

Occupational Licensing Reform: A Step-by-Step Approach for Pharmacy Licensing Boards

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Abstract

Occupational licensing reform is essential but challenging for state agencies. This paper presents a step-by-step framework for pharmacy licensing boards, inspired by the Idaho State Board of Pharmacy's (BOP) efforts, which achieved a 75% cut in regulatory page count while creating a more permissive practice environment. By establishing baselines, prioritizing reform areas, and setting clear reduction goals, the BOP streamlined licensing, modernized professional practice standards, and adopted technology-agnostic facility regulations. The transition to enforcement-centric accountability ensured public safety while fostering innovation and economic growth. Early results include increased pharmacy services, improved access, and significant industry investments. This framework offers a replicable approach for other licensing boards to reduce red tape, support economic growth, and enhance regulatory efficiency without compromising health and safety.

Keywords: Pharmacy Licensing Boards, Occupational Licensing Reform

Occupational licensing has increasingly been seen as a bipartisan priority for reform. States define the occupations requiring a license, ranging from hair braiders to physicians. Further, state laws may define and limit the activities that licensed occupations can perform and the facilities that licensees can operate in. A comprehensive approach reforming occupational licensure regulation is needed but knowing where to start may seem daunting.

Regulatory scholar James Broughel has outlined a five-step process for states to reduce their regulatory burdens across state government.¹ The process involves quantifying regulatory burden by measuring restrictions and establishing an objective reduction goal. Broughel also encourages the creation of a state oversight mechanism, such as a commission to track progress toward defined goals. The process is advantageous in its relative simplicity.

While statewide processes will be critical, the work of regulatory reform will necessarily involve the active engagement of individual state agencies, including licensing boards and commissions. Without the active leadership of agencies, it is unlikely that regulatory reform will be meaningfully achieved.

Our efforts at the Idaho State Board of Pharmacy (BOP) led to a sustained decrease of in our agency's regulations for seven years and counting.^{2,3} In addition, we believe that our efforts fostered a regulatory architecture that promotes innovation and economic growth while still protecting public health and safety. Based on our experience, we offer below a stylized representation of our agency-driven reform process adapting

Broughel's statewide process. We believe that this template will be useful for other individual licensing boards seeking to reduce red tape in three primary areas: 1) licensing; 2) professional practice standards; and 3) facility standards.

Profile: Idaho State Board of Pharmacy (BOP)

For more than 100 years, the Idaho State Board of Pharmacy has been charged with promoting, preserving and protecting the health, safety and welfare of the public by and through the effective control and regulation of the practice of pharmacy. The agency is governed by a five-member board appointed by the Governor, consisting of four pharmacists and one public member. The majority of funding for the BOP is generated through licensing & registration; additional funds come from fines, fees and the sale of printed material, with no monies appropriated from the state's general fund.

The BOP oversees licensing, compliance and investigations of nearly 300 in-state drug outlets and nearly 27,000 licensees. The board licenses both individuals (pharmacists, technicians, etc.) and facilities (pharmacies, distributors, manufacturers, etc.). Compliance officers inspect every in-state pharmacy on a regular basis, and BOP investigators respond to complaints alleging violations of law or patient harm. The BOP has enforcement authority over licensees. The BOP also serves as the state's controlled substance authority, and oversees the Prescription Drug Monitoring Program, a database used to combat opioid abuse.

1. Impetus for Action

Getting started is always the hardest part. While regulatory reform often starts with an external stimulus such as a Governor-led executive order or an enhanced focus from the state legislature, agencies need not wait and can initiate a reform process at any time. Signs that regulatory reform may be needed include:

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- Licensees are consistently petitioning for waivers or variances from current rules;
- The agency is regularly engaging in rulemaking to keep pace with changing business models or technology;
- Rulemaking often involves creating exceptions from current regulations;
- New business or technology vendors are constantly requesting presentations at agency meetings to determine if their product or service is allowable in the state; or
- When attending meetings of your agency's national association, your state is often an outlier on key issues.

We had found some of these to be the case with Idaho's pharmacy regulations and the BOP decided to initiate action to improve its own regulations.

2. Establish Baseline Regulatory Burden

There are many ways to quantify regulatory burden, each with various advantages and disadvantages. Recently, there has been a growing push to quantify overall regulatory burden by determining the overall word count and the total number of restrictions (e.g., the use of the terms like "shall" and "must"). While simplistic, this approach provides an easy starting point for establishing a baseline measure of regulatory burden.

To further characterize an agency's regulatory burden, comparison groups can be beneficial. Comparators may include:

- The same agency in neighboring states;
- Similarly situated in-state agencies; or
- Previous chapters of regulations from the same agency, which can help establish trends over time.

The BOP used its own regulations as its baseline, and used several comparison groups for benchmarking:

- 1) The Idaho boards of nursing and medicine regulations from 1996 to 2017;
- 2) Previous BOP regulations from 1996 to 2017; and
- 3) Other BOP regulations from 10 western states.

With respect to the former, the review found the pharmacy regulations had a word count significantly larger than both medicine (51.6%) and nursing (39.9%), a trend that had persisted every year to varying degrees since 1996.⁴ Pharmacy also had more restrictions in regulation than medicine (60.9%) and nursing (55%).

The BOP's own regulations grew word count by 41.9% from 1996 to 2017. By contrast, the nursing regulations had only grown 2.4% during the same time period.⁴ Growth in the BOP rules occurred in three substantive areas: 1) licensing (8.2% growth); 2) professional practice standards (36.6% growth); and 3) facility standards (116.6% growth).

Lastly, BOP regulations exhibited wide variation in overall regulatory burden as measured by word count (average of 65,882 words, SD=35,057) and restrictions (average of 1,563 restrictions, SD=1,106). Two states (Alaska and Hawaii) had lower overall regulatory volume than Idaho with no known patient safety outcomes.⁵⁻⁶

The totality of these comparisons suggested that there was opportunity to improve the regulatory structure with Idaho's BOP rules.

3. Identify Topics to Exclude from Reduction

In any regulatory reform effort, it is critical to distinguish between regulations that truly protect public health and safety, and those that are attempting to prevent speculative or unsubstantiated harms. Those in the latter category add red tape, hold back innovation, and may be better addressed through market mechanisms.

Through discussions, the Board identified two critical topics to exclude from its reform effort: regulations targeting controlled substances (e.g., opioids) and compounding (e.g., the mixing and making of drugs in the pharmacy). Both of these topics have a well-known public health nexus: the U.S. is in the midst of an opioid epidemic,⁷ and unscrupulous compounding practices in New England triggered a meningitis outbreak that was linked to more than 60 deaths and hundreds of illnesses,⁸ among other examples. Thus, while the Board sought to reduce its overall regulatory burden, it retained critical regulations addressing these two topics, and in some instances even strengthened regulations.

The BOP believed that reducing the overall regulatory burden while preserving critical areas would strengthen the focus on these priorities. Rather than Board compliance officers using their limited inspection time to focus on trivial matters, compliance officers would have more time to ensure controlled substance and compounding practices meet minimum standards.

4. Set a Target Reduction Goal and Deadline

After establishing the baseline and determining which priority topics will be excluded from a reform effort, setting an objective goal is paramount. Setting a goal for both word count and restrictions is an easy starting point. The targeted percent reduction on each of these measures could be an informed speculation based on the work that determined the baseline regulatory burden and taking into account the comparison groups used.

The BOP set a goal of cutting 50% of the page count and 50% of its restrictions. The goals stemmed from the baseline regulatory data: the BOP's own regulations had increased by more than 40% since 1996, and they were more than 50% larger than one of the comparator agencies. The 50% goal was aggressive, but

it kept the BOP motivated as it entered into the difficult task of actually reducing regulations.

Deadlines stem naturally from the state's Administrative Procedures Act. Idaho has a regimented schedule to follow in order to bring proposed rules forward for legislative review. Idaho is one of the states that requires legislative review of rules to ensure conformity with the statute. The BOP set a goal of having its new regulations legislatively reviewed during the 2018 session, and from that goal date, it was easy to work backwards to identify when pending rules had to be published in the state's administrative bulletin, which identified when proposed rules and an official public comment period had to be held, and so forth.

5. Develop Vision for Prioritized Work Streams

It had been our experience that simply removing old and obsolete rules was not enough. The BOP had successfully removed obsolete regulations and decreased word count by 25.8% from 2011 to 2012 (Figure 2); this decrease was not sustained, however, and word count actually increased annually through 2017, representing a 21.1% growth from the 2012 baseline.

Most of the word count growth came from additions necessary to keep up with practice and technological change. It had been our experience that "specificity breeds specificity" in that we were constantly adding new rules as new business models or technology emerged, and that a fundamental change in approach was needed. For example, while the board allowed automated dispensing machines to be used, over time it created separate rules for those in inpatient settings, those in outpatient settings, and those that are patient self-service.

Thus, before beginning the process of determining what to cut, the BOP divided its replacement efforts into three prioritized workstreams: 1) licensing; 2) professional practice standards; and 3) facility standards. The BOP set aside dedicated time to have strategic planning sessions on each of these topics, which allowed the Board to align around a common vision *before* reviewing specific rule language.

Licensing laws related to entry and renewal accounted for just 16.2% of the Board's laws, so focusing only on this element would have limited the overall impact of the effort. Focusing on all three primary workstreams enabled a comprehensive approach that is designed to create lasting regulatory reform that is substantive, not just symbolic.

We have covered the specifics of the BOP's re-write extensively elsewhere,²⁻⁴ but we present BOP's approach here as a set of general ideas for the benefit of other regulatory boards considering a similar approach.

Importantly, agencies must work within their sphere of statutory authority. Many licensing restrictions, professional practice restrictions, and facility restrictions may rest in statute. Thus, agencies may not have the authority necessary to make changes, even if identified as part of this process. The BOP found this to be the case in some instances but worked closely with members of the legislature to run legislation that resolved identified issues.

5A. Considerations for Licensing Regulations

The BOP approached the licensure laws with three goals:

- 1) Eliminate obsolete licenses;
- 2) Minimize barriers to entry and license renewal; and
- 3) Increase the portability and mobility of licenses.

To identify obsolete licenses, the BOP leveraged existing resources through the National Association of Boards of Pharmacy (NABP) which provides summaries of all 50 states' pharmacy laws to identify licenses that would be considered outliers. If Idaho was among a minority of states requiring a particular activity to be licensed, there is a rebuttable presumption that the license is not needed to protect the public health and safety, with considerations including:

- Does the BOP have a track record of receiving legitimate complaints alleging consumer harm from the licensed entities?
- Has the BOP pursued disciplinary cases against the licensed entities for consumer harms?
- Are there state-specific reasons why this activity should be licensed that may not exist in other states?

As one example, Idaho required a license for vendors of over-the-counter medications. This meant that any gas station that sold Tylenol needed to be licensed by the BOP. We found we were one of a minority of states that required licensure for this, and there were no disciplinary cases suggesting public health violations associated with this license type. Consequently, the license was eliminated.

For licenses that were not targeted for elimination, the BOP leveraged resources to ensure entry and renewal barriers were on par with and did not exceed requirements of sister boards in any other state. The BOP looked specifically at requirements regarding:

- Minimum age limits;
- Education;
- Licensure Examinations;
- Intern hours;
- Certifications; and
- Continuing education.⁸

If Idaho was found to be more stringent than any other state on any of those parameters, there was a rebuttable presumption that the restriction was not needed to protect the public health and safety. The BOP would carefully consider if there were any

state-specific reasons for the restriction that may not exist in other states.

While other states pharmacy boards provided the most natural comparison for licensing restrictions, it was also useful to use inter-professional comparisons within the same state to combat the potential for groupthink. For example, while most state pharmacy boards require a jurisprudence examination for entry into the profession, this was generally uncommon among other health professions in Idaho. After a review, the BOP eliminated the use of a jurisprudence exam, saving license applicants \$250 in direct costs, while creating a more level playing field across health professions.⁹

Harmonizing requirements for licensure and renewal naturally improves the portability and mobility of licenses.¹⁰ Evolving technology has also increased the prospects for cross-state practice. Numerous options are available to increase cross-state practice such as telehealth services. Some professions have compacts that, to varying degrees, promote practice across state lines. Another option is licensing nonresident facilities and granting automatic licensure to individuals who are licensed in their home state and working for a licensed nonresident facility. In the absence of a compact for pharmacists, the BOP took the facility approach and therefore limited the number of nonresident pharmacists who also need to hold an Idaho-issued license, while availing Idaho residents to beneficial services that can be provided across state lines.

5B. Considerations for Professional Practice Standards Regulations

Laws related to professional practice most prominently include “scope of practice” (SOP) provisions, which define the range of services a health professional may provide and the level of supervision necessary to provide such services. Studies have found that SOP provisions can “restrict competition, generate administrative burdens, and contribute to increased health-care costs, all while having no discernable health benefits.”¹² Further, restrictive SOP laws have been linked to professional burnout.¹³

SOP restrictions are often calcified in statute, so the extent regulatory boards can remove anticompetitive restrictions as part of a regulatory re-write is limited. Where applicable, the Board sought to harmonize its SOP regulations with the education, training, and experiences of licensees, an approach advocated by the FTC.¹⁴ Of course, each of these variables – education, training, and experience -- are modifiable. Even if SOP regulations are directly aligned with the pharmacy curriculum today, these laws can become quickly outdated as curricular standards change. This can force near-constant updates to regulations to keep pace with changing education, or it can serve as a deterrent to individuals investing in new education or training as they would be deprived of the ability to apply their newfound skills in practice. Similarly, colleges may

be disincentivized to add new content to their curriculum if their graduates would be unable to use those skills.

Legal scholar Barbara Safriet referred to this as the gap between “can” and “may” – where education determines what an individual *can* do, but the law determines what they *may* do.¹⁵ One means of closing this gap is aligning SOP laws with an evolving “standard of care” process, with accountability mechanisms to ensure individuals do not practice beyond their capabilities. This is an approach that some professions have used successfully. For example, the Idaho nursing regulations no longer list specific tasks that each category of nurses could provide; the rules provided a partial, non-exclusive listing of tasks “for illustrative purposes only.”¹⁶ In addition, the rules provide a decision-making model to help nurses evaluate whether a specific act is allowable. First, nurses must determine whether an act is expressly prohibited by any law.¹⁷⁻¹⁸ If an act is not prohibited, it may be allowed if the act is consistent with the nurse’s education, consistent with the facility’s policies where the nurse is employed, consistent with the standards of practice published by nursing organizations or supported by recognized nursing literature, and the act is “within the accepted standard of care that would be provided in a similar situation by a reasonable and prudent nurse with similar education and experience and the nurse is prepared to accept the consequences of the act.” We adopted this approach for pharmacy with a specific regulation.¹⁹

While an agency’s overall ability to enhance SOP regulations may be limited because of the statutory overlay, one specific area the regulatory agency may retain control over is what tasks can be delegated to licensed and unlicensed support staff. Rather than listing which specific tasks can be delegated to support staff, the BOP adopted an approach where any task could be delegated as long as the function is commensurate with the support staff’s education, training, and experience.²⁰ This moved the locus of delegation from one-size-fits-all regulations to the professional judgment of the supervising pharmacist, with the agency having accountability mechanisms to deal with cases that represent deviations from the standard of care. As one example, Idaho became the first state to allow pharmacy technicians to administer vaccines.²¹⁻²²

5C. Considerations for Facility Standards Regulations

Not all licensing boards oversee facilities or educational institution standards, so this section will not apply to all agencies. The BOP had two primary goals as it relates to facility standards:

- 1) Embrace “permissionless innovation” by making the regulations agnostic with respect to facility and technology; and
- 2) Enable decentralization of pharmacy functions to offsite locations rather than requiring all activities occur from a licensed physical facility.

Pharmacy facilities have historically been either community pharmacies or in hospital settings. In recent years, the profession has become more diverse, with diverse settings such as mail order, nuclear pharmacies, and telepharmacies (staffed by only a pharmacy technician) emerging.

Innovation scholar Adam Thierer has advanced the discussion around “permissionless innovation,” which refers to the notion that “experimentation with new technologies and business models should generally be permitted by default.”²³ There is a recognition that in rapidly-changing industries and professions, there is a need for flexible regulations that allow experimentation and innovation.

Rather than having overly prescriptive regulations that try to anticipate every future scenario, it may be worth focusing on the desired outcomes, not inputs or processes. We found that the goal of most pharmacy facility regulations was to deter controlled substance theft or loss, minimize the chance for medication errors, and prevent adulterated or misbranded products from reaching the public. Each of these elements was already addressed in the BOP’s accountability and enforcement framework (discussed below). Rather than trying to micromanage each of these elements for every new business model or emerging technology, the BOP transitioned to facility-agnostic and technology agnostic regulations.

With respect to the second primary BOP goal, many regulations limit a professional’s SOP to occurring within a licensed facility, and this can disrupt the adoption of new and emerging technology. The Board created a framework for decentralizing any pharmacy function from a licensed facility, as long as policies and procedures are in place.

6. Repeal & Replace Rules

When the agency has agreed on the direction for each of the prioritized work streams, the real work begins. Agencies should prune away remaining rules that are either:

- Not critical to the primary work streams; or
- Not related to the topics excluded from the regulatory reduction (as described above).

Deregulation turn out to be more complicated than expected. Each rule has some level of face validity, and post-hoc rationalizations were often raised to justify regulations that otherwise met the criteria for elimination.

For a significant regulatory reform effort, a full “repeal and replace” approach has its advantages. Namely, it guards against the natural tendency to resist change and err on the side of keeping rules. It was our experience that while stakeholders were generally supportive of the deregulation concept, few rules had unanimous or publicly-expressed support for removal. Even those rules disconnected from public health and safety were defended with private or even personal reasons.

Agencies can combat this inertia by repealing and replacing the rules. The BOP erred on the side of initially over-filtering out rules that did not align with the agreed upon direction. The BOP empowered staff to take the lead on the initial drafts and resisted the temptation to wordsmith in its limited meeting times. The initial draft of the new BOP rules was purposefully aggressive with cuts, and the BOP established a series of public meetings where written and verbal feedback would be accepted on what should be added back into the rules and why. Every rule was deemed fair game to be added back in to the replacement regulations. The BOP put forth key questions to consider for adding a regulation back into its substantive work streams, loosely adapted from the FTC’s report⁹ on nurse practitioner regulation (Figure 2). This “repeal and replace” approach was later adopted statewide in Idaho, under the name “zero-based regulation.”²⁴

It is important for regulatory boards not to become too puritanical on its evidence-based approach by setting a threshold for proof that is impossible to meet. A tongue-in-cheek systematic review reminds us that no randomized controlled trials exist that demonstrate parachutes are effective in preventing death or trauma from “gravitational challenges.”²⁵ Even in the face of speculative concerns, boards can consider its significance. Concerns related to functions that may result in severe, irreversible consumer harm with a high likelihood of occurring naturally merit consideration even in the absence of concrete proof. Such concerns should still be vetted to ensure new laws are needed to address the concern, and that the proposed remedy is narrowly tailored to address the core concern.

Agencies should create multiple opportunities for the public to engage early and often. We made efforts to share early drafts with key stakeholders such as professional and trade associations. In addition, we produced a cross-walk document that showed the disposition of each previous regulation in the new drafts; this inspired confidence that rules were not being overlooked or unintentionally left out.

Agencies should solicit public feedback at all stages of the rewrite, and be particularly inviting of rationales for re-inclusion of rules and regulations cut in the first stage. Establishing the process for adding a rule back in reduced inertia, guarded against having to primarily engage in theoretical arguments over rules, and minimized prognostications of worst-case-scenarios that have all-to-often become the norm in rulemaking.

7. Ensure Robust Accountability Mechanisms Are in Place

Removing prescriptive *ex ante* regulations that have been the hallmark of professional practice and facility standards and replacing them with more permissive rules may necessitate

augmenting the *ex post* enforcement and accountability mechanisms that are in place.

Ex post enforcement “focuses on actual, or at least specifically alleged, harms rather than attempt to predict future harms more generally.” Ohlausen identified benefits to an “enforcement-centric rather than rulemaking-centric” approach: 1) the agency’s information needs are lower as enforcement focuses primarily on information germane to the parties in a dispute; and 2) while enforcement actions have precedential value, future cases would still consider any changes in circumstances and thus actions are not globally binding.²⁶⁻²⁷

Further, such an approach leverages market forces which further weigh on licensees and can ensure consumer protection in a rapidly evolving field. Market forces include, but are not limited to:

- Consumer acceptance and demand;
- Payer policies;
- Private accreditation and credentialing;
- Facility policies (e.g., risk mitigation strategies);
- Liability insurer policies;
- Threat of civil liability; and
- Professional ethics and self-restraint.²⁸

Thus, even if the law does not prohibit a certain act, market forces may prevent it nonetheless. Similarly, even if the law does not mandate a certain act, market forces may still compel it. It has been our experience in particular that facilities, as a matter of risk management, routinely adopt corporate policies that are more stringent than law. For example, while Idaho law allowed pharmacists to immunize patients of any age, many companies adopted policies that limited it to patients aged 12 and above.²⁹

Making the transition to an enforcement-centric from a rulemaking-centric approach takes time to warm up to from an agency perspective, especially for agencies that have long embraced the latter. Indeed, a favorite pastime of many agency staff is envisioning the most obscure “what if?” scenario that could occur, regardless of how remote, and then insisting that that scenario be accounted for in the rulemaking process. One way to make the leap in thinking is to invite a similar agency that has already adopted an enforcement-centric approach – such as agencies that govern according to a prevailing “standard of care.” Having an agency head and their prosecutor demystify how cases are pursued and enforced under such a model can inspire confidence that public safety can be maintained or improved.

When considering that transition to an enforcement-centric approach, it is critical to examine the agency’s enforcement authority. Key areas to consider are if the board has the ability to:

- Revoke, suspend, and restrict licenses?
- Assess administrative fines? For each offense?
- Recoup prosecutorial costs?

Disciplinary cases involving deviations from a “standard of care” may compel the use of expert witnesses;³⁰ thus, ensuring the agency has the ability to recoup prosecutorial costs is a core element of being able to make the transition. Close discussion with the agency’s prosecuting attorneys, and perhaps even doing a tabletop demonstration of how a case would look under the new approach may be beneficial.

Further, it is worth repeating the BOP excluded two topics from regulatory reform: controlled substances and compounding. The BOP left prescriptive rules, such as recordkeeping requirements, for these topics. By streamlining the Board’s focus, compliance officers conceivably have more time to focus on these priorities during their regular proactive inspections. This leads to greater overall accountability for the topics most closely linked to public health and safety.

Lastly, given that many old laws were repealed, it also stood to reason that many pharmacy licensees had been disciplined for now-obsolete laws. To rectify this, the BOP set up an expungement pathway for pharmacists to remove reportable discipline from their record.³¹

8. Skillfully Implement and Track Outcomes

As new regulations take effect, skillful implementation of the new regulations by the agency is a must. Reforms may trigger:

- Needed updates to licensing forms and processes;
- Revisions to inspection forms and processes;
- Educational sessions held for licensees; and
- Cultural changes for agency staff.

Moreover, effort is needed to institutionalize reforms and ensure that the agency does not simply return to business as usual. As noted previously, the BOP word count increased 21% after a previous effort to remove obsolete provisions. To ingrain regulatory reform as part of its culture, the BOP added a specific goal to its 4-year strategic plan, for which performance measures must be reported annually: “Limit word count growth in Board rules to less than 5% of *baseline* across the life of strategic plan (excluding federal- or legislatively-imposed mandates).”³²

Conclusion

There are many potential approaches to regulatory reform and this framework presents just one pathway. Our framework has proven successful with a 75% decrease in regulatory page count from its peak regulatory volume in 2018. We are starting to see some early success stories, such as an increase in new pharmacists and pharmacies³³⁻³⁶ in areas of the state that had been without pharmacies for decades in some instances, and

anecdotes of increased access to new patient care services³⁷⁻⁴⁴ provided by pharmacists. Further, two national companies moved major central pharmacy operations to Idaho. Yet, despite massive deregulation and a more permissive regulatory framework, the number of complaints to the BOP and corresponding disciplinary actions has not increased.⁴⁵

While this process is laid out as a step-by-step approach, we are the first to admit that no process goes off without a hitch. The BOP would at times get stuck on a particular topic and have to table it for a subsequent meeting. Sometimes the substantive work streams bleed into each other, or we would have to revisit a previous step. The key is to keep moving forward towards the ultimate goal.

In discussing the process with our peers at similar boards, we have been met with great enthusiasm, and often a dose of skepticism. It is not uncommon for us to hear, “We would love to do that, but it would never work in my state.” Admittedly, we said the same. Until we got started.

Disclaimer: The statements, opinions, and data contained in all publications are those of the authors.

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Figure 1. Step-by-Step Process for State Agencies to Achieve Regulatory Reform

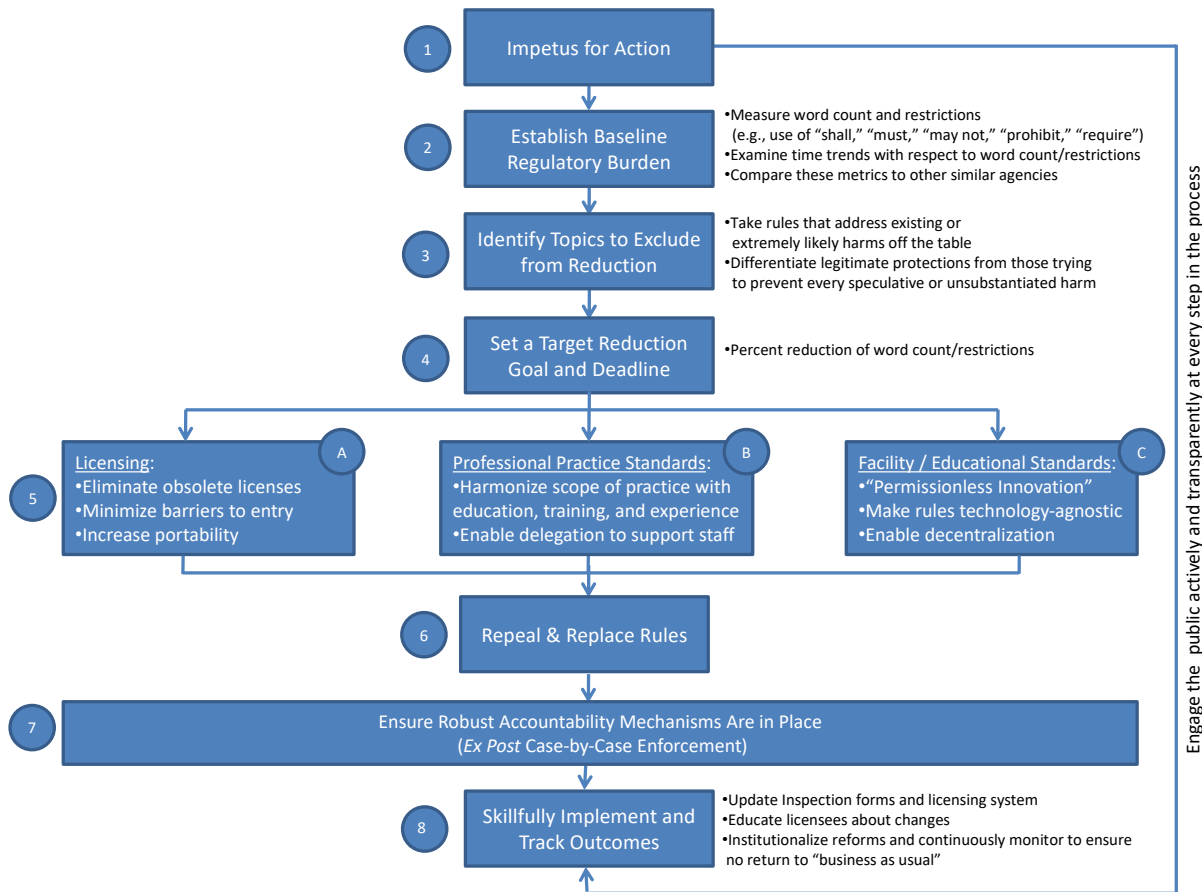


Figure 2. Page Count in Idaho Board of Pharmacy Regulations (1996 to 2024)

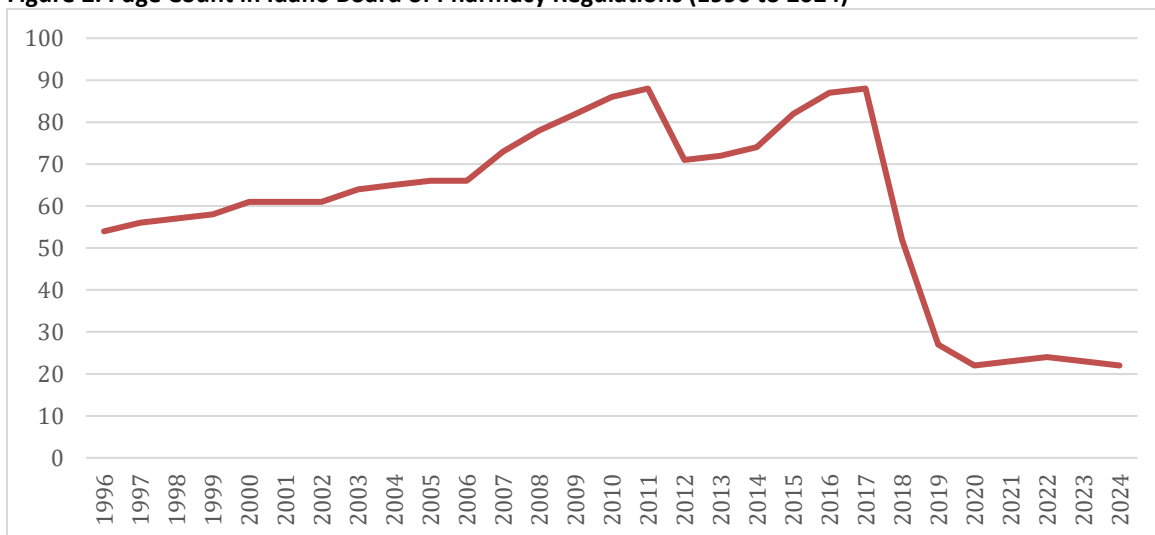


Figure 3. Key Questions for Considering Addition of a Regulation

