

STATEMENT
Of
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To
United States House of Representatives
Committee on Energy & Commerce
Subcommittee on Health
On
“Examining H.R. __, the Trafficking Awareness
Training for Health Care Act of 2014”

September 11, 2014

Thank you Chairman Pitts, Ranking Member Pallone, and Members of the Committee. I appreciate the opportunity to speak with you today on behalf of the American Association of Nurse Practitioners (AANP), the largest full service professional membership organization for Nurse Practitioners (NPs) of all specialties. With nearly 52,000 individual members and over 200 organization members, we represent the more than 192,000 nurse practitioners across the nation.

My name is Kenneth Miller and I currently serve as President of AANP. In addition to my position as President of AANP, I am the former Associate Dean for Academic Administration at The Catholic University of America in Washington, DC. I have served as the Director of the School of Nursing for the University of Delaware and was the Vice Dean for Internal Programs and Associate Dean for Research and Clinical Scholarship in the College of Nursing at the University of New Mexico Health Sciences Center. Before my tenure as Vice Dean, I held professorial positions at the Uniformed Services University of the Health Sciences in Bethesda, Maryland. I have also worked as a clinical nurse in medical centers and hospitals in California,

Arizona and Michigan and as a Family Nurse Practitioner in New Mexico, Delaware and the District of Columbia.

As you may know, Nurse Practitioners have been providing primary, acute, and specialty care for half a century. NPs are rapidly becoming the health care provider of choice for millions of Americans. In fact, the trust that patients have in NPs is evidenced by the more than 900 million visits made to them throughout the United States in 2013. NPs practice in every community in this country, both urban and rural, and see patients from all economic and social backgrounds.

Our data shows that the vast majority of NPs in the United States are primary care providers, with 88% of NPs educationally prepared to be primary care providers and over 75% currently practice in primary care settings. NPs bring a comprehensive perspective to health care by blending clinical expertise in diagnosing and treating health conditions with an added emphasis on health promotion and disease prevention. This comprehensive perspective is deeply rooted in NPs' education and background. In fact, all NPs must complete a master's or doctoral program, and have advanced clinical training beyond their initial professional registered nurse preparation. Didactic and clinical courses prepare them with specialized knowledge and clinical competency to practice in a variety of settings.

Daily practice includes assessments, ordering, performing, supervising and interpreting diagnostic and laboratory tests, coordinating care, making diagnoses, initiating and managing treatment, prescribing medications as well as non-pharmacologic treatments, and counselling and educating patients, their families and communities. Additionally, NPs undergo rigorous national certification, periodic peer review, clinical outcome evaluations, and adhere to a code for ethical practice. Self-directed continued learning and professional development is also essential to

maintaining clinical competency. It is important to note that NPs are licensed in all states and the District of Columbia and practice under the rules and regulations of the state in which they are licensed. *The following documents are enclosed for your reference: NP Facts, Scope of Practice for Nurse Practitioners, Standards of Practice for Nurse Practitioners, Quality of Nurse Practitioner Practice.*

Nurse practitioners provide care in all types of settings which include clinics, hospitals, emergency rooms, urgent care sites, private physician or NP practices, nursing homes, schools, colleges, retail clinics, public health departments and homeless clinics. It is also important to remember that in many of these settings nurse practitioners are the lead provider on-site. In fact, there are many Nurse Practitioner owned and managed clinics across the United States. It is in these various settings, particularly public health departments and primary care clinics, where Nurse Practitioners play a key role in recognizing many of the at-risk, vulnerable populations they treat. In many instances, especially in rural and underserved population areas, NPs are the only health care provider.

Nurse Practitioners, with their emphasis on primary care, health promotion and education, coupled with their nursing background, approach the care of their patients holistically. They not only address the physical health care needs of their patients but also factor in the mental and social aspects. Their expert assessment and interviewing skills, combined with their education and preparation uniquely positions them to gather information, which not only allows them to treat symptoms but also research causality crucial to effective prevention of emotional, physical, or sexual abuse. Knowing the correct assessments to perform and the right questions to ask when treating patients that are victims of other types of violent crime and abuse, is a skillset similar to what NPs must call upon when recognizing and treating victims of human trafficking.

We know today that practicing NPs are confronted with patients whom they suspect are victims of human trafficking, and we understand that as the provider of choice to millions of Americans, we must lead and work with other provider groups to develop best practices and procedures that will allow all providers to attain the skills needed to ensure that these victims are identified, treated and assisted. It is imperative that providers are given clear instruction and guidance on how to identify these victims and the steps to be taken to ensure that the victim receives the proper protection and care.

These best practices need to be carefully developed, given the variety of providers and the different care settings in which these victims may surface. Victims of human trafficking can be extremely difficult to locate after their initial health care visit due to the transient nature of these criminal acts. It is imperative that best practices include a program that provides guidance and gives providers the opportunity to assist victims as quickly as possible. We must work to ensure that providers and victims, working together, can develop these evidence based best practices and work to implement them across the health care spectrum. While developing best practices, it is critical that we focus on the services being provided and not the licensure of health care providers. It is important to note, that strategies may vary from clinic to clinic and from state to state. Developing best practices to identify signs and symptoms, and best screening tools is paramount to identifying those who are trafficked, and reporting procedures are key to removing the victim from their deplorable situation. For any program to be effective and to ensure that as many trafficking victims are being identified and assisted as possible, all health care professionals that come into contact with suspected victims of abuse, must be educated and clinically trained to identify these individuals. By casting a broad net to include all health care professionals and personnel, best practices can be shared with the largest number of providers to

impact the greatest number of victims. We are pleased to continue to work with Congresswoman Ellmers to develop legislation that addresses this issue in a provider neutral manner. This ensures that all practicing providers and health care personnel who may come in contact with victims of human trafficking are able to identify and assist them.

In summary, while developing best practices, it is paramount that all health care providers and personnel who are caring for patients are empowered to utilize their education and clinical training to identify and assist trafficking victims. Our organization has been a longtime supporter of the use of common guidelines for the assessment, identification and referral of victims of violence and the inclusion of violence prevention content in educational programs for all health care providers. This type of program is an extension of programs that are already a part of our educational curriculum and in our communities.

The American Association of Nurse Practitioners thanks the Committee and Congresswoman Ellmers for their work on this important topic and we look forward to working together in the development of this project. By working together we can put a stop to the terrible crime of human trafficking. As “*The Voice of the Nurse Practitioner*,” AANP can reach the rapidly growing NP profession throughout the country with this important information. We thank you for your time and respectfully request that we continue to work together on this important issue.

Attachments:

1. AANP NP Facts
2. AANP Scope of Practice for Nurse Practitioners
3. AANP Standards of Practice for Nurse Practitioners
4. AANP Quality of Nurse Practitioner Practice

The Voice of the Nurse Practitioner®

There are more than 192,000 nurse practitioners (NPs) practicing in the U.S.

- An estimated 14,000 new NPs completed their academic programs in 2011-2012
- 95.1% of NPs have graduate degrees
- 96.8% of NPs maintain national certification
- 87.2% of NPs are prepared in primary care; 75.6% of NPs practice in at least one primary care site
- 84.9% of NPs see patients covered by Medicare and 83.9% by Medicaid
- 44.8% of NPs hold hospital privileges; 15.2% have long term care privileges
- 97.2% of NPs prescribe medications, averaging 19 prescriptions per day
- NPs hold prescriptive privilege in all 50 states and D.C., with controlled substances in 49
- The early-2011 mean, full-time NP base salary was \$91,310, with average full-time NP total income \$98,760
- The majority (69.5%) of NPs see three or more patients per hour
- Malpractice rates remain low; only 2% have been named as primary defendant in a malpractice case
- Nurse practitioners have been in practice an average of 11.7 years

Distribution, Mean Years of Practice, Mean Age by Population Focus

Population	Percent of NPs	Years of Practice	Age
Acute Care	6.3	7.7	46
Adult+	18.9	11.6	50
Family+	48.9	12.8	49
Gerontological+	3.0	11.6	53
Neonatal	2.1	12.2	49
Oncology	1.0	7.7	48
Pediatric+	8.3	12.4	49
Psych/Mental Health	3.2	9.1	54
Women's Health+	8.1	15.5	53

+Primary care focus

Sources:

- AANP National NP Database, 2013
- Fang, D., Li, Y., Bednash, G.D. (2013) 2012-2013 *Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington DC: AACN
- 2012 AANP Sample Survey
- 2010 AANP National Practice Site Survey
- 2011 AANP National NP Compensation Survey

Additional information is available at the AANP website www.aanp.org.



Scope of Practice for Nurse Practitioners

Professional Role

Nurse practitioners (NPs) are licensed, independent practitioners who practice in ambulatory, acute and long-term care as primary and/or specialty care providers. They provide nursing and medical services to individuals, families and groups accordant with their practice specialties. In addition to diagnosing and managing acute episodic and chronic illnesses, NPs emphasize health promotion and disease prevention. Services include ordering, conducting, supervising, and interpreting diagnostic and laboratory tests, prescribing pharmacological agents and non-pharmacologic therapies, and teaching and counseling patients, among others.

As licensed, independent clinicians, NPs practice autonomously and in collaboration with health care professionals and other individuals. They serve as health care researchers, interdisciplinary consultants and patient advocates.

Education

NPs are advanced practice nurses - health care professionals who have achieved licensure and credentialing well beyond their roles as registered nurses (RNs). All NPs obtain graduate degrees and many go on to earn additional post-master's certificates and doctoral degrees. Didactic and clinical courses provide NPs with specialized knowledge and clinical competency which enable them to practice in primary care, acute care and long-term care settings. Self-directed continued learning and professional development are hallmarks of NP education.

Accountability

The autonomous nature of NP practice requires accountability for health care outcomes and thus national certification, periodic peer review, clinical outcome evaluations, a code for ethical practice, evidence of continued professional development and maintenance of clinical skills. NPs are committed to seeking and sharing information that promotes quality health care and improves clinical outcomes. This is accomplished by leading and participating in both professional and lay health care forums, conducting research and applying findings to clinical practice.

Responsibility

The role of the NP continues to evolve in response to changing societal and health care needs. As leaders in primary and acute health care, NPs combine the roles of providers, mentors, educator, researchers and administrators. They also take responsibility for advancing the work of NPs through involvement in professional organizations and participation in health policy activities at the local, state, national and international levels.

Standards of Practice for Nurse Practitioners

I. Qualifications

Nurse practitioners are licensed, independent practitioners who provide primary and/or specialty nursing and medical care in ambulatory, acute and long-term care settings. They are registered nurses with specialized, advanced education and clinical competency to provide health and medical care for diverse populations in a variety of primary care, acute and long-term care settings. Master's, post-master's or doctoral preparation is required for entry-level practice (AANP 2006).

II. Process of Care

The nurse practitioner utilizes the scientific process and national standards of care as a framework for managing patient care. This process includes the following components.

A. Assessment of health status

The nurse practitioner assesses health status by:

- Obtaining a relevant health and medical history
- Performing a physical examination based on age and history
- Performing or ordering preventative and diagnostic procedures based on the patient's age and history
- Identifying health and medical risk factors

B. Diagnosis

The nurse practitioner makes a diagnosis by:

- Utilizing critical thinking in the diagnostic process
- Synthesizing and analyzing the collected data
- Formulating a differential diagnosis based on the history, physical examination and diagnostic test results
- Establishing priorities to meet the health and medical needs of the individual, family, or community

C. Development of a treatment plan

The nurse practitioner, together with the patient and family, establishes an evidence-based, mutually acceptable, cost-awareness plan of care that maximizes health potential. Formulation of the treatment plan includes:

- Ordering and interpreting additional diagnostic tests
- Prescribing or ordering appropriate pharmacologic and non-pharmacologic interventions
- Developing a patient education plan
- Recommending consultations or referrals as appropriate

D. Implementation of the plan

Interventions are based upon established priorities. Actions by the nurse practitioners are:

- Individualized
- Consistent with the appropriate plan for care
- Based on scientific principles, theoretical knowledge and clinical expertise
- Consistent with teaching and learning opportunities

E. Follow-up and evaluation of the patient status

The nurse practitioner maintains a process for systematic follow-up by:

- Determining the effectiveness of the treatment plan with documentation of patient care outcomes
- Reassessing and modifying the plan with the patient and family as necessary to achieve health and medical goals

III. Care Priorities

The nurse practitioner's practice model emphasizes:

- A. Patient and family education
The nurse practitioner provides health education and utilizes community resource opportunities for the individual and/or family
- B. Facilitation of patient participation in self care.
The nurse practitioner facilitates patient participation in health and medical care by providing information needed to make decisions and choices about:
 - Promotion, maintenance and restoration of health
 - Consultation with other appropriate health care personnel
 - Appropriate utilization of health care resources
- C. Promotion of optimal health
- D. Provision of continually competent care
- E. Facilitation of entry into the health care system
- F. The promotion of a safe environment

IV. Interdisciplinary and Collaborative Responsibilities

As a licensed, independent practitioner, the nurse practitioner participates as a team leader and member in the provision of health and medical care, interacting with professional colleagues to provide comprehensive care.

V. Accurate Documentation of Patient Status and Care

The nurse practitioner maintains accurate, legible and confidential records.

VI. Responsibility as Patient Advocate

Ethical and legal standards provide the basis of patient advocacy. As an advocate, the nurse practitioner participates in health policy activities at the local, state, national and international levels.

VII. Quality Assurance and Continued Competence

Nurse practitioners recognize the importance of continued learning through:

- A. Participation in quality assurance review, including the systematic, periodic review of records and treatment plans
- B. Maintenance of current knowledge by attending continuing education programs
- C. Maintenance of certification in compliance with current state law
- D. Application of standardized care guidelines in clinical practice

VIII. Adjunct Roles of Nurse Practitioners

Nurse practitioners combine the roles of provider, mentor, educator, researcher, manager and consultant. The nurse practitioner interprets the role of the nurse practitioner to individuals, families and other professionals.

IX. Research as Basis for Practice

Nurse practitioners support research by developing clinical research questions, conducting or participating in studies, and disseminating and incorporating findings into practice.

Quality of Nurse Practitioner Practice

Nurse practitioners (NPs) are high quality health care providers who practice in primary care, ambulatory, acute care, specialty care, and long-term care. They are registered nurses prepared with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of settings. A graduate degree is required for entry-level practice. The NP role was created in 1965 and over 45 years of research consistently supports the excellent outcomes and high quality of care provided by NPs. The body of evidence supports that the quality of NP care is at least equivalent to that of physician care. This paper provides a summary of a number of important research reports supporting the NP.

Avorn, J., Everitt, D.E., & Baker, M.W. (1991). The neglected medical history and therapeutic choices for abdominal pain. A nationwide study of 799 physicians and nurses. *Archives of Internal Medicine*, 151(4), 694-698.

A sample of 501 physicians and 298 NPs participated in a study by responding to a hypothetical scenario regarding epigastric pain in a patient with endoscopic findings of diffuse gastritis. They were able to request additional information before recommending treatment. Adequate history-taking resulted in identifying use of aspirin, coffee, cigarettes, and alcohol, paired with psychosocial stress. Compared to NPs, physicians were more likely to prescribe without seeking relevant history. NPs, in contrast, asked more questions and were less likely to recommend prescription medication.

Bakerjian, D. (2008). Care of nursing home residents by advanced practice nurses: A review of the literature. *Research in Gerontological Nursing*, 1(3), 177-185.

Bakerjian conducted an extensive review of the literature, particularly of NP-led care. She found that long-term care patients managed by NPs were less likely to have geriatric syndromes such as falls, UTIs, pressure ulcers, etc. They also had improved functional status, as well as better managed chronic conditions.

Brown, S.A. & Grimes, D.E. (1995). A meta-analysis of nurse practitioners and nurse midwives in primary care. *Nursing Research*, 44(6), 332-9.

A meta-analysis of 38 studies comparing a total of 33 patient outcomes of NPs with those of physicians demonstrated that NP outcomes were equivalent to or greater than those of physicians. NP patients had higher levels of compliance with recommendations in studies where provider assignments were randomized and when other means to control patient risks were used. Patient satisfaction and resolution of pathological conditions were greatest for NPs. The NP and physician outcomes were equivalent on all other outcomes.

Congressional Budget Office. (1979). Physician extenders: Their current and future role in medical care delivery. Washington, D.C.: US Government Printing Office.

As early as 1979, the Congressional Budget Office reviewed findings of the numerous studies of NP performance in a variety of settings and concluded that NPs performed as well as physicians with respect to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction.

Cooper, M.A., Lindsay, G.M., Kinn, S., Swann, I.J. (2002). Evaluating emergency nurse practitioner services: A randomized controlled trial. *Journal of Advanced Nursing*, 40(6), 771-730.

A study of 199 patients randomly assigned to emergency NP-led care or physician-led care in the U.K. demonstrated the highest level of satisfaction and clinical documentation for NP care. The outcomes of recovery time, symptom level, missed work, unplanned follow-up, and missed injuries were comparable between the two groups.

Ettner, S.L., Kotlerman, J., Abdelmonem, A., Vazirani, S., Hays, R.D., Shapiro, M., et al. (2006). An alternative approach to reducing the costs of patient care? A controlled trial of the multi-disciplinary doctor-nurse practitioner (MDNP) model. *Medical Decision Making*, 26, 9-17.

Significant cost savings were demonstrated when 1207 patients in an academic medical center were randomized to either standard treatment or to a physician-NP model.

Horrocks, S., Anderson, E., Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal*, 324, 819-823.

A systematic review of 11 randomized clinical trials and 23 observational studies identified data on outcomes of patient satisfaction, health status, cost, and/or process of care. Patient satisfaction was highest for patients seen by NPs. The health status data and quality of care indicators were too heterogeneous to allow for meta-analysis, although qualitative

comparisons of the results reported showed comparable outcomes between NPs and physicians. NPs offered more advice/information, had more complete documentation, and had better communication skills than physicians. NPs spent longer time with their patients and performed a greater number of investigations than did physicians. No differences were detected in health status, prescriptions, return visits, or referrals. Equivalency in appropriateness of studies and interpretations of x-rays were identified.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2006). Substitution of doctors by nurses in primary care. *Cochrane Database of Systematic Reviews*. 2006, Issue 1.

This meta-analysis included 25 articles relating to 16 studies comparing outcomes of primary care nurses (nurses, NPs, clinical nurse specialists, or advance practice nurses) and physicians. The quality of care provided by nurses was as high as that of the physicians. Overall, health outcomes and outcomes such as resource utilization and cost were equivalent for nurses and physicians. The satisfaction level was higher for nurses. Studies included a range of care delivery models, with nurses providing first contact, ongoing care, and urgent care for many of the patient cohorts.

Lenz, E.R., Munding, M.O., Kane, R.L., Hopkins, S.C., & Lin, S.X. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: Two-year follow-up. *Medical Care Research and Review* 61(3), 332-351.

The outcomes of care in the study described by Munding, et al. in 2000 (see below) are further described in this report including two years of follow-up data, confirming continued comparable outcomes for the two groups of patients. No differences were identified in health status, physiologic measures, satisfaction, or use of specialist, emergency room, or inpatient services. Patients assigned to physicians had more primary care visits than those assigned to NPs.

Lin, S.X., Hooker, R.S., Lenz, E.R., Hopkins, S.C. (2002). Nurse practitioners and physician assistants in hospital outpatient departments, 1997-1999. *Nursing Economics*, 20(4), 174-179.

Data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) were used to identify patterns of NP and PA practice styles. NPs were more likely to see patients alone and to be involved in routine examinations, as well as care directed towards wellness, health promotion, disease prevention, and health education than PAs, regardless of the setting type. In contrast, PAs were more likely to provide acute problem management and to involve another person, such as a support staff person or a physician.

Munding, M.O., Kane, R.L., Lenz, E.R., Totten, A.M., Tsai, W.Y., Cleary, P.D., et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *Journal of the American Medical Association*, 283(1), 59-68.

The outcomes of care were measured in a study where patients were randomly assigned either to a physician or to an NP for primary care between 1995 and 1997, using patient interviews and health services utilization data. Comparable outcomes were identified, with a total of 1316 patients. After six months of care, health status was equivalent for both patient groups, although patients treated for hypertension by NPs had lower diastolic values. Health service utilization was equivalent at both 6 and 12 months and patient satisfaction was equivalent following the initial visit. The only exception was that at six months, physicians rated higher on one component (provider attributes) of the satisfaction scale.

Newhouse, R. et al (2011). Advanced practice nurse outcomes 1999-2008: A systematic review. *Nursing Economics*, 29(5), 1-22.

The outcomes of NP care were examined through a systematic review of 37 published studies, most of which compared NP outcomes with those of physicians. Outcomes included measures such as patient satisfaction, patient perceived health status, functional status, hospitalizations, ED visits, and bio-markers such as blood glucose, serum lipids, blood pressure. The authors conclude that NP patient outcomes are comparable to those of physicians.

Office of Technology Assessment. (1986). Nurse practitioners, physician assistants, and certified nurse midwives: A policy analysis. Washington D.C.: US Government Printing Office.

The Office of Technology Assessment reviewed studies comparing NP and physician practice, concluding that, "NPs appear to have better communication, counseling, and interviewing skills than physicians have" (p. 19) and that malpractice premiums and rates supported patient satisfaction with NP care, pointing out that successful malpractice rates against NPs remained extremely rare.

Ohman-Strickland, P.A., Orzano, A.J., Hudson, S.V., Solberg, L.I., DiCiccio-Bloom, B., O'Malley, D., et al. (2008). Quality of diabetes care in family medicine practices: Influence of nurse-practitioners and physician's assistants. *Annals of Family Medicine*, 6(1), 14-22.

The authors conducted a cross-sectional study of 46 practices, measuring adherence to ADA guidelines. They reported that practices with NPs were more likely to perform better on quality measures including appropriate measurement of glycosylated hemoglobin, lipids, and microalbumin levels and were more likely to be at target for lipid levels.

Prescott, P.A. & Driscoll, L. (1980). Evaluating nurse practitioner performance. *Nurse Practitioner*, 1(1), 28-32.

The authors reviewed 26 studies comparing NP and physician care, concluding that NPs scored higher in many areas. These included: amount/depth of discussion regarding child health care, preventative health, and wellness; amount of advice, therapeutic listening, and support offered to patients; completeness of history and follow-up on history findings; completeness of physical examination and interviewing skills; and patient knowledge of the management plan given to them by the provider.

Roblin, D.W., Becker, R., Adams, E.K., Howard, D. H., & Roberts, M.H. (2004). Patient satisfaction with primary care: Does type of practitioner matter? *Medical Care*, 42(6), 606-623.

A retrospective observational study of 41,209 patient satisfaction surveys randomly sampled between 1997 and 2000 for visits by pediatric and medicine departments identified higher satisfaction with NP and/or PA interactions than those with physicians, for the overall sample and by specific conditions. The only exception was for diabetes visits to the medicine practices, where the satisfaction was higher for physicians.

Sackett, D.L., Spitzer, W. O., Gent, M., & Roberts, M. (1974). The Burlington randomized trial of the nurse practitioner: Health outcomes of patients. *Annals of Internal Medicine*, 80(2), 137-142.

A sample of 1598 families were randomly allocated, so that two-thirds continued to receive primary care from a family physician and one-third received care from a NP. The outcomes included: mortality, physical function, emotional function, and social function. Results demonstrated comparable outcomes for patients, whether assigned to physician or to NP care. Details from the Burlington trial were also described by Spitzer, et al (see below).

Safriet, B. J. (1992). Health care dollars and regulatory sense: The role of advanced practice nursing. *Yale Journal on Regulation*, 9(2).

The full Summer 1992 issue of this journal was devoted to the topic of advanced practice nursing, including documenting the cost-effective and high quality care provided, and to call for eliminating regulatory restrictions on their care. Safriet summarized the OTA study concluding that NP care was equivalent to that of physicians and pointed out that 12 of the 14 studies reviewed in this report which showed differences in quality reported higher quality for NP care. Reviewing a range of data on NP productivity, patient satisfaction, and prescribing, and data on nurse midwife practice, Safriet concludes "APNs are proven providers, and removing the many barriers to their practice will only increase their ability to respond to the pressing need for basic health care in our country" (p. 487).

Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, M., Gent, M., Kergin, D.J., Hackett, B.D., & Olynich, A. (1974). The Burlington randomized trial of the nurse practitioner. *New England Journal of Medicine*, 290 (3), 252-256.

This report provides further details of the Burlington trial, also described by Sackett, et al. (see above). This study involved 2796 patients being randomly assigned to either one of two physicians or to an NP, so that one-third were assigned to NP care, from July 1971 to July 1972. At the end of the period, physical status and satisfaction were comparable between the two groups. The NP group experienced a 5% drop in revenue, associated with absence of billing for NP care. It was hypothesized that the ability to bill for all NP services would have resulted in an actual increased revenue of 9%. NPs functioned alone in 67% of their encounters. Clinical activities were evaluated and it was determined that 69% of NP management was adequate compared to 66% for the physicians. Prescriptions were rated adequate for 71% of NPs compared to 75% for physicians. The conclusion was that "a nurse practitioner can provide first-contact primary clinical care as safely and effectively as a family physician" (p. 255).