before the model definition was promulgated, nor was it included in some state act developed after 1955. In fact, some authorities believe that the decliamer was out of date when it was proposed since registered nurses were, in many practice settings, observing a patient, collecting data about the patient and making decisions about the type of nursing care to be provided the patient.

By 1970, a number of changes in nursing education had taken place, with the phasing out of diploma programs and the growth of collegiate nursing education. By 1978, only 23 percent of the nurses who graduated that year were diploma program graduates. The remainder received associate arts or baccalaureate degrees. By the 1970s, nursing education had become professional education and had moved far away from the apprentice orientation of the earlier part of the 1900s.

At the same time that nursing was becoming increasingly professionalized, changes were taking place in medicine. Because of the rapid growth in science and technology during the mid-1900s, medicine became more complex and more specialized. Although in the early 1900s most practitioners of medicine were in general practice, by 1976 the Department of Health, Education and Welfare reported that specialists outnumbered generalists by four to one. Specialization in medicine led to a shortage of primary care providers available to treat common illness and chronic conditions and an interest in alternative systems of primary care delivery.

As technical advances came about in health care, specialized nursing units were developed. The coronary care unit provides an example of the expansion of nursing practice. When it was recognized that many deaths following heart attacks could be prevented if arrythmias could be diagnosed and converted to normal rhythms, nurses with advanced specialized training begain to staff cardiac care units. Such nurses represented an incursion into what was formerly considered the sole realm of medicine. The nurses who staff intensive care units also represent an area of nursing practice once thought to be reserved for medicine only, functioning as they do in making on the spot diagnostic decisions and implementing appropriate treatment for intensive care patients without waiting to consult a physician.

Two other factors affecting the practice of nursing emerged in the 1960s and 1970s, a changing image of the role of women and rapidly escalating costs in health care. The first resulted in increasing dissatisfaction on the part of some nurses with the traditional role of nursing and a more assertive approach to updating both nursing practice and the laws that regulate such practice. The second intensified interest in the development of new ways to deliver health care, particularly primary care.

The 1970s were characterized by the expansion of nursing practice both in fact and by statute. Since 1971 most states have revised their nurse practice acts, with one of the most significant changes being deletion of language that excluded diagnosis and treatment from the definition of nursing. Most of the amendments to nurse practice acts also recognized in some way the nurse who, by virtue of education and training beyond the level necessary for entry into the profession, is qualified to practice beyond the basic level of nursing. The majority of state laws delegate the responsibility of dealing with the expanded role nurse or nurse practitioner to state boards of nursing or combinations of state boards of nursing and medicine. Generally, the delegation has taken the form of allowing the state board or boards to designate the qualifications and authorized practice of the nurse practitioner through rules and regulations. In several states, state boards of nursing have been able to take on the responsibility of setting the qualifications and dealing with the expanded functions of nurse practitioners without any new statutory authority. Idaho was the first state to recognize the nurse practitioner through changes in the Idaho nurse practice act in 1971. Kansas was among the last of the states to provide statutory authorization for the nurse practitioner through amendments to the nurse practice statutes in 1978.

At the same time that the practice of nursing has evolved, there have been forces operating to restrict the practice of nursing. Among these are the reaction of some segments of medicine to any expansion in the role of nursing in the health care field and divisions within the nursing profession itself as to the role of nurses.

Advanced Registered Nurse Practitioners in Kansas

In 1977, the Legislative Coordinating Council directed an interim Special Committee on Public Health and Welfare to study the role of physician extenders and to make recommendations thereon to the 1978 Legislature. The Committee focused its study on two different providers of health care, the physician's assistant and the expanded role nurse. In making its recommendations in the form of bill drafts to the 1978 Legislature the Special Committee, however, took very different approaches to the two types of providers.

The 1978 bill which related to physicians' assistants required that when such persons apply for registration by the Board of Healing Arts, they present to the Board the name and address of the physician responsible for the practice of the physician's assistant. The bill also provided that a person whose name has been entered on the register of physicians' assistants perform, only under the direction and supervision of a physician, acts which constitute the practice of medicine and surgery to the extent and in the manner authorized by the physician responsible for the physician's assistant. (Now K.S.A. 65-2896e.)

In contrast, the 1977 Special Committee on Public Health and Welfare rejected several recommendations that would have required the expanded role nurse to practice exclusively under the direction of a person licensed to practice medicine and surgery. The 1977 Special Committee on Public Health and Welfare also rejected a recommendation by the Kansas Medical Society that the rules and regulations governing advanced registered nurse practitioners (ARNPs) be jointly adopted by the Board of Nursing and the Board of Healing Arts. In the bill drafted by the Committee for introduction in 1978, the Committee proposed that the statutory definition of nursing be updated to reflect the changed role of nurses in the health care system and that the

Kansas nurse practice statutes be expanded and amended to authorize those nurses who have received advanced training to function in an expanded role if so authorized by the Board of Nursing to do so through certification of qualification to practice as an ARNP. In its report to the 1978 Legislature, the Special Committee on Public Health and Welfare, described the expanded role nurse, designated as an ARNP by the Committee bill, as follows:

> "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 responsibilities in a less structured setting than the nurse who does not have advanced training.
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> "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 interim committee bill, 1978 H.B. 2720, was enacted by the Legislature in substantially the form in which it was drafted by the interim committee. During consideration of the bill, the standing committees to which the bill was assigned rejected recommendations that would have proposed to define "expanded role" by statute and that would have created an advisory committee composed of nurses and physicians to advise the Board of Nursing in the development of rules and regulations defining the scope of practice of expanded role nurses. The bill was supported by the Board of Nursing and the Kansas State Nurses Association through a position paper supporting the concept of recognizing the expanded role nurse in statutes.

The development of the ARNP regulations was a long and difficult process. The first draft of the regulations prepared by the Board of Nursing in 1978 plunged the Board into a controversy within the nursing profession by requiring that, after July 1985, new applicants for a certification of qualification as an ARNP have a BS degree and, after July 1990, new applications have a MSN. The draft regulation also recognized a laundry list of ARNP specialities.

A second draft of ARNP regulations prepared in 1979 would have required the ARNP to have a masters degree in nursing with a major in a clinical specialty. The scope of practice of the ARNP was not clearly delineated but relied on the characteristics of graduate education in nursing prepared by the National League of Nursing as the scope of practice. The Board sent the draft regulations to the

Department of Administration for approval as to form as required by law. Following this action, the Board was invited to meet with the 1979 interim Committee on Public Health and Welfare to discuss the proposed rules and regulations. The interim committee was concerned about the requirement of a masters degree being proposed by the Board of Nursing as the entry level of education for the ARNP, believing that this requirement did not comply with the intent of the Legislature. Subsequently, in 1980 S.B. 566, the Legislature amended three of the statutes relating to the advanced registered nurse practitioner to add "training" to the reference to education programs in the requirement for ARNP status to make it clear that such programs are not limited to those that lead to an advanced degree. The Legislature rejected the Kansas Medical Society's recommendation that the statutes be amended to require that the ARNP work under the direction and supervision of a physician, but did amend the statutes to make it clear that the ARNP functions in an expanded nursing role.

During 1979, the Board of Nursing further amended the proposed ARNP regulations after a public hearing and an opinion from the attorney advising the Board. The Board adopted permanent regulations in December of 1979. The 1980 Legislature rejected the permanent regulations adopted by the Board of Nursing through the adoption of 1980 SCR 1676.

The Board of Nursing initiated new action on ARNP regulations immediately following the 1980 Legislative Session. One of the proposed regulations, K.A.R. 60-10-101, was amended to state, "ARNP's function as members of a physician directed health care team and within the framework of medically approved criteria, policies, and standing orders." The Joint Committee on Administrative Rules and Regulations reviewed the revised regulations in June of 1980 and, among other concerns, raised a question as to whether the sentence quoted above was consistent with the role of the ARNP, other language in the regulations and legislative intent. The latter part of the question referred to the interdependent status of the ARNP and advanced or expanded practice in a less structured role as set out by the 1978 interim committee in its report. Nursing also expressed concern with the sentence added to K.A.R. 60-10-101, pointing out that the language did not differentiate between basic nursing and advanced practice. The languge was rewritten by the Board of Nursing to state, "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." The Board then adopted the draft regulations as permanent regulations with some additional minor changes in November of 1980.

Following review of the permanent ARNP regulations filed by the Board of Nursing by the Joint Committee on Administrative Rules and Regulations in January of 1981 at which several members of the Kansas Medical Society asked the Committee to introduce legislation to reject the regulations, the Joint Committee introduced 1981 SCR 1607 which would have modified the language relating to educational programs to include "training." The 1981 Legislature did not adopt SCR 1607, and the permanent ARNP regulations became effective May 1, 1981. In May of 1981, the Kansas Medical Society filed the action in the Shawnee County District Court which led to the opinion by Judge Allen holding the Legislature failed to provide sufficient guidelines to the Board of Nursing in regard to the scope of practice of the ARNP. By the time the opinion was issued, 141 ARNPs had received certificates of qualification and 25 other registered nurses had applied for certification.

Nurse Practitioner Training and Practice

The 1977 Special Committee on Public Health and Welfare and the 1978 Legislature in working with the nurse practice bill, based their concept of the advanced registered nurse practitioner on two expanded role training programs then in existence in Kansas — the nurse clinician program at Wichita State University and the nurse practitioners program offered by the University of Kansas. In 1977, both were one-year expanded role training programs requiring both didactic study and clinical preceptorship training. These were but two of a number of programs around the country that were developed in the 1970s to train expanded role nurses. The yet unpublished data from the latest longitudinal study commissioned by the Department of Health and Human Services shows there were 91 nurse practitioner certificate programs and 141 masters level nurse practitioner programs in operation in the United States in 1980. Twenty-five of the certificate and 26 of the masters programs were pediatric nurse practitioner programs, nine certificate and 11 masters programs were nurse midwifery practitioner programs, 11 certificate and 14 masters programs trained maternity practitioners, 23 certificate and 39 masters programs offered family nurse practitioner training, 19 certificate and 36 masters programs trained adult nurse practitioners, four certificate programs trained emergency nurse practitioners, six masters programs trained psychiatric or mental health nurse practitioners and, nine masters programs trained practitioners in other specialties.

The Phase III Longitudinal Study of Nurse Practitioners, which reflects data collected in 1977, showed that 58 percent of the graduates of certificate programs were employed immediately after graduation. Thirty-six percent of the graduates of masters programs were employed immediately. Within one month after graduation about 80 percent of the graduates of certificate programs and 75 percent of the masters program graduates were employed. Of those not employed at the time of the survey, about one-half were not seeking employment and about one-third of those unemployed at the time of the survey had been employed since their graduation.

According to the Phase III study, 75.1 percent of the total nurse practitioner graduates (1977) were employed wholly or in part as nurse practioners, with 72.6 percent providing primary care and 2.5 percent teaching, consulting, etc. Of the 14.6 percent who were not practicing as nurse practitioners, 3.5 percent were employed in schools of nursing, 11.1 percent were employed in hospitals, nonhospital institutional settings, community settings or ambulatory practice, and 10.3 percent were not currently employed. Of the nurse practitioner graduates, 53.5 percent were functioning in a nurse practitioner role only, 30 percent were employed in both nurse practitioner and traditional nursing roles, and 16.5 percent were fulfilling only traditional nursing roles. Of the nurse practitioners practicing in a practitioner role, 22.6 percent were employed in inner city practice settings, 18.7 percent were in other urban settings, 14.8 percent were practicing in a suburban setting, 21.6 percent were in a rural practice setting, 7.8 percent were in a combination setting, and 14.5 percent were practicing in various institutional settings. The percentage of nurse practitioners practicing in a rural setting in Kansas is greater than the 1977 national percentage since many of the nurse practitioners who have completed the nurse clinician program at Wichita State are practicing in rural settings.