Utah Department of Commerce
Office of Professional Licensure Review

2025 Periodic Review

Advanced Practice Registered Nursing

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Executive Summary

Background

Advanced practice registered nurses (APRNs) are healthcare providers who have received graduate or post-graduate training in a specific area of care. They include: 1) nurse practitioners (NPs), who diagnose and treat patients and prescribe medications within a specialty, 2) certified registered nurse anesthetists (CRNAs), who provide anesthesia-related care, including sedation and pain management procedures, and 3) certified nurse midwives (CNMs), who help deliver babies and provide newborn, postpartum, and general obstetric and gynecological care.

Utah licenses NPs, CRNAs, and CNMs. Like other states, Utah requires applicants to graduate from an accredited education program and pass a certifying examination. States vary in the scope of practice they grant NPs, with 17 (including Utah) allowing NPs to diagnose, treat, and prescribe independently of a physician. Similarly, CRNAs' scope of practice differs between states, with 35 states granting CRNAs at least some level of prescriptive authority.

Regulatory Model Recommendation: *Continue to license NPs, CRNAs, and CNMs*

- APRNs provide advanced care that could cause serious and permanent harm.
- NPs and CNMs work with a high level of clinical independence. CRNAs often work under supervision due to reimbursement requirements from the federal government, though Utah's governor has exempted some rural hospitals from this requirement.

Recommended Regulatory Adjustments:

1) *Require 6,000 hours of RN-level nursing experience before NP licensure*
    - While the average NP applicant has extensive nursing experience, under state law an individual could become licensed as an NP with just over 1,200 hours.
    - Minimum NP clinical requirements in law are much lower than for CRNAs before licensure and physician assistants before independent practice.

2) *Allow CRNAs to prescribe medications related to a procedure, limited to a 5 day pre-op and 5 day post-op supply*
    - This could help continuity of care in rare, but real, circumstances (e.g., rural).
    - CRNAs receive pharmacology training in their doctoral program.

3) *Clarify regulations for ketamine and IV hydration clinics*
    - Ketamine and IV hydration clinics are becoming more common, but state regulation is unclear and underdeveloped for APRNs in these settings.
    - There are risks (though rare) of serious complications from ketamine. There is a lack of clinical evidence for the effectiveness of IV hydration for otherwise healthy patients, and harm can occur.

Context

Consistent with its legislative mandate,[1] the Office of Professional Licensure Review (OPLR) reviewed Utah's licensing laws for advanced practice registered nurses, including nurse practitioners, nurse anesthetists, and nurse midwives. The review evaluated how well current regulations:

1. Protect the public from present and consequential physical and financial harm
2. Balance public and practitioner access to the occupation
3. Limit the economic impact of regulation on consumers, practitioners and the state[2]

OPLR's research for this review included analysis of Utah's current laws and rules, licensing and complaint data from the Division of Professional Licensing (DOPL), licensee survey results, academic literature, as well as laws and policies in other states. OPLR also conducted interviews and focus groups with employers, educators, and state agencies. See Appendix 1 for more information.

Within the nursing profession, the term advanced practice registered nurse (APRN) is often used as an overarching term to refer to nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), and certified nurse midwives (CNMs). For clarity, the report will use these terms in this way, despite the fact that the Utah NP license is titled APRN.

OPLR's research focused heavily on NPs and CRNAs. Initial research on CNMs did not reveal any major licensure-related issues to be addressed.

Background

Profession Overview

Advanced practice registered nurses (APRNs) are healthcare providers who have received advanced, graduate or post-graduate training (beyond that of a registered nurse) in a specific area of care. The most common types of APRNs, and those with distinct licenses in Utah, are nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), and certified nurse midwives (CNMs). APRNs are vital healthcare providers who help meet medical needs in important areas such as primary care, anesthesia, and women's health.

NPs represent a broad segment of advanced nurses who train in a wide range of medical specialties, including family practice, pediatrics, gerontology, and psychiatry.[3] These providers diagnose and treat ailments and diseases and prescribe medications within their specialty.

[1] UCA 13-1b-203(2)
[2] UCA 13-1b-302
[3] "Types of Nurse Practitioners Specialties," American Nurses Association

Patients are increasingly utilizing NPs for care,[4] and there is evidence that NPs provide cost-effective,[5] safe care[6] and that their work in primary care improves access to services and health outcomes, including in rural areas.[7]

CRNAs are advanced nurses trained specifically to provide anesthesia-related care. This includes sedating patients for surgical procedures and performing pain management procedures, such as epidurals and nerve blockers. CRNAs play an important role in providing safe anesthesia care to areas that lack an adequate supply of anesthesiologists,[8] which is particularly true in rural areas where studies suggest that CRNAs provide the majority of anesthesiology care.[9]

CNMs are trained to provide prenatal, labor, delivery, and postpartum care. They also provide general gynecological care to women in all stages of life. They diagnose, treat, and prescribe medications within their specialty.[10] CNMs help increase access to care for low-risk pregnancies, and evidence shows that they provide cost-effective, safe care.[11]

Evolution of Profession

The concept of a nurse practitioner arose in the 1960s in response to a shortage of primary care providers caused by the increased specialization of physicians.[12] RNs began working with physicians to treat the primary care needs of underserved communities and, as the need grew, leaders in the nursing industry created advanced education opportunities. This allowed nurses to expand their abilities to care for communities.[13] Education standards for the NP profession developed alongside their growing role, shifting from mostly certificate programs to master's or more advanced programs by the 1990s.[14] Despite industry efforts to make a doctoral degree the minimum requirement for NPs, accrediting bodies still approve master's programs as the standard.[15] For decades, efforts within the NP industry have been concentrated on increasing

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[4] Patel et al. (2023); In 2019, an estimated 17% of Medicare-covered health checkups were performed by NPs. This was up from an estimated 9% in 2013.
[5] See, for example, Perloff et al. (2015), Razavi et al. (2021), and Smith et al. (2020). However, some studies show no difference in cost (see, for example Liu et al. (2020)) and at least one study revealed lower costs for physicians in emergency departments (Chan Jr. & Chen (2024)).
[6] See, for example, Mundinger et al. (2000), Liu et al. (2020), and McMenamin et al. (2023).
[7] Savard et al. (2025)
[8] Vitale & Lyons (2021)
[9] Cohen et al. (2020) found that more than 80% of anesthesiology providers in rural counties were CRNAs.
[10] "Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives," American College of Nurse Midwives
[11] See, for example, Carlson et al. (2018), Altman et al. (2017), Johantgen et al. (2012) and Hamlin et al. (2021)
[12] Ohio Association of Advanced Practice Nurses & Lewis (2022)
[13] American Association of Nurse Practitioners
[14] Martsolf et al. (2023)
[15] As early as 2004, the American Association of Colleges of Nursing made it their official statement that a doctorate should be the minimum qualification for nurse practitioners. In 2018, the National Organization of Nurse Practitioner Faculties called for the phasing out of master's programs for all advanced practice

the ability of NPs to practice without physician oversight under state licensing laws, an effort that has been largely successful.[16]

Surgeons trained nurses to provide anesthesia care as early as the Civil War. In the ensuing decades, including during World War I, surgeons and nurses continued to work together to advance the field of anesthesia, and nurses became an increasingly important source of anesthesia services.[17] The American Association of Nurse Anesthetists began accrediting CRNA programs in 1952. The minimum education required for a CRNA shifted to a bachelor's in 1986, a master's in 1998, and doctorate in 2022.[18] CRNAs have been granted the authority to practice without the supervision of a physician in 18 states, though requirements from the Center for Medicare and Medicaid (CMS) complicate the landscape (see the 'Profession in Utah' section below for a more in-depth discussion about CMS requirements).[19]

Midwifery has been practiced throughout human history in cultures throughout the world.[20] In the U.S., midwives attended the majority of births until the beginning of the 20th century, when it became more common for births to be performed by physicians in hospitals.[21] In response, leaders in the midwife community developed the concept of a nurse midwife, trained to provide midwifery services in a hospital or other setting. The American College of Nurse-Midwives was created in the 1970s to establish education and certification standards for the profession.[22] In 2002, the American College of Obstetrician and Gynecologists made an official statement with the American College of Nurse-Midwives stating that CNMs and physicians are considered equivalent healthcare providers and direct physician supervision was no longer an industry standard.[23] In 2010, a graduate degree became the minimum standard for entry into the CNM profession.[24]

Profession in Utah

a) Licensure requirements

Utah licenses NPs, CRNAs, and CNMs.[25] NPs and CRNAs are governed by the Nurse Practice

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nursing programs by 2025. However, this has not been achieved for NPs, and the two main NP accrediting bodies (CCNE and "ACEN Accreditation Manual," ACEN) still accredit master's programs.

[16] Brom et al. (2019); "State Practice Environment," AANP

[17] Boehning & Punsalan (2023); Koch (2015)

[18] Statmerican "Statement on Comparing…," American Society of Anesthesiologists; "Standards for Accreditation of Nurse Anesthesia Programs," Council on Accreditation of Nurse Anesthesia Educational Programs

[19] "Certified Registered Nurse Anesthetists," National Conference of State Legislatures

[20] Boehning & Punsalan (2023)

[21] National Association of Certified Professional Midwives

[22] National Association of Certified Professional Midwives

[23] Dawley et al. (2010) While industry standard no longer requires physician supervision, state regulations still vary in requiring physician supervision or not.

[24] "Position Statement: Mandatory Degree Requirements for Entry into Midwifery Practice," American College of Nurse-Midwives

[25] In Utah, NPs are licensed as "advanced practice registered nurses" and CRNAs are licensed as "advanced practice registered nurses - CRNA without prescriptive practice"; see UCA 58-31b-301(2).

Act,[26] and CNMs are governed by Nurse Midwife Practice Act,[27] though all three professions are combined under the same DOPL board.[28]

At the time of OPLR's review, there were 6,705 NPs, 463 CRNAs, and 243 CNMs licensed in Utah.[29] The licensure requirements for each type of provider are fairly similar:

To become an NP in Utah, an applicant must be a licensed registered nurse (RN), earn a graduate degree from an accredited program that includes "course work in patient assessment, diagnosis and treatment, and pharmacotherapeutics", pass an approved certifying examination, and pass a background check.[30] Those who wish to specialize in psychiatric mental health must also complete 4,000 hours of mental health and psychiatric clinical experience.[31] NP accreditors approve both master's and doctorate degrees, though NPs in Utah have become more likely to have a doctoral degree over time.[32] Additionally, those who will prescribe controlled substances must receive a controlled substance license from DOPL.[33] NPs must renew their license every two years by documenting continued certification with an approved organization and completing three and a half hours of continuing education related to prescribing controlled substances.[34]

To become a CRNA in Utah, an applicant must be an RN, earn a graduate degree from a nurse anesthesia program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA), pass an approved examination, be certified by a credentialing organization, and pass a background check.[35] Unlike NP accrediting bodies, COA began requiring programs to issue doctoral degrees in 2022.[36] Additionally, COA requires programs to

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[26] UCA 58-31b
[27] UCA 58-44a
[28] All advanced practice nurses are under the Board of Nursing and Certified Midwives.
[29] DOPL Licensee Data, accessed January 2025
[30] UCA 58-31b-302(5); UCA 58-31b-302(6); R156-31b-302e(1); applicants must take a certifying exam offered by an organization approved by the National Commission for Certifying Agencies or the Accreditation Board for Specialty Nursing Certification.
[31] UCA 58-31b-302(5); R156-31b-302e(2); Applicants get credit for 1,000 hours of clinical experience upon graduation. They must then complete another 3,000 hours after passing their qualifying exam.
[32] DOPL APRN Licensee Renewal Survey, November 2023; 27% of respondents who completed their qualifying education in the last 10 years did so with a doctoral degree, compared to 15% of those who finished their education 11-20 years ago and 8% of those who finished their education 21-30 years ago.
[33] UCA 58-37-6(2); "Controlled Substance" DOPL; to get a controlled substance license, a person must show evidence of licensure in a profession that can prescribe controlled substances. There are no additional requirements.
[34] UCA 58-31b-305(1); R156-31b-303(3)(b); UCA 58-31b-305(2); UCA 58-37-6.5. Certification bodies require varying amounts of continuing education for renewal. NPs credentialed with the ANCC, for example, must renew their license every five years by completing 75 hours of continuing education within that five-year period. Licensees must also watch a suicide prevention video.
[35] UCA 58-31b-302(5); UCA 58-31b-302(6); R156-31b-302e(1); applicants must be certified by an organization approved by the National Commission for Certifying Agencies or the Accreditation Board for Specialty Nursing Certification. The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) is the certifying body for CRNAs.
[36] "Standards for Accreditation of Nurse Anesthesia Programs," Council on Accreditation of Nurse Anesthesia Educational Programs

only accept applicants with a year of full-time equivalent experience in a "critical care setting."[37] CRNAs must renew their license every two years by documenting continued certification with an approved organization.[38]

Applicants for a CNM license must have an RN license, complete a graduate program accredited by the Accreditation Commission for Midwifery Education (ACME) or a foreign school that is proven to be equivalent, pass a test administered by the American Midwifery Certification Board, and pass a background check.[39] ACME accredits both master's and doctoral programs.[40] CNMs must renew their license every two years by maintaining certification from the American Midwifery Certification Board.[41]

b) Practice authority

NPs in Utah have full independent practice authority. This means that they can diagnose, treat, and prescribe medications without mandated consultation with a physician or other advanced practitioner.[42] They can also operate their own practice or clinic and supervise other healthcare practitioners. Traditionally, Utah NPs had to enter a collaborative agreement with a physician to prescribe scheduled II and III medications.[43] However, the Utah Legislature gradually loosened laws requiring a collaborative agreement, and in 2023 it removed all remaining collaborative agreement requirements for NP prescribing authority.[44] NPs licensed in Utah typically work in hospitals and outpatient clinics, and about one in ten are self-employed.[45]

CRNAs in Utah provide anesthesia care to patients before, during, and after a procedure. They can perform assessments, select and administer drugs, and evaluate patients after a procedure. While their scope of practice includes "selecting, ordering, or administering" medications when a

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[37] "Standards for Accreditation of Nurse Anesthesia Programs," Council on Accreditation of Nurse Anesthesia Educational Programs

[38] UCA 58-31b-305(1); R156-31b-303(3)(b); UCA 58-31b-305(2). CRNAs must renew their NBCRN A credential every four years by completing 60 hours of continuing education courses and 40 hours of professional development activities. Licensees must also watch a suicide prevention video.

[39] UCA 58-44a-302; R156-44a-302

[40] "Criteria for Programmatic Accreditation of Midwifery Education Programs," ACME

[41] UCA 58-44-303; R156-44a-303. CNMs must renew their AMCB certification every five years by either 1) completing three education modules, 20 hours of continuing education, and a "task analysis survey," or 2) retaking and passing the certification exam.

[42] UCA 58-31b-102(11)(a)-(c)

[43] Drugs are classified according to a "schedule" developed by the United States Drug Enforcement Administration (DEA). Classifications range from Schedule I to Schedule V and are determined mainly by the drug's potential for abuse. Schedule I drugs, such as heroin, have a high potential for abuse, whereas those in Schedule V, such as Lyrica, have a low potential for abuse; see U.S. DEA. Utah's adopted drug schedule can be found in UCA 58-37-4.

[44] For example, in 2016 S.B. 58 allowed NPs to prescribe schedule III drugs without a collaborative agreement and to prescribe schedule II drugs without a collaborative agreement after two years or 2,000 hours of NP experience. S.B. 36, passed in 2023, eliminated all collaborative agreement requirements imposed on NPs.

[45] DOPL APRN Licensee Renewal Survey, November 2023; 21% of respondents reported working in an inpatient (13%) or outpatient (8%) hospital, and 17% reported working in a non-hospital based outpatient clinic. Thirteen percent (13%) reported being self-employed or a consultant.

patient is in a clinic or hospital for a procedure, they cannot prescribe medications for use before or after a patient comes in for the procedure.[46] CRNAs work "upon the request of a licensed health care professional," though state law does not mandate that they be supervised.[47] However, the Center for Medicare and Medicaid Services (CMS) requires a CRNA to be supervised by a physician or anesthesiologist for reimbursement unless a state's governor formally opts-out of the requirement.[48] Governor Spencer Cox requested an opt-out of the supervision requirement for critical access and some rural hospitals in 2022.[49] CRNAs licensed in Utah typically work in hospitals and ambulatory surgical centers.[50]

CNMs in Utah provide care leading up to, during, and after the delivery of a baby, including prescribing schedule II-V medications and the limited administration of anesthesia. CNMs also care for babies up to age one and provide general gynecological care for women.[51] There are no supervision requirements imposed on CNMs, though they are required to have a "safe mechanism for obtaining medical consultation, collaboration, and referral with one or more consulting physicians." and must have a consultation agreement with a physician to prescribe schedule II and III medications.[52] CNMs licensed in Utah typically work in hospitals, outpatient clinics, and physician specialty groups.[53]

Approaches in Other Jurisdictions

All states license NPs, CRNAs, and CNMs, and entry requirements are relatively standardized throughout the United States.[54] However, states differ on whether they allow NPs to practice independently of a physician and whether they grant prescriptive authority to CRNAs.

A plurality of states (17, including Utah), allow NPs to treat, diagnose, and prescribe independently of a physician immediately upon licensure, 17 states allow NPs to practice independently after a period of collaboration, 2 states require NPs to collaborate with physicians only when prescribing medications, and 14 states require NPs to work collaboratively with a physician throughout their careers.[55] For states that require a period of collaboration before treating, diagnosing, and prescribing independently, the transition period ranges from 2,080 hours (MN) to 6,240 hours (AR).[56] See Appendix 2.1 for more detail.

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[46] UCA 58-31b-102(11)(d)
[47] UCA 58-31b-102(11)(d)
[48] Centers for Medicare and Medicaid Services
[49] "Opt-Outs", American Society of Anesthesiologists
[50] DOPL APRN Licensee Renewal Survey, November 2023; 43% of respondents reported working in inpatient (24%) or outpatient hospitals (19%), and 21% reported working in ambulatory surgical centers.
[51] UCA 58-44a-102(9)
[52] UCA 58-44a-102(9)(b)(i); UCA 58-44a-102(9)(c)(iii)(C)
[53] DOPL APRN Licensee Renewal Survey, November 2023; 32% reported working in an inpatient (19%) or outpatient (13%) hospital, 13% work in a 'non-hospital' based outpatient clinic', and 13% reported working in a 'physician single specialty group.'
[54] OPLR Policy Scan
[55] OPLR Policy Scan; Of the 17 states that allow independent practice after a collaborative period, 5 only require the collaborative period for prescriptive authority.
[56] OPLR Policy Scan

Fifteen (15) states (including Utah) do not allow CRNAs to prescribe, 22 allow CRNAs to prescribe with limitations, and 13 grant CRNAs full prescriptive authority.[57] Examples of state-imposed limitations to CRNA prescribing include: a transition period of physician collaboration (5 states), a limited supply or timeframe (5 states), set of drugs (4 states), certain procedures (2 states) or settings (2 states).[58] See Appendix 2.2 for more detail.

Utah is one of four states that have adopted the APRN Licensure Compact, though the compact will not activate until three more states adopt it.[59] The compact allows NPs, CRNAs, and CNMs to qualify for a multistate license which allows them to practice in compact-member states without having to obtain a license for each state.[60] To qualify for a multistate license, a person must meet their home state's licensing requirements as well as the 'Uniform Licensure Requirements' outlined in the compact.[61]

Regulatory Model Assessment

The Framework

In an effort to standardize how appropriate regulatory models are determined for each profession (e.g. license, registry, no regulation, etc.), OPLR developed a framework which incorporates its statutory review criteria.[62] Appropriate models are determined principally by an evaluation of the potential for harm and related factors that may aggravate or mitigate the potential for harm. These factors include the availability of consumer choice, vulnerability of patients, and independence of practice. See Appendix 3.1 for potential regulatory models and the factors in OPLR's framework.

Recommendation

OPLR concludes that the roles of NP, CRNA, and CNM warrant continued licensure.

Potential for Harm

NPs, CRNAs, and CNMs deliver complex medical care that has the potential to cause serious harm. If an NP makes an incorrect diagnosis, a patient may fail to receive the care they need or may receive care that worsens their condition. Prescribing medications also comes with risk, including adverse reactions and dependency. CRNAs work with powerful anesthetic drugs that

[57] OPLR Policy Scan: of the 13 states that grant full prescriptive authority to CRNAs, 10 do so by including CRNAs in the prescriptive authority of APRNs generally.
[58] OPLR Policy Scan
[59] "About the Compact," NCSBN
[60] UCA 58-31d-101
[61] For a list of the 'Uniform Licensure Requirements,' see "Uniform Licensure Requirements: APRN Compact Multistate License," NCSBN.
[62] Among other criteria, OPLR is required to evaluate "whether the regulation of the occupation is necessary to address a present, recognizable, and significant harm to the health, safety, or financial welfare of the public" and consider "potentially less burdensome alternatives to the… existing regulation". UCA 13-1b-302

can cause death if they are administered incorrectly. CNMs assist with childbirth, which comes with inherent risks to both mother and baby. The U.S. Department of Labor's O*Net Consequence of Error Ranking, which estimates and ranks the severity of harm that could arise from different professions, places NPs at 85, CRNAs at 94, and CNMs at 92, out of 100.[63] Additionally, all provider types work with vulnerable patients who are sick, injured, or in a compromised state, which aggravates the harm they can cause. Providers are often alone with patients in private settings involving physical or intimate touch to perform their work.

Related Harm Factors

NPs and CNMs can work with a high level of clinical independence, increasing the potential for harm. They are not required to be supervised by other providers in employed settings. They can also operate their own clinics, though CNMs are required to have a mechanism for obtaining medical consultation or collaboration with a physician and a consultation and referral plan with a physician if prescribing schedule II and III medications. CRNAs are more limited in their clinical independence given CMS supervision requirements and the underlying uses for anesthesia, though CRNAs in some rural areas are exempt from this requirement.

The harm that can be caused by NPs is mitigated somewhat by consumer oversight. Patients have some choice regarding which NP they see, especially in a primary care setting, through reviews and provider bios or personal referrals. This is also true for CNMs but not for CRNAs.

NPs, CRNAs, and CNMs have private certifying bodies. These organizations can discipline a provider or revoke a certification for poor behavior, which can help address issues of patient harm.[64] However, these organizations manage the certifications for all APRNs in the U.S. and likely do not have the same resources available to states to actively investigate issues.

For more details on OPLR's analysis of NPs, CRNAs, and CNMs according to the framework, see Appendix 3.2.

Model Adjustments

After determining an appropriate regulatory model, OPLR's framework also evaluates whether adjustments should be made within a recommended model to address any material and existing safety and access issues affecting the Utah public and practitioners. Regulatory model adjustments may include changing entry qualifications, the scope of practice, unprofessional or unlawful conduct, and/or supervision and independence provisions (see Appendix 4.1).

Safety Issues

Available safety data does not reveal any major safety issues with ARPNs in Utah, although

[63] O*Net Consequence of Error Ranking
[64] See "Causes for Denial, Suspension, and Revocation of Certification," ANCC; "Disciplinary Policies and Procedures," NBCRNA; and "Professional Discipline," AMCB

OPLR identified several gaps in regulatory oversight.

OPLR uses data on complaints brought to DOPL against professions as one source of information. This data shows that APRN complaint rates seem on par with other advanced providers. Between 2017 and 2022, the complaint rates for NPs, CRNAs, and CNMs were 2.4, 2.5, and 2.3 per 100 practitioners respectively. These rates are higher than registered and licensed practical nurses (who have a more limited scope of practice) but are roughly comparable to physicians.[65] Additionally, case analysis shows that while some complaints stem from patient harm, the majority do not. Among a random sample of 30 complaints against NPs, there were five cases stemming from the same two instances of identifiable harm (one physical and one financial). Of the rest, approximately half did not result in harm and half did not contain enough information to determine if there was harm.[66] Among the 13 substantiated complaints brought against CRNAs between 2017 and 2022, only one was categorized as 'client harm or endangerment', and in a deeper review of six randomly chosen cases, none resulted in patient harm.[67] None of the six substantiated complaints brought against CNMs between 2017 and 2022 were categorized as 'client harm or endangerment.'[68] However, a review of each of these cases revealed that at least one resulted in physical and psychological harm.[69] See Appendix 4.2 for information on how OPLR uses DOPL complaint data.

OPLR did hear anecdotal concerns in focus groups and interviews with practitioners and employers about a small segment of newly licensed NPs who may not be fully prepared for independent practice. Individuals expressed concern that some nurses rush through the education process (with some moving almost directly from RN graduation to starting an NP program).[70] These were most often mentioned within a broader statement that the majority of NPs are well trained and prepared for independent practice. As a result of these concerns, OPLR conducted further research into Utah's statutory requirements for clinical experience of advanced healthcare providers prior to licensure and found that NPs do not have the same statutory minimum clinical hour requirements that are in place for CRNAs, PAs, and physicians (MDs, DOs).

The following table summarizes OPLR's estimates of the ***minimum amount of clinical experience*** a person could have prior to full practice authority ***under law*** (see Appendix 4.3 for more details about these calculations).

[65] DOPL Complaint Data; While OPLR considers DOPL complaint data holistically, direct comparisons across occupations are difficult as each work in different contexts and with patients of varying acuity. Fine comparisons are likely less meaningful than very large differences.
[66] DOPL investigator analysis of 30 randomly chosen NP complaints between 2017 and 2022.
[67] DOPL Complaint Data; OPLR analysis of six CRNA complaints between 2017 and 2022.
[68] DOPL Complaint Data
[69] OPLR analysis of six CNM complaints between 2017 and 2022. One complaint stemmed from identifiable harm, three did not, and two did not contain enough information to assess whether a patient was harmed.
[70] OPLR Interview Series and Focus Groups

Estimated Minimum Clinical Experience Required By Law Before Full Practice Authority			
	In School	Out of School	Total
NP (family practice)	1,250 hours	None	1,250 hours
CRNA*	2,500 hours	2,000 hours	4,500 hours
PA (all specialties)	1,650 hours	10,000 hours	11,650 hours**
MD (family practice)	3,000 hours	7,800 hours	10,800 hours**

* CRNAs do not have independent practice authority, as they cannot prescribe–they are included here for comparison purposes.
** The hours for PAs and family practice MDs include assumptions for hours worked per week and are a rough estimate. Additionally, the MD hours estimate uses a family practice residency. Other specialties likely require more time in residency. See Appendix 4.3.

While far from the norm, it is possible under current law for a person to become licensed as an NP with full independent practice authority with only the 1,250 hours of supervised nursing experience required while in school. By extension, an NP can legally open a clinic or practice directly after graduation from an NP program with the rough equivalent of 8 months of full time experience, and this in a structured, supervised context.

OPLR sent a survey to all Utah NPs and CRNAs asking about their clinical experience prior to licensure (both in school and outside of school).[71] Among Utah NPs, the median number of hours of RN experience upon graduation from an NP program was just under 15,000 (or seven and a half years of full-time work). However, 31% had fewer than 10,000 hours of experience, 14% had fewer than 6,000 hours, and 5% had fewer than 4,000 hours (see chart in Appendix 4.4). CRNAs had a lower median amount of experience (9,700 hours), but only 2% had fewer than 4,000 hours.[72] With current accreditation standards, there are no CRNAs graduating with fewer than 4,000 hours of experience.[73] See Appendix 4.4 for more information on OPLR's survey of NPs and CRNAs.

Additionally, in an open-ended question in which OPLR invited licensees to provide any feedback on state licensing, more than 50 respondents commented on newly-graduated NPs lacking experience upon graduation (representing about 13% of responses). This theme was

[71] OPLR NP/CRNA Licensee Survey, August 2025; 'Clinical experience' was defined as time spent doing clinical work in an RN education program, working as an RN before starting an NP program, and clinical work in an NP program. It did not include time working as an RN during an NP program.
[72] OPLR NP/CRNA Licensee Survey, August 2025
[73] The Council on Accreditation of Nurse Anesthesia Educational Programs, which accredits CRNA programs, mandates that programs require applicants to have a year of "full-time work experience, or its part-time equivalent, as a registered nurse in a critical care setting." Additionally, they require programs to include 2,000 hours of clinical experience during the education program. The three CRNA respondents on the OPLR NP/CRNA survey who reported less than 4,000 hours of experience upon graduation finished their programs 10 years ago or more.

one of the two most common themes.[74] See Appendix 4.5 for examples of these comments.

Other regulatory gaps OPLR identified relate to the increase in ketamine and IV hydration clinics in Utah (sometimes with NPs as medical director) and anecdotal concerns about public safety. Ketamine is increasingly used to treat mental health disorders but can be harmful. IV clinics offer health benefits that may not be substantiated and involve risks from infection and side effects. While not specific to APRNs, OPLRs discussions with regulators revealed that Utah has a confusing, under-developed regulatory structure in these emerging areas.[75] This is relevant to APRNs because NPs are allowed to operate these clinics independently as advanced providers. Additionally, in OPLR's analysis of DOPL complaints, of 30 randomly chosen NP complaints, 2 were complaints brought against an NP whose IV therapy administration caused sepsis in a patient.[76] See Appendix 4.6 for more detail on ketamine and IV clinics in Utah.

OPLR did not uncover any major safety concerns with CRNAs or CNMs in its qualitative research. Administrators, practitioners, and educators were overwhelmingly positive in their assessment of the CRNAs they interact with. No specific concerns were raised regarding CNMs.[77]

Access Issues

Overall, Utah has sufficient numbers of APRNs, though they are not distributed optimally throughout Utah. Rural areas, in particular, may struggle to attract and retain NPs and CNMs. Utah appears to have insufficient numbers of CRNAs, though this is balanced by greater numbers of anesthesiologists relative to other states and may be addressed in time with the anticipated expansion of education programs.

Utahns have sufficient access to NPs. The number of licensed NPs in the state has grown 14% annually over the past decade, far outpacing population growth (see Appendix 4.7).[78] The Health Resources Service Administration (HRSA), which uses state-specific population data to inform estimates of supply and demand for healthcare professions, suggests that Utah has ample NPs (110% adequacy and predicted to grow to 139% adequacy by 2037).[79] This was supported by stakeholder feedback.[80] There is evidence, however, that the distribution of NPs throughout the state is uneven and that some rural areas may struggle with access to NPs more

[74] OPLR NP/CRNA Licensee Survey, August 2025; the second most common theme was support for current NP independent practice policies.
[75] OPLR Interview Series
[76] OPLR Interview Series; DOPL investigator analysis of 30 randomly chosen NP complaints between 2017 and 2022.
[77] OPLR Interview Series and Focus Groups
[78] DOPL Licensee Data; Utah experienced 1.9% annualized population growth between 2014 and 2024 (Public Health Indicator Based Information System, DHHS).
[79] Health Resources Service Administration Workforce Projections
[80] OPLR Interview Series

than urban areas.[81] See Appendix 4.8 for a more in-depth discussion on access to NPs in different parts of Utah.

Access to CRNAs in Utah may be more of an issue. The number of licensed CRNAs in Utah grew 6% annually during the last decade (see Appendix 4.7), also well above population growth.[82] However, HRSA estimates that Utah has only enough CRNAs to meet 35% of the state's needs, and this is expected to only grow to 41% by 2037. At the same time, HRSA also estimates that Utah has sufficient anesthesiologists to meet demand (107% adequacy), a higher percentage than 40 other states.[83] A lack of CRNAs is likely felt most in rural areas. In a survey of focus group participants comprising rural hospital administrators, three said it's easy to fill CRNA positions, one said it's difficult, and one said it's very difficult.[84] There is anticipated CRNA program expansion in Utah which could help address supply issues.[85]

OPLR heard from some rural hospital administrators that they could provide more timely, continuous care to their patients if CRNAs were allowed to prescribe medications, though others stated it would not be useful in their facility. Those who said it would be useful described a range of instances (or 'use cases') in which it could help ensure access to needed care (see Appendix 4.9 for a more in-depth discussion). The most common use cases mentioned were prescribing pre-operatively (e.g., prescribing anti-anxiety medications, such as a benzodiazepine, to ensure patients are in a safe mental and physical condition as they come in for a procedure) and post-operatively (e.g., prescribing pain management or anti-nausea medications to ensure comfort for the patient until they can see their primary care physician).[86] This would often be a 'backup' use case where the CRNA could prescribe when other prescribers were unavailable and thus provide more timely care to patients in provider-constrained times and places. However, some administrators told OPLR that they do not see a need for CRNAs to prescribe in this way because the surgeon involved in the procedure, or a patient's primary care physician, can prescribe the needed medications. Despite this, these administrators felt that, if limited to pre- and post-operative scenarios, allowing prescribing would not cause major safety issues. Other use cases, such as pain and ketamine clinics, prompted greater safety concerns from administrators.[87]

Utah experienced a 5% annualized growth in the number of CNMs over the past decade (see Appendix 4.7). Additionally, HRSA modeling predicts that Utah has more than enough CNMs to meet demand (120% adequacy rate). However, geographic distribution is uneven, and women in some areas, particularly rural areas, have less access to CNMs than other areas. Data from

[81] OPLR analysis of data from "Utah…," U.S. Bureau of Labor Statistics and "State Population…," U.S. Census Bureau.
[82] DOPL Licensee Data
[83] Health Resources Service Administration Workforce Projections
[84] OPLR Survey of Rural Hospital Administrators, July 2025: one administrator said they do not use CRNAs, and three remained neutral on the issue of hiring.
[85] OPLR Interview Series
[86] OPLR Interview Series and Focus Group with Rural Hospital Administrators, July 2, 2025

[87] OPLR Interview Series and Focus Group with Rural Hospital Administrators, July 2, 2025

the Kem C. Gardner Policy Institute indicates that Utah CNMs are overwhelmingly concentrated in six counties, and that twelve counties do not have any CNMs.[88]

Recommendation: Require 6,000 hours of RN-level nursing experience before NP licensure

OPLR recommends that Utah require individuals to have a minimum amount of nursing experience before becoming licensed as an NP. OPLR considers 4,000-10,000 hours to be a reasonable range for this requirement but ultimately settled on 6,000 hours. The low end (4,000 hours) reflects requirements for CRNAs (through the accrediting body, but referenced in statute), and the high end (10,000 hours) reflects requirements for PAs.[89] These hours could be a combination of hours spent in RN program capstone and clinical placements, working as an RN before and during an NP program, and in NP program clinical placements. OPLR recommends both a longer implementation timeline and giving DOPL rulemaking authority to make exceptions to this rule for a limited time as potential licensees and education programs adjust to the new requirement.

As mentioned previously, there is strong evidence that NPs generally provide safe care. However, these studies do not focus specifically on the practice of the subset of NPs this recommendation is meant to address: new NPs with limited nursing experience practicing independently of other providers.[90] This is a small segment of NPs and therefore their safety outcomes are likely not picked up by studies of NPs in aggregate. Additionally, while OPLR's typical view is that changes to licensing laws should be informed by data indicating *actual* harm occurring in the state, a more proactive approach to harm prevention is warranted in this case given the nature of an NP's broad scope of practice. NPs practice medicine at a high level, including by prescribing controlled substances, diagnosing and treating disease, delegating to and supervising other health care professionals–and, critically, they perform this scope independently from the first day of licensure as an NP. Professions that perform a broad, highly complex scope with complete independence and a high potential for harm to the public should be held to a higher standard for regulatory purposes.

Given the issue of a small segment of NPs with limited experience, OPLR considered three potential solutions. The first (and perhaps most obvious) is to limit NP practice to group healthcare settings (though without formal collaboration or supervision required) for some period of time. This option, while it directly addresses the issue by placing the new graduate around more seasoned providers, may go against the initial legislative intent behind the move to full practice authority for NPs. The second is to regulate NP programs, imposing minimum experience at the point of admission or graduation. This recommendation, while effective, unnecessarily constrains programs (and thereby students) in the design and structure of education programs. Third is the recommendation OPLR chose–to require minimum experience at licensure. This is the most flexible option, allowing individual students and programs to

[88] Beagley (2025): Utah CNMs are concentrated in Salt Lake, Wasatch, Sanpete, Sevier, Garfield, and Grand Counties.
[89] see UCA 58-70a-307(2)
[90] See, for example, Mundinger et al. (2000), Liu et al. (2020), and McMenamin et al. (2023).

choose the sequence and timing of experience that works best in the market, and appears to be the narrowest and least restrictive way to address the issue.

One justification for Utah allowing NPs to practice independently without any transition period was that NPs typically have extensive nursing experience upon graduation.[91] OPLR's research confirms this. However, when looking at licensing policy, legislators should consider what the law allows as a *minimum* rather than what is occurring on average. OPLR's recommendation would increase the minimum amount of experience required of someone to be licensed without affecting the majority of applicants.

The recommendation would more closely align the training of advanced practitioners by imposing a statutory floor for NPs that already exists for CRNAs (through their accrediting body, reinforced in statute) and PAs (through state law). CRNAs currently have a higher minimum clinical practice requirement in law than NPs despite not having the same prescriptive privileges as an NP. Additionally, NPs and PAs, while coming from distinct training paths, have similar scopes of practice, and both practitioners can eventually treat, diagnose, and prescribe independently of other providers.[92] Therefore, OPLR posits that the minimum clinical practice required by law before independent practice for these professions should be more similar than it currently is (12,000 hours versus 1,250).

OPLR's recommendation would not impact the majority of individuals who are already becoming licensed as NPs with extensive experience. OPLR's survey data suggests that only a small proportion (14%) of those seeking licensure graduate from NP school with less than the recommended 6,000 hours of clinical experience.[93] Rather than impose post-licensure supervision requirements on all NPs, this approach would narrowly impact only those who enter the profession without extensive nursing experience. Importantly, OPLR's recommendation would not impact the full independent practice authority of Utah NPs. Licensed NPs would have the same legal authority they do now upon licensure as an NP.

This recommendation would also not impact Utah's standing in the (not yet enacted) APRN Licensure Compact. Based on OPLR's reading of the compact language and discussions with representatives from the National Council of State Boards of Nursing (NCSBN), Utah can add licensure requirements above those by the compact or its member states.[94] Individuals seeking to qualify for a multistate license through Utah would first need to qualify for a Utah license, including the completion of 6,000 hours of pre-licensure clinical experience. Those seeking to practice in Utah through a multistate license who qualified in a state other than Utah would not be required to meet the 6,000 clinical hour requirement. They would, however, need to show

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[91] Audio Recording of the House Business, Labor, and Commerce Committee Meeting, February 17, 2021; Those presenting H.B. 287 said that most NPs graduate with 15,000-20,000 hours of experience. OPLR's NP/CRNA Survey supports this claim.

[92] NPs can practice independently upon licensure. PAs must work under a collaborative agreement with a physician for the first 4,000 hours of practice and a collaborative agreement with a physician or PA for the following 6,000 hours of practice before practicing independently (see UCA 58-70a-307).

[93] OPLR NP/CRNA Licensee Survey, August 2025

[94] OPLR Interview Series

evidence of 2,080 hours of NP practice in their home state as part of the qualifications for a multistate license.[95] While this could create an opportunity for Utahns to skirt the 6,000 hour requirement via the compact, given that only 14% of all NP candidates currently have less than 6,000 hours at licensure, and the barriers to seeking training and employment out of state for at least one year, OPLR views this as a limited concern to be monitored in implementation.

Similarly, the 6,000-hour clinical hour requirement could impact NPs licensed in another state who then move to Utah, however this impact is likely not significant either. Applicants for licensure by endorsement would have to either: 1) show that the license requirements in their home state are equivalent to Utah's requirements (which may not be possible if a clinical hour requirement is adopted by Utah) or 2) have worked with their license in good standing for one year.[96] Of NPs licensed in Utah during the last five years, 28% were licensed in another state first.[97] Some of these NPs may not have worked for a year in their home state before moving to Utah, though OPLR was unable to determine the size of this group. However, even if the clinical hour requirement prevents some NPs from moving to Utah until they have a year of experience, this is unlikely to meaningfully impact the supply of NPs given OPLR's finding that Utah has an adequate supply of NPs.

Recommendation: Allow CRNAs to prescribe medications related to a procedure, limited to a 5 day pre-op and 5 day post-op supply

OPLR recommends allowing CRNAs to prescribe medications, limited to a 5-day supply before and a 5-day supply after a procedure they are directly involved in.

Allowing CRNAs to prescribe in this limited way is unlikely to cause significant safety issues for several reasons. First, CRNAs receive pharmacology education in their doctoral program that is comparable to, and can exceed that of NPs. Based on OPLR's analysis of five CRNA doctoral programs and six family NP programs (three master's and three doctorates), CRNAs receive more credit hours of pharmacology training than master's-trained family NPs and about the same amount as doctorate-trained family NPs.[98] A CRNA's pharmacology training is likely more narrowly focused on drugs related to anesthesia than an NP's training. However, OPLR's recommendation allows only narrow prescriptive authority for CRNAs related to a procedure they are involved in and is unlikely to involve general prescribing. Second, it is unprofessional conduct under state law for a nurse, including a CRNA, to practice beyond their competency.[99] If a CRNA prescribes medications for which they do not have the training, they could be disciplined by DOPL.Third, CRNAs would be subject to the same prescribing constraints for

[95] Based on OPLR's reading of UCA 58-31d and conversations with NCSBN administrators.
[96] See UCA 58-1-302(2)&(3)
[97] DOPL Licensee Data
[98] Family NP master's programs typically require one class (three credits) of pharmacology, and family NP doctoral programs typically require one to two classes (three to six credits). CRNA doctoral programs typically require two to three classes (six to nine credits).
[99] See R156-31b-502(1)(k) and UCA 58-31b-801.

controlled substances as other providers.[100] Finally, a majority of states (35) allow CRNAs to prescribe to some extent, and the current recommendation represents one of the most restrictive options relative to other states. OPLR spoke with regulators from some of those states and they did not indicate serious safety concerns.[101]

The need for a CRNA to prescribe medications immediately before and after a procedure is narrow, and it is likely that most CRNAs would not use this authority. CRNAs provide anesthesia care for a patient who is undergoing a procedure performed by a surgeon, dentist, or other practitioner who has prescriptive authority and can therefore prescribe medications for the patient. However, OPLR heard from several rural administrators that there are occasional situations in which a surgeon may be occupied with other tasks and that it would be helpful for a CRNA to be able to prescribe a limited supply of relevant medications.[102] OPLR posits that, even if only used rarely initially, allowing CRNAs to be able to prescribe a 5-day supply before and after a procedure is safe, and thus should be allowed by the State. Additionally, hospitals would be able to innovate and possibly discover new, more effective methods of providing care that involves a CRNA prescribing in this way.

OPLR considered, but chose not to recommend broader forms of prescribing for CRNAs.

Recommendation: Clarify regulations for clinics administering IV hydration and ketamine for non-anesthetic purposes

OPLR recommends that DOPL create guidance documents that clearly outline current regulations related to ketamine and IV hydration clinics. DOPL should then highlight any gaps in regulation that should be addressed to ensure patient safety in these settings.

Regulation in Utah related to ketamine and IV hydration clinics is minimal, vague, and spread across multiple sections of law and rule. This likely causes confusion for those seeking to offer these services and may contribute to unsafe practice. A clear guidance document from DOPL would help address these issues. DOPL should address what current regulation says about who can provide the different aspects of these services (e.g. who can prescribe the intervention, who can prepare the infusion, who can perform the service, etc.) and the procedures that must be followed. It is likely that, as DOPL writes this document based on current regulations, gaps will emerge that need to be addressed through new legislation or rules. DOPL can then ask the legislature to consider any statutory gaps that need to be addressed to ensure patient safety.

At least 25 states have agencies or boards that have issued guidance documents related to IV hydration clinics. Common issues addressed in these documents are 1) whetherRNs can work

[100] For example, those who prescribe Schedule II or III opioids must check the controlled substance database the first time they prescribe for a patient and periodically in subsequent prescriptions (see UCA 58-37f-304).
[101] OPLR Interview Series
[102] OPLR Interview Series and Focus Groups

from standing orders rather than individualized care plans for patients developed by an advanced practitioner and 2) the type of informed consent required to offer IV services.[103]

At least eight states have issued guidance surrounding ketamine clinics and address issues such as standing orders, informed consent, and who can perform different parts of the process.[104]

Rule Review

In accordance with Utah Code 13-1b-203(5), OPLR conducted an in-depth review of DOPL's NP and CRNA rules, found in R156-31b, and CNM rules, found in R156-44a.

The rule review covered potential rule changes needed to:

1. address specific rules that may be either overly burdensome (e.g., for individuals seeking to practice a profession or given the potential risk to public safety from a profession, etc) or insufficient (e.g., to ensure safe practice);
2. address rules misaligned with statutory language;
3. clarify language and correct references to statute or other rules; or
4. support OPLR's recommendations.

OPLR's review of R156-31b and R156-44a found:

1. one rule for DOPL to monitor for potential burdens to CNMs and one rule that is potentially insufficient for NPs. These are outlined in Appendix 5.1 and Appendix 5.2, respectively;
2. no rules misaligned with statutory language;
3. no unclear rule language but four incorrect references to statute. These are outlined in Appendix 5.3; and
4. new rules will need to be written to 1) help NP students and education programs adjust to the new pre-licensure clinical experience requirement and 2) establish how NP applicants will demonstrate their nursing experience. DOPL may find it necessary to establish rules related to CRNA prescriptive authority (e.g. what constitutes a "procedure").

[103] OPLR Policy Scan; aided by Sivakumar (2025)
[104] OPLR Policy Scan

Appendix

Contents

1 Context

1.1 General Methodology

OPLR's methodology combines qualitative and quantitative methods with robust stakeholder engagement. Methods include:

- Analyzing data from workforce surveys administered by the Department of Professional Licensing (DOPL) as part of licensure renewal
- Conducting quantitative analysis of DOPL licensee and complaint data and publicly available data from other state and federal government entities (e.g., Utah Department of Health and Human Services, Utah Department of Workforce Services, Health Resources and Services Administration, National Practitioner Database)
- Reviewing academic literature and reports on a profession's practice, efficacy and safety
- Scanning education and credentialing requirements, programs and content
- Reviewing state occupational regulation policies across the U.S.
- Engaging with a wide range of stakeholders, including: Utah and other state governments and agencies, industry organizations, researchers, practitioners, and business owners and employers within a variety of settings (e.g., acute inpatient hospital, private outpatient, hospital system outpatient, home health, and skilled nursing facilities)

1.2 DOPL APRN Licensee Renewal Survey

Survey overview

OPLR utilized a survey available to NPs, CRNAs, and CNMs during their 2023/24 renewal period for information on the workforce in Utah. This survey is administered by DOPL for use by the Health Workforce Information Center (HWIC) to inform legislators and the public about workforce trends and projections. For more information regarding the information collected, the survey instrument can be found **here**.

Survey Limitations

The survey was available to all NP, CRNA and CNM licensees during their license renewal process so results were not affected by sampling bias. The response rate was a robust 51%. Results may be affected by non-response bias (e.g., if those who chose to respond to the survey shared characteristics not representative of the true population). Survey respondents were more likely to be male, younger, and living in Utah than non-respondents.

Other possible limitations include measurement error (which occurs when questions do not accurately measure the variable interest due to errors in question design) and recall bias (where respondents misremember and inaccurately answer questions). For example, recall bias may impact the estimates of hours worked per week or debt at graduation. All of these potential errors may cause some variability or systematic bias.

OPLR uses the survey data to provide background understanding of a profession, outline patterns, and identify general trends rather than to provide exact estimates. Therefore, the limitations articulated above should not unduly impact OPLR's findings or recommendations.

1.3 APRN Literature and Policy Scans

To better understand the academic literature about and regulatory environment for NPs, CRNAs, and CNMs, OPLR utilized the deep research function of Gemini (Google's AI tool). OPLR analysts validated all results produced by Gemini. The validated sources were then used to evaluate research findings about APRNs, map the national policy landscape, find patterns in regulation, make cross-state comparisons, and discover outliers. OPLR also used the data to help inform recommendations.

The following is an example of a prompt OPLR used to gather studies on cost of care comparisons:

"*Please look for academic studies that compare the cost of care for nurse practitioners and physicians. Group these into studies that show no cost difference, studies that show lower NP costs, and studies that show lower physician costs. Please put this information into a table, with the name of the article in column 1, the authors in column 2, the key findings in column 3, and the URL to the study in column 4."*

OPLR verified all academic sources by scanning each source before utilizing them and conducted literature reviews without using Gemini when the data provided was insufficient.

OPLR also used Gemini to research how jurisdictions differ regarding specific policies, such as whether they allow NPs to practice independently and whether they allow CRNAs to prescribe medications. The following is an example of a prompt used to research NP scope of practice and entry requirements:

"*Will you analyze the nurse practice act and associated rules for entry practice requirements for APRNs for all 50 states? Highlight main differences between states and then put the data into the following table: column 1 contains the state, column 2 indicates whether an APRN can work independently from a physician (put either "Yes", "No", or "Yes, with limitations"), in column 3 describe any limitations an APRN's independent practice authority (put "NA" if not applicable), in column 4 indicate whether an APRN can prescribe medications without physician consultation (put either "Yes", "No", or "Yes, with limitations"), in column 5 describe any limitations an APRN's prescriptive authority (put "NA" if not applicable), in column 6 indicate whether the state requires an RN license before becoming an APRN ("Yes" or "No"), in column 7 indicate whether the states requires that a person practice as an RN for a specific amount of time before getting their APRN license ("Yes" of "No"), in column 8 list the mandated amount of time the state requires a person practice as an RN before APRN licensure (put "NA" if not applicable), in column 9 indicate whether the state requires a certain number of clinical training hours in an*

APRN program ("Yes" of "No"), in column 10 indicate the number of state-required clinical training hours in an APRN program (put "NA" if not applicable), and in column 11 put the link to the statues and rules you used to inform the rest of the columns. Please only refer to state statutes and rules.

OPLR analysts then verified Gemini's results for every state. Analysts also checked categorizations against existing public sources (AANP and NCSL designations)[105], though OPLR's final designations do not match these sources exactly.

This approach does contain limitations related to normal human error. It is possible that there is slight misreporting of some data due to limited accessible state information, errors in data entry, or mistakes made by Gemini that were not caught by OPLR's manual verification.

2 Background

2.1 Nurse Practitioner Independent Practice Authority

There is variation among states regarding whether NPs can practice without the supervision or collaboration of a physician. While at least two organizations, the National Conference of State Legislatures (NCSL) and the American Association of Nurse Practitioners (AANP), have published data on state-by-state comparisons of NP scope of practice, these sources do not always categorize states the same way.[106] OPLR conducted its own policy scan (see Appendix 1.3) and categorized states according to whether an NP: 1) can treat, diagnose, and prescribe independently, 2) can treat, diagnose, and prescribe independently after a transition period, or 3) cannot treat, diagnose, or prescribe independently.

		Treat and Diagnose		
		Independent	Transition Period	Restricted
Prescribe	Independent	17 States *UT is here		
	Transition Period	5 States	12 States	
	Restricted	2 States		14 States

*OPLR Policy Scan

[105] See "Nurse Practitioner Practice and Prescriptive Authority," NCSL and "State Practice Environment," AANP

[106] See "Nurse Practitioner Practice and Prescriptive Authority," NCSL and "State Practice Environment," AANP

Among the 12 states that allow NPs to treat, diagnose, and prescribe independently after a period of supervision or collaboration, the required transition period ranges from 2,080 hours (Minnesota) to 6,240 hours (Arkansas).[107]

Among the 5 states that require a period of supervision or collaboration only before independent prescriptive authority, the required transition period ranges from 2,000 hours (Nevada) to 4 years (Kentucky).[108]

2.2 CRNA Prescriptive Authority

With the assistance of Gemini (see Appendix 1.3) and a state-by-state policy map from the National Conference of State Legislatures (NCSL), OPLR grouped states by whether they allow CRNAs to prescribe, allow CRNAs to prescribe in a limited way, or grant full, independent prescriptive authority to CRNAs. In a plurality of states (20), CRNAs have full independent prescriptive authority, 13 states grant CRNAs limited prescriptive authority, and 17 states do not grant CRNAs any prescriptive authority.[109] These are listed below.

CRNA Prescriptive Authority Throughout the U.S*		
No Prescriptive Authority (17 States)	Limited Prescriptive Authority (13 States)	Full Prescriptive Authority (20 States)
AL	AR	AK
AZ	FL	CO
CA	KS	CT
GA	ME	DE
IL	MD	HI
IN	MN	IA
LA	NJ	ID
MI	NV	KY
MO	TN	MA
NC	TX	MS
NE	VA	MT
NY	WI	ND
OH	WV	NH
OK		NM
PA		OR
SC		RI
UT		SD
		VT
		WA
		WY

*OPLR Policy Scan

[107] OPLR Policy Scan
[108] OPLR Policy Scan
[109] OPLR Policy Scan

The limitations states place on CRNA prescriptive authority include only allowing a CRNA to prescribe: 1) after a mandatory transition period before prescribing independently, 2) for a limited supply or during a specific timeframe, 3) specified drugs, 4) for specified procedures, and 5) in specific settings.[110] Examples of these limitations are listed in the table below.

Limitations on CRNA Prescriptive Authority*				
Transition Period	Limited Supply or Timeframe	Specific Drugs	Procedures	Settings
MA, VT After 2 years of physician collaboration	**RI, VA** During the perioperative period only	**AR** Only Schedule III-V	**NV** In connection with surgery or childbirth	**NV** Critical access hospital only
CO After 3 years of practice as either RN or APRN and a 750-hour mentorship	**ME** 4-day supply limit	**WI** Cannot prescribe amphetamine or sympathomimetic amine drugs	**MN** Nonsurgical pain therapies (with physician collaboration)	**ME** Critical access or rural hospitals only
WV After 3 years of physician collaboration	**MD** Only up to 10-days post-op	**SD** Drugs related to anesthesia practice or pain management		
KY After 4 years of physician collaboration	**WV** 3-day supply limit of Schedule II narcotics	**KS** Cannot prescribe anesthesia-related drugs		

*OPLR Policy Scan

Note: Excludes FL, NJ, TN, and TX which allow CRNAs to prescribe under a collaborative agreement with a physician

3 Regulatory Model Assessment & Recommendation

3.1 Menu of Regulatory Models and Factors Considered in Framework

Please see **this working document**, OPLR's Occupational Regulation Framework, for a more detailed explanation of OPLR's approach to assessing occupational regulation and evaluating different regulatory models.[111]

[110] OPLR Policy Scan

[111] The document is also available on OPLR's website in the "About OPLR" section, accessible here: https://oplr.utah.gov/about-oplr/

3.2 Model Assessment of NPs, CRNAs, and CNMs

The following tables summarize OPLR's analysis of NPs, CRNAs, and CNMs, respectively, according to factors that OPLR determined should influence the appropriate regulatory model for an occupation. Factors that OPLR considered as particularly determinative in its assessment of these professions are highlighted in bold.

Model Assessment of Nurse Practitioners (NPs)	
Harm Factors	
Mechanism of Harm	**If an NP misdiagnoses, a patient may not receive the care they need or may receive care that exacerbates issues. Incorrect prescribing can cause serious side effects, including death. If an NP is undisciplined in their prescription of controlled substances, patients could fall into dependency.**
Severity, Permanence, and Likelihood of Harm	**Misdiagnosis and improper prescribing can lead to severe and permanent harm, including disability or death. Improper care is likely if a person is untrained given the comprehensive scope of health care provided by NPs.**
Consequence of Error	**85 out of 100***
Downstream Impact	If a primary care NP fails to provide proper care, a patient's health may deteriorate, necessitating further medical attention.
Consumer & Setting Factors	
Patient Vulnerability	**NPs work with a variety of populations, many of which are vulnerable (e.g. sick and injured, elderly or disabled, children).**
Frequency of Physical Touch	**NPs frequently touch their patients, including in invasive ways.**
Frequency of Private Setting	**NPs are often alone with patients for extended periods of time. Additionally, patients may be in various stages of undress.**
Information Asymmetry	NPs provide complex care that a typical patient would not fully understand.
Related factors	
Independence	**While NPs often work in care teams with other providers, they are legally allowed to work without supervision. An estimated 13% of NPs working in Utah are self-employed or a consultant.****
Patient Choice	In many instances, a patient can choose who their NP will be (e.g.

	a primary care NP provider). However, there are situations in which a patient does not choose their NP (e.g. if cared for by an NP in a hospital).
Information Availability	In situations where a patient can choose their NP, there is often information available to indicate provider quality (e.g., website directories with provider bios and reviews).***
Level of Oversight	*Employers:* The level of oversight from employers is variable. NPs who work in large hospital systems likely have extensive oversight, those working in smaller clinics likely have modest employer oversight, and those who work independently are not overseen by employers. *State/Federal:* Besides licensing from DOPL, NPs are subject to state oversight through facility rules from the Department of Health and Human Services (DHHS) as well as Medicaid reimbursement policies. Federal oversight of NPs comes through Medicare and Medicaid reimbursement policies. *Private Bodies:* NPs are required to obtain certification from a private credentialing body, which likely can deny or revoke certification for poor behavior, but may lack the same investigative and enforcement resources available to states.****

* O*Net Consequence of Error Ranking

** DOPL APRN Licensee Renewal Survey, November 2023

*** See Zocdoc, for example.

**** For example, see "Causes for Denial, Suspension, and Revocation of Certification," ANCC.

Model Assessment of Certified Registered Nurse Anesthetists (CRNAs)	
Harm Factors	
Mechanism of Harm	**A CRNA can harm a patient by administering the wrong type, dose, or combination of anesthetic drugs.**
Severity, Permanence, and Likelihood of Harm	**Anesthetic drugs are powerful and if administered incorrectly can cause severe and permanent harm, including death. Administering anesthesia is complex and is highly likely to be performed improperly by an untrained individual.**
Consequence of Error	**94 out of 100***
Downstream Impact	As above, services provided by CRNAs contain potential for severe and permanent harm, including death.
Consumer & Setting Factors	
Patient Vulnerability	**CRNAs work with individuals undergoing a range of**

	procedures, from minor (e.g. wisdom teeth removal) to serious (e.g. heart surgery). Patients are often completely sedated and are therefore unable to advocate for themselves.
Frequency of Physical Touch	**CRNAs frequently touch their patients as they administer anesthesia.**
Frequency of Private Setting	CRNAs may be alone with a patient as they administer anesthesia in preparation for a procedure, though this is likely of short duration.
Information Asymmetry	The delivery of anesthesia is highly complex, and the typical patient receiving these services lacks this understanding.
Related factors	
Independence	State law does not require CRNAs to be supervised, though they must work 'upon the request of a licensed health care professional.'** CMS does require anesthesiologists to supervise CRNAs, but Governor Cox has exempted several rural hospitals in Utah from this requirement.*** An estimated 45% of CRNAs working in Utah report being self-employed or a consultant.****
Patient Choice	Patients do not choose their CRNA. They may decide which surgeon to see for a planned procedure, but they likely do not make this decision based on the CRNA associated with the surgeon.
Information Availability	Beyond licensure status, patients do not have access to information about the quality of the CRNA caring for them.
Level of Oversight	*Employers:* CRNAs often work in hospitals or ambulatory surgical centers, which likely provide rigorous oversight of their employees and contractors.***** CRNAs in other settings, such as dentists offices, may experience less oversight from employers. *State/Federal:* Besides licensing from DOPL, CRNAs are subject to state oversight through facility rules from the Department of Health and Human Services (DHHS) as well as Medicaid reimbursement policies. Federal oversight of CRNAs comes through Medicare and Medicaid reimbursement policies. *Private Bodies:* CRNAs are required to obtain certification from a private credentialing body (the National Board of Certification and Recertification for Nurse Anesthetists), which can deny or revoke certification for poor behavior, but lacks the same investigative and enforcement resources available to states.******

* O*Net Consequence of Error Ranking

** UCA 58-31b-102(11)(d)

*** Centers for Medicare and Medicaid Services; "Opt-Outs", American Society of Anesthesiologists

**** DOPL APRN Licensee Renewal Survey, November 2023

***** DOPL APRN Licensee Renewal Survey, November 2023; 43% of respondents reported working in inpatient (24%) or outpatient hospitals (19%), and 21% reported working in ambulatory surgical centers.
****** See "Disciplinary Policies and Procedures," NBCRNA

Model Assessment of Certified Nurse Midwives (CNMs)	
Harm Factors	
Mechanism of Harm	**CNM can cause harm through the mishandling of gynecological care for women, prenatal care for women or fetuses, or childbirth.**
Severity, Permanence, and Likelihood of Harm	**Improper care delivered by CNMs could cause severe, permanent harm, including disability or death of a woman or baby. Given the complex nature of the care provided by CNMs, those without experience would likely cause serious harm.**
Consequence of Error	**92 out of 100***
Downstream Impact	Improper care could lead to health complications for women or babies that may require urgent medical intervention and/or ongoing management.
Consumer & Setting Factors	
Patient Vulnerability	**CNMs work with pregnant women and newborns, populations which are at increased risk of injury or illness. CNMs also provide more routine care to women in less vulnerable states.**
Frequency of Physical Touch	**CNMs frequently touch their patients as they deliver care, often intimately.**
Frequency of Private Setting	**CNMs are often alone with patients. Additionally, patients may be in various stages of undress.**
Information Asymmetry	CNMs provide highly complex care, and the typical patient would not fully understand all that they do.
Related factors	
Independence	**CNMs can work independently as long as they have a "mechanism for obtaining medical consultation, collaboration, and referral" from a physician and a consultation and referral plan with a physician if prescribing schedule II and III medications. However, only an estimated 7% of CNMs licensed in Utah report being self-employed or a consultant.****
Patient Choice	**Patients can choose their CNM.**
Information Availability	There is often information available to indicate CNM quality (e.g., website directories with provider bios and reviews).***

Level of Oversight	*Employers:* The level of oversight from employers is variable. CNMs who work in large hospital systems likely have extensive oversight, those working in smaller clinics likely have modest employer oversight, and those who work independently are not overseen by employers. *State/Federal:* Besides licensing from DOPL, CNMs are subject to state oversight through facility rules from the Department of Health and Human Services (DHHS) as well as Medicaid reimbursement policies. Federal oversight of NPs comes through Medicare and Medicaid reimbursement policies. *Private Bodies:* CNMs are required to obtain certification from a private credentialing body (the American Midwifery Certification Board), which can deny or revoke certification for poor behavior, but lacks the same investigative and enforcement resources available to states.****

* O*Net Consequence of Error Ranking

** DOPL APRN Licensee Renewal Survey, November 2023

*** See Zocdoc, for example.

**** See "Professional Discipline," AMCB

4 Regulatory Model Adjustments & Recommendations

4.1 Possible Adjustments

Please see **this working document**, OPLR's Occupational Regulation Framework, for a more detailed explanation of how OPLR approaches whether adjustments should be made within a recommended regulatory model.[112]

4.2 DOPL Complaint Data

The Division of Professional Licensing (DOPL) receives complaints from individuals, other state agencies, co-workers, professional associations, and licensing boards. DOPL is required to "investigate unlicensed practice in regulated professions, acts or practices inconsistent with recognized standards of conduct, allegations of gross negligence or incompetence, and patterns of gross negligence or incompetence."[113] Violations that meet the criteria for investigation are then prioritized and assigned to an investigator. DOPL may resolve investigations in a variety of ways, including: closing an investigation due to a lack of evidence; referring the case to another agency or to law enforcement if appropriate; carrying out informal or formal administrative sanctions or stipulated agreements; issuing a citation; or denying, suspending, or revoking an individual's license.

[112] The document is also available on OPLR's website in the "About OPLR" section, accessible here: https://oplr.utah.gov/about-oplr/

[113] An Explanation of the Complaint Handling Process for the Division of Occupational and Professional Licensing, DOPL

To analyze complaints sent to DOPL, OPLR used My License Office (MLO) to access closed complaints investigated by DOPL between 2017-2022 for all licenses/professions. This data contains information on the license name, the complaint type, and the disposition of the complaint, among many other data fields not relevant to OPLR's analysis. DOPL personnel helped code the complaint dispositions as either substantiated, unsubstantiated, or no jurisdiction. Substantiated complaints are those where a disposition includes some type of disciplinary action, whether formal or informal (e.g., letter of concern, verbal warning, surrender of license). Unsubstantiated complaints have dispositions without a disciplinary action (e.g., dismissed, lack of evidence, unfounded). 'No jurisdiction' complaints are complaints that may or may not have basis, but DOPL was not able to take action on the case.

OPLR filtered complaints to exclude any likely duplicates and then used substantiated complaints to calculate the number of complaints per license type or profession. OPLR estimated the complaint rate for each license type by dividing the number of substantiated complaints by the number of unique individuals who held that license type over the same period.

Complaint Case Notes Analysis

A more detailed analysis of historical case notes was conducted on a sample of 30 NP complaints and 6 CRNAs complaints, as well as all 6 CNM complaints, closed between 2017-2022.

For NPs, an initial stratified random sample was pulled from all 'substantiated', 'pending', or 'no jurisdiction' complaints,[114] with stratification based on complaint type. OPLR chose to oversample complaints labeled 'client harm or endangerment' given that the intent of the analysis was to understand the type of harm caused by professions. In its final sampling, OPLR randomly chose 17 'unprofessional conduct' cases, 9 'client harm or endangerment' cases, 2 'unlicensed or aiding unlicensed' cases, and 2 'scope violation' cases. The cases represent about 15% of all NP complaints during this time. DOPL investigators then reviewed these case files and pulled specific information, such as whether a patient was harmed from the incident and how long the individual had been licensed when it occurred.

For CRNAs, OPLR analyzed the one 'client harm or endangerment case', two randomly chosen 'substance use related issues' complaints, one randomly chosen 'unlicensed or aiding unlicensed' case, one randomly chosen 'unprofessional conduct' case, and one randomly chosen 'other' case. This represents just under half of the substantiated complaints brought against CRNAs between 2017 and 2022.

OPLR analyzed all six substantiated cases brought against CNMs between 2017 and 2022.

[114] "No jurisdiction" complaints were included in the case note analysis and not the complaint rate analysis because they are not complaints where DOPL took an action, but they may include legitimate client harm that DOPL had to refer to another agency. Although they can not be classified as "substantiated", OPLR felt these complaints could help contextualize client harm resulting from APRNs.

Limitations

There are significant limitations to this analysis, and the information collected should not be interpreted as a precise estimate of harm caused by APRNs. DOPL data likely underestimates true harm, as many instances of harm may be handled in other ways (e.g., directly by employers), reported to other entities, or may never be reported.

There could also be latent factors correlated with both the likelihood of complaint and the profession, systematically biasing the comparisons across professions. This is especially true in healthcare, as certain professions, by their nature, include a greater scope and potential for harm (e.g., surgeons) and may generate more complaints.

For these reasons, OPLR uses DOPL complaint data as directionally informative but avoids direct comparisons across professions wherever possible. Fine comparisons across professions are unwarranted and unsupported by this data.

4.3 Minimum Clinical Experience Upon Graduation for Advanced Practitioners

OPLR analyzes state statute and rule, as well as requirements from accreditors, to estimate the minimum amount of clinical experience advanced practitioners could receive before gaining full independent practice authority (for NPs, PAs, and MDs) or licensure (for CRNAs). The following table details how OPLR arrived at its estimates.

Estimates of Minimum Clinical Experience Required by Law			
Profession	Time-frame	Estimate	Explanation
NP *(For licensure and full practice authority)*	In School	1,250 Hours	**500 clinical hours in RN program:** Program accreditors have not set a clinical hour requirement. A sample of RN programs in Utah revealed a range of 500-900 clinical hours.* **750 clinical hours in NP program:** NP program accreditors have signaled a move toward requiring 750 hours of clinical practice.**
	Out of School	None	State law requires NP applicants to be licensed as an RN, but it does not mandate that they practice as an RN before their NP program. It is common for NP programs to require a year or two of RN experience before admittance, but this is not required by state law or accreditors.*** In Utah, NPs have the authority to practice

			independently immediately upon licensure.
	Total	1,250 Hours	This is the combination of RN and NP program clinical hours (1,250) and required clinical hours outside of a program (0).
CRNA *(For licensure)*	In School	2,500 Hours	**500 clinical hours in RN program:** Program accreditors have not set a clinical hour requirement. A sample of RN programs in Utah revealed a range of 500-900 clinical hours.* **2,000 clinical hours in CRNA program:** The CRNA accrediting body, requires programs to include a minimum of 2,000 clinical hours.+
	Out of School	2,000 Hours	The CRNA accrediting body requires programs to only accept students with at least a year (or part-time equivalent) of RN experience in a critical care setting.++
	Total	4,500 Hours	This is the combination of RN and CRNA program clinical hours (2,500) and minimum required clinical hours outside of a program (2,000).
PA *(For full practice authority)*	In School	1,650 Hours	PA program accreditors have not set a minimum amount of clinical hours in the program. A sample of programs in Utah reveal requirements of three semesters, 40 weeks, and 30 credits. OPLR based this estimate on 40 weeks, with 35 hours of work a week.^
	Out of School	10,000 Hours	Utah law requires PAs to work under collaboration with a physician for 4,000 hours and a physician or PA for an additional 6,000 hours before practicing independently.^^
	Total	11,650 Hours	This is the combination of estimated PA clinical hours (1,650) and required clinical hours outside of a program before gaining independent practice authority (10,000).
MD *(For licensure and full practice authority)*	In School	3,000 Hours	An estimate by the Association of American Medical Colleges found that the average medical school clerkship was 59 weeks. OPLR based this estimate on 60 weeks, with 50 hours per week.~
	Out of School	7,800 Hours	The length of residency varies by specialty. OPLR used family medicine for its estimate, which requires a 3-year residency. OPLR based this estimate on a 3-year residency with 50-hour work weeks.~~

	Total	10,800 Hours	This is the combination of estimated MD clerkship hours (3,000) and hours required for a family medicine residency (10,000).

* OPLR used Gemini to identify the clinical hour requirements for RN programs in the state. Analysts verified the data for the bachelor's program with the lowest and the bachelor's program with the highest hour requirement. See "ACEN 2023 Standards and Criteria," ACEN and CCNE for accreditation requirements.
** See "Standards for Quality Nurse Practitioner Education, 6th Edition," National Task Force on Quality Nurse Practitioner Education
*** See UCA 58-31b-302(5) for Utah's NP licensure requirements. OPLR used Gemini to identify the RN experience requirements for family NP master's programs in the state as well as online family NP master's programs. An analyst verified all results. All four Utah programs require at least a year of RN experience. However, 13 of the 41 online programs did not list an RN experience requirement.
+ The Council on Accreditation of Nurse Anesthesia Educational Programs requires programs to include 2,000 hours of clinical experience during the education program.
++ The Council on Accreditation of Nurse Anesthesia Educational Programs mandates that programs require applicants to have a year of "full-time work experience, or its part-time equivalent, as a registered nurse in a critical care setting."
^ OPLR analyzed the clinical curriculum for three PA programs in the state. See ARC-PA for program accreditation standards.
^^ See UCA 58-70a-307
~ Association of American Medical Colleges; average was for the 2019-2021 period.
~~ See "Training Requirements," American Board of Family Medicine

OPLR did not include clinical hours that may be required before admittance to an RN, PA, or MD program.

4.4 OPLR NP/CRNA Licensee Survey

To help understand the typical amount of clinical experience that advanced practitioners graduate from NP or CRNA programs with, OPLR sent a survey to all NPs and CRNAs licensed in Utah. OPLR used DOPL data to generate contact information for the licensees and sent the survey using Qualtrics.

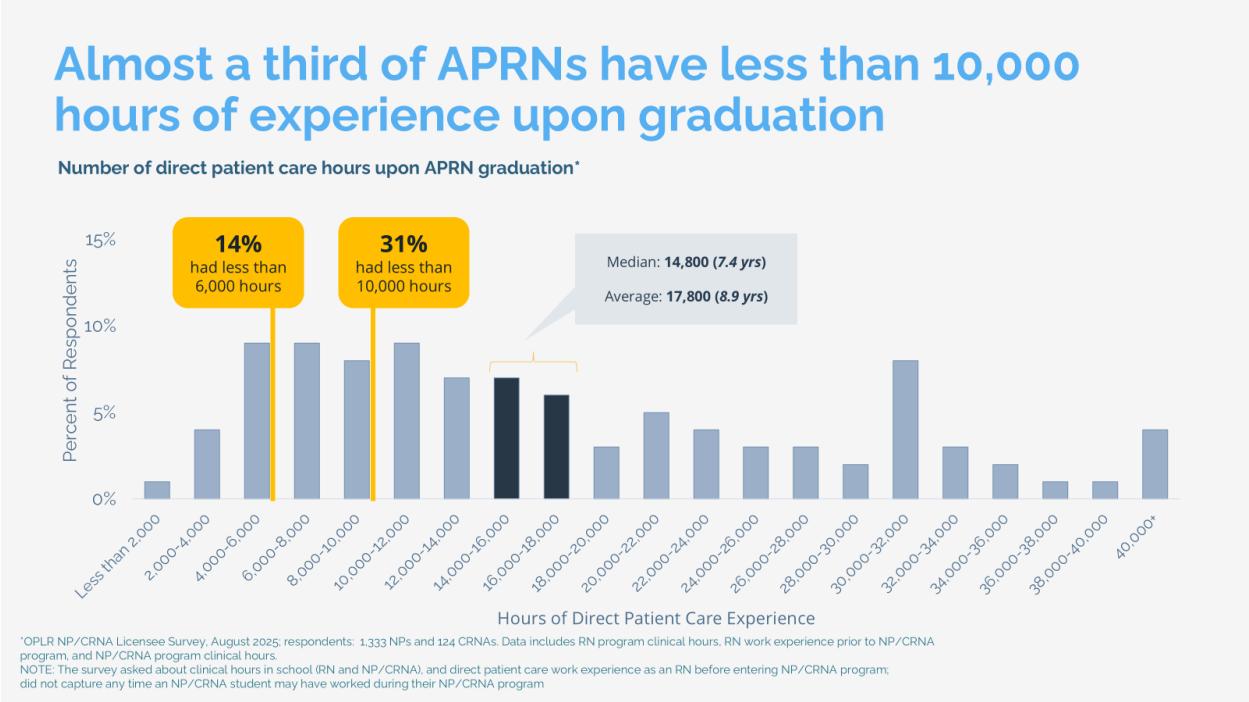
The survey was open from July 29th-August 5th. OPLR sent an initial email with an invitation to participate as well as three reminder emails. Response rates were as follows:

- NPs: 18% response rate. The survey was sent to 7,432 NPs, and 1,333 completed the survey.
- CRNAs: 26% response rate. The survey was sent to 485 CRNAs, and 124 completed the survey.

The survey asked licensees to report the number of clinical hours they received in their RN and NP/CRNA programs as well as the amount of time spent working as an RN before beginning their NP/CRNA program. It also asked about employment status, the type of NP/CRNA program attended (e.g. private in-person, private online, public online, etc.), year of graduation, and

confidence in the ability to practice independently. It also included an open-ended question to allow licensees to share any opinions they have about state licensing.

OPLR was primarily interested in the distribution of total RN-level nursing experience upon graduation of an NP or CRNA program. The chart below shows this distribution for NPs.



Limitations

OPLR sent the survey to all actively licensed NPs/CRNAs in Utah, so the data is free from sampling bias. However, results may be affected by non-response bias (e.g., if those who chose to respond to the survey shared characteristics not representative of the true population). Survey responses were not tied to license numbers, so OPLR is unable to compare the characteristics of respondents to the characteristics of non-respondents.

Other possible limitations include: measurement error (which occurs when questions do not accurately measure the variable interest due to errors in question design) and recall bias (where respondents misremember and inaccurately answer questions). Recall bias is of particular concern for this survey given that questions asked licensees to report the number of clinical hours included in their education programs that they may have completed decades ago. All of these potential errors may cause some variability or systematic bias.

Lastly, OPLR did not include a question to measure the amount of time spent working as an RN *during* a person's NP/CRNA program. Given that some students work during their program, the survey may have missed a segment of nursing experience for some licensees.

4.5 NP/CRNA Survey Open-Ended Response Examples

OPLR's NP/CRNA licensee survey included an open-ended question at the end, which read: *"Thank you for participating. Before you go, please share any comments or suggestions about state licensure for advanced practice nurses in Utah. We want to hear from you!"*

One of the most common themes, mentioned in 51 of the 387 responses (13%), was concern regarding the preparedness of new NPs. Some examples include:

- *"With time, I am seeing more and more RNs go back to school to become APRNs, but they are doing it through online programs and are coming to clinicals and graduating ill prepared for what they will be doing. My recommendation would be that there be requirements for real nursing experience (minimum of 5 years) before starting any of these programs."*
- *"As an NP I have strong opinions that the Masters NP route generally does not sufficiently prepare NPs to practice independently in their first 2 years after graduation. I STRONGLY recommend increasing collaboration and oversight for NEW GRAD NPs within their first 2 years, ESPECIALLY ones without a doctorate degree."*
- *"I personally feel that the number of clinical hours required for an NP should be raised. As a professional group, we are given more autonomy than PAs but are responsible for few training hours. I feel that the more training during education, the better. Furthermore, I know there are schools that are trying to create a track that starts with the RN and leads to NP. I personally feel this would be a mistake. I felt relatively comfortable when I went into practice, but I had spent 11 years as an RN learning for the providers around me. Without that on-the-job education, I would have been lost. I feel that being a nurse for a period of time is a vital component of becoming an advanced practice RN."*

Forty-five (45) comments (12%) indicated positive views of Utah's independent practice policies. Some examples include:

- *"I am happy they can practice independently. I believe NP's are highly qualified to deliver great care."*
- *"I am so grateful for full practice for NPs here in Utah. I was trained in WA state and would not have moved here to work without full practice authority."*
- *"I'm incredibly thankful that Utah is a full practice authority state for APRNs. It allows me, as a nurse practitioner, to care for my patients independently—assessing, diagnosing, prescribing, and managing treatment plans without physician oversight. I'm grateful for the opportunity to serve my community in this way and to practice to the full extent of my training and education. This independence not only helps expand access to quality care, especially in underserved areas, but also empowers me to open and run my own practice, provide patient-centered services, and make a meaningful impact every day."*

4.6 Ketamine and IV Hydration Clinics

Ketamine, a schedule III drug most commonly used as an anesthetic, is increasingly being used to help treat mental health disorders, such as treatment resistant depression and post-traumatic stress disorder (PTSD). A growing body of research indicates that the dissociative effects of a small dose of ketamine, administered through IV, intramuscular shot, or nasal spray, can help alleviate these issues.[115] However, while the most common side effects from properly administered ketamine are temporary and of minor concern (e.g. headache, nausea, etc.), in rare cases and when taken at higher doses, ketamine can cause damage to the urinary tract or liver, psychotic episodes, or dependency that can lead to death.[116] Utah statute currently only mentions ketamine explicitly twice, once to classify it as a schedule III drug[117] and once to require anyone administering ketamine for a 'non-anesthetic purpose' to have someone on site who has 'advanced airway training and the knowledge and skills to recognize and treat airway complications and rescue a patient who entered a deeper than intended level of sedation.'[118]

IV hydration clinics offer IV-administered 'cocktails' made up of various vitamins and minerals and promoted as a means of addressing ailments such as dehydration, fatigue, and hangovers.[119] There is little evidence that such treatments benefit healthy individuals, and there are risks of infection, allergic reaction, and vitamin toxicity.[120] A recently released study found that a majority of clinics made claims about the health benefits of IV hydration without citing evidence, and that a majority did not discuss potential side effects with prospective clients.[121] While there is not an available estimate of the number of IV hydration clinics in Utah, industry members report a growing number in the state.[122] Researchers have found that states differ widely in the extent to which they regulate these clinics and that Utah lacks a regulatory framework for this space.[123]

4.7 DOPL Licensee Data

OPLR used DOPL licensee data queried in January 2025 to conduct analyses on the number of licensees per year, inflow and outflow of licensees, overlap of licenses, and time with license. The dataset included individuals first licensed after 1970 to those actively licensed as of January 2025. Each row in this dataset was a unique combination of individual and license type and contained information regarding when the license was issued, the status of the license, the date the status was last updated, and the sex and year of birth of the individual. OPLR estimated the

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[115] See, for example, Almeida et al. (2024), Kryst et al. (2020), Grunebaum et al. (2017), and Newport et al. (2015).
[116] Grinspoon (2024); Northwestern Medicine; Rogers (2024); Beck et al. (2020); Chaves et al. (2023).
[117] UCA 58-37-4(2)(c)(ii)(G)
[118] 58-1-510(2)(g)(ii)
[119] Sivakumar et al. (2025)
[120] Alangari (2025); Gregory (2024); There is evidence to support the delivery of vitamins using IV for patients with conditions that lead to vitamin deficiencies and dehydration.
[121] Sivakumar et al. (2025)
[122] Peterson (2023)
[123] Sivakumar et al. (2025)

number of licensees in each year by summing the number of unique individuals whose licenses were active during any point in each year. Additionally, OPLR excluded any individual with a null or incorrect value for their license issue date and license expiration date, as OPLR could not determine how long or for what years they were actively licensed. License counts may slightly underestimate the true number of licensees due to this, but the effect is fairly negligible given OPLR's use of the data to determine trends over time rather than estimate with precision for specific dates.

4.8 Nurse Practitioner Supply by Region

OPLR estimated the distribution of NPs across Utah using employment data from the U.S. Bureau of Labor Statistics (BLS) and population data from the U.S. Census Bureau. Estimates show that the number of NPs per 100,000 people differs across BLS-defined regions in Utah. Estimates for the U.S., Utah, and BLS-defined regions in Utah are as follows:[124]

- Salt Lake City: 110
- St. George: 99
- United States: 84[125]
- **Whole State: 78**
- Logan: 63
- Eastern Utah: 56
- Provo-Orem: 55
- Ogden-Clearfield: 54
- Central Utah: 45

A lower concentration of NPs in Utah compared to the U.S. generally does not necessarily indicate a nursing shortage in Utah. The demand for healthcare in Utah is likely distinct from the other areas of the country due to its demographics. In reaching its conclusions, OPLR relied on supply adequacy estimates from sources such as HRSA. OPLR also used input from employers in different settings and different regions across Utah to test overall conclusions about the adequacy of Utah's nursing workforce, and to understand where pockets of need may still remain.

4.9 CRNA Prescribing Use Cases

Stakeholders described several different situations, or 'use cases', in which it could be beneficial to have a CRNA prescribe medications. These included the following:

- **Immediately before a procedure:** prescribing anti-anxiety medications, such as a benzodiazepine, to ensure patients are in a safe mental and physical condition as they come in for a procedure.

[124] "Utah…," U.S. Bureau of Labor Statistics; "State Population…," U.S. Census Bureau
[125] "May 2023…," U.S. Bureau of Labor Statistics; "U.S. Population Trends…", U.S. Census Bureau

- **Immediately after a procedure:** prescribing pain management or anti-nausea medications to ensure comfort for the patient until they can see their primary care physician.
- **Follow-up visit for pain:** performing a pain management procedure, such as a blood patch or nerve block, and prescribing associated pain management medications.
- **Pain clinics:** operating a pain clinic, which includes performing pain management procedures and prescribing medications to manage chronic pain.
- **Ketamine clinics:** operating a clinic that administers ketamine, a drug that can be used to sedate, reduce pain, or increasingly to induce a dissociative state for mental health treatment.[126]

5 Rule Review

5.1 Potential Rule Burdens

Currently, the only exam approved by DOPL to become a CNM is the exam offered by the American Midwifery Certification Board (AMCB).[127] This may be appropriate, as OPLR is not aware of exams offered by other organizations. However, DOPL should loosely monitor whether other organizations emerge that fulfill a similar role as effectively.

5.2 Potential Insufficient Rules

DOPL rules require NPs specializing in psychiatric mental health to complete 2,000 hours of supervised clinical practice.[128] However, the rules are not clear regarding the type of supervision required (e.g. direct, indirect, general supervision). The vagueness of the rule may lead to improper oversight of these new practitioners, which could result in patient harm. OPLR recommends that DOPL, in collaboration with the Nursing Board, decide on the type of supervision required to ensure patient safety and explicitly list this in the rule.

5.3 Incorrect References

OPLR identified the following incorrect references in the Nurse Midwife Practice Act Rule (R156-44a):

[126] OPLR Interview Series and Focus Group with Rural Hospital Administrators, July 2, 2025
[127] See R156-44a-302
[128] See R156-31b-302e(2)(a)(ii)(C) and UCA 58-31b-302(5)(g)

Rule	Incorrect Reference	Correct Reference
R156-44a-102(3)	Refers to programs “accredited by the AMCB.”	Should refer to programs “accredited by the ACME.”
R156-44a-102(5)	R156-31b-102(14)	R156-31b-102(15)
R156-44a-102(6)	R156-31b-102(15)	R156-31b-102(16)
R156-44a-102(7)	R156-31b-102(16)	R156-31b-102(17)

6 Stakeholder Engagement

6.1 OPLR Interview & Focus Group Series

OPLR relied heavily on stakeholder engagement and qualitative interview data, combined with OPLR’s other analysis, to conduct this review and develop recommendations. OPLR engaged with employers, educators, industry associations, Utah legislators, and Utah and other state regulators. OPLR prioritized diversity of perspective and relevance to the industry in selecting stakeholders.

Interviews were conducted in person, over the phone, and via video conferencing using semi-structured interview methods.They were conducted one-on-one and with multiple members. Extensive notes were taken for all interviews.

OPLR conducted initial interviews to understand the role of APRNs, determine the largest issues related to safety and access, and identify potential areas for change. OPLR engaged with stakeholders later in its review to test initial findings from analysis and preliminary recommendations. OPLR reflected on and synthesized feedback across multiple discussion sessions to develop clear and achievable evidence-based recommendations.

Additionally, OPLR conducted six focus groups with administrators from various health care facility types: rural hospitals (eight administrators), rural health clinics (five administrators), ambulatory surgical centers (two administrators), skilled nursing facilities (four administrators), assisted living facilities (eight administrators), and home health and hospice companies (five administrators). Industry association leaders helped OPLR identify participants for these focus groups. Before the sessions, OPLR sent participants a short survey to identify any hiring and safety concerns for the nursing and related professions covered in this year’s review (including NPs, CRNAs, and CNMs). During the focus groups, OPLR asked participants follow-up questions on these topics. Insights from the focus groups were used to direct OPLR’s analysis and help refine recommendations.

Limitations

This interview sample was not randomly selected and, therefore, is not completely representative. OPLR spoke to individuals most likely to represent the broad aims and concerns of their groups. Additionally, OPLR did not contact "consumers" of APRNs (patients), so these perspectives were not incorporated. Thus, the stakeholder engagement and findings from these interviews should not be understood as fully representative of the views of all Utahns, employers or any other person, group, or population.

Note that stakeholders' views are not always reflected in OPLR's recommendations. OPLR is directed by Utah Code 13-1b-302 to apply specific review criteria. These can and do lead to recommendations that diverge from stakeholder preferences. A stakeholder's appearance here is not an endorsement of OPLR's recommendations as such.

6.2 Stakeholder Engagement Summary

The following is a comprehensive list of individuals OPLR engaged with throughout the review of nursing and related professions. Professional credentials (such as MD and DNP) were omitted for simplicity. Stakeholders who contributed to the APRN review specifically are highlighted in gray.

Stakeholder Engagement Summary	
Utah State Legislature	
Legislative Working Group	**Rep. Bridger Bolinder** **Rep. Steve Eliason** **Rep. Katy Hall** **Rep. Cory Maloy** **Rep. Logan Monson** **Rep. Angela Romero** **Rep. Douglas Welton** **Sen. Luz Escamilla** **Sen. Keith Grover** **Sen. Ann Millner** **Sen. Jen Plumb** **Sen. Evan Vickers** **Seth Anderson,** Policy Analyst, LRGC **Brian Bean,** Senior Policy Advisor, Utah Senate **Greg Gun,** Associate General Counsel, LRGC **Alan Houston,** Associate General Counsel, LRGC **Tyler Moore,** Associate General Counsel, LRGC **Rohnin Randles,** Policy Analyst, LRGC **Lisa Sorenson,** Policy Analyst, LRGC **Chris Williams,** Associate General Counsel, LRGC **Robert Wood,** Policy Analyst, LRGC
Other Government Stakeholders	
Utah Department of Commerce	**Margaret Busse,** Executive Director

	Carolyn Dennis, Deputy Director **Jacob Hart,** Deputy Director **Mark Steinagel,** Managing Director & Director, Division of Professional Licensing **Deborah Blackburn,** Assistant Division Director, Division of Professional Licensing **Jana Johansen,** Assistant Division Director, Division of Professional Licensing **Connie Kitchens,** Assistant Division Director, Division of Professional Licensing **Benjamin Baker,** Chief Investigator, Division of Professional Licensing **Jeff Busjahn,** Licensing Administrator, Division of Professional Licensing **Camille Farley,** Chief Investigator, Division of Professional Licensing **James Garfield,** Bureau Manager, Division of Professional Licensing **Dean Healey,** Investigator, Division of Professional Licensing **Larry Marx,** Licensing Administrator, Division of Professional Licensing **Sharilee Scheller,** Investigator, Division of Professional Licensing **Kirsten Shumway,** Legal Analyst, Division of Professional Licensing
Division of Professional Licensing (DOPL) Boards	**David Escobar,** Board Member, Respiratory Care Board **William Hamilton,** Board Member, Medical Board **Erica Nelson,** Board Member, Nursing Board **Curtis Nielsen,** Board Member, Nursing Board **Marie Pittman Cherrington,** Medical Board **Ralph Pittman,** Board Member, Nursing Board **Wendy Rusin,** Board Member, Nursing Board **Sheryl Steadman,** Board Chair, Nursing Board **Shane Yardley,** Board Member, Nursing Board
Utah Department of Health & Human Services	**Nate Checketts,** Deputy Director **Heather Borski,** Assistant Deputy Director **Laurie Baksh,** Director, Office of Maternal & Child Health **Stacey Bank,** Medical Director **Kendyl Brockman,** Health Workforce Policy Analyst, Office of Primary Care & Rural Health **Jared Brown,** Program Manager, Office of Licensing **Trent Brown,** Assistant Director, Office of Reimbursement Continued Care & Audit **Matt Cottrell,** Research Analyst, Health Workforce Information Center **Liz Craker,** Health Program Coordinator, Office of Primary Care & Rural Health **John Curless,** Director, Office of Reimbursement, Coordinated Care & Audit **Jessica Fiedel,** Licensing Manager, Office of Licensing **Heather Flint,** Licensing Manager, Office of Licensing **Michelle Geller,** Policy Specialist, Office of Primary Care & Rural Health **Eric Grant,** Director, Office of Financial Services

	Shanna Jaggers, Research Consultant, Office of Research & Evaluation **Rick Little,** Director, Office of Research & Evaluation **Kyle Lunt,** Director, Office of Data, Systems & Evaluation **Stephanie McVicars,** Director, Early Hearing Detection & Intervention (EHDI); Cytomegalovirus (CMV) Public Health Initiative; Children's Hearing Aid Program (CHAP) **Ashley Moretz,** Director, Health Access Division **Nune Phillips,** Senior Policy Advisor **Mary Rindler,** Manager, Newborn Screening Program **Heather Sarin,** Quality Improvement Director, Utah Women & Newborns Quality Collaborative **Florencia Schapira De Grout,** Director, Office of Licensing **Suzanne Smith,** Coordinator, Perinatal Mortality Review **Jim Stamos,** Director, Office of Healthcare Policy & Authorization **Jennifer Strohecker,** Director, Division of Integrated Healthcare & State Medicaid **Heidi Sylvester,** Outreach Coordinator, Perinatal Mortality Review **Greg Trollan,** Director, Office of Managed Healthcare **Marc Watterson,** Director, Office of Primary Care & Rural Health **Anna West,** Workforce Development Coordinator, Office of Primary Care & Rural Health
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