

**EMS Consultation Group Minutes**  
**June 20, 2011 – 1 p.m.**

**Attendance:**

Dr. Harry Chen, Commissioner  
Chris Bell, VDH  
Pete Cobb, EMT Volunteer  
Pat Malone, IREMS  
Jim Finger, VAA/Regional Ambulance  
Mark Considine, EMS District Rep (ph)  
Dr. Steve Leffler, EMS District Med Advisor  
Donna Jacob, VDH  
Mike O'Keefe, VDH  
Bill Hathaway, VSFA

Bessie Weiss, VDH  
Tracy Dolan, VDH  
Seth Lasker, VT Career Fire Chiefs' Assoc  
Dixie Henry, VDH  
Jill Olsen, VAHHS, Representative from Office  
of Professional Regulation  
John Vose, VAA/Upper Valley Ambulance (ph)  
Mike Paradis, Newport Ambulance  
Will Moran, Professional Firefighters' Assoc.

**Absent:**

Mike Skaza, VSFA  
Matt Vinci, VT Professional Firefighters

Dr. Barry Heath, FAHC  
Maria Royal, Legislative Council

**Introductions**

The meeting was opened by Commissioner Harry Chen, who introduced and welcomed Chris Bell, the new director of OPHP and EMS. Chris Bell joins us from Columbus Public Health in Ohio, and has an 18 year background in EMS in addition to being a paramedic. Introductions were made around the table and on the phone.

**Minutes of May 16, 2011:**

The minutes of the May 16 meeting had been previously distributed. Dr. Chen accepted a motion from to approve the minutes. The question was called, approval was unanimous and no comments were made.

**Major topics**

Dr. Chen said Matt Vinci had expressed interest in bringing some issues not directly related to Act 142 to the consultation group. Matt was not on the phone, and when asked, no one else was aware of what his intent might have been.

Chris Bell thanked Dr. Chen for the introduction. He told the group that he has been involved in EMS since 1993, serving on volunteer and paid services first in Pittsburgh, then in Colorado and Ohio. He said he was excited to be involved in EMS in VT, understood the importance of the group and was happy to be a part of the process.

Chris distributed a list of major topics discussed during previous consultation group meetings. He explained that not having attended any of the previous meetings, he had reviewed the minutes and taken what he believed were key points from those meetings. If there had been more than one option discussed, he had summarized those options. Chris went on to note that if there was an omission or a misrepresentation, it was purely an error on his part, not having been familiar with past discussions. He said the intention was not to gain consensus but to identify the different perspectives of the group to be

brought forward to Dr. Chen as he prepares the report to the legislature later in the year or early next year. Chris apologized to those on the phone, saying he would send out the list electronically after the meeting.

### **Certification or Licensure**

[Pat Malone, Dr. Steve Leffler and Will Moran arrived, and Jill Olsen called in.]

Chris said that his reading of the minutes, there seemed to be broad consensus that the term licensure as the state's permission to practice

### **Individual Practicing Above the Level of Service Licensure**

Chris noted that in reading the minutes, it seemed that this part of the legislation had been added to cure a rare incidence. Chris explained that in his reading, there were a couple individual instances of where an individual might have been working with a service that was licensed at a lower level than the individual's certification level. Act 142 allows the consultation group to consider whether or not this recommendation should be put forward in the Commissioner's report. He said there seemed to be support from most everyone that this was probably something that folks did not want included in the recommendations. The burdens of the additional paperwork, cost of equipment and medications, and a potential DEA conflict of having an individual carrying pharmaceuticals in their personal vehicles all combined to cause people to reconsider

Dr. Leffler agreed. He said he remembered Dan Manz had noted that perhaps 10 people in the state were practicing at a higher level than the volunteer squad they were on. For all the reasons you just stated, the group felt this was not a recommendation they wanted to support at this time.

Jim Finger noted that if the individual is affiliated with two different services, one at a higher level than the other, the individual may function at the higher level with the lower level service if the DMA and the agencies are both in agreement. He noted this is not an individual and one agency deciding, it's all parties.

Dr. Chen clarified that an Intermediate level agency has a paramedic who volunteers for them. DMA is okay with it...would they be able to function as a paramedic? Jim said that if their licensed paramedic service was okay with them providing that level of service at the intermediate level service and they had the equipment, but all parties have to be okay with it.

Chris offered a scenario. Works for Service A. Service B is at a lower level. If A and B and the district medical advisor agrees, then if I show up as a member of Service A to assist Service B's patient, that's okay. Seth noted they are living this now. They have two medics working for Burlington Fire at this time, but Burlington is licensed as an intermediate level service. He asked if the medics could function at the paramedic level if they also were affiliated with a paramedic level service. Jim explained that this would be possible if the paramedic level agency was meeting them. Dr. Chen said this almost sounds like an agreed upon exception.

Pete Cobb recommended that this be in writing. Seth Lasker said he would prefer to see the service license at the paramedic level.

Chris asked the pleasure of the group. He said while he is new to the reading of the Vermont EMS Rules, this seems like it is not included and wondered if perhaps it should be placed in rule.

Bessie Weiss said she was unclear what was being proposed.

Bill Hathaway said he is a paramedic with Bennington Rescue, which is licensed at the paramedic level, but he also rides with Pownal Rescue, licensed at an Intermediate level. He said he would function as a paramedic, or perhaps more of a super Intermediate, when he knows that ALS intercept is coming from Bennington to assist the patient he's tending for Pownal. Dr. Chen said it seemed we have 3 choices: status quo with what we have now, update the rules, or repeal this section of Act 142.

Dr. Leffler asked Bill if he has his own medic equipment and medications when he's in Pownal and he suddenly becomes a paramedic. Bill said sometimes he has equipment but not medications. Dr. Leffler said he felt this was a different situation. Using your knowledge base as a paramedic is different than carrying your own set of equipment and medications, and all of the issues that this implies. He said he has a problem with a paramedic functioning fully with a lower level service. Bill said he functioned basically as a super intermediate. He carries intubation equipment but not medications.

Pete Cobb said it seems like Bill is functioning under Bennington as an intercept, and Pownal and Bennington have that agreement. He said that it appeared the only time Bill would be functioning as a paramedic was when Bennington is functioning in an intercept capacity, so to him it is a non issue. You're still licensed under your paramedic service.

Jim Finger said that they feel the language of Act 142 that allows people to function on their own at a level higher than their service is what they would like repealed. Chris said he believed Dan had stated that currently no one has applied under the terms of Act 142, but he did understand that in an intercept capacity, what Bill Hathaway described does happen around the state. Dr. Chen noted that what happens today is covered under the old rules.

Bessie read the Act 142 language, noting that it specifies "pending the results of the study." The in-between provision is that the individual could develop a protocol, etc. and no one has done that. She said she did not believe the discussion as heard counted as a repeal of Act 142 or a new rule.

Chris clarified that if the study group recommends that this end, that would be the recommendation put forth to the legislature.

[Mike Paradis arrived.]

### **Credentialing of providers**

Chris summarized some of the major topics:

- Locally-based

  - Challenge for small and/or volunteer agencies

- State-based

  - Standard setting or local control

- Standardization vs. burden imposed on local providers

Chris said there appeared to be no consensus in his reading of the minutes, and he said that this was a fine message to put forward.

Steve Leffler agreed that there was not a consensus and people each had strong opinions on what they thought was best. Some thought the legislation was trying to get folks toward a statewide standardization, but others felt like knowing the local flavor of who is good at what was a good way of doing it. Dr. Chen noted that his purpose is to be in a listening mode, and there may be middle ground between statewide and local.

Pat said he thought folks agreed on a state standard, but disagreed on how it would be delivered. He thought the credentialing format would be standardized, but small services might need help or might group together. Jim Finger said he thought the different methods were going to be advertised but it would be up to the local areas to decide how they would accomplish credentialing and with what tools. Steve Leffler said he did think the group agreed that every EMT-I in Vermont would have to be credentialed using the same minimum bar, but they hadn't agreed on the bar. And everyone needs more information on where the bar is and what it includes...the bar being the standard. The way they achieve the bar might be different but it would need to be achieved.

Pete Cobb said it was so easy in the past because the state held exams and everyone had to meet those standards. This is completely different to everyone and no one knows where the bar will be set or how it will be achieved. Pete pointed out that the DMAs only know probably 5% of their own district's providers and they never see first responders. This almost dictates that credentialing has to be resolved at the local level, with state standardization somehow. It's not going to be easy.

Dr. Chen asked the group what they would say if testing was left as an option, not the only option, but as an option for recertifying. If a squad didn't have the ability to do cme and recertification, the individuals could test. Bill Hathaway said that question had been posed during the public meetings as an option, just like the NREMT allows you to challenge the test and be recertified. Continuing education would have to be done but for credentialing, the individual would have the option of going through local level credentialing or taking the state recertification exam.

Jim noted that under Act 142 the state cannot offer testing. Dr. Chen agreed. Jim then pointed out that twenty people can't just decide to take the test and become credentialed. Dr. Chen asked if it was credentialed or licensed, and it was pointed out that currently the term is certified. Dr. Chen then said he thought we were talking about using the test for licensing. Dr. Leffler said that this is an interesting part of the law, since he felt that people were relatively happy with the way it was before Act 142. Testing mostly worked. He asked Pat's opinion.

Chris asked a clarifying question, wondering if testing every two or three years was in lieu of continuing education. Seth said no, that in the past continuing education was turned in and the individual took a recertification exam, but now under the new rules and with the switch to NREMT, the number of continuing education hours has jumped. Pat felt there were issues with the test and that it was a skills demonstration, not a pass/fail. There were multiple tries to demonstrate skills, plus then there was a written test. In Pat's view, testing had expenses related to it that were not directly funded. Chris asked who would offer the exam. Pat explained the district would offer it and the state would proctor it, but the district's providers would basically run the exam.

Will Moran said he thought that if the testing option worked and folks wanted to build it back in, that was a viable option. But he did feel that credentialing as built into the rules was a good system for services that see high call volumes and have the systems in place to deliver that higher volume of ce.

Chris noted that he was in Colorado when they reverted to the National Registry. This was just after the press and legislature discovered that virtually every service in the state had a copy of the certification exam in their possession. The knowledge of the exam had filtered out to the entire state. It's a drain of man hours, expense and experience to keep a test current. He said he suspected this was one of the problems that had driven both Colorado and Vermont to change to the National Registry, since they have the manpower and resources to keep the tests current and secure.

Pete Cobb said he believed there would be a cost to credentialing. The individual squads will do the credentialing, but the new rules indicate that the state can and will inspect those records. He asked what oversight there would be. Chris noted the question is a good one but that currently there is no answer.

Jim Finger said he thought the concept of the new rule that would allow them to do continuing education is one part of it, but the main 24 hours is the basis. The services and personnel will have to keep those records and those records will have to be turned into the National Registry. The credentialing part is the skills part, so he was talking about taking the practical test in lieu of the credentialing. Perhaps the written could be used as well, but he said he was talking about the practical.

Mike Paradis said the complaint from those folks involved in Act 142 was that everyone passed the recert. From a district point of view, he said he knew everyone was going to pass the exam as well, and no, they did not have a copy of it. But Mike said his paid service and many volunteer services looked at it as a way to refresh skills. Maybe if the test had been more of a pass/fail, it might have been more stressful on the candidates. As it was, they stressed a lot already, but they practiced for weeks before and honed their skills. Dr. Leffler noted that the test was a nice way to set the bar. They had to have a minimum amount of knowledge to meet it.

Mark Considine said that the option for testing should be left as a plausible option. Some border states like NH currently have a testing requirement as part of their rules. Unless they amend their rules, personnel who function dually in Vermont and NH are required to test in NH and recertify their NREMT, and can then show that back to Vermont. However, because testing has been eliminated in Vermont, doing the reverse is no longer an option. Changes to rules have to be worked out in collective bargaining units of the larger services, so ample opportunity for discussion is important.

Dr. Chen clarified that the removal of the opportunity for testing really hurt border services. Mark pointed out that an individual belonging to his service could meet every requirement for certification in Vermont but still be blocked from functioning in NH because they have a higher standard. For example, NH doesn't accept that Vermont EMTs are not required to test but they still have to test in NH to qualify for recertification. When Chris asked, Mark explained that depending where the individual is in their cycle, testing involves either the first go-around of NREMT testing or for subsequent recertification, it's a state-approved practical examination that's been developed. The written exam is tied into the formal full NH refresher with a course approval number tied to it, and testing is part of that final refresher approval.

Chris said he heard that testing should at least be an option for a way to certify/license for the state.

Will Moran asked at whose discretion testing would be an option...the individual, the agency, the DMA? Jim Finger said he believed that under Act 142 it would be the service and the DMA who would jointly decide if the method of credentialing was okay. Chris asked for a clarification, and Jim Finger said he was talking about credentialing. Turning in the continuing education and recertifying with NREMT would still remain, but testing could be used in lieu of service credentialing. If the service didn't want to credential their personnel or wasn't able to for some reason, they could send them to the state for a practical exam.

Seth asked whether that would eliminate the hours of CE. Jim said no, CE has to be turned in no matter who you are. But to credential the individual internally, they would either go through skills checks within their service or district, or an agreement might be made to send their people (or a particular person) to go take a test. CE is tied to the National Registry, and can't be changed.

Everyone seemed to be in agreement, although it was agreed jokingly that this certainly isn't easier.

Chris summarized that there seemed to be broad support for a state practical testing option as a way of showing ongoing credentialing at the discretion of the DMA and service. Everyone was in agreement with his statement.

Mark Considine recommended that something go out to services regarding credentialing since the new draft service licensing packet needs to be presented soon to the services so they'll be ready. Part of the new service licensing packet speaks to credentialing.

### **Advisory Group for EMS**

Make-up of group

Representatives from each district

Medical advisors

Different types of members (career, volunteer, urban, rural, fire-based,  
third-service, private, etc.)

Advisory or licensing or disciplinary

Chris said most comments seemed to support some type of advisory group that would have a relationship to the EMS Office, VDH, or the Commissioner. He said there was a great deal of discussion about whether this group would be advisory, or would take the place of the Board of Health with regard to licensing or disciplinary actions.

Chris went to say that there was a great deal of discussion about the makeup of the group. Members from each district as well as District Medical Advisor representation had been mentioned, as well as having different types of members (career, fire based, urban, rural, third service, private, etc.) There was also discussion about whether the group should be advisory, providing advice to the EMS Director, the Commissioner of Health, whether it should be a licensing group or disciplinary in nature.

Chris said he did not feel in the reading of the minutes that a consensus had been reached on the type, makeup or purpose of the group but that there had been agreement that some type of group should exist. He asked if he had interpreted the minutes correctly.

Dr. Leffler said he felt it was accurate. Different people in the room felt the group should have different functions, and were perhaps at odds with each other as to these purposes. Dr. Leffler said that regardless of the purpose or makeup of the group, there did seem to be a desire to have some type of group that could address issues on an ongoing basis.

Dr. Chen commented that the differing purposes of the group might not be mutually exclusive. For example, the group might start off being advisory and then at some point that it should become disciplinary.

Mike Paradis pointed out that the EMS District Chairs used to meet regularly as did the District Medical Advisors. Dr. Leffler noted that ED Directors in Vermont meet at Dartmouth on a quarterly basis. All but about 3 ED Directors are also DMAs, so there is some regular communication and consistency. A meeting could be tagged or an agenda item presented to this group.

Jim Finger cautioned that Vermont is very diversified and you have to go slow....mold them and lead them rather than just turning on a switch.

Pete Cobb asked if Vermont EMS would remain similar. Chris noted that currently there are some positions that will become vacant and that some responsibilities may be shifting a bit, but essentially most of the same people will be in the same or similar roles. The State EMS Office is open to other perspectives if you think there are different ways we should do business. Chris said he'd reached out to the 13 districts to find a time when he could visit each to introduce himself and find out their needs and how the EMS Office can be of service to them.

Dr. Chen said he saw the report and process as integral into creating the future destiny. There is a possibility for changes but there is nothing immediate in terms of a drastic overhaul that is required.

John Vose noted that NH has an emergency medical and trauma services coordinating board that works well for their state. Perhaps looking at the makeup and purpose of the board as outlined on the website would give folks a starting place.

<http://www.nh.gov/safety/divisions/fstems/ems/boards/coordinating/index.html>

Chris said that many other states around the country have some type of advisory group and there are other models that could be considered.

Bill Hathaway said he'd been a part of the NH system for 6-7 years. NH has Regional Councils, and the Regional Councils all sit on the advisory board. There were Regional Medical Directors appointed by each region and they sat on a medical control board. It worked well to bring forward changes of medication or protocol.

## **EMS Training**

Funding

Local or central coordination (academy-type or resource support)

Distance education

Mobile support for local training (sim lab/equipment/instructors)

Background checks

Self-reporting vs. mandated – agency or EMS Office

The unanimous thing Chris read was funding was a major concern and permeated through all of the topics. There seemed to be no consensus as to types of training that should be offered. It was thought that distance learning and perhaps a mobile training unit was a good idea. There was also discussion about background checks and how they could/should be performed, as well as a discussion about agency background checks, which are now required under the new rules.

Dr. Leffler noted that the fire service offers a mobile training service and that this type of model also might be of value to EMS. Chris said he did remember that being mentioned, and that there had also been a point made about the quality of instruction offered by the fire service as being varied.

Bill Hathaway noted that with 72 hours of ce required, continuing education programs would have to be boosted. He expressed concern that the EMS Conference had been cancelled, saying that this had previously afforded approximately 16 hours of ce for both days. EMS Staff noted that it was 8 hours over the 2 days of the conference, with more possible from preconference workshops.

There was a brief discussion about continuing education hours due—72 hours every 2 years, with 24 of those hours being a refresher course or the equivalent continuing education components delivered locally, and 48 hours of additional education.

Will Moran said that the theme of the discussions during the public hearings was that this was a chance to turn Vermont EMS into what we want it to be rather than just to morph into what we had. We look at funding as a hurdle, but have we looked into it. It's a great way to elevate EMS within the state and mature it as a profession. The state has to have the mechanisms in place so that providers can meet the 72 hour ceu bar.

Mike Paradis said that EMS at present is pretty much like the firefighter model. Training is delivered locally, not at an academy. Each district approves courses and instructors, and therefore has control over the quality and quantity of courses. Instructor coordinators have been certified through the state to teach these courses. As he looked at the fire model vs. the Vermont EMS model, he objected to the term "raise our professionalism in Vermont." He said that after 40 years in EMS in Vermont, he felt providers were very professional already. There are services that need work, as there are also fire departments that need work. He agreed funding is needed for EMS, and fire service seems to find that funding. But he disagreed with statements saying that the EMS education system needed to change in Vermont. And he worried about the burden on communities to fund changes.

Dr. Leffler said he felt there needed to be a relatively cheap and easy way to help folks achieve the 72 hours needed for recertification, adding that he feared people would quit EMS if the time burden on volunteers becomes too great.

Mike Paradis said that an EMT Basic course in District 2 costs students \$500 to enter a course. Newport says that if a student pays their way through a Basic course and then stays with the service 6 months, Newport will refund the student the cost of the course. The fire service started out telling firefighters that they had to go to the academy. They quickly learned that volunteers were not taking the Firefighter I course in Pittsford, both because of money and time. Now the course is satellited out similar to what is done with EMS courses. Pat Malone noted that the difference is the funding piece—the firefighter doesn't have to shell out \$500 for FFI. State funding provides for that training. The model of local delivery is the same and an excellent one.

Will Moran told Mike Paradis that his comments were not to take away from EMS training, but merely to look for ways to make it better.

Jim Finger said the major consideration is whether people are going to leave. EMS providers have to be trained, but firefighters do not have to have all the training and maintain certification at certain levels. Paid services will do okay, but volunteer services and providers need to be supported.

Pete Cobb said some help from Vermont EMS would be useful concerning the 72 hours of continuing education. Everyone knows the 24 hour required topics but beyond that, some guidance would be helpful.

Chris agreed, saying a meeting was scheduled the next day to discuss that very topic. Tracy assured attendees that support to providers and services is of utmost importance to the Department, as well as again holding an EMS Conference.

Chris asked about background, self-reporting vs. the State EMS Office either requiring the check at the beginning of the course or as part of the testing process. No comments were heard.

Mark Considine asked if there would be a discussion about transitioning to the new educational standards and would it be possible to have those transition plans in place by 2013. Chris said that the thought of using a bridge course, usable as ce for that cycle, was a topic that could be discussed.

### **Need for Minimum Standards**

Responder type/level

Paramedic intercept model

Response times

Chris said there was not a consensus reached about what type or level of care should be provided to all Vermonters. He said that the paramedic intercept model was one method mentioned to balance the local support and need with the desire to provide Vermonters with that quality of coverage. Many folks seemed to be satisfied about the level of care provided throughout the state and value was placed on local capabilities and preference. Also, response time was discussed, but there was no consensus about whether there should be a specific response time required to different types of emergencies.

Bill Hathaway said PSAPs might play a role, and that currently in Vermont there is not priority medical dispatch. Bill said he remembered that when it was started in other areas, people were dead set against it. They believed that those types of decisions should be made at the local level. Bill noted that having

been a part of systems that utilize priority medical dispatch, he'd come to value the service. A paramedic level intercept is not normally needed for a bloody nose or a lift assist. Determining critical need is important.

Chris explained that EMD (emergency medical dispatch) is a system where a person answering the phone uses cards or some type of screening to determine what types of resources should be sent and how fast. Bill Hathaway said currently the call goes from the PSAP to a police dispatcher, who may dispatch for a difficulty breathing call. Dr. Chen said that it might be useful to have a discussion with E-911. Chris Bell said he'd worked in both types of systems: He explained he's gone lights and siren to a kitty in a tree and also gone quietly to the scene of a pulmonary embolism where the patient was hypotensive. EMD isn't necessarily going to solve those problems but it's worth having a conversation.

Pete Cobb said that this situation varies through the state. With his service, dispatch goes through Keene Mutual Aid, which is an EMD center.

Dr. Leffler said it was unrealistic for every person to receive paramedic care every time in the state of Vermont. Vermonters love living rurally until they have a heart attack, and response times are going to be long regardless of the best efforts. Every ambulance service in the state is at least at the Intermediate level, and the consensus was that this is reasonable.

Dr. Chen said this might be the type of discussion to continue as a part of health reform, but that he didn't believe a decision needed to be reached today as far as what level or the speed of every response.

Bill Hathaway noted that an agency may be intermediate on board but said that where possible, it would be great if the receiving agency had intercept capability at the paramedic level.

Mike Paradis said that from his experience, the outlying services got a little touchy when the facility started sending intercepts on every call. Bill Hathaway said that when EMD was first instituted, it was met with a great deal of resistance. There was a brief discussion about intercept services in District 11 and the changes that have occurred over many years.

### **Overarching – Fund Stream**

Advisory group

Education

Credentialing

Other support to agencies

Chris again noted that a fund stream seemed to be a consensus throughout all of the themes discussed.

Hearing nothing, he asked if anything had been missed. Dr. Chen mentioned there might be new topics presented, and Chris Bell said the plan at the next meeting was to present a draft report but not to take new comment necessarily.

Mark Considine asked the status of the statewide protocols that will match the new educational materials and the transition. Mike noted that it's on the list. It has to be a package that is coordinated.

Mark said that previously Dan mentioned he was going to try to get the support for providers to get back into the National Registry, particularly for the volunteer staff. Chris Bell said it was on his personal radar, but didn't have an answer at the moment.

Mark Considine explained there are services using software other than SIREN/Image Trend to import call data, and that this data needs to be imported into SIREN. He asked if any progress had been made in this area. Mike said he had emailed the data dictionary to several software vendors and services, but that he had not heard back from any of them. This provides the vendors with the information they need to develop the systems to transfer the data. Mark said it continues to be an ongoing issue at VAA meetings. Services using other software wish to comply, but it may be necessary to put some pressure on vendors from the VDH level or that some help might need to be targeted toward developing data transfer modules.

Seth Lasker asked about RNs who are interested in joining the EMS system. These RNs are untested and relatively untrained, and there's some level of concern about that. Jim Finger said that the thought was that the DMA would work with the RN to look at their training and assure that they have the skills and knowledge required. Pete Cobb noted that District 11 will be offering one of their modified bridge courses again soon. Mike O'Keefe said that District 11 pioneered the approach of an accelerated EMS course for healthcare providers and other branches of allied health. A very instructor coordinator met with them on a regular basis to cover materials. Carl Matteson is about to do the third of these courses, and the course is very time intensive. Mike noted that the procedures are currently being developed to allow RNs to become EMS providers, and said he expected that this topic would also be on the meeting agenda tomorrow. Chris Bell noted that the rules say the RN has to take a registry exam and how the RN has to get signed off before they take that exam. He told Seth the Department would get back to folks soon.

Pete Cobb asked about the process in the works to allow providers to regain National Registry if they once held it. Chris explained that this topic was the original purpose for the meeting scheduled for tomorrow. There will be a process whereby Vermont providers in good standing who previously held National Registry to regain their NR certification without testing. Information on this process will be out as soon as details are finalized.

**Next Meeting/Topic:**

September 19, 2011 at 1 p.m., Cherry Street Room 3B

Dixie Henry said that the plan for September 19 is to have a summary of input from this group to the Commissioner, then move on to findings/recommendations, and then draft legislation.

Dr. Chen and Chris Bell thanked all of those who participated.

**Adjourned:** 2:34 p.m.

Minutes respectfully submitted by  
Donna Jacob