HEALTH WORKFORCE REGULATION:
What it is and Why it Matters
Room C

Get the facts at www.bowenportal.org
SETTING THE STAGE: OCCUPATIONAL REGULATION 101 & INDIANA’S CURRENT PROCESSES

Ronne Hines
Council on Licensure, Enforcement & Regulation

Meredith Lizza
Indiana Professional Licensing Agency
Defining Occupational Regulation

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations
Why Regulate?

Public Interest

✓ Response to risks to public safety that may arise from unlicensed work
✓ Regulatory authorities often have missions of preserving, promoting, and protecting health, safety and welfare.

Public Choice

✓ Self-interested behavior of licensed practitioners seeking to limit entry to profession and raise their own wages
✓ Advocates for new/expanded licensing usually practitioners and associations, not consumers
Why Regulate?

**Asymmetry of information**
Consumers don’t have access to pertinent info or are not skilled enough to make sound judgments

**Remedies**
- Internet and review websites (e.g. WebMD)
- Self-regulation, such as through national certifications
- Government regulation

**Best practice**
Rely on combination of government regulation with other options, as each tackles different aspect of asymmetric information
Occupational Regulation 101

Why Regulate?

Regulation provides consumers more equal access to the market.

Wealthy consumers have more power to affect the marketplace than poor consumers.

Legal costs may be prohibitive to a poor consumer. Even if an incompetent practitioner remedies a wealthy consumer via a lawsuit, without regulation, the practitioner can continue to practice.

Department of Regulatory Agencies
Division of Professions and Occupations
Occupational Regulation 101

Where We’ve Been - Where We Are

Nationally, the number of jobs requiring at least some governmental permission has skyrocketed since 1950.

**REGULATED WORKERS**

- 5% in 1950s
- 25% of workforce now

Licensing associated with lower unemployment and higher wages for a profession.
Occupational Regulation 101

Regulatory Arrangements

- Government
- Self Regulation
- Least Burdensome Regulation
- Scope of Practice
- Entry to Practice
- Investigation into Complaints
Occupational Regulation 101

Current Regulatory Challenges

- Deregulation & regulatory reform
- Identifying, describing, and quantifying risk to public harm
- Consumer movement and interaction
- Technology
- Mobility
- Business models
- Insurance reimbursements
- Legislation
- Determining sanctions that best protect the public without unnecessarily limiting market access
Regulatory Spectrum and Models

Autonomous

- Only autonomous boards
- Autonomous boards delegate some functions to central agency

Centralized

- Boards subject to supervision by central agency
- Central agency has complete regulatory authority

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations
Colorado’s Regulatory Framework

DORA IS AN UMBRELLA AGENCY ESTABLISHED IN 1968

CURRENTLY LICENSES OVER 100 PROFESSIONS AND OCCUPATIONS

Majority regulated by Department of Regulatory Agencies (DORA)

DORA’s Division of Professions and Occupations (DPO) regulates about 345,000 licensees in about 50 professions

EXAMPLES OF PROFESSIONS NOT REGULATED BY DORA

- Emergency Medical Technicians
- Teachers
- Attorneys
DPO’s Regulatory Framework

- Regulatory Boards and “Director-Model Programs” under one agency
- Boards/Programs supported by fees and funds appropriated by the Legislature
- Boards, the DPO Director, and DPO Staff share duties.
  - **Entry to practice**
    - Established by the boards of DPO Director
  - **Rulemaking**
    - Handled by staff with approval by boards or the DPO Director
  - **Investigations**
    - Handled by DPO staff
  - **Discipline**
    - Handled by the boards or the DPO Director
Colorado’s Regulatory Environment

**Occidental Regulation 101**

**Some professions in Colorado are “self-regulated”**

**Four main “levels” of regulation in Colorado by the government**

- Title Protection (least restrictive)
- Certification
- Registration
- Licensure (most restrictive)

**DORA enforces the same – no matter the level**

**Increased levels associated with increasingly difficult barriers to entry**

Examples: Education, Testing, Training, Hours

**Department of Regulatory Agencies**
**Division of Professions and Occupations**
Colorado’s Regulatory Goals

- Streamlined
- Minimal Barriers to Entry
- Robust Enforcement
Occupational Regulation 101

Regulatory Similarities

- Protect, promote and preserve the public health, safety and welfare

- Balance economic liberty with legitimate concerns to protect the public
Occupational Regulation 101

QUESTIONS OR COMMENTS
2019 Indiana Health Workforce Summit

5/21/2019

Meredith Lizza
Director, Communications and Legislative Affairs
Indiana Professional Licensing Agency
Division #14

- Optometry Board
- Respiratory Care Committee
- Physical Therapy Committee (Until 07/01/2019)
- Occupational Therapy Committee

Division #10

- State Board of Health Facilities Administrators
- Athletic Trainers Board

Formally overseen by the Medical Licensing Board without a standing board or committee:

- Acupuncture
- Diabetes Educator
- Genetic Counselors
- Anesthesiologist assistant
- Dietitians (As of 07/01/2019)
Of the 39% of total health care licenses issued:
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<td></td>
<td>101,584</td>
<td>133,505</td>
<td>178,348</td>
<td>242,615</td>
<td>334,537</td>
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</table>

| Total Active Licenses - All Professions        | 154,902  | 205,141  | 275,406  | 375,455  | 525,773  |

### Growth in Issuance of Healthcare Professional License Issuance

- **2000 to 2005**: 31,921
- **2005 to 2010**: 44,843
- **2010 to 2015**: 64,267
- **2015 to 2019**: 91,922
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<td>Medical Licensing Board</td>
<td>17,528</td>
<td>23,497</td>
<td>30,475</td>
<td>39,627</td>
<td>55,845</td>
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<td>Physical Therapy Committee</td>
<td>3,016</td>
<td>4,204</td>
<td>5,570</td>
<td>7,231</td>
<td>9,411</td>
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<tr>
<td>Podiatric Medicine Board</td>
<td>347</td>
<td>442</td>
<td>557</td>
<td>694</td>
<td>962</td>
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<tr>
<td>Chiropractic Board</td>
<td>567</td>
<td>706</td>
<td>885</td>
<td>1,082</td>
<td>1,354</td>
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<tr>
<td>Physician Assistant Committee</td>
<td>126</td>
<td>320</td>
<td>920</td>
<td>1,801</td>
<td>3,308</td>
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<td>Dentistry Board</td>
<td>5,738</td>
<td>7,157</td>
<td>8,935</td>
<td>12,573</td>
<td>15,963</td>
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<tr>
<td>Health Facility Admin Board</td>
<td>394</td>
<td>582</td>
<td>806</td>
<td>1,119</td>
<td>1,702</td>
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<tr>
<td>Hearing Aid Dealer Committee</td>
<td>80</td>
<td>118</td>
<td>162</td>
<td>220</td>
<td>308</td>
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<tr>
<td>Optometry Board</td>
<td>1,458</td>
<td>1,760</td>
<td>2,135</td>
<td>2,506</td>
<td>3,111</td>
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<td>Psychology Board</td>
<td>686</td>
<td>904</td>
<td>1,165</td>
<td>1,503</td>
<td>1,955</td>
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<td>Speech Lang Path &amp; Audio Board</td>
<td>1,006</td>
<td>1,448</td>
<td>2,079</td>
<td>2,976</td>
<td>4,412</td>
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<td>Veterinary Board</td>
<td>1,941</td>
<td>2,534</td>
<td>3,341</td>
<td>4,643</td>
<td>6,426</td>
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<tr>
<td>Pharmacy Board</td>
<td>6,112</td>
<td>10,439</td>
<td>15,455</td>
<td>22,192</td>
<td>37,038</td>
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<td>Nursing Board</td>
<td>55,301</td>
<td>69,400</td>
<td>92,437</td>
<td>124,197</td>
<td>163,704</td>
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<tr>
<td>Respiratory Care Committee</td>
<td>1,834</td>
<td>2,292</td>
<td>3,033</td>
<td>3,935</td>
<td>4,924</td>
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<tr>
<td>Occupational Therapy Committee</td>
<td>1,367</td>
<td>2,107</td>
<td>2,898</td>
<td>4,297</td>
<td>5,648</td>
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<td>Behavioral Health Board</td>
<td>3,397</td>
<td>4,429</td>
<td>5,882</td>
<td>9,663</td>
<td>14,920</td>
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<td>Athletic Trainer Board</td>
<td>232</td>
<td>447</td>
<td>650</td>
<td>1,014</td>
<td>1,674</td>
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<td>Dietitian Certification Board</td>
<td>454</td>
<td>628</td>
<td>821</td>
<td>1,122</td>
<td>1,568</td>
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<tr>
<td>Acupuncture Committee</td>
<td>0</td>
<td>91</td>
<td>142</td>
<td>220</td>
<td>291</td>
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<tr>
<td>Midwifery Committee</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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</tbody>
</table>
NAVIGATING REGULATORY POLICY IN INDIANA: A CASE STUDY OF EMS PERSONNEL

Michael Kaufmann
Indiana Department of Homeland Security

Michael Cook
Office of Medicaid Policy and Planning
EMT/Paramedic Workforce Regulation

Michael A. Kaufmann, MD, FACEP, FAEMS
State EMS Medical Director
Indiana Department of Homeland Security
### Indiana EMS Certifications/Licensure

- Training Institutions: 117
- Supervising Hospitals: 91
- Providers: 833
- Vehicles: 2,600
- Personnel:
  - EMR: 4,975
  - EMT: 14,133
  - Advanced EMT: 578
  - Paramedic: 4,408
  - Primary Instructor: 566
The Current State of the System

• There is currently no “Law” that REQUIRES EMS to be provided to Hoosiers as a third tier of public safety.

• It is “highly recommended” that EMS be provided but doesn’t specify at what level EMS is needed to meet the emergency healthcare demands of the public.

• EMS coverage is determined by the “local subdivision of government.”

• Indiana has adopted the National Scope of Practice and follows the National Educational Curricula for EMS.
EMS Regulation: Current State

• Occupational Regulation – Personnel certification
  • First Responders
  • EMT
  • A-EMT
  • Paramedics (Licensed)

• Delivery Regulation
  • EMS Certification
  • Must be affiliated with an EMS provider organization
  • Practice under the direction of a licensed medical director

• National Initiatives in EMS Regulation and Practice:
  • The EMS Compact (REPLICA)
  • Mobile Integrated Healthcare/Community Paramedicine (MIHP)
Recognition of EMS Personnel Interstate Licensure Compact (REPLICA)

EMS Workforce Regulation
EMS Regulation: Compact Commission Governed by the States

• The EMS Compact is a licensure compact that allows EMS personnel the privilege to practice in all compact states under their home state license.

Sources:
https://scholarworks.iupui.edu/bitstream/handle/1805/18433/Licensure%20Compacts%20Brief%20-%20REPLICA.pdf?sequence=1&isAllowed=y
EMS Regulation: EMS Compact Operational Scenarios

Source: https://www.emscompact.gov/compact-information/ems-personnel/
REPLICA: Potential Benefits and Challenges

Potential Benefits

• Privilege to practice in other compact states
• Enhanced coordination of license information through a national database
• Quality assurance of EMS Personnel

Potential Challenges

• Costs associated with participation – currently no states are being charged any fees
• Potential variations in practice provisions across state lines for those states that go above and beyond the national scope of practice model.

Source: https://scholarworks.iupui.edu/bitstream/handle/1805/18433/Licensure%20Compacts%20Brief%20-%20REPLICA.pdf?sequence=1&isAllowed=y
EMS Regulation: Where are we at now?

• Proposal of SB 510 (REPLICA / EMS personnel licensure interstate compact)

• Status: Bill was not read in committee

• Concerns to be researched:
  • Impact of compact on wages
  • Barriers to border states’ participation

Source: http://www.iga.in.gov/legislative/2019/bills/senate/510
Mobile Integrated Health / Community Paramedicine

EMS Workforce Innovation
Introduction

• Every day throughout our nation, EMS is on the front lines of patient care.
  • Answering 911 calls for assistance
  • Going into peoples homes and places of business
  • Providing treatment and seeing first hand the lives and health of people in the communities that they serve
  • Many of these calls are life-and-death emergencies
  • Some of these calls are not!
Introduction

- Many calls placed to EMS are NOT life threatening.
- Many of these individuals have chronic illness
  - CHF
  - DM
  - Asthma
- They simply don’t know where else to turn when their symptoms flare.
- Others have issues that need attention, but not necessarily emergent.
  - Abuse
  - Mental health problems
  - Elderly and frail
  - Lacking social support
  - They call EMS because they know SOMEONE will come
Introduction

• EMS has traditionally been limited in what its providers could do to help patients address their complex issues and get on a path to better health.
  • Many of these patients could be better served in a place other than an ER
  • Most states require EMS to deliver patients hospitals exclusively
  • Likewise, EMS can only bill and get reimbursed for transportation and NOT the delivery of care, treatments, or procedures.
EMS Agenda for the Future (Circa 1996)

• “Emergency medical services (EMS) of the future will be community-based health management that is fully integrated with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to treatment of chronic conditions and community health monitoring. This new entity will be developed from redistribution of existing health care resources and will be integrated with other health care providers and public health and public safety agencies. It will improve community health and result in more appropriate use of acute health care resources. EMS will remain the public’s emergency medical safety net.”
EMS Solutions

• Over a decade ago, forward thinking EMS provider agencies began developing new programs designed to meet healthcare needs of their communities.
• This was spurred in part due to the Institute for Healthcare Improvement’s “Triple Aim” recommendations:
  • Improve patient experience of care
  • Improve population health
  • Reduce per capita cost of healthcare
EMS Solutions

• This new delivery of care methodology was called Mobile Integrated Healthcare or Community Paramedicine (MIH-CP)
  • These programs identified gaps in healthcare resources
  • Engaged EMS in finding solutions to those gaps

• Central Premise Unique to MIH-CP
  • EMS providers are trained and trusted medical professionals
  • Available 24/7
  • Accustomed to working in the field
  • Embedded in every community in the nation
MIH-CP

• Mobile Integrated healthcare-Community Paramedicine (MIH-CP) is the provision of healthcare using patient-centered, mobile resources in the out of hospital environment.

• MIH is provided by a wide array of healthcare entities and practitioner/providers that are administratively or clinically integrated with EMS agencies.

• CP is one or more services provided by EMS agencies and practitioner/providers that are administratively or clinically integrated with other healthcare entities.
Community Paramedicine: What’s all the buzz about?

Community Paramedicine as defined by HRSA (Human and Human Services Health Resources and Services Administration):

“an organized system of services, based on local need, which are provided by EMTs and Paramedics integrated into the local or regional health care system and overseen by emergency and primary care physicians”

Indiana has several Community Paramedicine programs such as:

1. “We Care” and “Breath Easy” programs in Fishers, Indiana
2. Crawfordsville Fire Department – Project Swaddle, SUD treatment
3. Community Paramedicine-based model in Parkview Health

2. Crawfordsville Fire Department
MIH-CP in Action

• MIH-CP currently offered in 33 states plus Washington, D.C.
  • 70% consider themselves CP
  • 30% consider themselves MIH
MIHP: Indiana Related Legislation

• SEA 498 (Mobile Integration Healthcare program)

• Details:
  • Allows the emergency medical services commission to develop the mobile integrated healthcare program in consultation with the state department of health.
  • Requires FSSA to apply for money and waiver to set up a system of reimbursement for these activities to Medicaid members.
  • Establishes the Mobile Integrated Healthcare Grant Fund to encourage and foster development of new and innovative programs.

Source: http://www.iga.in.gov/legislative/2019/bills/senate/498
Why These Programs are Sorely Needed
Without Change
Thank You!

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State EMS Medical Director
Indiana Department of Homeland Security
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Medicaid and Paramedicine
State Plan Amendments

CENTERS for MEDICARE & MEDICAID SERVICES
State Experiences

• Approved paramedicine State Plan Amendments:
  – Nevada
  – Minnesota

• Notable difference: enrollment of emergency responders
Indiana Medicaid

• Community Health Worker benefit
  – Diagnosis-related patient education
  – Facilitation of cultural brokering
  – Health promotion education
  – Preventive services
Success depends upon our providers
Stressing Partnership

Indiana Medicaid

Provider Community
Provider Associations
Managed Care Entities
CMS
State Legislature
Idea into Reality

- Gather Input
- Build the System
- Federal/State Approval
- Continuous Improvement
- Publish the Policy
NETWORKING LUNCH

Food in Rooms 1 & 2

Seating in Rooms A, B, C

#INHealthWorkforce
Get the facts at www.bowenportal.org
LEARNING PROMISING PRACTICES IN
REGULATORY POLICY FROM LEADING STATES

Ronne Hines
Council on Licensure, Enforcement & Regulation

Saul Larsen
Colorado Department of Regulatory Agencies

Chris Winters
Vermont Secretary of State’s Office

#INHealthWorkforce
Get the facts at www.bowenportal.org
Sunrise and Sunset Process

What is Sunrise?

What is Sunset?
Sunrise and Sunset Process

The Beginning

✓ Colorado was the first state in the country to pass “sunset” legislation [CRS 24-34-104].

✓ The General Assembly wanted more oversight over regulatory agencies and greater input into their functions/programs and the need for agencies’ continued existence.
**Sunrise and Sunset Process**

**Changes in Oversight and Implementation**

**BIG MOVE**
- [Sunset review functions moved to Department of Regulatory Agencies]

**LIFESPAN I**
- [Maximum sunset “life” extended to 10 years for existing agencies/boards/etc.]

**LIFESPAN II**
- [Maximum sunset life for new agencies, etc., kept at 6 years]

**BURDEN SHIFTS**
- [Burden to prove that current regulations are least restrictive option available consistent with public interest up to agency, board.]

**CHANGING FACTORS**
- [Updated sunset review factors shift to their current form]

**BALANCE ACHIEVED**
- [Compared to factors as originally drafted, current sunset review factors more balanced in terms of a bias for/against continued regulation]
**INITIAL REVIEW:**
DORA conducts an evaluation of programs et al. up for review

**SUBMIT REPORT:**
DORA submits a report to the Office of Legislative Legal Services (OLLS)

**LEGISLATION:**
OLLS prepares “based solely on recommendations set forth in report”

The appropriate committee of reference considers the recommended legislation during the next session
Sunrise and Sunset Process

THANK YOU!
Colorado’s Sunset law was one of the first accountability tools designed to examine the need for and impact of state regulation on the economy and the effectiveness of state regulation. At the time of the creation of the Sunset process, many Colorado regulatory boards were seen as ineffective and unaccountable.
Colorado’s was the first Sunset law passed in the United States. It was signed on April 11, 1976 by Governor Richard D. Lamm. In June of 1976, the *Wall Street Journal* reported Colorado’s Sunset law as being a model for other governments to follow and as a remarkable innovation in state government. The *Journal* was impressed by the determination of Colorado’s Legislative and Executive Branches to examine existing government programs, terminate those which were found to be unnecessary and improve those which were found to be in need of improvement.
<table>
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<th><strong>Statutory Trigger</strong></th>
<th><strong>Effect of Trigger</strong></th>
<th><strong>Wind Up</strong></th>
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<tr>
<td>This article is repealed effective September 1, 2019. Prior to such repeal, it shall be reviewed in accordance with section 24-34-104.</td>
<td>Affirmative legislative action required to continue the statute.</td>
<td>Program will cease to exist on September 1, 2020.</td>
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Sunset Process

Research
Late Fall 2018 Through Early Summer 2019

Writing
Early Summer 2019 Through October 15, 2019

Legislative
January 2020 Through May 2020
Is regulation necessary to protect the public and if it is, does it represent the least restrictive form of government consistent with the public interest?
Research

• Data Collection
• Literature Review
• Colorado Statutes, Rules, etc.
• Statutes and Rules of other states
• Statutes and Rules of the U.S.
• Stakeholder Process
Stakeholder Process

- Trade, industry and professional associations
- Any individuals known to have an interest, consumers
- Federal, state & local officials
- Recognized experts
- Board members
- Online Comments: http://www.dora.state.co.us/pls/real/OPR_Review_Comments.Main
Stakeholder Process

- The more diverse the input at the beginning, the better the public policy is at the end.
- Very open, inclusive process.
- No one ever has to wait for COPRRR to initiate contact.
### Report Template
- Background
- Statutory Recommendations
- Administrative Recommendations

### Report Due Date

### Previous Reports
All reports issued since 1992 are online at: colorado.gov/dora-oprrr
Legislative Process

• Automatic legislation
• Draft bill reflects sunset report
• Typically heard within first four to six weeks of session
• Even-numbered years, sunset bills begin in the House
• Odd-numbered years, sunset bills begin in the Senate
The Sunset Hearing

- COPRRR presents report and draft bill to committee of reference
- Committee will take public testimony
- Committee may/may not entertain amendments
- COPRRR’s goal: bill introduction
- Introduced bill will return to the same committee for first official hearing, and more public testimony
Sunset results have resulted in the elimination of 63 regulatory boards, committees or functions of government

Refund Anticipation Loan Facilitators - 2018
Automobile Theft Prevention Authority and Board - 2008
29 Reports
Number of Sunset Reports in 2018

128 Recommendations
Number of Statutory Recommendations in 2018

95% Pass Rate
Percentage of 2018 Sunset Recommendations Adopted by General Assembly in 2019
Thank you!

Questions?

Saul Larsen
Saul.larsen@state.co.us
303.894.2996
https://www.colorado.gov/dora-oprrr

Colorado Office of Policy, Research & Regulatory Reform
Vermont Office of Professional Regulation Sunrise Review

Deputy Secretary of State Chris Winters
Created as an “umbrella agency” in 1989 for efficiency in professional licensing

Professions were scattered, siloed, independent, and unaccountable

Consolidation under one roof made sense for many reasons
Creation of OPR resulted in:

- Savings through the enhanced productivity of shared resources (staff, space, legal services, IT)
- Efficiency through implementation of best practices
- Less red tape and more confidence for the regulated community due to consistent and predictable approaches to regulation
- Improved public protection and customer service through efficiency, increased transparency, and co-location of similar services
Recent licensing discussions:

- Massage Therapists
- Precious Metal Dealers
- Foresters / Loggers
- Speech Language Pathology Assistants
- Dental Therapists
- Behavior Analysts and Assistants
- Home Inspectors
- Alcohol and Drug Abuse Counselors from DOH
- Home improvement contractors

Professional Regulation – Unify. Streamline. Focus.
16.8 % of professions regulated
16.8% of professions regulated
VT Sunrise laws (26 V.S.A. § 3101)

It is the policy of the state of Vermont that regulation be imposed upon a profession or occupation solely for the purpose of protecting the public. The legislature believes that all individuals should be permitted to enter into a profession or occupation unless there is a demonstrated need for the state to protect the interests of the public by restricting entry into the profession or occupation. If such a need is identified, the form of regulation adopted by the state shall be the least restrictive form of regulation necessary to protect the public interest.
VT Sunrise History

- **1977** - Added the chapter; reviews assigned to Legislative Council

- **1997** - Amended to allow reviews by OPR (we offered)
  - Time, expertise and resources to do the review
  - Application, report and recommendation process
  - Vet issues, evidence-based decisions, early involvement

- **2015** - Amended to add more specific criteria and allow for ongoing assessment (regulatory review)
VT Sunrise Reviews

- A gatekeeper; the ability to slow down and do the analysis
- Based on facts, not emotion, money, pride
- Empower legislators to defer
- Protective of legislative time
  - Landscape architects, dog walkers, massage therapists, foresters, residential contractors
THANK YOU!

Please contact me with any questions.

Chris Winters
Vermont Deputy Secretary of State
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802-828-2124
chris.winters@sec.state.vt.us

OPR Sunrise Review and Reports: https://www.sec.state.vt.us/professional-regulation.aspx
PLENARY PANEL

Starting at 3:00pm

Please make your way to the Auditorium

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Get the facts at www.bowenportal.org