



Legislative Update

Nursing & Allied Health Licensure Review

August 20, 2025

OPLR 2025 Recommendation Summary

1. **Speech/Hearing:** Move to 'mandatory certification'
2. **Advanced Practice Provider (APPs):** Re-align clinical experience requirements across APRNs, CRNAs, PAs
3. **CRNAs:** Limited prescribing for CRNAs (nurse anesthetists)
4. **Scope of Practice:** Create a collaborative, objective process for considering scope of practice expansions
5. **Various:** Incremental changes to streamline entry requirements, improve supervision, or expand scope of practice

Licenses in OPLR review

2025 Review

Nursing & Related

APRN, CNM, CRNA, Direct Entry Midwife, LPN, Medication Aide, Physician Assistant, Respiratory Therapist, RN, RN Apprentice

Allied Health – Physical:

Acupuncturist, Athletic Trainer, OT, OT Assistant, PT, PT Assistant

Allied Health – Speech/Hearing:

Audiologist, Hearing Instrument Intern, Hearing Instrument Specialist, Speech Language Pathologist

2026 Review (Proposed – TBC)

- Anesthesiologist Assistant
- Chiropractic Physician
- Dentists & Hygienists
- Naturopathic Physician
- Optometrist
- Pharmacists & Pharmacy Technicians
- Physicians & Surgeons (incl. Osteopathic)
- Podiatric Physician
- Radiologic Technicians & Assistants

OPLR review criteria for healthcare professions

Safety

- Harm to the **health, safety,** or **financial welfare** of the public
- **Severity, probability,** and **permanence** of harm
- The extent to which the proposed or existing regulation of the occupation **protects against** or **diminishes** the harm

Access

- The **supply** of qualified practitioners
- **Barriers to service** that are not in the public interest
- **Barriers to entry** into the occupation or related occupations
- Potentially **less burdensome** alternatives

Affordability

- Imposes **new costs** on existing practitioners
- Barriers to service that are not in the **public financial welfare**
- Impacts the health care provider's **ability to obtain payment**
- **Barriers to entry** into the occupation or related occupations

Takeaways from our last meeting

Takeaways

Some allied health occupations have **low potential for harm**, and very low substantiated DOPL complaints

The current nursing and allied health **workforce appears generally adequate** for the state's needs

- Nonetheless, there **remain pockets of greater need** in some geographies (e.g., rural), settings (e.g., long-term care), populations (e.g., pediatrics) and license types (e.g., OT)
- There are **multiple factors not related to licensure** affecting views on access such as: setting-related issues (e.g., caseload), reimbursement, education escalation, cost of living pressure

Some aspects of licensure are **slow to adapt to innovations in technology and practice** (e.g., scope of practice, supervision requirements)

Implications

1 Consider alternative models (e.g., certification) for overseeing some professions

- 2 Evaluate targeted licensure changes** for select professions where practitioner or public access may be an issue, e.g.,
- **Education/Experience** requirements & pathways (e.g., for PT/OT)
 - **Potential scope of practice** (e.g., CRNA) or **supervisory clarification** (e.g., AT)

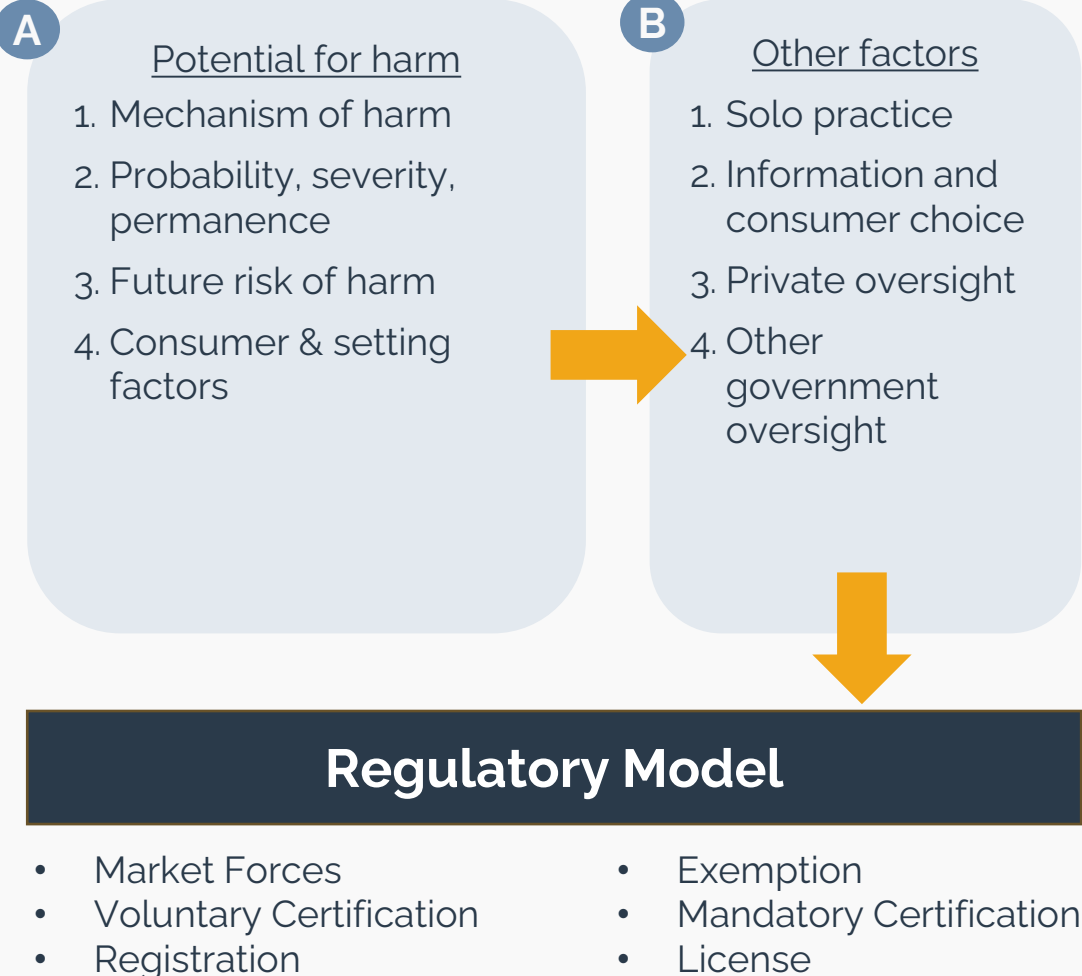
3 Scan and evaluate approach to this challenge in other jurisdictions

Stakeholder engagement to date

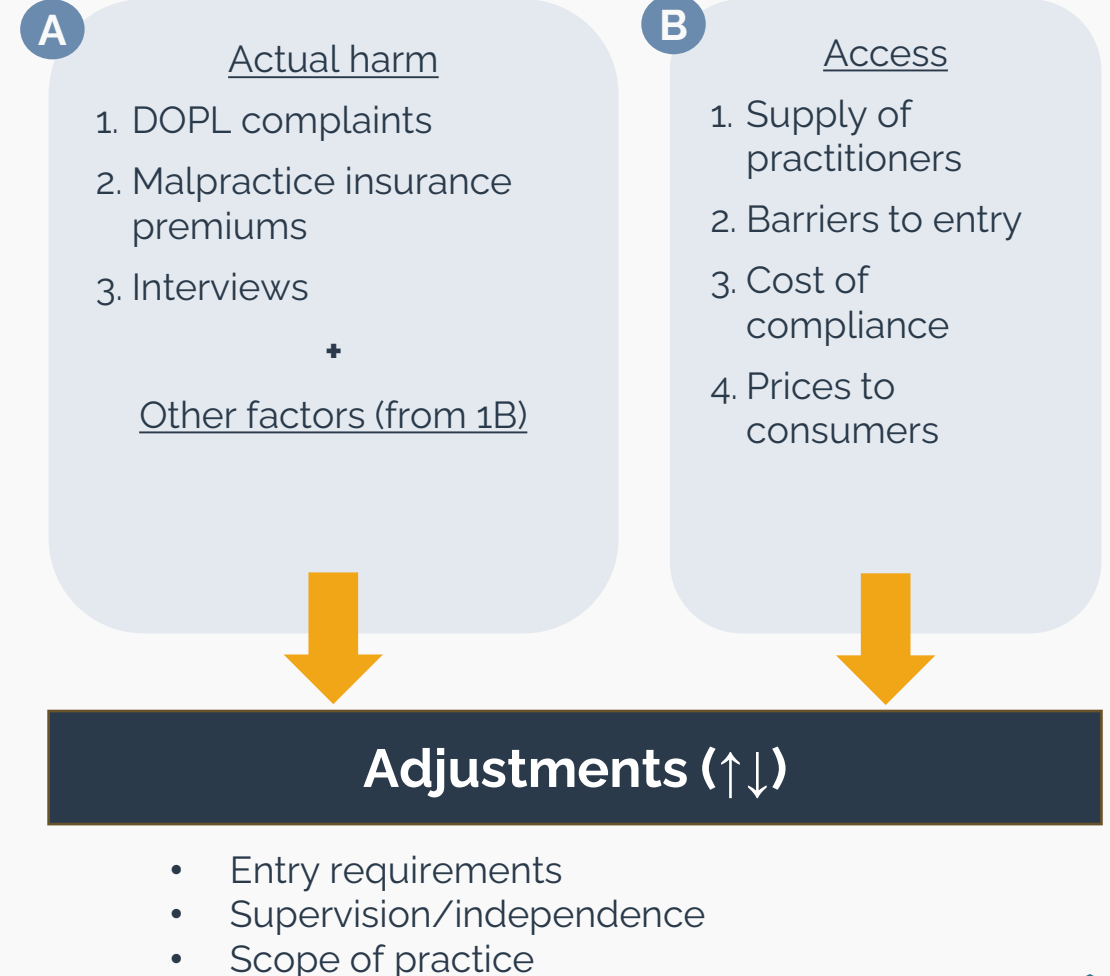
Industry Associations	Employers	Experts	Other
~40 individuals <u>Sample organizations:</u> • Utah Nurse Practitioner Association • Utah Nursing Association • Utah Occupational Therapy Association • Utah Athletic Trainers' Association • National Board for Certification in Hearing Instrument Sciences (NBC-HIS)	~55 individuals <u>Sample organizations:</u> • Intermountain Health • University of Utah Health • Avista Senior Living • Craig H. Neilsen Rehabilitation Hospital at University of Utah • Hand & Orthopedic Physical Therapy Specialists • Costco Hearing Aid Center	~35 individuals <u>Sample organizations:</u> • Kem C. Gardner Policy Institute • Salt Lake Community College • Rocky Mountain University • University of Utah • University of Alabama Law School • The Ohio State University	~65 individuals <u>Sample organizations:</u> • Utah DOPL • Utah DOPL Licensing Board Chairs • Utah DHHS • Utah State Board of Education • Alabama Medical Board • Colorado Office of Policy, Research & Regulatory Reform

OPLR's general review framework

1 Regulatory model choice



2 Adjusting within existing model



Agenda

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OPLR considered alternative regulatory models for several occupations

 Key recommendation

	Occupation	Main licensure issues	Draft recommendation	Rationale
Nursing & Related	Certified Medication Aide	Anecdotes about harm; uneven regulation for medication passing	Clarify setting in which Certified Medication Aides is required	• Fact base on widespread harm is hard to substantiate • Align regulatory model with optional use of this qualification
	Occupational Therapy (OT)	Relatively low harm profession	Maintain OT as a license	Vulnerability of patients tips potential for harm towards licensure
Physical Allied Health	Athletic Trainer (AT)	Potential for harm but almost all work for employers	Maintain AT as a license	Nature of clients (children) and injuries being treated (e.g., concussion) points to full licensure
	Speech Lang. Pathology Audiology Hearing Instr. Specialist	Relatively low harm profession; some issues with access	Move to 'mandatory certification' (not licensure) for all speech/hearing professions	• Align regulatory model with risk • Maintain competency to prevent downstream costs • Support access

Source: OPLR analysis

Elements of proposed 'Mandatory Certification' for Audiology, SLP, and HIS

Mandatory Certification	Proposal	Rationale
	'Once and Done' Certification	• DOPL certifies entry credentials & conducts background checks (moving to FBI Rap Back) • Determines entry competencies and qualifications • Lessens administrative burden on providers
	Maintain National Certification or Maintain Continuing Education* or Maintain Minimum Number of Hours without Lapse**	• Maintains a level of oversight • Lessens administrative burden on providers • Ensures providers maintain and develop skills and knowledge • Eliminates mismatched continuing education timeline
	Eliminate Board	• Determinations of safe practice and harms are very infrequent; DOPL can call on experts ad hoc as needed • Eliminates administrative burden on Board and DOPL
	Account for swallowing disorders (<i>SLP only</i>)	• Ensures proper training in diagnosing and treating swallowing disorders via unprofessional conduct provision

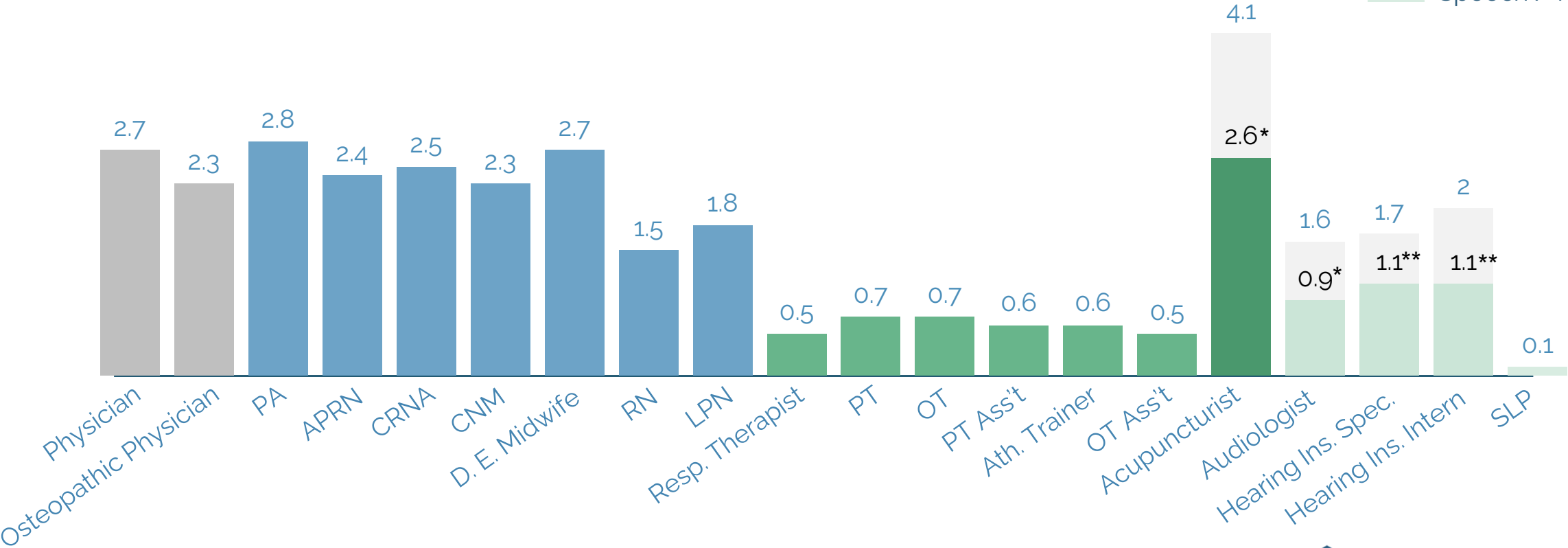
Source: OPLR analysis; *Continuing education: 10 hrs/yr for AUD/SLP & 8hrs/yr for HIS; **Minimum hours without lapse: 500 hrs/2 yrs for AUD/SLP & 250 hrs/2 yrs for HIS

Education, training and oversight help mitigate the worst patient harms

DOPL complaint rate – substantiated complaints per 100 practitioners 2017-22

Number

- Nursing & related
- Physical
- Speech / Hearing



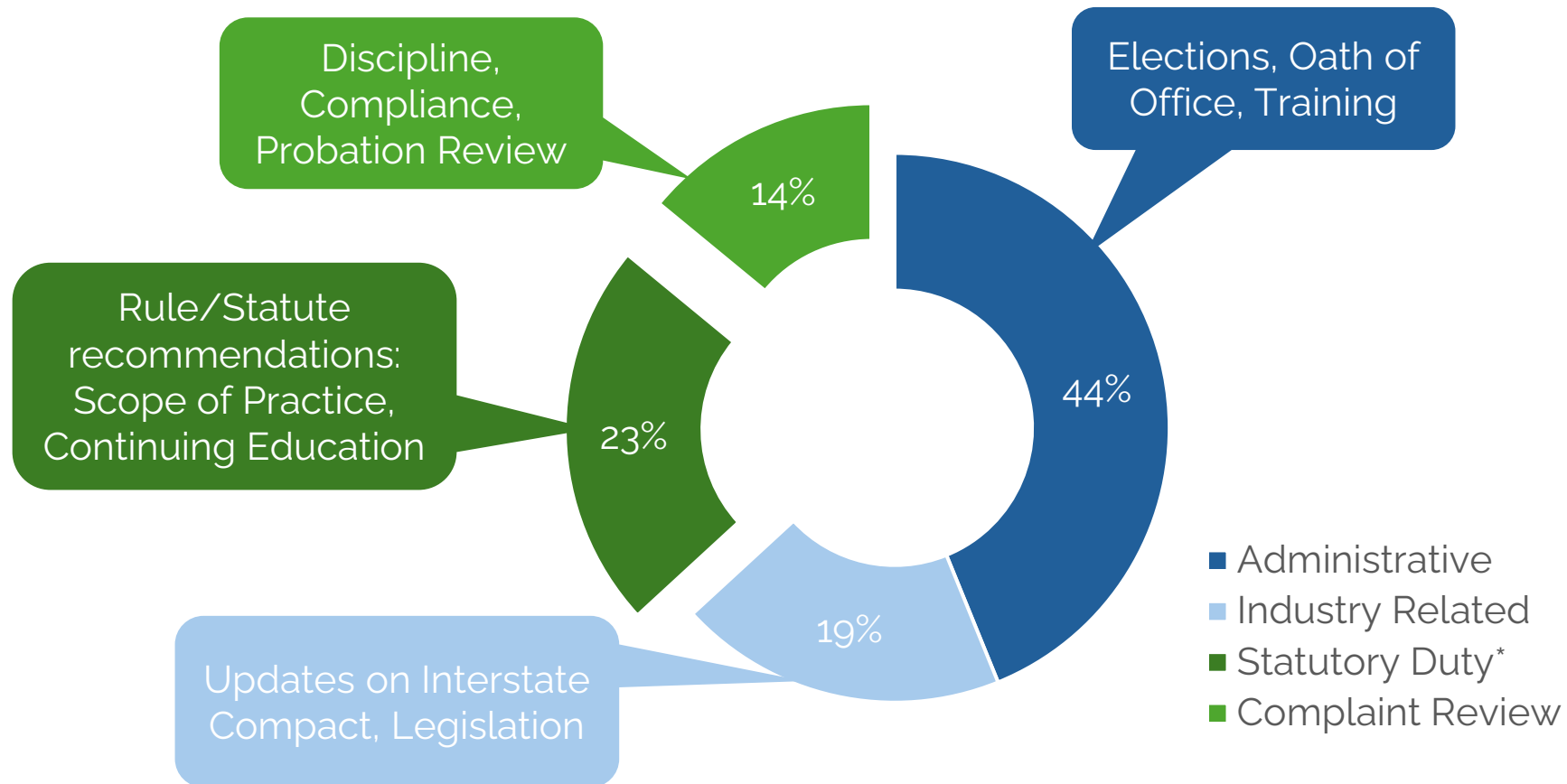
* Adjusted for interrelated complaints (i.e. same practitioner or same practice)

** Adjusted for two interrelated complaints involving Hearing Instrument Specialists and Interns, reducing 5 combined complaints for both licenses to 3

Source: DOPL license data; DOPL complaint data; OPLR analysis

The SLP and Audiology tasks could be performed by DOPL with the industry support

% of all DOPL SLP/Audiology board agenda items 2020-2025



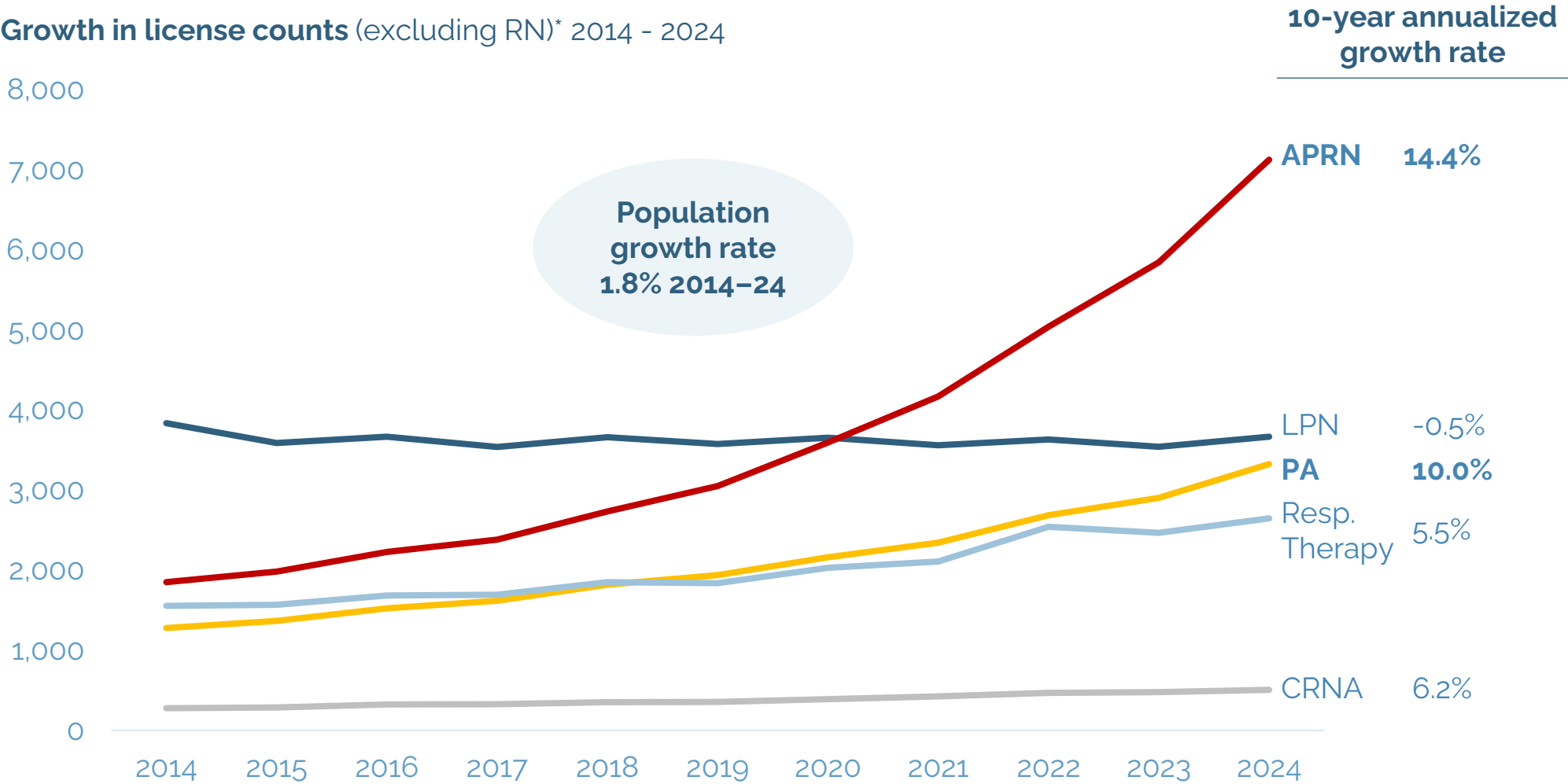
In the absence of a Board, DOPL and the relevant industry association can fill the Board's current functions

Source: OPLR analysis of Speech-Language Pathology and Audiology Board counts of agendas items; Analysis excludes standing agenda items such as calling meeting to order and approving previous meeting minutes; n=57 agenda items *Statutory duty as defined by 58-1-202 & 58-1-203

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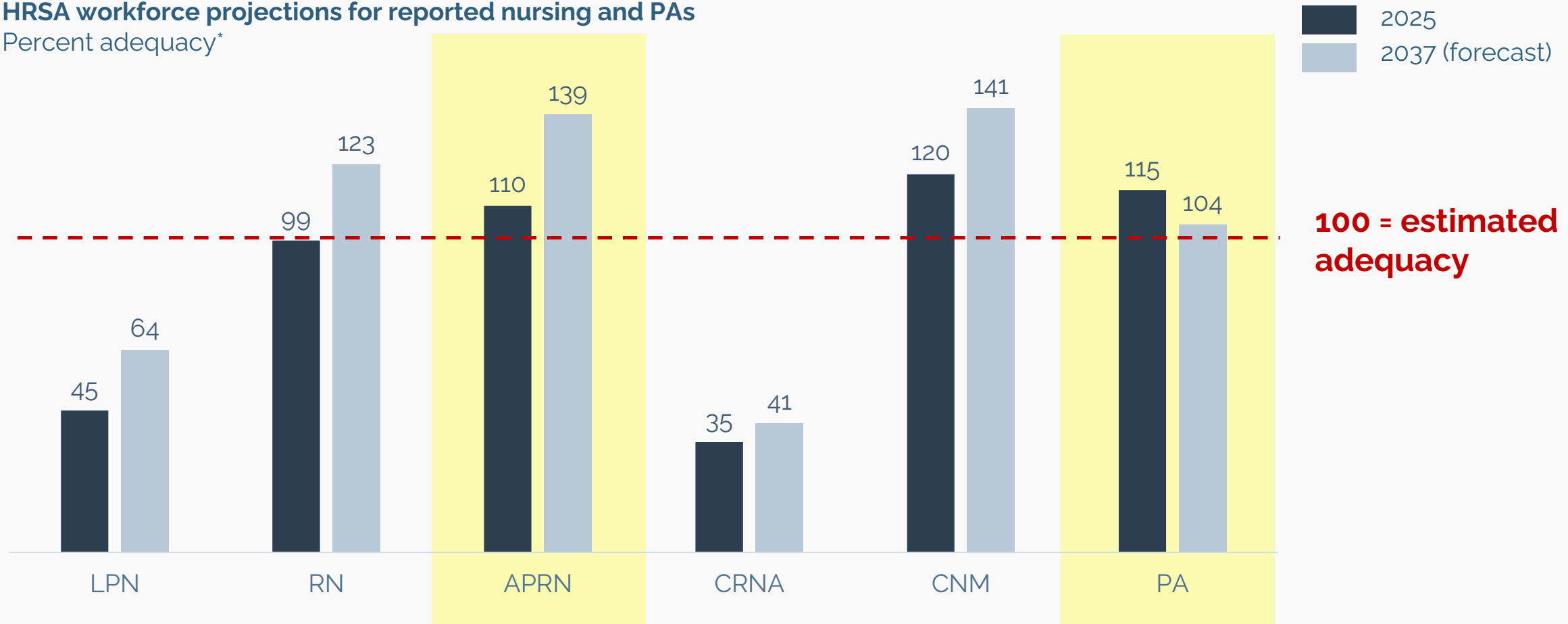
Context: APRN and PA counts have grown rapidly



* Growth rates based on compound annual growth rate formula (CAGR). Graph excludes RNs (CAGR 4.3%) because the large number of licenses affects the graph's scale. RN Apprentice (CAGR 16.8%), Certified Nurse Midwife (CAGR 5.1%), Medication Aide (CAGR 34.0%), and Direct Entry Midwife (CAGR 9.7%) are also excluded due to their small numbers
Source: DOPL license data; OPLR analysis

Context: Utah has adequate (or better) workforce for APRNs and PAs

HRSA workforce projections for reported nursing and PAs
Percent adequacy*

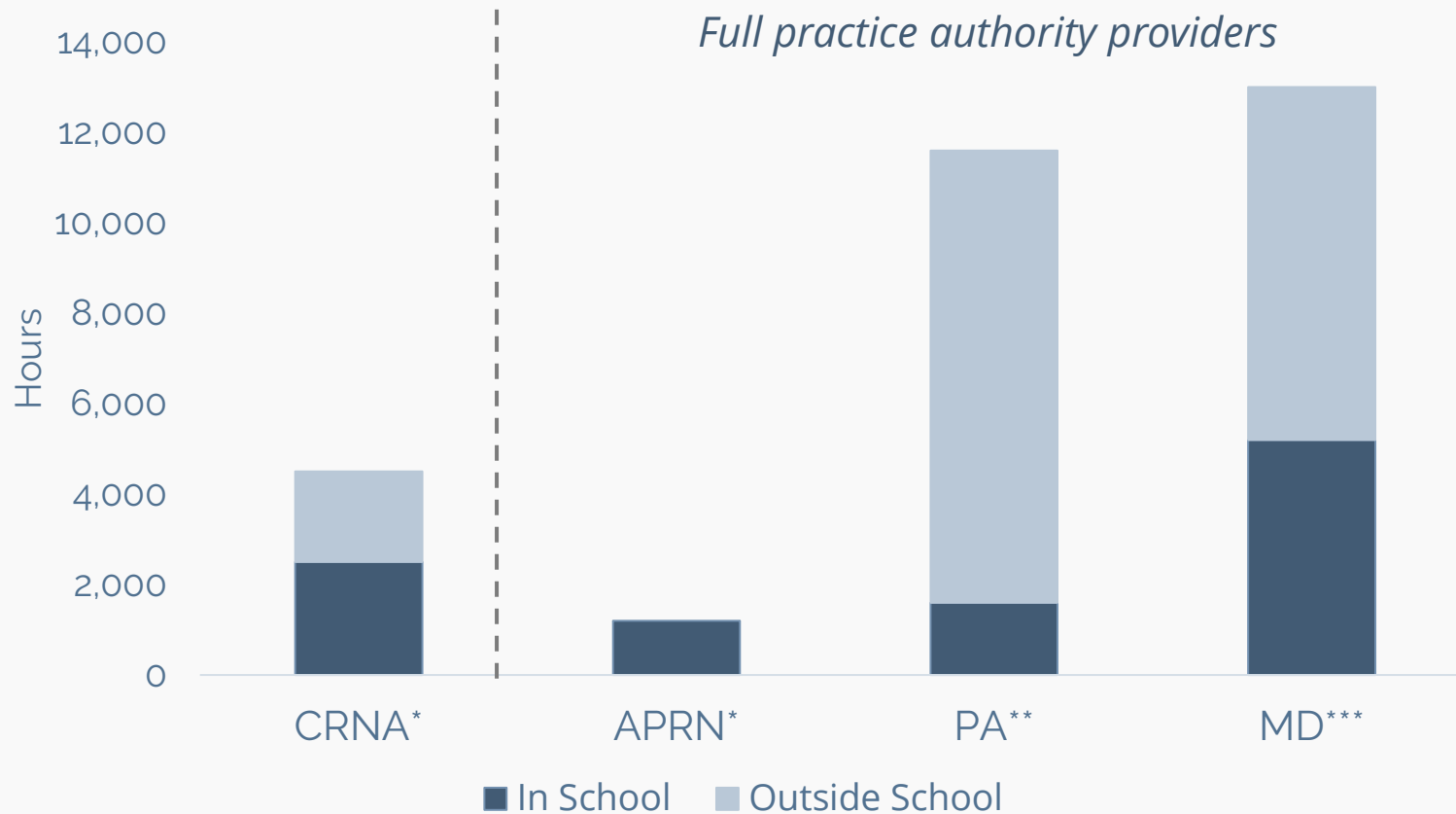


*Supply estimates include factors such as exam pass rates, 40-hour work week (which may lead to undercounting for roles working <40 hours) and workforce attrition, but do not account for new programs or program growth. Demand estimates include population growth and demographic projections, health risk factors and provider ratios.

Source: HRSA workforce projections (<https://data.hrsa.gov/topics/health-workforce/nchwa/workforce-projections>)

Experience requirements for independent providers are not uniform in Utah law

Minimum number of direct patient care hours required by law



Minimum requirements in law include experience:

Required by accreditors named in statute/rule:

- Experience pre-program (e.g., '2,000 hours critical care')
- Clinical training during program (e.g., RN clinical hours)

Required in statute:

- Statutory requirements post education (e.g., 10,000 hours supervision/collaboration)

* APRN and CRNA 'Required in Law' hours include clinical hours in their RN program.

** PA 'Required in Law' hours assumes 40-hour weeks for 40 weeks.

*** MD hours estimates are based on 50-hour work weeks and a 3-year residency.

APRN full independence is based on a historical assumption about nursing experience and training

'The average APRN has extensive experience:

- **15,000-20,000 hours, or**
- **6-8 years**¹

Nurse leader:

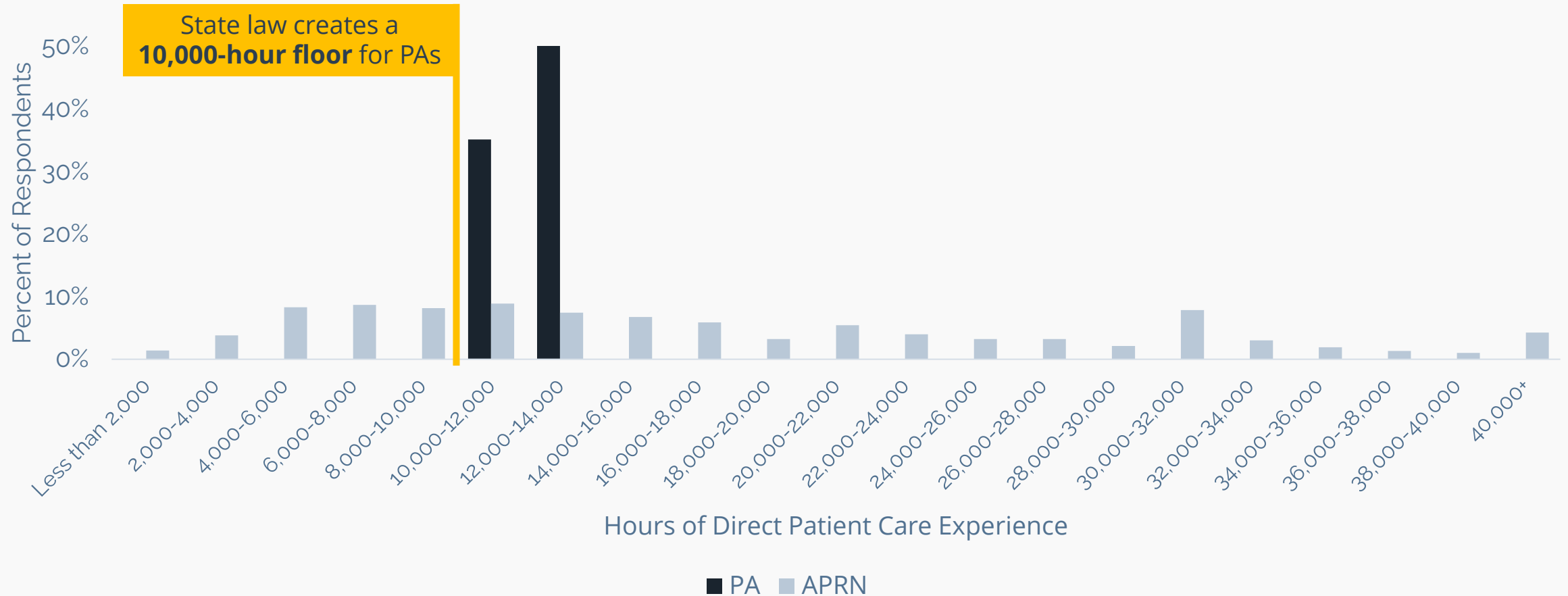
*'The unwritten rule was...
5 years work experience
before master's program*²

1. Presentation before House Business, Labor, and Commerce Committee, February 17, 2021

2. OPLR interview series, 2025

APRNs have much greater variability in experience upon independent practice authority than PAs

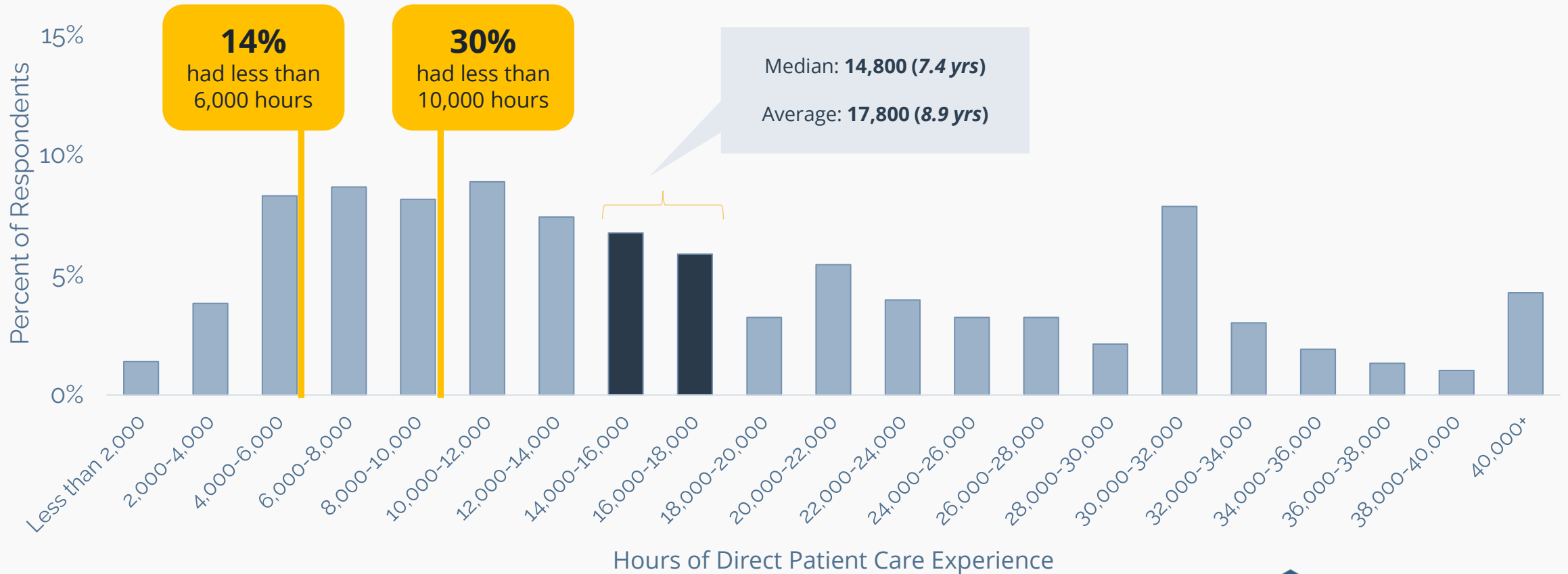
Number of direct patient care hours upon receiving full practice authority*



*OPLR APP Licensee Survey, August 2025; respondents: 1,333 APRN, 124 CRNA, 717 PA. For APRNs, data includes RN program clinical hours, RN work experience prior to APRN program, and APRN program clinical hours; for PAs, data includes PA program clinical hours and the 10,000 hours of required collaborative practice as a PA
NOTE: The survey asked about clinical hours in school (RN and APRN), and direct patient care work experience as an RN before entering APRN program; did not capture any time an APRN student may have worked during their APRN program

Almost a third of APRNs have less than 10,000 hours of experience upon graduation

Number of direct patient care hours upon APRN graduation*



*OPLR APP Licensee Survey, August 2025; respondents: 1,333 APRN, 124 CRNA, 717 PA. For APRNs, data includes RN program clinical hours, RN work experience prior to APRN program, and APRN program clinical hours; for PAs, data includes PA program clinical hours and the 10,000 hours of required collaborative practice as a PA
NOTE: The survey asked about clinical hours in school (RN and APRN), and direct patient care work experience as an RN before entering APRN program; did not capture any time an APRN student may have worked during their APRN program

Other data sources support additional clinical experience for APRNs

1. **Preceptors (supervisors):** describe well-prepared APRN students; but also a subset of APRN students unprepared for full independent practice
2. **Employers:** express reticence to hire new grad APRNs; prefer those with more experience; considering 'residency' program
3. **Individual APRNs:** indicate concerns with new APRN preparation as most common theme in open response survey question
4. **Academic studies:** find a clear correlation between clinical experience and clinical competence
5. **DOPL investigators:** most common APRN issues are 1) early career 2) professionalism, and 3) prescribing

Some surveyed APRNs expressed concerned about unprepared new APRNs

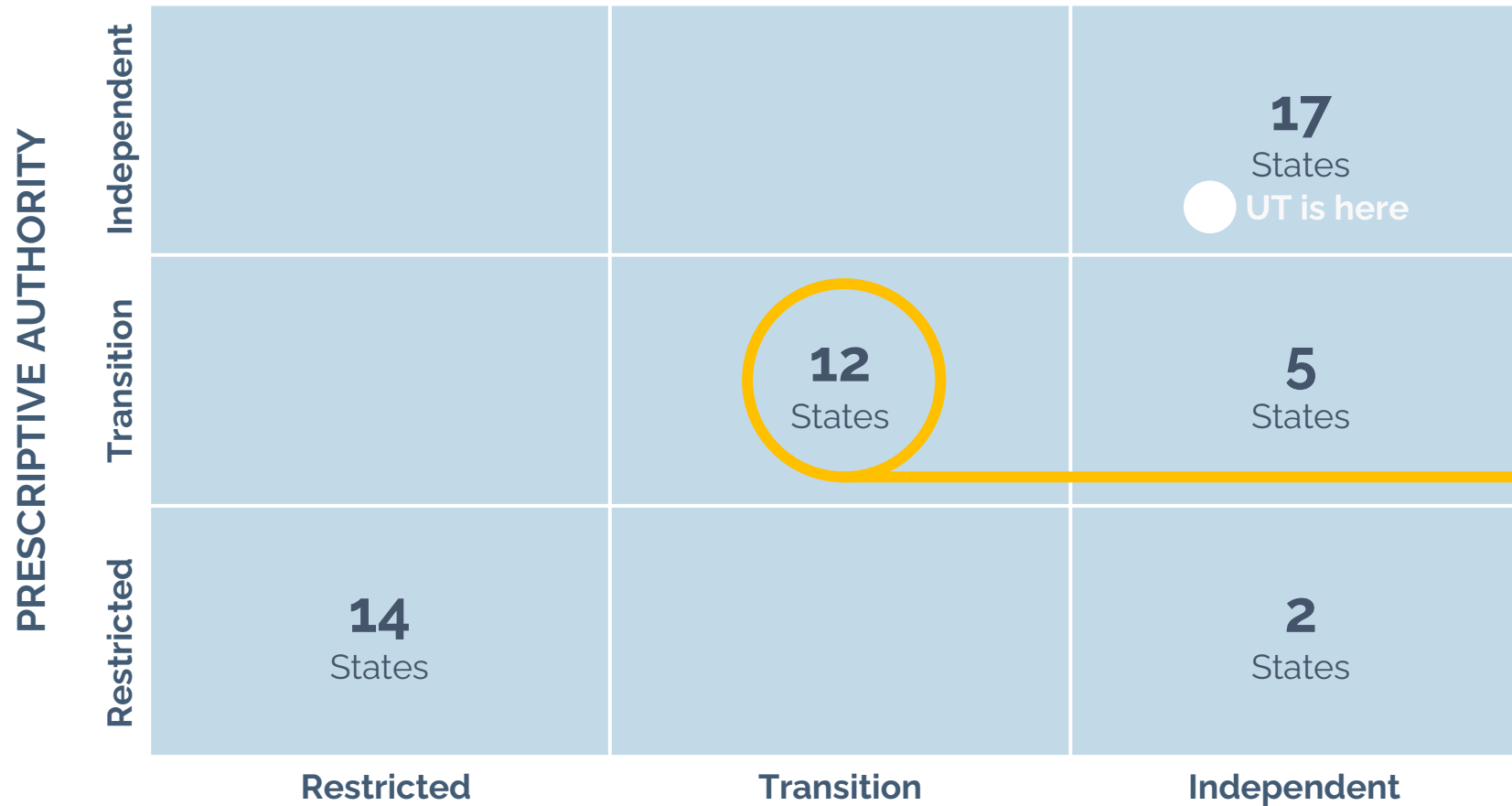
“ I’m seeing new NPs start independent practices with **very little clinical experience** ... First year should have some type of required supervision. ”

“ Should be a minimum requirement of direct patient care ... before advanced practice program. **Too many are going straight from RN to APRN** ... inexperienced with patient care and lack critical thinking. ”

“ We have students from online/private NP programs ... **nowhere near competent enough to care for patients** directly without physician support. ”

“ If new RNs are able to go right on to NP school, they **don’t come with the clinical experience needed.** ”

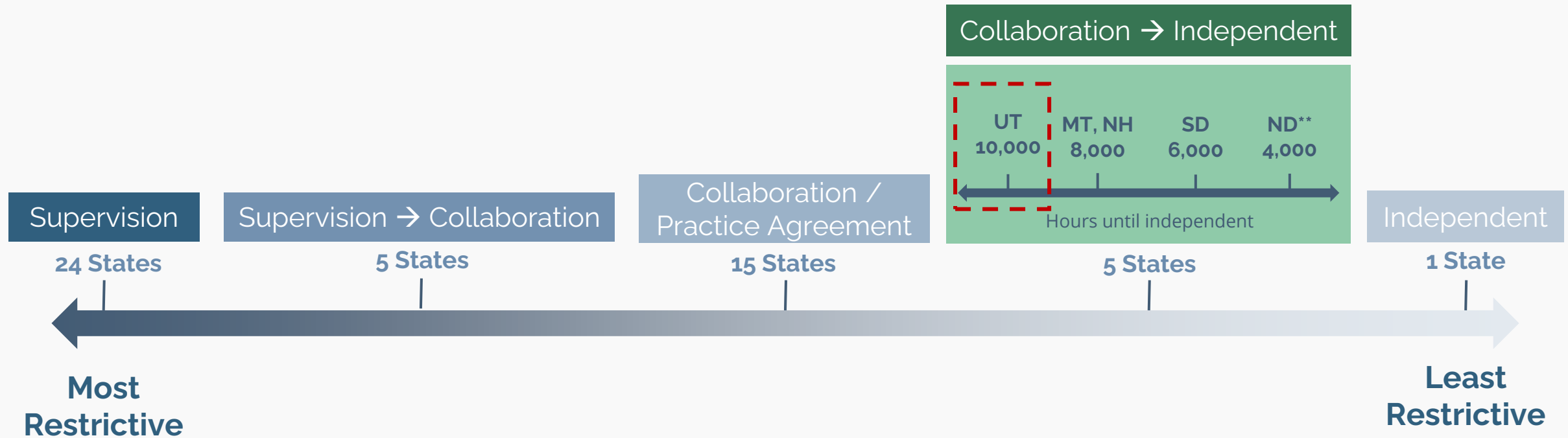
There is variability in the level of independence states give NPs



Transition periods range between
2,000 hours (NE) – 6,240 hours (AR)

ALL OTHER SCOPE (BESIDES PRESCRIBING)

Utah's PA policy is less restrictive than most states; highest of those allowing independence



*Based on OPLR policy scan of states.

**ND only has independent practice for rural areas.

Recommendation: APRNs and PA experience requirements

1. Rationalize APRN and PA clinical experience requirements

- As advanced practice providers with very similar scope of practice and independence, APRN and PA minimum requirements should not differ significantly
- Reasonable total clinical experience would be 4,000 – 10,000 hours

2. Set minimum clinical experience for APRN

- Require clinical hours for the APRN license to mirror experience levels as understood in prior legislation
- Requirement would recognize any hours at RN (or higher)
- Requirement should be as flexible as possible; e.g., clinical hours in school (RN or NP programs) or work experience out of school (before, during, or after NP program)

3. Align requirement for PA independent practice

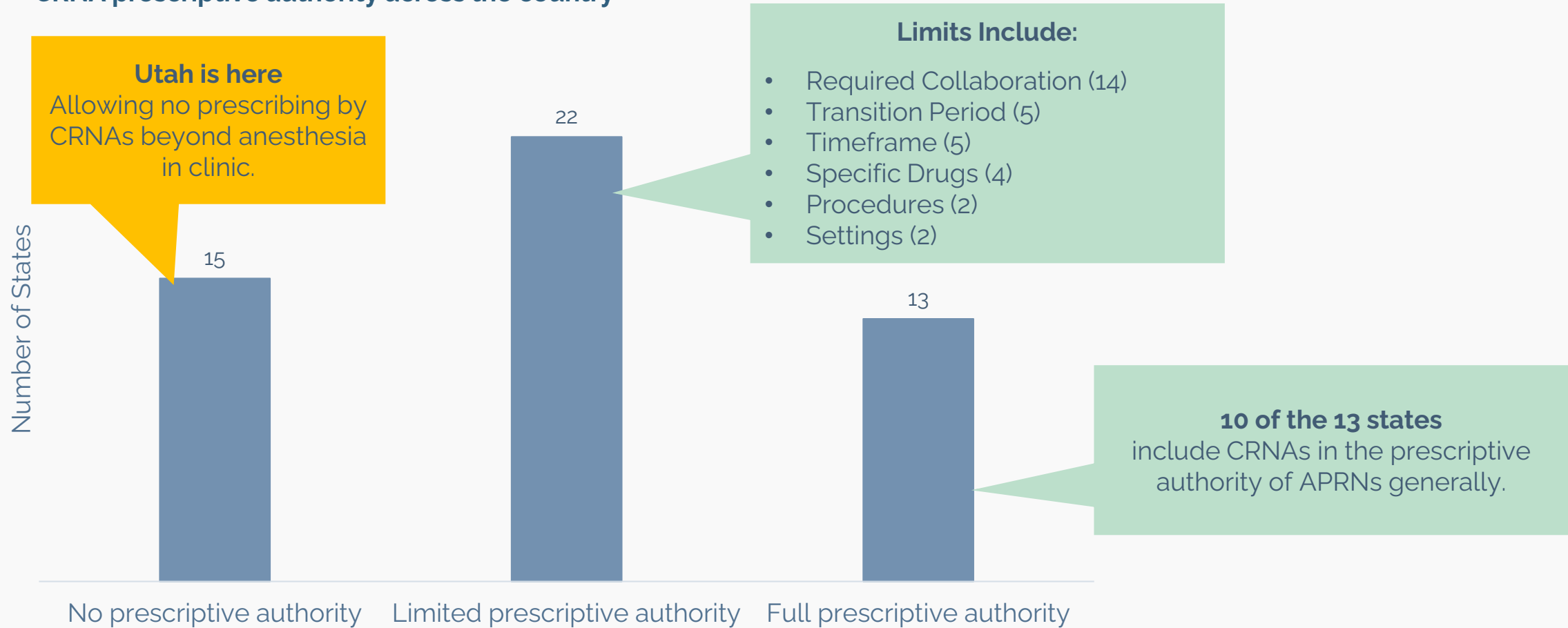
- Require fewer than 10,000 hours
- Consider scope of practice, CE, and psych specialty alignment for PAs

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Most states allow CRNA prescribing; some full, some with limitations

CRNA prescriptive authority across the country*



*Based on an OPLR policy scan that utilized Gemini and data from the National Conference of State Legislatures.

CRNA training includes more pharmacology and prescribing than nurse practitioners (who have Rx)

APRN

- **No required minimum** RN experience before admittance
- Moving towards **750 clinical hour minimum** during the program¹
- **3-4 credits** in pharmacology²
- **2.4** complaints per 100 practitioners⁴

CRNA

- **One year RN** experience 'in a critical care setting' before admittance³
- **2,000-hour clinical hour minimum** during the program³
- **6-9 credits** in pharmacology²
- **2.5** complaints per 100 practitioners⁴

1. 2022 Standards for Quality Nurse Practitioner Education; 2. Based on OPLR analysis of 3 master's FNP and 5 doctorate CRNA programs;
3. Standards for Accreditation of Nurse Anesthesia Programs, CANAEP; 4. 2017-2022 DOPL complaint data

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Scope of practice changes have significantly altered patient care over time

Services traditionally performed only by physicians now open to other health care providers...

Nurse Practitioners

- Diagnose and treat independently
- Prescribe independently
- Order labs/imaging
- Operate independent practices

Physician Assistants

- Diagnose, treat, prescribe independently (after 10K hrs)
- Order labs/imaging (after 10K hrs)
- Manage chronic diseases

Physical Therapists

- Direct access to services (w/o physician referral)
- Order imaging (x-ray, MRI)
- Certifying disability placards
- Prescribe durable medical equipment (DME)

Pharmacists

- Prescribe specific drugs for specific or common issues (e.g., Naloxone, HIV prevention, UTIs, smoking cessation)
- Administer FDA-approved vaccines
- Management of uncomplicated diabetes/hypertension

Problem: technological innovation (AI) requires more rapid adaption of scopes of practice

Context:

- Technology is evolving rapidly in healthcare (think AI, diagnostics, medical devices, drugs)
- Preparation of providers (education, training, clinical) is thus similarly evolving rapidly
- Enabling new providers to perform tasks previously limited to doctors should benefit patients*

Problem:

- Scope of practice (SOP) laws are static, impeding innovations
- SOP changes in statute are complex, technical, and difficult in the typical legislative process



*“Changing existing scope of practice regulations for a profession is often a **costly, time-consuming, adversarial, and incremental process**”*
–Health Workforce Technical Assistance Center at SUNY

Potential Solution: creating a collaborative, objective process

Statutory criteria for scope expansion

Establish statutory criteria focused on the Utah public such as:

- **Demonstrated safety** for patients
- **Demonstrated benefits** for patients (access, affordability)
- **Industry demand** from hospital and employers
- **In-state education and training** for providers on the specific procedure
- **Others** as adopted by the Legislature

Assessment by a neutral group

A neutral group assesses any proposed scope expansion vis the statutory criteria. This could be:

- An **existing state body** (e.g., OLRGC, Commerce, DHHS),
or
- A **new group** with carefully constructed members from physicians, other healthcare professionals, researchers, and patient advocates

The result of the assessment is **one of three outcomes...**

'Does the proposed scope expansion meet the statutory criteria?'

1

Yes: Move to bill drafting and presumptive adoption by legislature (could still be voted down)*

2

Insufficient information: Refer the question to the 'regulatory sandbox' for demonstration, monitoring and evaluation

3

No: No further action

*Could be treated like CCJJ sentencing guidelines where changes must go through the legislative process and could (in theory) be voted down, though the legislature by default passes the bill in deference to CCJJ's process

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Draft recommendations: Targeted adjustments

 Key recommendation

Nursing & Related	Occupation	Main licensure issues	Draft recommendation	Rationale
	MAC	Underutilized; unclear regulation	Clearly specify when required	Confusion regarding when it's required
	LPN	Underutilized; unprotected scope	No change	Mixed support and no evidence for scope changes
	RN	Mainly not licensure-related	No change	License is working as needed
	APRN (NP)	Preparedness for solo practice, rapid progression;	Require minimum hours (e.g., 2 years experience as RN or APRN)	Uneven requirements vs PAs, no statutory min requirements; anecdotal concerns
		IV/Ketamine clinic oversight	DOPL issue guidance re ketamine/IV	Anecdotal concerns from DOPL re clinics
	CNM	No material issues identified	No change	License is working as needed
	CRNA	Many states allow CRNA prescribing; some use cases	Allow some limited prescribing (e.g., duration, certain medications)	Approach adopted in many states; support amongst stakeholders (rural)
	PA	Equivalency with APRNs	Align minimum hours (e.g., 2 years of experience)	Create consistent minimum experience requirements for advanced providers
	Resp. Therapist	Concerns about program interest and access to services	Create RT Apprentice license Adopt RT compact under conditions	Apprentice option is valued, enhances access Restrictions must be minimal (e.g., CRT & RRT)
	LDEM	Questions about voluntary licensing	No change	Current preference for non-licensure avenues to enhance safety/quality

Draft recommendations: Targeted adjustments

	Occupation	Main licensure issues	Draft recommendation	Rationale
Physical Allied Health	Physical Therapy (PT)	Access to services	Clarify that PTs may prescribe durable medical equipment (DME) Broaden imaging privileges beyond X-ray & MRI	Supports efficiency, aligned with education
	PT Assistant	No material issues identified	Alter supervision ratios to 3 PTAs, 5 total	License is working as needed
	Occ. Therapy (OT)	Access to services Supervision of assistants and aids K–12	Allow OTs to prescribe DME Align with USBE re expectations of supervision given K–12 constraints	Supports efficiency, aligned with ed. Requirements for supervision seem to vary across DOPL and USBE/individual school districts
	OT Assistant	No material issues identified	Alter supervision ratios to 3 OTAs, 5 total	License is working as needed
	Ath. Trainer	Clarity of relationship between ATs and physicians	Define more clearly when ATs must seek physician guidance	Adherence to statute; states offer other approaches (e.g., OR)
	Acupuncturist	No material issues identified	Enable supervision of unlicensed assistants	Supports access; allowed in other states

Draft recommendations: Targeted adjustments

Key
recommendation

	Occupation	Main licensure issues	Draft recommendation	Rationale
Speech & Hearing	Speech Lang. Pathology (SLP)	How to account for higher risk practices (e.g., swallowing therapy)	Account for swallowing therapy in unprofessional conduct standards	Other states do not offer a license or certification for this area of practice; some require procedure counts or physician supervision
	Audiologist (AUD)	Access to services, some concerns regarding efficiency, reimbursement	Leave scope broad and do not itemize allowed practices (e.g., ordering blood work or imaging, cerumen removal)	Only 2 states itemize blood work and imaging
		Overlap in dispensing activities between AUDs and HIS	Align some hearing aid dispensing requirements with HIS e.g., - AUD may supervise a HIS - Standardize consumer protections as appropriate	Alignment and streamlining of regulation; access to mentors
	Hearing Instrument Specialist (HIS)	Concerns about training pathways	Clarify and improve education/ experience pathways, e.g., - Improve mentorship requirements - Remove explicit reference to national certifying body (NBC-HIS) - Streamline required exams	Clarifies requirements, lessens burden on applicants

Source: OPLR analysis; NBC-HIS: National Board for Certification in Hearing Instrument Sciences

Appendix

Considerations: scope of practice framework

- **Assessment process optional**

- Legislators could always run bills apart from this process; it would exist for those thorny, contentious proposals that would benefit from deeper dive
- However, the statutory criteria would still be in force, informing the debate around any scope expansion bill

- **Staffing and resourcing**

- Any assessment without related staffing and resources would be unlikely to fulfill the purpose
- Independent staffing provides resources for independent data collection and analysis which is key to de-politicizing the process

- **Regulatory relief**

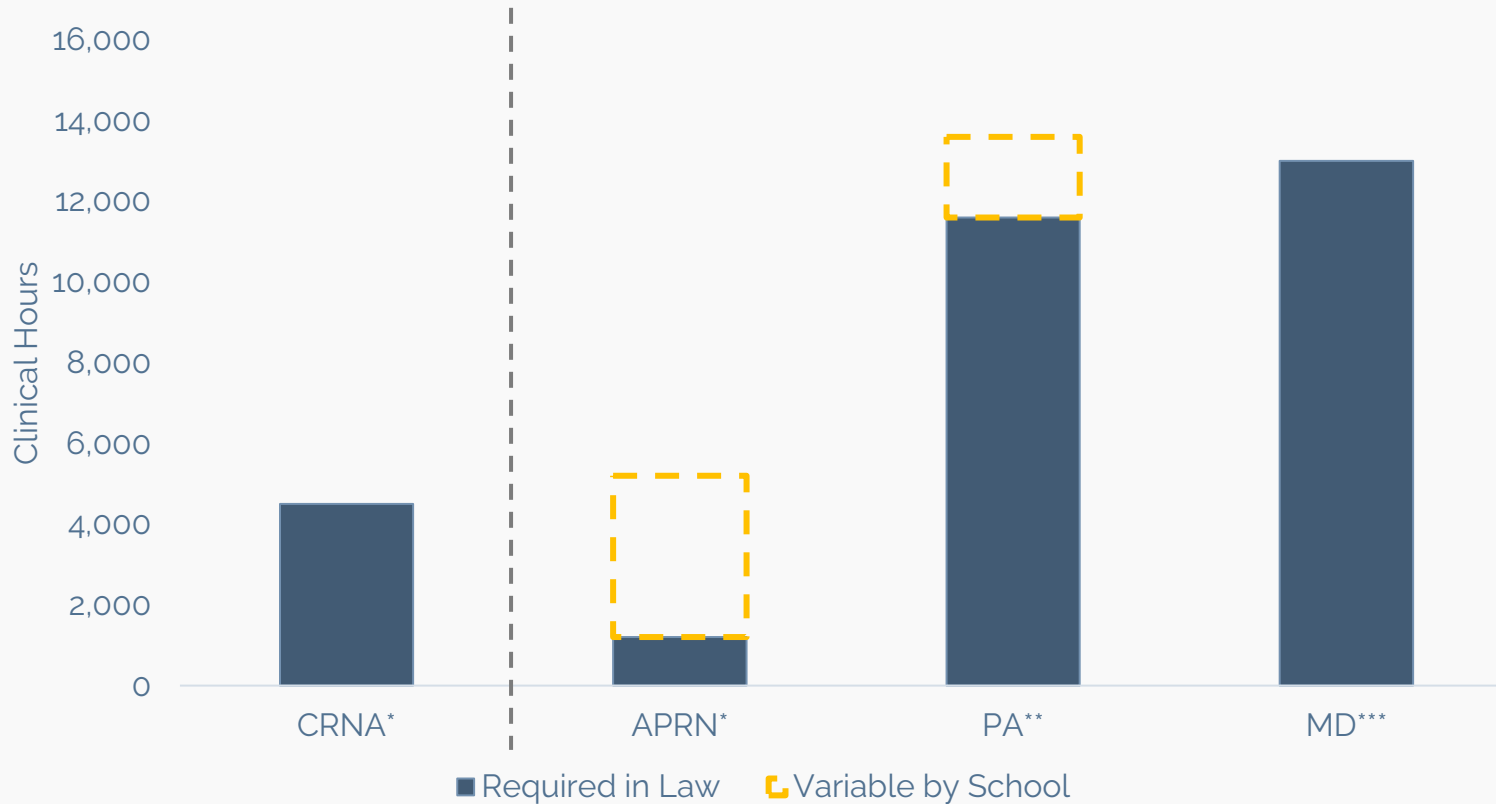
- Current 'regulatory sandboxes' (GOEO, OAIP/Commerce) are not set up for healthcare, nor for data collection; expanding an existing sandbox (or creating new) would be necessary

- **Relationship to OPLR**

- Under 13-1b, OPLR only considers scope expansions during a periodic review (every 10 years); the pace of change in healthcare (AI, diagnostics, imaging) requires more frequent change
- This process would mimic the OPLR sunrise process and allow industry participants (associations, employers, hospital systems) to trigger assessment as well
- The focused and technical nature of healthcare questions requires outside expertise (e.g. physicians, nurses, researchers, patient advocates)

Clinical training for independent practitioners is not uniform

Minimum number of clinical hours possible before independent practice authority



* APRN and CRNA 'Required in Law' hours include clinical hours in their RN program.

** PA 'Required in Law' hours assumes 40-hour weeks for 40 weeks.

*** MD hours estimates are based on 50-hour work weeks and a 3-year residency.

1. Examined entry requirements for NP programs at BYU, Rocky Mountain University, SUU, and Westminster University

2. OPLR analysis of 41 online NP programs

3. Examined entry requirements for PA programs at the University of Utah, Utah Valley University, and Rocky Mountain University

Traditional NP programs in Utah require **1-2 years of RN experience**.¹

13 of 41 sample online NP programs do not specify any RN experience requirement beyond licensure.²

PA programs in the state require between **250-2,000 hours of patient care experience**.³

Some surveyed APRNs expressed concerned about unprepared new APRNs

“ Without that [11 years of] on-the-job education, I would have been lost ... **Being a nurse for a time is a vital component of becoming an APRN.** ”

“ I strongly believe my 7 years in an ICU as an RN provided me **critical thinking skills which are crucial to working independently** as a [family nurse practitioner]. ”

“ I believe it is important for the NP to **work in a collaborative practice setting** for several years before moving on to independent practice. ”

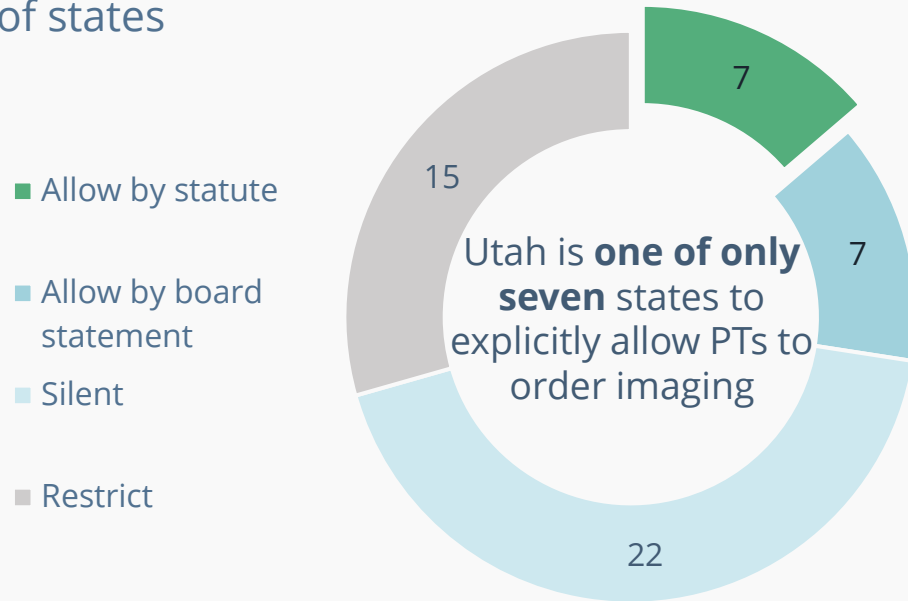
“ **Work experience is a necessary component** of providing independent healthcare. ”

Utah has historically enabled PTs to work to the full extent of their training

Utah expanded PTs scope to include dry needling over a decade ago and has recently classified PTs as primary care providers [SB196] to further improve patient access

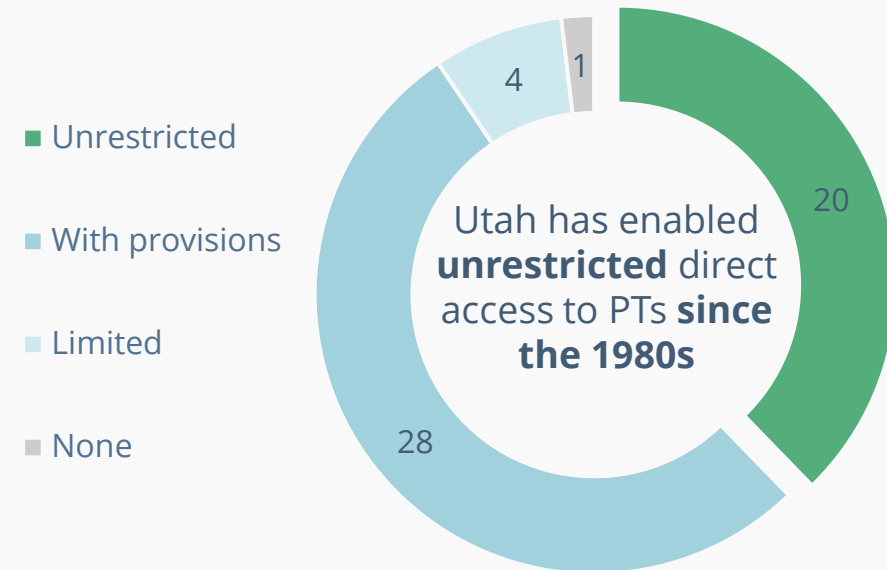
Imaging Privileges for PTs¹

of states



Direct Access to PTs²

#of states



1. OPLR policy Scan 2. <https://www.fsbpt.org/LRG/Home/ReferralRequirements>

States vary in requirements for use of special equipment by SLPs to assess swallowing

Considerations for Specialized Equipment	Number of States	Examples
None Specified	33	Utah, Texas, Washington Utah: Scope of practice broad enough to include instrumentation use (e.g., endoscopy)
Yes; specifying instrumentation use is within scope	10	Alabama, Arkansas, Colorado, Pennsylvania Colorado: Scope includes instrumentation such as videofluoroscopy, endoscopy, or stroboscopy to observe, collect data, and measure parameters of communication and swallowing
Yes; with guardrails	7	California, Indiana, Michigan, Virginia California: Minimum of 25 flexible fiberoptic nasendoscopic procedures, only under the direct authorization and supervision of a physician