

2025 Periodic Review

Occupational Therapy

Published January 2026

Executive Summary

Background

Occupational therapists (OTs) are licensed healthcare professionals who promote independence for clients struggling to perform activities of daily living (ADL) due to injury, illness, disease, or disability. Occupational therapy assistants (OTAs) are licensed practitioners who provide care under the direction and general supervision of a licensed OT. These two providers treat individuals of all ages and they work in a variety of acute and non-acute settings.

Utah requires OTs and OTAs to be licensed. Licensure requirements and scope of practice are relatively standard throughout the U.S. However states differ on whether they authorize OTs to engage in expanded practices, such as use of physical agent modalities (PAMs), wound care, or dry needling. Utah is one of a few states which do not specify a number of training or practice hours necessary to use PAMs or perform wound care. All states that authorize dry needling, including Utah, require additional training.

Quantitative and qualitative data on the OT workforce suggests that access to occupational therapy services is constrained. The U.S. Health Resources and Services Administration's (HRSA) state-level modelling and forecasting of occupational therapy supply, demand, and percent adequacy suggests Utah is experiencing a workforce shortage of OTs that could worsen in the future.

Regulatory Model Recommendation: Continue to license OTs and OTAs

- Many OTs and OTAs provide physically intimate care to exceptionally vulnerable patient groups in private settings (i.e. helping someone shower or dress), which has serious implications for the risk of sexual or other ethical misconduct.
- A lack of consumer oversight, available information, and consumer choice increases the risk of harm from potentially unsafe or underqualified practitioners in situations without sufficient employer oversight.

Recommended Regulatory Adjustments:

1) Allow OTs to prescribe durable medical equipment (DME)

- Education and experience qualify OTs to prescribe DME.
- Allowing OTs to prescribe DME may improve access for patients and streamline an OTs workflow by reducing unnecessary barriers.

2) Increase the supervision ratio for OTAs

- Increasing the supervision limit expands OTs' flexibility in using OTAs, enabling OTs to treat more patients and focus on higher complexity tasks.

Context

Consistent with its legislative mandate,¹ the Office of Professional Licensure Review (OPLR) reviewed Utah's licensing laws for occupational therapists. 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 state²

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, health workforce data, as well as laws and policies in other states. OPLR also conducted interviews with occupational therapists, business owners, employers, faculty, and other subject matter experts. See [Appendix 1.1](#) for more information.

Background

Profession Overview

Occupational therapists (OTs) are licensed healthcare professionals who promote independence for clients struggling to perform activities of daily living (ADL) due to injury, illness, disease, or disability. Occupational therapy involves “the use of strategies, activity, environment and tool adaptations, and exercises to help clients develop new skills or make the adjustments needed to regain function...or help them make changes to accommodate a permanent disability”.³ OTs approach treatment through a holistic lens, focusing on all factors (i.e. physical, emotional, psychosocial, environmental) impeding on an individual's quality of life. This differentiates them from related practitioners, such as physical therapists and speech-language pathologists. The role of an OT is not to treat a specific injury, ailment, or physical disability, but rather to enable a person to accomplish ADLs like brushing their teeth or making dinner for their family. As such, the scope of occupational therapy is necessarily broad, and treatment may include the use of manual therapy, therapeutic exercises, physical agent modalities (PAMs),⁴ orthotics and prosthetics, assistive technology, environmental modification, and wound care.^{5,6}

OTs often work with supportive personnel. Occupational therapy assistants (OTAs) are educated and licensed professionals who provide care under the direction and general supervision of a

¹ [UCA 13-1b-203\(2\)](#)

² [UCA 13-1b](#)

³ Creighton University (2024) [Occupational Therapist vs. Physical Therapist: Understanding the Difference and How They Work Together](#)

⁴ PAMs refer to a broad group of physical interventions, including the use of superficial thermal agents (i.e. cryotherapy, hot packs), deep thermal agents (i.e. therapeutic ultrasound), and electrotherapeutic agents (transcutaneous electrical nerve stimulations (TENS)). See the following for more detail on these modalities: [The American Occupational Therapy Association \(2008\) Physical Agent Modalities: A Position Paper](#)

⁵ American Occupational Therapy Association [Interventions to Support Occupations](#)

⁶ American Occupational Therapy Association (2018) [Role of Occupational Therapy in Wound Management](#)

licensed OT. OTAs implement the treatment plan created by an OT, which may include assisting patients with therapeutic exercises, helping patients use adaptive equipment, and monitoring and recording the progress of their patients.⁷

Additionally, unlicensed OT aides support OTs and OTAs with any client/patient or non-patient related functions that they can competently and safely perform. Supportive tasks include setting up treatment rooms, helping move patients, performing clerical duties, and implementing routine aspects of a treatment plan. Aides often must work under direct, line-of-sight supervision, as they may have no formal training or education related to occupational therapy.

OTs & OTAs treat individuals of all ages who have, or are at risk of developing, any illness, condition, injury, or disease that impacts their ability to engage in ADL. This may include traumatic injury, stroke, multiple sclerosis, autism spectrum disorder, and behavioral health disorders like depression or anxiety.⁸ OTs work in schools, institutional/inpatient settings (i.e. acute care, rehab facilities, psychiatric hospitals, long term care facilities), outpatient settings (i.e. private clinics, medical and therapy offices), and home and community settings (i.e. private residences, day care, homeless shelters).⁹

Profession in Utah

Utah had 1,525 licensed OTs and 554 OTAs at the beginning of 2025.¹⁰ To become licensed as an OT in the state, an individual must graduate with a bachelor's or graduate degree from an education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) and pass the Occupational Therapist Registered (OTR) Certification exam administered by the National Board for Certification in Occupational Therapy (NBCOT). However, since 2007, ACOTE only accredits Master of Occupational Therapy (MOT) programs. An OTA seeking licensure in Utah must graduate from an OTA educational program accredited by ACOTE and pass the Certified Occupational Therapy Assistant (COTA) exam administered by NBCOT. ACOTE accredits both associate's and bachelor's OTA programs.¹¹

Beyond initial education and examination, OT and OTAs must renew their license every two years. Renewal requires licensees to complete 24 continuing education units.¹²

The scope of practice for OTs in Utah is broad, enabling expanded therapeutic practices, such as PAMs, wound care and dry needling.¹³

⁷ Concorde staff (2025) [What is an Occupational Therapy Assistant?](#)

⁸ OTs may treat those with behavioral health disorders through life skills development, vocational training, community reintegration, and working on emotional regulation and social skills, among many others. An OT does not perform the same role as a psychologist or mental health counselor, who treat disorders and provide psychotherapy.

⁹ [The American Occupational Therapy Association \(2021\) Occupational Therapy Scope of Practice](#)

¹⁰ DOPL Licensing Data. See [Appendix 3.3](#) for information on this data.

¹¹ [UCA 58-42a](#)

¹² Ibid.

¹³ Dry needling is an invasive procedure where a fine needle is inserted into the skin and muscle at myofascial trigger points. It is often used to relieve pain.

In Utah, most OTs work in a hospital setting (27%), outpatient clinics (22%), schools (14%), home health (11%), and long-term care settings (11%). The rest work in settings like academia, early intervention, mental health hospitals and others.¹⁴

Approaches in Other Jurisdictions¹⁵

Every state in the U.S. licenses both OTs and OTAs, and the requirements for licensure are largely uniform across the nation. Every state requires OT and OTA licensees to pass the applicable NBCOT exam. The NBCOT requires anyone sitting for the exam to have completed an ACOTE accredited program, thereby standardizing the educational requirements across all states. Regardless of the degree requirement set in statute, adopting this exam requires that OTs must hold at least a master's, and OTAs must receive at least an associate's degree.

Most states, including Utah, also dictate the amount of clinical experience required for licensure, commonly requiring either six months or 24 weeks of supervised fieldwork for OTs and two months or 16 weeks of supervised fieldwork for OTAs. These requirements are largely redundant, as ACOTE accreditation requires programs to include 24 weeks of supervised fieldwork for OTs and 16 weeks of fieldwork for OTAs.

The scope of practice for OTs is also fairly standardized, except for the use of PAMs, wound care, and dry needling. The majority of states either explicitly allow, or remain silent on,¹⁶ the practice of PAMs and wound care, although many require additional training.¹⁷ A few states, such as Kentucky and Tennessee, require licensees to receive additional certifications from the state to use these modalities. Utah, along with a few other states, allows OTs to engage in PAMs and wound care without requiring licensees to complete a specific number of treatments or hours of education.¹⁸ Approximately 11 states, including Utah, explicitly allow OTs to dry needle.¹⁹ In these states, OTs must often complete a set number of hours of education and experience to receive authorization to dry needle, with requirements ranging from 24 to 304 hours of education and supervised practice.²⁰

Regulatory Model Assessment & Recommendation

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

¹⁴ DOPL Occupational Therapy Renewal Survey. See [Appendix 1.2](#) for more information on this survey.

¹⁵ OPLR Occupational Therapy Policy Scan. See [Appendix 1.3](#) for more information.

¹⁶ Remaining silent does not necessarily imply that the modality is included in the scope of practice

¹⁷ In states that require additional training, licensees must complete anywhere between 6 to 270 hours.

¹⁸ [R156-42a](#) still requires OTs to have relevant education, training, and/or experience in PAMs and wound care to practice either, but the details are not prescribed.

¹⁹ OPLR Policy Scan. Many states remain "silent" on the issue of dry needling, which makes it difficult to estimate the exact number of states that allow this practice.

²⁰ Ibid. Some states also require OTs to pass a dry needling exam.

incorporates its statutory review criteria.²¹ 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 2.1](#) for potential regulatory models and the factors in OPLR's framework.

Recommendation

OPLR determined that licensing is the most appropriate form of regulation for occupational therapy. Significant considerations for this recommendation include:²² downstream impact, patient vulnerability, frequency of physical touch, and lack of consumer oversight.

Potential for harm

For the most part, the services involved in occupational therapy are unlikely to result in severe harm. Exceptions may include employing manual therapy or PAMs incorrectly, which could exacerbate an injury, result in burns, or cause other relatively minor and temporary damage. Additionally, incorrectly utilizing assistive equipment or technology could cause falls. O*Net's Consequence of Error, which rates professions on a 100-point scale based on the seriousness of potential harm, gives OTs a score of only 47. This is relatively low for a health care practitioner.²³ However, the consequences of poor OT can be severe in some instances because OTs often treat very vulnerable and acute patients. For these patients, errors that may not permanently harm the average individual (i.e. failing to prevent falls) may cause severe harm.

Importantly, OTs work hands-on with vulnerable populations in sometimes very private and intimate settings. This has serious implications for the risk of sexual or other ethical misconduct. Occupational therapy often requires extended physical interaction between patient and OT, and it includes assisting patients in intimate activities such as showering, dressing, and addressing topics like sexual function. OTs also treat severely disabled pediatric and geriatric populations, patients often unable to advocate for themselves or indicate whether their provider is harming them.

The potential for harm in occupational therapy is somewhat exacerbated by the downstream implications of untrained care. Failing to prevent falls or worsening existing injuries may necessitate further medical intervention, which comes with additional cost and risk. Additionally, occupational therapy promotes independence. The failure to provide competent care may

²¹ 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](#)

²² This is not a comprehensive list of all factors. Please see [Appendix 2.2](#) for more information on OPLR's analysis of the potential for harm related to occupational therapy.

²³ [O*Net OnLine Consequence of Error](#)

negatively impact a patient's quality of life,²⁴ their contributions to their community,²⁵ and place greater burden on caretakers-although data on this is limited.²⁶

Related harm factors

Although OTs operate with a high level of clinical independence, the majority work under employer oversight, mitigating some of the potential for harm. Private, independent practice is less common within occupational therapy than in physical therapy or physician practice.²⁷ Many OTs work under sophisticated employer oversight and are integrated into interdisciplinary teams, such as those in acute settings (i.e., emergency care and rehabilitation hospitals), and outpatient clinics associated with hospital systems. However, approximately one-third of OTs in Utah work in settings in which they may have minimal employer oversight (such as home health and schools) or no employer oversight (such as in private outpatient clinics).²⁸

There is little consumer oversight of OT services. Information on individual OTs in employed settings is minimal, and patients are typically assigned an OT with no input. Additionally, some patients treated by OTs may be unable to communicate negative experiences with their provider, further limiting the information available regarding an OT. This can increase the risk of harm in cases where employers fail to provide sufficient oversight, as there is no way for individuals to vet and avoid potentially unsafe or underqualified practitioners.

Given the low risk of physical harm associated with occupational therapy treatment modalities, OPLR considered recommending mandatory certification²⁹ as a lower-burden regulatory model. Mandatory certification would still sufficiently protect the scope of practice and set a standard for competence via entry requirements. This is warranted due to the downstream implications of incompetent care and lack of consumer oversight. However, certification may not provide

²⁴ Although the data tends to be of lower quality, multiple studies point to the efficacy of occupational therapy in improving quality of life and independence in certain patients. See: Tofani et. al. (2020) [Efficacy of Occupational Therapy Interventions on Quality of Life in Patients with Parkinson's Disease: A Systematic Review and Meta-Analysis](#), Legg et. al. (2023) [Occupational Therapy For Adults with Problems in Activities Of Daily Living After Stroke](#), Sheerin et. al. (2023) [Effectiveness of Occupational Therapy Interventions on Function and Occupational Performance Among Adults with Conditions of the Hand, Wrist, and Forearm: A Systematic Review and Meta-Analysis](#), Rao et. al. (2014) [Systematic Review of the Effects of Exercise on Activities of Daily Living in People with Alzheimer's Disease](#), Saito et. al. (2025) [Occupational Therapy Intervention for Improvement of Activity and Participation in Home Rehabilitation for Community-Dwelling Older Adults: A Scoping Review](#)

²⁵ For example, one study found that occupational therapy return-to-work interventions were effective for people with depression. Christie et. al. (2021) [A Systematic Review into the Effectiveness of Occupational Therapy for Improving Function and Participation in Activities of Everyday Life in Adults with a Diagnosis of Depression](#)

²⁶ Williams et. al. (2019) [Interventions for Reducing Levels of Burden Amongst Informal Carers of Persons with Dementia in the Community. A Systematic Review and Meta-Analysis of Randomised Controlled Trials](#) and Bennet et. al. (2019) [Occupational Therapy for People with Dementia and Their Family Carers Provided at Home: A Systematic Review and Meta-Analysis](#) found that occupational therapy was associated with reduced carer burden (i.e. the number of hours spent assisting), although authors warned the results should be interpreted with caution. <https://pubmed.ncbi.nlm.nih.gov/25587088/> Whitehead et. al. (2015) [Interventions to Reduce Dependency in Personal Activities of Daily Living in Community Dwelling Adults Who Use Homecare Services: A Systematic Review](#) found insufficient evidence to determine whether occupational therapy reduced dependency in activities of daily living.

²⁷ OPLR Stakeholder Interviews

²⁸ DOPL Occupational Therapy Renewal Survey

²⁹ See [Appendix 2.1](#) for information on different regulatory models, including mandatory certification

vigorous enough oversight to address the potential risk of sexual and ethical misconduct. Although most OTs work under employer oversight, the level of oversight can be variable and potentially insufficient given that OTs engage in intimate activities with highly vulnerable patient populations. Licensure, with its two-year renewal cycles, is better suited to stop harmful practitioners from continuing to practice.³⁰

Regulatory Model Adjustments & Recommendations

Framework

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 3.1](#)).

Safety Issues

OPLR found no evidence that licensed occupational therapy practitioners in Utah are causing widespread, serious harm to the public based on available information. OPLR analyzed the Department of Professional Licensing's (DOPL) complaint data and found that OTs and OTAs had low complaint rates.³¹ Between 2017-2022, OTs had a rate of 0.7 complaints per 100 practitioners and OTAs had a rate of 0.46, one of the lowest in OPLR's 2025 review.³² A review of complaint case notes illustrated that, even among these substantiated complaints, only two involved any reported patient harm.³³

Despite few formal complaints regarding OT licensees, OPLR heard widespread OT concern over the use of unlicensed OT aides (often referred to in this context as motor aides)³⁴ within Utah elementary schools.^{35,36} This occupational therapy service delivery model relies on motor aides to implement much of each student's treatment plan. An OT supervises the motor aide's actions in-person only during monthly or quarterly visits, otherwise relying on the motor aide to provide feedback to the OT (who may be at another school location) through phone calls, emails, and notes.³⁷

³⁰ Other avenues for redress (e.g., criminal law, litigation) are costly, possibly difficult to pursue, and would not restrict an individual from eventually returning to practice.

³¹ DOPL Complaint Data. Between 2017-2022, OTs received 12 substantiated complaints and OTAs received 3 substantiated complaints. See [Appendix 3.2](#) for more information on OPLR's use of DOPL complaint data.

³² OTs received 12 substantiated complaints and OTAs received 3 substantiated complaints in that time period.

³³ One case involved financial harm while the other alleged sexual misconduct.

³⁴ They are called motor aides because they have historically primarily assisted in the treatment of fine motor issues.

³⁵ OPLR Stakeholder Interviews

³⁶ The majority of school-based OT services are offered in grade school, which is why the issue is contained to this setting. Watt et. al. (2017) [Integrated Services or Pullout? Factors Influencing School-based Occupational Therapy Service Delivery Models](#), estimates that 70% of the students that school-based OTs treat are in grade school.

³⁷ OPLR analyzed the results of a survey sent out by the Utah Occupational Therapy Association which asked respondents about the supervision they either received as a motor aide or provided as an OT. OPLR coded the free response question and found that, out of 35 respondents, only 7 indicated that they nearly always provided direct supervision. 5 indicated that direct supervision occurred most of the time, 1 said about half of the time, 14 said

The concerns expressed by OTs were more about the appropriateness of this delivery model, than about it leading to serious student harm. Schools that utilize this delivery model require OTs to violate their practice act, which requires licensees to provide direct, within line-of-sight supervision of OT aides. Much of the concern regards the efficacy of care provided by motor aides, which (in OTs' view) may stall progress and lengthen the time a student requires OT services.³⁸ One stakeholder noted multiple instances in which students were physically harmed, albeit temporarily, by motor aides failing to use equipment correctly or prevent falls.³⁹

High caseloads for Utah OTs may explain the use of this delivery model. For example, one small survey found that the average caseload for school-based OTs in Utah was 93.7 students, more than twice that of OTs in Colorado (42.6).⁴⁰ This is higher than national estimates (40-50).⁴¹ OTs reported high caseloads and explained that this could be due, at least in part, to elementary students receiving OT services (e.g., for handwriting) who may not require such specialized therapy. Some OTs noted that these children (who don't show any other signs of neurological underdevelopment) may be better served by remaining in the classroom and receiving additional tutoring and practice by paraprofessionals trained in these techniques.

Access Issues

Quantitative and qualitative data on the OT workforce suggests that access to occupational therapy services is heavily constrained. The U.S. Health Resources and Services Administration's (HRSA) state-level modelling and forecasting of occupational therapy supply, demand, and percent adequacy⁴² suggests Utah is experiencing a workforce shortage of OTs that could worsen in the future. The percent of demand met by supply for OTs is currently the third worst in the nation at only 65% and is projected to decline to 55% by 2037. HRSA's projection for OTA percent adequacy is slightly higher, at 74% in 2025, and expected to stay fairly constant for the next decade.⁴³ At the same time, the supply of OTs and OTAs is likely to increase more than projected, as HRSA modelling intentionally does not account for the recent creation or expansion of new education programs.⁴⁴ Three new OT education programs and two

occasionally (once to a few times a month), 3 said never, and 5 didn't answer. The Utah Occupational Therapy Association released [this statement](#) on the issue.

³⁸ OTs were also concerned that parents were often unaware that OT services were being provided by aides with no formal education or training.

³⁹ OPLR Stakeholder Interviews

⁴⁰ Watt et. al. (2017)

⁴¹ Seruya and Garfinkel (2020) [Caseload and Workload: Current Trends in School-Based Practice Across the United States](#). The national estimate is based on a survey of 371 school-based OTs and is therefore limited. It's possible that the survey is not representative, biasing the estimate.

⁴² Percent adequacy is a measure of how well forecasted supply meets forecasted demand

⁴³ [HRSA Workforce Projections](#), accessed 3/12/2025.

⁴⁴ HRSA modeling is robust, incorporating data on licensee counts and demographic data from the APTA to identify and account for unique trends in each state. The supply forecast takes the status quo and extends it into the future to estimate the number of practitioners should no external changes occur which may inflate/deflate supply. For more information on HRSA's methodology, see: HRSA (2024) [Technical Documentation for HRSA's Health Workforce Simulation Model](#)

new OTA programs have been recently established in Utah.^{45,46} Utah previously had only one accredited OT program and one accredited OTA program. These new programs should increase the current workforce and, at the very least, prevent further decline in access.

OPLRs interviews with OT practitioners and employers largely support the conclusion that Utah lacks access to OT services.⁴⁷ Feedback includes that OT services in rural areas tend to be sparse and access to out-patient pediatric services generally is very constrained. Few pediatric clinics exist, and patients may wait between 6-12 months for an initial evaluation. These clinics can be difficult to operate due to low pay for OT practitioners and issues joining payor networks and obtaining reimbursement. In general, many employers expressed facing some difficulty in filling positions, and a large employer of both OTs and physical therapists agreed that wait-times for OT services tend to be longer.

Not all settings uniformly reported struggling with access. Stakeholders in long-term care and home health settings reported less friction in providing OT services, though some facilities or areas (e.g., rural) still struggled.⁴⁸

Individuals looking to enter the occupational therapy workforce face moderate barriers to entry. OTs must achieve at least a master's degree, with the cost of MOT programs in Utah ranging from ~\$65k-\$68k and the cost of ODT programs in Utah ranging from ~\$76k-\$100k.⁴⁹ OTs in Utah report graduating with an average of \$40-\$60k in debt⁵⁰ and earn median incomes of \$93k a year.⁵¹ The return on educational investment may be higher for OTs than professionals in related occupations. For example, in Utah, physical therapists make a similar median annual salary of \$98k, while Doctor of Physical Therapy programs cost between \$82k-160k.⁵² OTAs require only an associate's degree, although two-thirds of the programs in Utah are now at the bachelor's level. OTA program costs are ~\$11k for an associate's and ~\$27k-\$30k for a bachelor's,^{53,54} and OTAs earn median incomes of ~\$61k a year.⁵⁵ Salary estimates may vary significantly depending on an OT's or OTA's setting. Thus, the return on educational investment

⁴⁵ Rocky Mountain University established two new OT programs, a Master's bridge program for OTAs and a Doctor of Occupational Therapy (OTD) program. However, these degrees are offered primarily online, which likely will result in fewer graduates remaining in Utah compared to an in-person program. Utah Tech University has recently created an ODT program as well. The first cohorts should graduate from each school in 2026 and 2027, respectively.

⁴⁶ Utah Valley University and Weber State University are now accepting students into their newly created bachelor's level OTA programs.

⁴⁷ OPLR Stakeholder Interviews

⁴⁸ Ibid.

⁴⁹ See [University of Utah's](#) and [Rocky Mountain University's](#) MOT and OTD resident tuition estimates. Costs will be higher for out-of-state students.

⁵⁰ DOPL Occupational Renewal Survey

⁵¹ Salary estimate pulled from: [The Department of Workforce Services Occupational Information Data Viewer: Occupational Therapists](#)

⁵² OPLR used [DWS](#) for salary estimates and program websites for cost.

⁵³ [Salt Lake Community College's OTA program estimate](#) is based off of the 2023-2024 academic year and has likely increased since then.

⁵⁴ OPLR used [Utah Valley University's 2025-2026 one year resident tuition estimate](#) and [Weber State's 2024-2025 one year resident tuition estimate](#) to calculate the total program costs (costs included tuition, fees, and books and supplies). This estimate assumes completion of 8 semesters for each OTA program. Costs will be higher for out-of-state students.

⁵⁵ Salary estimate pulled from: [The Department of Workforce Services Occupational Information Data Viewer: Occupational Therapy Assistant](#)

can range from high to low, although it tends to be higher for OTAs than OTs due to the vast difference in program costs.

Discussion

Given evidence that levels of reported harm are low and current licensing requirements appear to mitigate the potential for harm from OT practitioners, OPLR does not recommend making any adjustments to OT or OTA licensure to address safety issues.

OPLR also does not recommend making any changes to OT aide provisions or supervision requirements. The Utah State Board of Education (USBE), in collaboration with the Utah Occupational Therapy Association (UOTA), is working toward shifting supervision of the paraprofessionals (motor aides) from OTs to classroom teachers so that all students can have opportunities to develop their fine motor skills. As an extension of the educator, the paraprofessional could then guide all students in routine fine motor activities. OTs would then be freed up to work with students experiencing more severe developmental delays and complex medical needs. If this shift in supervision is implemented, it should reduce caseloads for OTs in the schools, thereby enabling them to directly supervise OT aides or reduce their use of them. See “Other Considerations” for OPLR’s proposal should this policy not be implemented.

Access to occupational therapy services is a concern, but it is not one that can be solved through licensure model adjustments. Insurance reimbursement issues are beyond the scope of licensure, and OPLR does not recommend reducing (nor raising) the requirements for licensure.⁵⁶ Lowering the requirements would require significant investment by the state, as DOPL would need to create and administer a state specific licensing exam, and at least one institution in Utah must be willing to create an unaccredited OT program. Additionally, Utah has taken considerable steps to address the accessibility issues through the creation of five new OT and OTA programs, which should increase the supply of practitioners substantially.

To further support access, OPLR proposes making small, targeted adjustments to expand the scope of practice for OTs and give them greater flexibility in their use of OTAs.

Recommendation 1: Allow OTs to prescribe durable medical equipment (DME)⁵⁷

Currently, OTs may “assess, design, fabricate, apply, fit, and provide training in assistive technology and adaptive, orthotic, and prosthetic devices”,⁵⁸ but they may not prescribe or order any of these devices. OPLR recommends expanding this scope to enable OTs to prescribe

⁵⁶ There is a movement towards making the OTD the entry-level degree for OT and a bachelor’s the entry level degree for OTAs. ACOTE mandated that, beginning in 2027, it would only accredit OTD programs. They dropped this mandate after a formal petition from 3,300 OTs across the country.

⁵⁷ DME refers to a category of medical devices designed to assist individuals with disabilities, injuries, or chronic health conditions. OTs commonly use the following DME: mobility devices (wheelchairs, crutches), hospital beds, oxygen equipment, traction devices, continuous passive mobility devices, and others.

⁵⁸ [UCA 58-42a](#)

DME, as OTs are educated and capable of performing this scope appropriately, and it may reduce inefficiencies in the healthcare system.

Education and experience qualify OTs to prescribe DME. ACOTE accreditation standards require OT educational programs to include instruction on DME in their curriculum. Students must learn how to properly assess patients for the necessity of DME, apply and fit DME to each individual patient, train the patient in use of their DME, and write the justification to secure funding for these devices.⁵⁹ Occupational therapy frequently incorporates the use of DME, meaning that OTs gain extensive clinical experience in applying their education.

Allowing OTs to prescribe DME may also improve access for patients and streamline an OTs workflow by reducing unnecessary barriers. Currently, OTs must coordinate with physicians to order, and thus obtain reimbursement for, DME. If issues arise in this process (e.g., with reimbursement, supply chain, receiving equipment, etc.) the OT often can not appeal directly to the insurer or medical supplier, as they are not the prescriber. The task of coordination can further delay treatment, which presents safety issues for patients, and take more of an OT's time away from patient care.

Utah would not be the only state to expand OT's scope in this way. Colorado recently became the first state to authorize OTs to recommend and prescribe DME.⁶⁰

Recommendation 2: Increase the supervision ratio for OTAs

OTs in Utah may supervise “two full-time occupational therapy assistants at one time, or four part-time occupational therapy assistants if the combined work hours of the assistants do not exceed 40 hours per week”.⁶¹ OPLR recommends:

1. extending the limit to four OTAs regardless of hours worked, and
2. removing the provision from statute and placing it in rule.

OTAs play a pivotal extender role in occupational therapy by allowing the supervising therapist to work on higher complexity tasks⁶² while OTAs carry out less complicated aspects of a patient's care plan. Utah's limit on supportive personnel is restrictive compared to other states, many of which do not set a cap at all,⁶³ and may negatively impact accessibility. Extending the supervision limit would increase OTs' flexibility in using OTAs and likely enable them to care for more patients without sacrificing the quality of care.

OPLR recommends moving this provision to administrative rule to allow for these limits to evolve as technology and treatment methods advance and to mirror the physical therapy practice act.

⁵⁹ [2023 ACOTE Standards and Interpretive Guide](#)

⁶⁰ [HB25-1016](#)

⁶¹ [UCA 58-42a-306\(5\)](#)

⁶² Higher complexity tasks may include assessment, treatment planning, or implementing manual therapy or physical agent techniques.

⁶³ OPLR Policy Scan.

Other Considerations

Supervision of OT aides

In the absence of shifting the supervision of paraprofessionals (motor aides) from OTs to educators, OPLR recommends exempting OTs working in school settings from the requirement to directly supervise OT aides engaged in rote treatment of fine motor skills. This change is unlikely to present safety concerns, as OTs explained that treatment of these issues specifically comes with very low risk of harm.⁶⁴ In addition to this change, OPLR recommends that USBE create a certification or establish uniform training required for these aides to ensure they provide effective treatment.

OPLR prefers the solution suggested by UOTA and USBE, as occupational therapy should be primarily utilized for children with neurological or developmental disorders. Non-specialized OT-related activities should be separated from the responsibilities of school-based OTs to reduce their extensive caseloads and allow them to spend more time treating the highest-need children.

Rule Review

In accordance with Utah Code 13-1b-203(5), OPLR conducted an in-depth review of DOPL's occupational therapy rules, found in R156-42a.

The rule review covered potential rule changes needed to:

1. address specific rules that may be 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, clarify language, and correct references to statute or other rules; or
3. support OPLR's recommendations

OPLR's review of R156-42a found:

1. There are two rules that may be overly burdensome for OTs and OTAs:
 - a. OTs and OTAs may not currently count any clinical practice hours towards their CE requirements. OPLR recommends changing this to align with the CE rules for physical therapists, which allows licensees to count 50 hours of clinical practice as one CE, up to 10 CEs.⁶⁵
 - b. Renewal requires 24 CEs for both OTs and OTAs. OPLR recommends reducing this to 20 CEs for OTAs, which is aligned with the renewal requirements for physical therapy assistants.
2. There is one incorrect and/or outdated references:

⁶⁴ It is important to specify the scope in this instance. The examples of harm caused by OT aides referred to aides engaging in activities not related to the rote treatment of fine motor skills. Any aides providing more complex services, even in schools, should continue working under direct supervision.

⁶⁵ [UAR R156-24b-303b](#)

- a. The reference to R156-1-107 in R156-42a-104 is incorrect, as R156-1-107 does not exist.
3. The recommendation to increase the supervision ratio of supportive personnel should be moved from statute to administrative rule

Appendix

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1. Context

1.1 General Research 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, publicly available data from other state and federal government entities (e.g., DWS, HRSA, NPDB), and data from industry organizations (e.g., UOTA)
- 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 Occupational Therapy Renewal Survey

A. *Survey overview*

OPLR utilized a DOPL survey available to OTs during their 2025 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](#).

The survey was not utilized for OTAs, as the response rate was ~3%. OPLR was unable to determine why so few OTAs completed the survey, but it may have been due to distribution errors.

A. *Survey Limitations*

The survey was available to all licensed occupational therapists during the license renewal process so results were not affected by sampling bias. Additionally, the response rate was fairly high at 56%. However, results still 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). 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 to provide a 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 Occupational Therapy Policy Scan

To better understand the regulatory environment for occupational therapy, OPLR conducted a review of state occupational regulation in the U.S., which was almost entirely dependent upon the following reports published by the American Occupational Therapy Association (AOTA) State Affairs Group:

- State Occupational Therapy Statutes, Regulations, and Policy Statements with Specific Physical Agent Modality Provisions
- Occupational Therapy Profession - Scope of Practice Definitions
- OT Qualifications and Licensure Requirements
- OTA Qualifications and Licensure Requirements

These reports contained specific references to statute and rule for each jurisdiction for each topic. OPLR used this data to understand jurisdictions' general approach to licensing (e.g., qualifications, requirements, scope of practice) as well as compare and contrast how different jurisdictions regulate physical agent modalities. AOTA's reports were either published or updated in April of 2025, and they can be found [here](#).

After compiling the information in each report, OPLR filled any gaps in information by reading the relevant state's occupational therapy statutes and administrative rules.

This review 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 manual entry. Potential bias or measurement error introduced by these limitations likely did not substantially alter any information, as the review was utilized to find patterns rather than report exact numbers.

2. Regulatory Model Assessment and Recommendations

2.1 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.⁶⁶

2.2 Model Assessment of Occupational Therapy

The following tables summarize OPLR’s analysis of occupational therapists according to factors that OPLR determined should influence the appropriate regulatory model for an occupation. Factors that OPLR considered particularly determinative in its assessment are highlighted in bold.

Model Assessment of Occupational Therapy	
Harm Factors	
Mechanism of Harm	Exacerbate injury, musculoskeletal injury, burns
Severity, Permanence, and Likelihood of Harm	Low severity, moderate likelihood if untrained. Likely impermanent
Consequence of Error	47*
Downstream Impact	High. Failure to properly treat may lead to increased dependence, future accidents necessitating immediate medical care, or decreased quality of life
Consumer & Setting Factors	
Patient Vulnerability	Extremely high. OTs almost exclusively treat patients with serious physical, behavioral, or neurological injuries or disorders. Many treat children and geriatric populations specifically.
Frequency of Physical Touch	Occupational therapy requires constant physical interaction with patients
Frequency of Private Setting	Frequent in specific settings, infrequent in others. For example, an OT may help someone bathe or dress themselves, which is a private activity, or may work with children in a shared treatment space.
Information Asymmetry	High. A patient is unlikely, especially given the vulnerability of the patient population, to understand whether treatment is effective.

⁶⁶ The document is also available on OPLR’s website in the “About OPLR” section, accessible here: <https://oplr.utah.gov/about-oplr/>

Related factors	
Level of Independence	<p><i>Structural:</i> Low to moderate. OTs may run independent practices, but it is far more common for OTs to work as employees in larger institutions</p> <p><i>Clinical:</i> High. OTs assess patients, develop treatment plans, and implement those treatment plans according to their own knowledge and expertise</p>
Patient Choice	Patients often do not choose their OT. Most OTs are employees and are assigned to a specific hospital, school, or home health agency. Patients may choose when it comes to certain settings, like private out-patient.
Information Availability	Fairly low. As employees, there may be little information available regarding the qualifications of an OT or patients' experience with them
Level of Oversight	<p><i>Employers:</i> Moderate. OTs almost always work as employees of existing organizations, although the oversight may be variable. The oversight of an OT working in acute hospital settings, where they are integrated into a multidisciplinary team, is significantly higher than that in a home health agency or school where OTs tend to work with higher independence</p> <p><i>Government:</i> Some government oversight through CMS guidelines and facility licensing through DHHS</p> <p><i>Private Bodies:</i> Low.</p>

* [O*Net Consequence of Error Ranking](#)

3. Regulatory Model Adjustments & Recommendations

3.1 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.⁶⁷

3.2 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

⁶⁷ The document is also available on OPLR's website in the “About OPLR” section, accessible here: <https://oplr.utah.gov/about-oplr/>

of gross negligence or incompetence”.⁶⁸ 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.

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 occupational therapy complaints closed between 2017-2022. A stratified random sample was taken from all complaints categorized as substantiated or no jurisdiction,⁶⁹ with stratification based on complaint type. All complaints related to client harm (3) were included and complaint types more likely to include client harm (i.e. unethical conduct) were oversampled. OPLR analysts read through case notes from ten complaints, out of a total of twenty-five. For each complaint they summarized the issue, noted whether or not client harm occurred or potentially occurred, and (if harm was present) the type and severity.

Limitations

There are significant limitations to this analysis, and the information collected should not be interpreted as a precise estimate of harm caused by occupational therapists. DOPL data likely underestimates true harm, as many instances of harm may be handled in other ways (e.g.,

⁶⁸ DOPL, [An Explanation of the Complaint Handling Process for the Division of Occupational and Professional Licensing](#)

⁶⁹ 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 OTs and OTAs.

directly by employers), reported to other entities, or may never be reported. Additionally, some unsubstantiated complaints may have resulted in harm but the necessary evidence was not produced.

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 potential for harm and may generate more complaints. For example, surgeons have a higher likelihood of causing severe harm to a patient than occupational therapists because surgery is inherently far riskier, not because surgeons are “less safe” or less competent than occupational therapists.

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 these data.

3.3 DOPL Licensee Data

OPLR used DOPL licensee data queried in January of 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 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.

Between 2014-2024, the number of OT licenses in Utah grew with a Compound Annual Growth Rate (CAGR) of 7.2%, and the number of OTA licenses increased with a CAGR of 5.7%, both of which far outpace the growth in the population of Utah during that period (1.8%).⁷⁰

⁷⁰ OPLR used the annual Utah population estimates from the IBIS Query Builder using Kem C. Gardner Policy Institute Population Estimates. See: <https://ibis.utah.gov/ibisph-view/query/builder/pop/PopKemG/Count.html>

4. Stakeholder Outreach

4.1 OPLR Interview 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 OTs, OT business owners and employers, occupational therapy educators, industry associations, Utah legislators, and Utah and other state regulators. OPLR prioritized diversity of perspective and relevance to the industry in selecting stakeholders. Variety in practice setting was also prioritized, and OPLR contacted stakeholders associated with all the following settings: acute in-patient, private outpatient, hospital system outpatient, home health, and skilled nursing facilities.

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 occupational therapy industry, 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.

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 occupational therapy (i.e. occupational therapy patients), so their perspectives were not incorporated into this review. Thus, the stakeholder engagement and findings from these interviews should not be understood as fully representative of the views of all Utahns, occupational therapists, occupational therapy employers or clinic owners, 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.

4.2 Stakeholder Engagement Summary

Stakeholder Engagement Summary - Occupational Therapy	
Government Stakeholders	
Utah Department of Commerce	Margaret Busse , Executive Director Carolyn Dennis , Deputy Director Jacob Hart , Deputy Director Mark Steinagel , Director, Division of Professional Licensing Lisa Martin , Bureau Manager, Division of Professional Licensing
Division of Professional Licensing (DOPL) Board	Lyndsay Fait , Board Chair, Physical Therapies Board
Utah State Board of Education	Leah Voorhies , State Director of Special Education, Deputy Superintendent of Student Achievement
Industry Stakeholders	
Industry Associations	Vanessa Rapier , Past President, UOTA Lynn Farley , Vice President, AOTA Matt Hansen , Executive Director, Homecare and Hospice Association of Utah Allison Spangler , President & Chief Executive Officer, Utah Health Care Association
Employers	Joseph Kamerath , Senior Medical Director for Rehabilitation Services, Intermountain Health Clay Watson , Owner and Physical Therapist, Western Summit Rehab
Subject-Matter Experts	
Academics, Researchers, & Clinicians	Randy Carson , Inpatient Medical Rehabilitation Therapy Coordinator, Neilson Rehabilitation Hospital, and Center Coordinator of Clinical Education for Acute care and Inpatient rehabilitation, University of Utah Travis Chamberlain , Occupational Therapist, Weber School District Gabe Byars , Program Coordinator and Associate Professor, Salt Lake Community College Lauren Devall , Clinical Director, Children in Motion

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