State of Vermont
Office of the Secretary of State

Office of Professional Regulation
89 Main St., 3rd Floor
Montpelier, VT 05620-3402
www.sec.state.vt.us

James C. Condos, Secretary of State
Christopher D. Winters, Deputy Secretary
Colin R. Benjamin, Director

Memorandum

Date: April 5, 2018
To: Senator Claire Ayer, Chair
Senate Health and Welfare Committee
CC: Faith Brown, Committee Assistant
Re: H.684, Sec. 15. 26 V.S.A. §§ 1612 & 1613

As an umbrella agency overseeing 50 professions, more than 150 license types, approximately 60,000 licensees, and a rapidly changing regulatory landscape, one of OPR's primary functions is to engage in an ongoing review of its regulatory programs and seek legislative changes to modify laws specific to certain professions where appropriate and consistent with the overarching legislative intent concerning professional regulation in Vermont. 26 V.S.A. § 3101(b) sets forth the State's policy. If the need for regulation of a profession is identified, "the form of regulation adopted by the State shall be the least restrictive form of regulation necessary to protect the public interest. If regulation is imposed, the profession or occupation may be subject to review by the Office of Professional Regulation and the General Assembly to ensure the continuing need for and appropriateness of such regulation." *Id.*

The purpose of the revisions to 26 V.S.A. §§ 1612 & 1613 passed by the House concerning the State's ongoing regulation of Advanced Practice Registered Nurses ("APRNs") is to align regulatory requirements with real world practice, cut red tape, and free institutions, medical practices, and licensees from totally unnecessary paperwork.

First, Section 15 of the OPR bill strikes a requirement, at 26 V.S.A. § 1612, that advanced practice registered nurses receive biennial OPR approval of paperwork known as practice guidelines. Practice guidelines were intended to formalize each APRN's population focus and specialty. In the modern health-care system, though, APRNs work in institutional settings where facility policies and supervisory hierarchies provide much more tailored and efficient constraints upon professional practice. As APRNs integrated into hospitals, clinics, and provider offices, practice guidelines became less and less useful as an articulation of practice scope. Today, practice-guideline paperwork creates administrative waste for the State, and gratuitous paperwork for busy providers' offices, that offers no genuine benefit to the public health and safety. It is superfluous to regulate health care professionals by making them write and file miniature job descriptions on an ongoing basis with OPR. As a practical matter, these job descriptions take time away from the practitioner, need review and approval by OPR staff, and then find their way into a file cabinet or digital space and are not utilized thereafter by the State. This, to OPR, is the essence of unnecessary red tape. Working within the bounds of one's education, training, and experience is integral to what it means to be a licensed professional. Section 129a(a) of Title 3 gives OPR prosecutors ample tools to deal with professionals practicing in areas they should not.

Similarly, Sec. 15 of the bill reforms provisions that require a formal agreement with a collaborating provider, found at 26 V.S.A. § 1613. It must be stated at the outset that the agreement at issue here is not about, and does not in any way contemplate or require, supervision. Moreover, the collaboration agreement does not even require collaboration; it merely identifies available parties. This paperwork requirement was meant to ensure that a collaborating practitioner in the state was available to an APRN for consultation. However, OPR found that collaborative-practice agreements were purely administrative red-tape. Substantive collaboration always has occurred with peers in the workplace, according to expertise and case-specific need. The issue is not about the importance of collaboration; all stakeholders and interested parties agree it is essential. Under Section 129a(a) & (b) of Title 3, it would be unprofessional conduct for any practitioner, especially a newly licensed one, to step into an area of complexity beyond their education, training and experience without seeking collaboration and mentorship. This standard applies across all professions. The question is whether state government should play matchmaker. OPR believes the answer is no.

For APRNs in large institutions or practices, having a go-to person listed on an OPR form has become an empty formality unrelated to actual peer consultation. In addition, in certain circumstances, the requirement creates an impediment to access and continuity of care where the parties identified change positions, employment, or retire. Modern APRNs are so thoroughly integrated into healthcare teams that nearly all practice is collaborative practice.

Although collaborating-provider agreements filed with the State are unnecessary in modern institutional settings and large practice groups, where colleagues are readily available for consultation, a small minority of new APRNs may wish to practice in very small settings where that sort of collaboration may be less readily available. For that reason, section 1613(a) preserves transition-to-practice agreements for new APRNs who go directly to settings that do not employ two or more experienced APRNs or physicians.

Interestingly, there are currently 12 other states and the District of Columbia that allow APRNs to practice independently without any collaboration agreement requirements or practice guidelines. This is an important baseline to consider in deciding whether the form of regulation adopted by Vermont is in fact the least restrictive form of regulation necessary to protect the public interest.

I look forward to providing testimony tomorrow and answering any questions the Committee may have.

Best regards,

Colin Benjamin
Director