Approved: February 14, 2005
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Jim Morrison at 1:32 P.M. on February 9, 2005, in Room 526-S of the Capitol.

Committee members absent:
Representative Brenda Landwehr- excused
Representative Patricia Kilpatrick- excused

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Mary Galligan, Kansas Legislative Research Department
Renae Jefferies, Revisor of Statutes' Office
Norm Furse, Revisor of Statutes' Office
Gary Deeter, Committee Secretary

Conferees appearing before the committee:
Terri Roberts, Executive Director, Kansas State Nurses Association
Debbie Folkerts, Kansas State Nurses Association
Diana Corpstein, Kansas State Nurses Association
Carla Lee, Kansas Alliance of Advanced Nurse Practitioners

Others attending:
See attached list.

The minutes for February 8, 2005, were approved.

The Chair opened the hearing on **HB 2256**.

Terri Roberts, Executive Director, Kansas State Nurses Association, spoke as a proponent. (Attachment 1) She suggested two changes to the bill that would clarify the term "mid-level practitioner." She then gave a brief history for advanced registered nurse practitioner (ARNP), explaining that in 1971 the Nurse Clinician Program was initiated in Kansas, a program which by 1979 brought legislative recognition of advanced nursing practice, recognition which was challenged in court. By 1983 legislation was established for independent practice by advanced nurse practitioners. Responding to concerns from the Board of Pharmacy, the legislature in 1989 amended **K.S.A. 65-1130 (d)** to allow a "responsible physician" a degree of authority over an ARNP in prescribing medications. Ms. Roberts noted that the law allowed the DEA to grant ARNPs authority to prescribe scheduled drugs, saying that since 2001 ARNPs have joint protocols with physicians to write prescriptions.

Ms. Roberts stated that there are 2600 ARNPs in Kansas, four different categories (Nurse Practitioners, Clinical Nurse Specialists, Nurse Midwives, and Nurse Anesthetists), and of the 168 rural health clinics in Kansas, more than half are staffed by ARNPs. She noted that fewer than half–24 states–require physician involvement with ARNPs. She urged members to pass the proposed legislation, thus enabling ARNPs to

better serve their constituents.

Debbie Folkerts, representing the Kansas State Nurses Association, also spoke as a proponent. (Attachment 2) She stated that in 1990 she assumed the practice of a retiring physician as a Family Nurse Practitioner; presently she has her own specialty in urology and serves as a consultant in 43 states. She said that, in spite of public misconceptions, ARNPs can practice without a physician's oversight, relying on a physician only through written protocols for prescribing medications, noting that research validates an ARNP's ability to prescribe medications that are low-cost, safe, and with limited side effects.

Diana Corpstein, representing the Kansas State Nurses Association, testified that she has been a Family Nurse Practitioner for 15 years, presently serving in a clinic with 4 medical doctors, 3 osteopathic doctors, as well as several staff nurses, noting that many of her patients over the past 10 years have never seen a physician. She commented on the collegial atmosphere of the clinic, saying that each member knows when to refer patients who need care outside his/her area of expertise, such as to a surgeon or psychiatrist. (Attachment 3) She stated that, if the bill passes, she can receive lab reports directly, patients will receive information more quickly, and medications will be properly labeled–all of which will result in better health care for patients.

Carla Lee, representing the Kansas Alliance of Advanced Nurse Practitioners and speaking for the President, Lou Miller, testified about her past experience and education. (Attachment 4) She said presently a master's degree is the entry level for an ARNP; eventually a clinical doctorate will become the standard.

Conferees answered questions posed by committee members:

Ms. Folkerts replied that if the legislation passes, she would not change her practice, but the bill would remove barriers and restrictions. She said she was trained in family practice. She said her training would not allow her to do surgery nor work in a trauma center. She said Blue Cross and Medicare reimburse ARNPs 15% less than they do for physicians, noting that the bill would have no effect on her liability insurance. She said 30 hours of continuing education is required every two years before she can renew her certification.

Ms. Roberts said that the Board of Nursing investigates 600-800 complaints of incompetence each year; last year there were 147 cases of disciplinary action, reflecting an aggressive attitude toward complaints. She noted that the Board of Nursing must report all complaints and that part of the responsibility of nurses is to provide a check and balance for physicians' prescriptions and practice.

Ms. Corpstein explained that ARNPs follow a clear set of protocols for emergency measures, whether they are alone in a rural clinic or, as she is, working with other medical personnel. She said currently only a physician can pronounce a person's death.

Ms. Folkerts replied that physician supervision over ARNPs has been removed in over half the states, a change that has not resulted in increased litigation, noting that ARNPs are careful to practice within the scope of their training, referring critical-care and complex cases to specialists. She said she has staff privileges in

local hospitals, receives referrals from physicians, conducts her own battery of tests, but does not do invasive procedures.

Ms. Roberts said ARNPs receive training in pharmacology and are solicited by the same pharmaceutical companies as are physicians.

The meeting was adjourned at 3:12 p.m. The next meeting is scheduled for Thursday, February 10, 2005.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: FEBRUARY 9 2005

NAME	REPRESENTING
Brenda Kuder	SRS - HCP/MP
Greta Hamm	SRS - HCP/MP
Rebecca Bailey	KMS
Jerry Slaughter	KMS
Chip Wheelen	KAOM
Carolyn McClendon	Ks St Ds Assn
Diane M. Glynn	KSBN
Mary Blubaugh	KSBN
Patty Brown	KSBN
DEBORAH STERN	KS. HOSP. ASSN.
Robyn Parker	self / KSNA
Terri Roberts	KSNA
Janis Jones	KSNA
Queen Tatkers	KSNA
Diana Carpenter	KSNA
John Kiefhaber	Ks. Pharmacists Assoc.
Laura Hamlin	KSNA
Traci Doering	hammco
Ward Cook	American Cancer Society

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HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: Feb. 9, 2005

NAME	REPRESENTING
Bud Burke	Ks Physical Therapy Assn

For More Information Contact
Terri Roberts J.D., R.N.
troberts@ksna.net

Chairmen Morrison and members of the House Health and Human Services Committee, my name is Terri Roberts J.D., R.N. and I am here representing the Kansas State Nurses Association. KSNA requested this bill introduction and is pleased that the Committee is conducting a hearing on H.B. 2256. This bill actually makes three changes to statutes that will permit ARNP's to prescribe medications and perform and deliver care for their respective clients. Let me first say that what is proposed is clearly in line with the emerging trends throughout the country, and its been over twenty years since this section has been revised.

There are two amendments to H.B. 2256 that I want to first review

The first is in line 28 through 31. The (1) that is currently in line 30 before the word a rural health network physician should have been placed in front of the word "physician" on line 28. This section should read:

"Mid-level practitioner" means a (1) physician assistant who has entered into a written protocol with a rural health network physician *or (2) an advanced registered nurse practitioner.*

The second change is to clarify that there is only one area where ARNP's are added to the list of pharmacy act definitions. ARNP's have been added to the definition of "practitioner" on line 24 of page 7. The old language in the definition of "Mid-level practitioner" on line 6 on page 9 should be deleted and reference only PA's. This section should read:

(ii) "Mid-level practitioner" means ~~an advanced registered nurse practitioner issued a certificate of qualification pursuant to K.S.A. 65-1131 and amendments thereto who has authority to prescribe drugs pursuant to a written protocol with a responsible physician under K.S.A. 65-1130 and amendments thereto, or~~ a physician assistant licensed pursuant to the physician assistant licensure act who has authority to prescribe drugs pursuant to a written protocol with a responsible physician under K.S.A. 65-28a09 and amendments thereto.

The History of Advanced Practice in Kansas will give you a brief look

Attachment 1
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at where the practice of ARNP's has been the past thirty years.

The Early Years of Advanced Practice Nursing in Kansas

1960's: The Advanced Practice role in nursing in the United States began in this decade.

1971: The Nurse Clinician Program in Kansas was initiated by the Regional Medical Program. Also during this year, Idaho was the first state to revise its nurse practice act to define advanced practice nursing.

1972: The University of Kansas admitted the first class.

1973: Wichita State University admitted its first class.

1974: There was discussion in Kansas to propose changes to the nurse practice act.

1977: 30 states had changed their nurse practice act to accommodate advanced practice. In the fall of 1977, the Kansas State Nurses Association held 21 forums in 16 districts to educate nurses and other health care professionals and consumers about advanced practice and the proposed legislation.

1978: According to the February 1978 newsletter of the Nurse Clinicians/Nurse Practitioners/Clinical Nurse Specialists Conference Group, "KSNA had planned to open the NPA in 1979. However, the State Department of Health and Environment suggested if KSNA did not open up the NPA in 1978 to include the expanded role of nursing, then they would do so." At the beginning of the legislative session of 1978, the bill to sanction and define advance practice nursing was introduced by the Senate Public Health and Welfare Committee. Joyce Olson, President of KSNA, spoke in favor of the legislation. It was opposed by the Kansas Medical Society. It was passed with one amendment by the optometrists prohibiting advanced practice nurses from practicing optometry.

1980: A survey of advanced practice nurses was taken at a meeting in Overland Park, Kansas, in May, which describes the salary, education, and certification levels of the nurses active at that time.

1981: The conference group formally changed its name to the Advanced Practice Conference Group. In September the Assistant Attorney General filed a motion on behalf of the Kansas State Board of Nursing to dismiss a lawsuit opposing the ARNP statute, previously filed in Shawnee County by the Kansas Medical Society.

1982: On June 21, Judge Adrian Allen of the Shawnee District Court ruled the ARNP statute unconstitutional. In July the Board of Nursing voted to ask for a "stay" which would allow nurses to continue practicing until the matter was settled. Judge Allen denied the motion. In September the Executive Director of KSNA

gave testimony to the Interim Public Health and Welfare Committee about the issue of control, or "supervision," which was the basis for the complaints by the Kansas Medical Society.

1983: In January a new bill to re-enact the ARNP statute was submitted by the Senate Public Health and Welfare Committee. The Kansas Medical Society tried on two occasions, as it passed from the House to the Senate, to amend the bill to provide for supervision by physicians. An overwhelming response on the part of nursing contributed to their defeat in this attempt. On April 22nd Governor John Carlin signed into law the bill which allows Kansans to receive the services of advanced practice nurses, who are legally responsible for their own practice.

Since 1983 there have been two more changes that are significant to the practice of ARNP's.

KSA 65-1130 (d) was added in 1989, at the request of the Board of Pharmacy to make it clear that ARNP's could issue prescriptions. This was the first and only introduction into the statute of any physician language, and the term "supervision" was intentionally not used when the description of "responsible physician" was included. The Kansas Medical Society actually insisted on the responsible physician language and wrote it.

The second change to this section 65-1130 (d) was made by the 1999 Legislature. Again the Board of Pharmacy insisted on clarity about the use of DEA numbers, then being used by multiple ARNP's. Effective April 1, 2000 ARNP's were required (if prescribing Schedule 11 Drugs) to prescribe schedule drugs using their own DEA number.

There are currently over 2600 ARNP's in Kansas, in four different categories; Nurse Practitioners (1251), Clinical Nurse Specialists (649), Nurse Midwives (56) and Nurse Anesthestists (693). Nurse Anesthetists are also governed by a separate statute, passed in 1986 that describes their respective scope of practice. The three categories of ARNP's that this statute will address are the NP, CNS and CNM.

Kansas currently has over 165 Rural Health Clinics. By definition to qualify as a Rural Health Clinic they must be staffed 50% of the time with either an ARNP or a Physician Assistant. In Kansas, over half of the rural health clinics are staffed by ARNP's. These nurses are providing primary care to what would otherwisee be underserved communities. We are very proud of the contributions that this ARNP's make in Kansas, and it our sincere desire to remove the unnecessary practice restrictions imposed by the "responsible physician" language so that they can better care for their patients and communities. It is also fair to say that a high number of ARNP's provide primary care to the medically underserved in the indigent clinics and Federally Qualified Health Centers in the state.

My colleagues will address the practice arena with specific information about why this is important legislation.

Before I turn it over to Debbie Folkerts, there are a couple additional items that I need to share about this proposal.

1. Twenty-one states do not require any physician involvement, six states require physician involvement in the form of collaboration, supervision, authorization, and/or delegation—but no form of written documentation, and 24 states including Kansas have a requirement that the involvement must be documented in writing.

2. ARNP Education in Kansas is currently at the Master's level. Two additional years of clinical and didactic education on top of the baccalaureate degree. BSN graduate RN's have at least 2 years of clinical, pharmacology and didactic education in nursing. There will be an argument that ARNP's are not educationally prepared to be given this "expanded" scope.

There is no evidence that ARNP's lack competency to prescribe properly and perform simply and minor office based treatments (casting, suturing).

Physicians are and will always be, just like nurses, an integral member of the healthcare team. ARNP's are first licensed nurses with an independent scope of practice, and with additional education are recognized as ARNP's with an "expanded" scope of practice. They are competent to prescribe, as demonstrated through the past 15 years of experience with prescribing, and they are providing primary care with a very low litigation rate, or for that matter formal disciplinary action for either competency or exceeding their scope of practice.

We believe that it is time to amend the statutes to reflect the true practice arena.

For More Information Contact
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H.B. 2256 ARNP-Prescribing Medications
February 9, 2005

Chairperson Morrison and Members of the House Health and Human Services Committee,
my name is Debbie Folkerts, and I am testifying today to ask for your support of H.B. 2256, which proposes changes to the current Advanced Registered Nurse Practitioner statutes.
At issue in the United States, and closer to home here in Kansas, we face some very critical issues to our population: access to health care.

Because our state is so vast and expansive, it is imperative that patients not be restricted to only one or two types of "providers." ARNPs are highly educated, qualified health care providers that will often work in underserved and rural areas that their MD/DO colleagues will not serve in, mostly because there is an inadequate supply of primary care physicians, but also because more densely populated areas are where they can best meet more health care needs.

ARNPs also work in inner-city and suburban areas and fulfill roles in a variety of specialties such as family practice, pediatrics, neurology, gastroenterology, cardiology, women's health, etc. They complement busy specialty clinics that are overworked and short-staffed, but nonetheless very much still needed. These are services and care that could easily be further expanded to the more remote areas, and Kansas could encourage more recruitment as a "practice-friendly environment" if the "responsible physician" language is removed from the current statute (65-1130). ARNPs are willing to serve these populations but are "handcuffed" by these regulations that impede the normal course of our jobs and thus prevent health care access to Kansans.

Small communities like McLouth, Easton, Carbondale, Phillipsburg, Lakin, and Ludell would undoubtedly benefit from ARNP-staffed clinics, and would welcome the opportunity to have a local health-care provider for their needs. The misconception to the public is that the ARNP can't practice without an MD. The truth is that the ARNP must have a written protocol with
the physician **only** for writing prescriptions. That is the extent of the

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written relationship.

This bill seeks to eliminate this requirement. It also adds more progressive language to the scope statement that provides clear guidance to ARNPs and other health care providers.

For More Information Contact
Terri Roberts, R.N., J.D.
Executive Director
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H.B. 2256 ARNP-Prescribing Medications
February 9, 2005

Dear Chairperson Morrison and Members of the
House Health and Human Services Committee:

I am testifying today to ask for your support of H.B. 2256, which proposes changes to the current Advanced Registered Nurse Practitioner statutes. I am a Family Nurse Practitioner serving the Leavenworth County area for over 15 years. I previously worked as a staff nurse in the emergency room and operating room. Prior to that I was a licensed Adult Care Home Administrator in Kansas. My education includes a B.S.N. from Washburn University in Topeka and an M.S.N. from the University of Kansas. I have a minor in Health Care Administration. I am also Board Certified as a Family Nurse Practitioner.

I am very committed to my community and to the many patients that I serve. Most of my patients have never seen the responsible physician whose collaborative medication protocols I use, unless they needed his name to fill out a referral. Most of my patients have been with me over ten years—and I see them in the stores, at church, at school, and around town. Through the years, I have informed them they were expecting, done prenatal care, made newborn rounds, performed kindergarten physicals, diagnosed and treated ear infections, strep, heart murmurs, Down's syndrome, and many, many scrapes and tummy aches. I have sewed up lacerations, casted many, many fractures, and referred countless others to a wide variety of specialists whom I am proud to call my physician colleagues. I have been there when these same families have suffered through a child addicted to drugs, a motor vehicle accident involving the death of a family member, informing a patient they have AIDS, telling them they have cancer, or telling their families that their Mom or Grandma is dying. I have picked up medicine and delivered it, and made house calls when necessary. I call and check on patients on the weekends. This is what I do, and in many parts of our state, this is what a lot of ARNP's do .

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I may refer some patients to the physician, the social worker, the psychiatrist, the physical therapist, and/or the surgeon. Health care is all of the disciplines working together to provide the best service possible under the worst possible conditions. Physicians are, like nurses, an essential element of the health care system.

I would like to share with you some experiences that are less likely to occur when this bill is passed. Some practice concerns that will be better served if this bill passes include:

1 Proper and timely lab and test correspondence being received;
2 Accurate labeling on prescription bottles.

Lab/Diagnostic Testing

Some hospitals, labs, and diagnostic testing centers have the misguided notion that physicians only have to get results. By removing "responsible physician" language, this information will come directly to the ordering ARNP, and streamline results for more efficient, reliable, quality patient care. (This represents a potentially significant safety issue.)

Example: Nurse Practitioner ordered arteriogram. Results came to Dr. J. Smith. The practice has two Drs. Smith—the N.P.'s collaborative MD was Dr. C. Smith. Results were delayed by eight days—the patient needed surgery.

Referrals

We currently must put the physician's name on referrals to specialists. (Example: podiatry, ENT, neurosurgery.) The consultant reports and results then come to the "responsible physician"—often, this physician has never even seen the patient. This report may then sit on a desk or get filed, and the results may get delayed or recommendations

may not be
followed up on.

Example: Nurse Practitioner refers patient to neurosurgeon for low back pain, lower extremity tingling, numbness, abnormal MRI. Results come back to the clinic in the name of the collaborating MD. MD is out of town from Tuesday through Friday. The MD gets to the reports on the following Tuesday. A total of twelve days elapse. The recommendations include steroid injections and physical therapy. Treatment is delayed while the patient remains in pain.

Prescriptions

Not all pharmacies will put the name of the ARNP who writes a prescription on the label; sometimes they put the name of the responsible MD/DO instead. This confuses the patient and the staff, especially for refills. (E.g., when N.P. Jones writes a prescription for blood pressure medicine, and it comes out on the label as "Accupril 20 mg by Dr. Joe Smith—no refills," when it is time for a refill, Dr. Joe Smith gets called. If he doesn't remember the patient,
it may cause unnecessary delays in refills, or possibly no refill at all.) In large clinics
with several MD's and ARNPs, with many who take call, it could be very confusing.

The failures in this system cause significant reduction in the ability to deliver quality care.
The patient is entitled to quality, efficient care by the provider of choice. For the thousands
of patients in Kansas who have chosen to utilize nurse practitioners as their primary health care providers, it is imperative that these critical barriers be removed to improve the safety and health of these populations.

The new language proposed in KSA 65-1130, "*The authorization to perform acts of medical diagnosis and prescription of medical, therapeutic and corrective measures under this section comes from the advanced registered nurse practitioner's educational preparation, national certification and authorization to practice in compliance with rules and regulations established by the board*,"

will make it clear, so there is no ambiguity, that ARNP's have the legal authority to write prescriptions, write orders for lab and diagnostic tests and receive corresponding results,
and practice within the parameters of their education.

Kaanp

Kansas Alliance of Advanced Nurse Practitioners
2251 N. Maize, #88
Wichita, KS 67205

February 8, 2005

Jim Morrison, Chair; Peggy Mast, Vice-Chair; Bob Bethell; Pat Colloton; Willa DeCastro; Geraldine Flaharty; Delia Garcia; Mario Goico; Don Hill; Tom Holland; Kasha Kelley; Mike Kiegerl; Patricia Kilpatrick; Brenda Landwehr; Frank Miller; bill Otto; Eber Phelps; Judy Showalter; Sue Storm; Jason Watkins
House Health and Human Services Committee
Topeka, KS

Dear Committee Members:

Your committee recently introduced H.B. 2256 relating to the Advanced Registered Nurse Practitioner practice. This bill has come to the attention of the Kansas Alliance of Advanced Nurse Practitioners, the Kansas Affiliate of the American Academy of Nurse Practitioners. The organization will be watching the progression of this bill as the legislative session continues.

The Kansas Alliance of Advanced Nurse Practitioners (KAANP) was initially established as a Task Force in 1987 and approved as an affiliate of the American Academy of Nurse Practitioners (AANP) in 1989. The Kansas Alliance of Advanced Nurse Practitioners is the recognized state organization for Advanced Registered Nurse Practitioners in the State of Kansas.

The mission of KAANP is to promote the advancement of the role of advanced practice nursing. The initial concerns for the organization were legislative, liability, protocol, prescriptive authority, and third party pay as well as general advanced practice issues. These concerns are just as important today as they were fifteen years ago. Our organization has worked with other healthcare organizations, including the Kansas State Board of Nursing, to promote quality, cost-effective, and most importantly safe health care to the residents of the State of Kansas.

The general purposes of the organization are to: promote high standards of health care delivered by advanced registered nurse practitioners, serve as a forum to enhance identity and continuance of the role of advanced registered nurse practitioners, and function as a network of key information for advanced registered nurse practitioners.

The services provided by KAANP include professional meetings to address issues and

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concerns of advanced practitioners. The alliance holds an annual assembly for addressment of the issues in addition to conducting business before the membership and provision of a relevant practice topic for continuing education needs. KAANP also plans and holds programs addressing legislative and third party pay, protocol, including preparations of testimony, platforms, and proclamations. The annual assembly held in August 2004 addressed the KSBN proposed ARNP regulation revisions by having KSBN staff give details to the membership. Other services of the organization include networking between colleagues to share practice and professional ideas and co-joint planning of addressing issues with other organizations regarding advanced practice nursing in the state of Kansas.

As current President of the Alliance, I have previously established an Ad Hoc committee, which has worked closely with the Kansas State Board of Nursing ARNP committee for approximately the last two years on proposed ARNP regulation revisions. There has been significant progress with the committee work in making revisions without need to open the statutes at this time. Due to the rapidity of the movement of this committee, KAANP has not had time to fully study the ramifications on the future of advanced registered nurse practice in the state. KAANP is notifying the membership regarding H.B. 2256 and will be studying the issue closely.

During the past two years, our Ad Hoc committee has studied the advanced registered nurse practice acts of all fifty states, the standards and scopes of practice from each of the nursing specialties and accrediting bodies to ensure that revisions made to the current KSBN nurse practice act will be congruent with regard to quality, safe care and evidence based practice. Our organization has made suggestions to the KSBN ARNP subcommittee working on the proposed revisions on several occasions and continues to work with them. Part of this work has included definitions such as protocol and collaboration as well as addressing the need for national certification for ARNPs to practice in the State of Kansas. National certification of Kansas ARNPs has been a goal of KAANP since the organization formed in 1987.

KAANP will continue to follow H.B. 2256 and other legislation related to advanced registered nurse practice in the state of Kansas to ensure high quality, cost-effective, and safe health care to the residents of the great State of Kansas now and for the future. KAANP is pleased to see that the entire state is well represented on this committee and that nursing and other health care professionals are represented as well. We would be most grateful to assist the legislators in their endeavors to do the same.

Sincerely,

Lou Miller, EdS, MSN, ARNP, FNP
President, Kansas Alliance of Advanced Nurse Practitioners (KAANP)

The Kansas Alliance of Advanced Nurse Practitioners (KAANP) established in 1987 and approved as the Kansas affiliate of the American Academy of Nurse Practitioners

(AANP) in 1989.

The mission of KAANP is to promote the advancement of the role of advanced practice nursing.

Kaanp

Kansas Alliance of Advanced Nurse Practitioners
2251 N. Maize, #88
Wichita, KS 67205 316- 962-7467

February 8, 2005

Gary Deeter, Secretary
House Health and Human Services Committee
Topeka, KS

Dear Gary,

I am writing you in regards to H.B. 2256, which pertains to Advanced Registered Nurse Practitioners. I am currently President of the Kansas Alliance of Advanced Nurse Practitioners. We are requesting that KAANP be placed on the agenda for February 9. Carla A. Lee, PhD, ARNP will represent our organization.

I am attaching a letter for the committee. Please distribute prior to the meeting on February 9.

Thank you,

Lou Miller, EdS, MSN, ARNP, FNP
President, Kansas Alliance of Advanced Nurse Practitioners (KAANP)

Kansas Alliance of Advanced Nurse Practitioners initially established as a Task Force in 1987 and approved as an affiliate of the American Academy of Nurse Practitioners (AANP) in 1989.

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