The Elimination of the Written Practice Agreement
Vermont Nurse Practitioner Association Position Statement

The role of the advanced practice nurse (APRN) is well established. Numerous studies document high quality, cost effective healthcare independent of physician involvement. Outcome measures are consistent or superior to that of physicians in similar settings. The advance practice nurses offer a "value-added" service to healthcare consumers through emphasis on disease prevention, education, and health for the individual, family, and/or community. Public demand for accessible, quality care places advanced practice nurses in an optimal role to fulfill this void. Restrictive practice agreements prevent public access to such services, curtailing APRN workforce.

In 2006 there were 529 practicing APRNs in the state of Vermont. Of that number 321 or 60% were in a primary care setting. Sixty-five percent of APRN workforce has been in practice for five or more years and 93% possess prescriptive authority. Seventy three percent of APRNs hold a masters degree or higher. Most APRNs work in a physician/APRN group setting (34%), a hospital-based setting (33%), or in a community health center (17%)[1]. Pearson[2] reports Vermont APRNs are among the lowest in the nation for reported misconduct, reflecting their safety in providing healthcare. Vermont advanced practice nurses may apply for hospital privileges and are recognized as primary care providers for Vermont Medicaid. APRN includes: nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialist.

APRNs place emphasis on disease prevention, education, and health for the individual, family, and/or community[3]. Advanced practice nurses are skilled at improving the knowledge base and the level of physical functioning of individuals, families, and their communities. They provide comfort and assist in adapting to loss or change. Advanced practice nursing care is holistic. Brooten and colleagues[4] report better outcomes based upon utilizing preventive services, fostering patient independence, promoting healthy lifestyles, increasing quality of life, assisting in adjustment to illness, and providing symptom relief. Direct cost savings were demonstrated through shorter inpatient stays and fewer emergency room visits. The "value added" APRN effects result in indirect cost savings, increased satisfaction, and improved outcomes. Direct cost savings estimated by the Department of Health and Human Services of an office visit with an NP was 10-40% less than comparable services provided by physicians[5]. According to the American College of Nurse Practitioners, nurse practitioners cost 40 cent less per U.S. dollar than physicians and provide value added effects. Advanced practice nurses are particularly cost-effective with their expertise in counseling, education and case management in administering preventive care[6]. Some estimates suggest that up to $8.75 billion U.S. could be saved in long term costs by fully utilizing nurse practitioners[7].

Nurse practitioners currently practice autonomously and collaboratively with other health care professionals, under their own license and with their own provider number. They serve as healthcare researchers, interdisciplinary consultants and patient advocates[8]. It is important to recognize ultimately that the language change does not affect scope of practice, including the ability to collaborate. Removal of collaborative practice agreements would result in increased access to primary care services, would decrease administrative overhead services, and address the current mandate for a chronic care initiative with the appropriate workforce.

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[3] Fitzpatrick, E. (1998). Analysis and synthesis of the role of the advanced practice nurse. Clinical Nurse Specialist, 13(3), 106-107.
[4] Brooten, D., Youngblut, J., Kutcher, J., & Bobo, C. (2004). Quality and the nursing workforce: APNs, patient outcomes and healthcare costs. Nursing Outlook, 52, 45-52.
[5] Fitzgerald, M., Jones, E., Lazar, B., McHugh, M., & Wang, C. (1995). The midlevel provider: Colleague or competitor? Patient Care, 23-37.
[6] Appleby, C. (1995). Boxed in? Hospitals and Health Networks, 28-34.
[7] Canadian Nurses Association. (2002). Cost effectiveness of the nurse practitioner role: Fact sheet. Retrieved April 15, 2006, from http://72.14.203.104/search?q=cache:Ubt5MfCIeV0J:www.cna-nurses.ca/CNA/documents/pdf/publications/FS10_Cost_effectiveness_Nurse_Practitioner
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