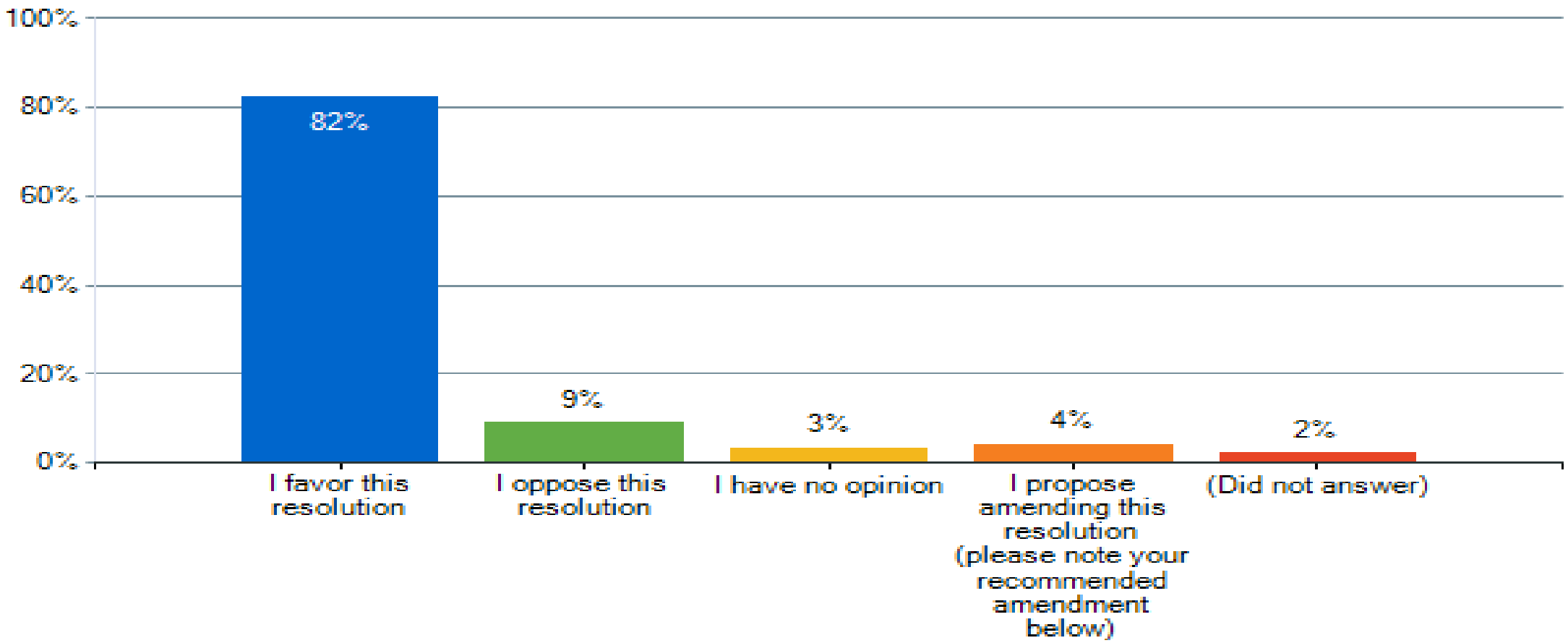
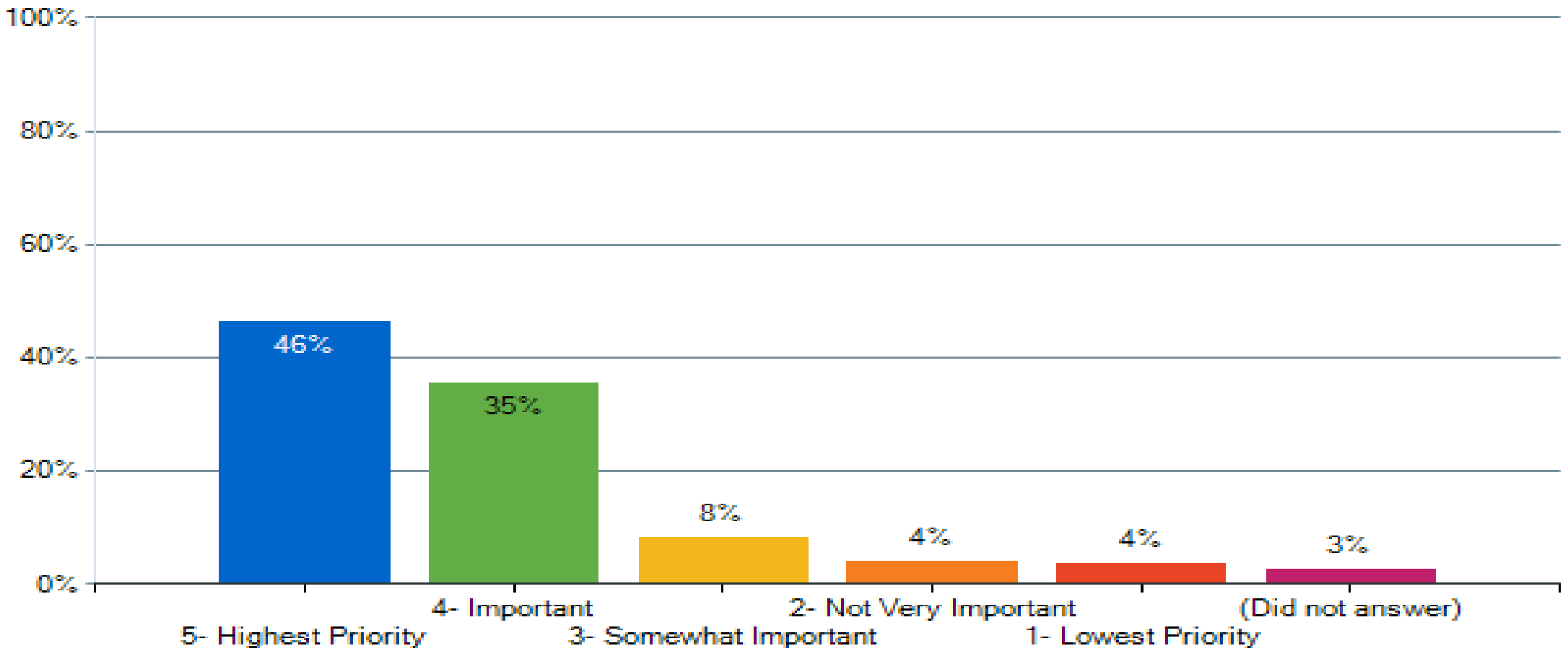
State Legislation Proposal for Scope of Practice Limitation for Nurse Practitioners in Initial Specialist Assessment



191 Responses

Please indicate your view of this resolution as an ISMS priority.



190 Responses

Q1. Comments

SR No.	Response No.	Response Text
1	5	Thank you for addressing this .
2	13	I'm concerned that limiting NP's from providing initial consult or evaluation is too broad of a resolved that would severely negatively impact rural medicine and access to care.
3	16	This would severely limit patients' ability to get help for mental health or medical issues. This would only put limits on clinics or hospitals because of a lack of doctors being available to provide care or assessment
4	17	I agree with ISME.
5	20	Timely may need to be defined.
6	21	I believe strongly based on the level of training for each provider discussed that this practice is allowed to continue and has been allowed in the first place.
7	24	Agree with this legislation. Initial specialist evaluation and treatment plan should be performed by the specialist physician.
8	32	Totally agree
9	35	If you want to further limit the treatment of patients and want to further delays, then push this bill forward. Specialist physicians are already not able to get to all of the patients referred to them and perform the documentation adequately. This will.make getting to patients in all setting more difficult and will lengthen the time to get specialist care not shorten or improve the care. I assume that an NP with a collaborative agreement will collaborate with the physician. Why no limit the NPs who have no collaborative agreement?
10	36	I emphatically agree with this and hope that the ISMS continues to advocate for physician-lead healthcare.
11	40	If a patient treated by a nurse practitioner fails to appropriately manage a patient's care they should be sued for malpractice. Any complications that may occur as a result of a failure to provide "standard of care" to a referred patient should indemnify a subsequent treating physician from damages resulting from such a breach of the standard. A subsequent treating physician can use this breach of standard as a defense so as to mitigate subsequent damages.
12	41	Having done rotations in Rockford with private practice specialists I've seen situations where there were just too many admissions for the MD/DO's to handle by themselves, so they hired and trained a team of APNs to help with admissions. I asked them about it and they said that it takes several years to train these APNs and afterwards "they work at the level of 3rd year fellows". From what I can tell this arrangement is needed as there are no fellowships in

		Rockford yet so these private practices don't have fellows they can have help with the workload. I think it's important to regulate the degree of responsibility/autonomy that NP/PA/APNs have, but maybe there's a way to allow them to continue helping with large workloads while still ensuring patient safety; e.g. pushing for requiring standardized training systems (like a mini-residency). Yes we need more physicians, but at least for now we also need more mid-levels to fill the gap.
13	42	I agree. In favor
14	44	I like this idea, but how do you define a specialist? Is a hospitalist a specialist? How about an outpatient doc with a mixed primary/speciality practice? What about a family physician who offers cosmetic and aesthetic services?
15	46	One of the chief impediments in office practice now is the need for extensive documentation. To the extent that this can be done by clerks or nurses , it improves a physician's practice (and life satisfaction). The proposed legislation could limit this severely depending upon how it is written and how it is interpreted in courtrooms when the plaintiff lawyer is pointing out that initial history gathering was in violation of a state law.. Who a "specialist physician" is when most physicians are Board Certified including both Internal and Family Medicine is also an area of potential mischief in a malpractice suit. There is a legitimate concern here, but I don't think this is the way to solve it.
16	49	I agree with the resolution.
17	50	STRONGLY support, there are social justice implications in having a non-physician be the initial consultant for specialties, especially for our underserved populations
18	51	essential resolution
19	63	Conflict of interest - I do supervise several nurse practitioners. Some do have specialist training and certification. This is a very broad proposal.
20	67	Nurse practitioners definitely should not be used instead of specialist physicians to see new patients referred to specialist physicians. To use nurse practitioners as substitutes for specialist physicians is not fair to patients, primary care providers seeking higher expertise, and nurse practitioners themselves, and is shameful because it is not in the best interests of patients. It may delay optimal treatment and puts everyone involved at increased risk of inadvertent medical mistake.
21	68	Should include scope of practice for PAs
22	69	YES! A specialist should have extended training in a specific area. Sending a patient from any physician to a nurse practitioner or physician assistant is a downgrade in care.
23	73	Agree that new patients to a specialist such as myself should be evaluated by the specialist first. Our training is

		much more extensive, and the expertise we offer is invaluable when we consult on a patient.
24	75	Permitting NPs to provide initial snd independent specialty car is another way / or only a shade of grey away from full independent stand alone practice.
25	76	Agree. This should be supported.
26	77	I am in agreement with this- nurse practitioners are extenders of care, not initiators of care. This legislation is consistent with best clinical practice and the physician-mid level relationship.
27	95	Many referrals come to our specialty from mid-level providers. There are certain common and often benign referral reasons that we shunt to our APN because of standardized work-up and being understaffed because of national shortage of pediatric subspecialists. If we were not allowed to have an APN do initial visit, this patients would likely wait 4-6 months for a new patient appointment. Until the reimbursement structure changes to give pediatric subspecialists incentive to go into a subspecialty field, I don't expect the national shortage to resolve. Most pediatric subspecialists make less and have a 500-800k drop in lifetime earnings compared to a general pediatrician.
28	108	I agree that specialty level Of assessment, requested by a physician is not a request for an opinion by any other than a physician specialist
29	110	Agree 100%
30	111	Agree. Why have specialists if such training is not worthwhile? Common sense.
31	114	This seems like a reasonable proposal though I do wonder how realistic it is given the huge proliferation of APNs throughout hospital systems.
32	123	I support this resolution. Patients often need evaluations and treatments from more experienced, higher levels-of-knowledge, specialist physicians, i.e. patient care is being transferred to a higher level of care. APRNs/NPs do not meet that higher level of care standard because in all, or almost all cases, the referring physician already has more training and experience than a specialty APRN/NP. The physician specialist should be doing the consultation and this should be the "standard of care" for patients. Perhaps amending this resolution to included that patients need to be informed if their specialist evaluation is being done by an APRN/NP and the patient should sign an informed consent form that they know they will be receiving a lower standard of care evaluation by an APRN/NP.
33	125	To vague "without timely" NP's have collaborative agreements with supervising Physician and how they so business is their business
34	126	It needs to be clear to patients the difference between a "Doctor" (MD or DO) and a nurse practitioner

35	147	This a timely issue. I think it is a slap in the face to any referring physicians to have their patients assessed by someone with less training.
36	151	Support this resolution
37	161	A long-overdue idea that I believe will improve patient care.
38	164	In general I agree with the premise of this proposal, but I have dealt with several excellent Nurse Practitioners - I am concerned that limiting their ability to perform the initial evaluation may lead to delays in care due to the an inadequate number of physicians in some subspecialties and areas of the country - a stipulation requiring a period of "timely, in-person, co-assessment by the specialist physician" would hopefully facilitate adequate training - I would hope that the supervising subspecialist would realize that it isn't in their best interest to allow a Nurse Practitioner to practice above their skill/knowledge base
39	165	Nurse Practitioners -should be limited to very basic medical treatment. They seem to think they know more than they do 1. Dangerous
40	167	Very appropriate proposal.
41	168	This is too limiting to the specialists that use nurse practitioners. Perhaps something that puts more accountability on the specialist, but does not make specific rules.
42	169	This is overdue. When a physician refers due to provide greater expertise in a particular area of patient need, it is inadequate for the consultation to be performed by someone following directions but without the full scope of training required to be fully licensed in the practice of medicine. The specialist must participate in the completion of the consultation.
43	172	Thank you for your advocacy on behalf of physician specialists, and primary care providers who refer to said specialist. All are recognizing their scope of practice upon referral and asking for more highly trained providers then themselves-which must be honored for both provider and patient.
44	178	I don't agree with the verbiage. They are presuming that all advanced practice providers are the same. That is not the case. In our hospital system, APP's are required to have collaborating physicians and to sign off on their notes. Our ER group (Vituity) has extensive post education training for APP's that work with them in specialist areas.
45	179	Support in theory but need to define timely. I would say at least 24 hrs. Our GI APN gives national lectures on GI topics to other APNs and PCPs. She has an extensive GI knowledge base and better decision making than some new GI physicians fresh out of training.

46	180	It is absolutely critical that a board certified consultant provides evaluation of patients requiring specialty consultation and co-management.
47	184	We are swimming upstream on this one, powerful economic and political currents against us. Yet we should advocate for the best care for our patients. We may not prevail, but it is righteous to try.
48	186	I agree. There should also be a board that certifies nurse practitioners to be a “SPECIALIST”:This should,also apply to Physician Assistants.
49	187	This is a significant problem in the hospital setting. It often is associated with lack of supervision by the collaborating physician.
50	192	I agree. The PA and APN do not have the same depth of knowledge as a MD and DO. They do not have the depth of understanding the pathophysiology. They can miss alternative diagnosis
51	194	When. for instance. an internist refers to a specialist, the last thing he/she wants is for someone with less training to give the consult.
52	198	Agree. Need supervision in person by physician.
53	199	this is the best thing I have read all day. I hope to see more of this.
54	219	Excellent resolution! I support 110%. I’m so happy to see ILMS is finally taking the very serious issue of scope of practice seriously. Patients lives are at risk!
55	220	It used to be, APN's were nurses with years of clinical experience who would go back for certification. Now programs are graduating APN's with no experience outside of their clinical rotations. Unnecessary additional testing is done and complex patients care is compromised
56	221	I think it is ok for them to see the patient initially but ONLY with oversight and co examination by a physician.
57	222	I favor this legislation, but would like to see specific time parameters regarding the "timely, in-person, co-assessment by the specialist physician." Alternatively, adding a resolve that the NP will immediately inform the specialist physician that a patient was seen at the conclusion of their examination would prompt the consultant physician to schedule the patient depending on their schedule.
58	224	Great initiative to continue providing excellent healthcare to patients and insuring they receive the care they deserve.
59	226	I find it degrading and disrespectful to hear that a patient the I, as a pediatrician, referred to a pediatric specialist has been evaluated by a nurse practitioner only. Regardless of training, does one really believe a nurse practitioner knows more than the referring pediatrician?
60	230	I agree with this due to the addition of the part about timely, in-person, co-assessment by the physician.

61	233	As a specialty physician, I oppose this because APN's should be allowed to be the initial consultant in simple specialty cases. In my experience they can competently assess and recommend further testing for simple specialty practice issues. I think that the specialty APN should not practice independently but should be required to have a supervising physician with whom they can discuss any questions.