Department of Commerce
Office *of* Professional Licensure Review

2025 Periodic Review

Medication Aide Certified

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Executive Summary

Background

Medication aides certified (MACs) distribute routine medications to residents in long-term care settings, including skilled nursing (SNFs) and assisted living facilities (ALFs). By employing MACs, a facility can use its nurses for more complex care tasks.

Utah issues a MAC license, which is mandatory for medication passing in SNFs and currently functions as optional for medication passing in ALFs. Requirements for the MAC license include being a certified nursing assistant (CNA) with at least 2,000 hours of experience, completing 100 hours of medication-related training, and passing an examination.

Most U.S. states have some form of regulation for medication aides (e.g., license, certification, required training). Unlike Utah, 28 states allow MACs to administer insulin in at least one long-term care setting, often with additional training and in a limited capacity.

Regulatory Model Recommendation: *Remove the DOPL MAC license and require medication passers in all long-term care settings to be trained as part of facility licensing*

- Medication errors are common in these settings, though most do not cause severe harm
- Research indicates that training results in lower rates of medication error
- Responsibility for training rests on employers; enforcement through DHHS facility licensing may be more effective than an individual license, as indicated by a lack of DOPL complaints despite frequent medication error citations within facilities

Recommended Regulatory Adjustments:

1. *Require individuals passing medications in SNFs or ALFs to complete the same DHHS-approved certification course and have at least six months of prior setting-specific experience*
    - Similar medications are being passed to residents of SNFs and ALFs
    - Variable levels of medication training between ALFs put some residents at risk
    - Offering the same training is more efficient
    - Prior experience promotes familiarity with residents and setting

2. *Allow medication passers in SNFs and ALFs to administer long-acting insulin in a limited capacity (e.g., via a preloaded pen) with training*
    - The inability of medication aides to administer insulin prevents ALFs from caring for some individuals with diabetes
    - This approach addresses issues with ALF residents self-administering insulin when they may have motor or cognition issues
    - Many states allow medication aides to administer insulin with specific training

Context

Consistent with its legislative mandate,[1] the Office of Professional Licensure Review (OPLR) reviewed Utah's licensing laws for medication aides certified. 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 Utah Division of Professional Licensing (DOPL), inspection data from the Utah Department of Health and Human Services (DHHS), licensee survey data, academic literature, as well as laws and policies in other states. OPLR also conducted interviews and focus groups with employers, educators, industry associations, and state agencies. See Appendix 1 for more information.

Background

Profession Overview

A Medication aide certified (MAC) is an individual trained to administer routine medications to residents of long-term care settings such as skilled nursing facilities (SNFs) and assisted living facilities (ALFs). A MAC's job includes consulting physician and nurse notes on medications to be administered, selecting the appropriate dose, and distributing the medication to a resident. By undertaking specific and routine tasks related to medication, MACs help free up time for licensed nurses to focus on care tasks that require more specialized knowledge.[3]

Profession in Utah

The MAC license was created in Utah as a pilot program in 2006 due to anticipated need stemming from Utah's aging population, the lack of 24-hour registered nurse (RN) presence in ALFs, and the lack of uniformity in medication training given to nursing aides.[4] Despite the pilot program never starting,[5] the Utah Legislature voted in 2008 to make the MAC an official, ongoing license administered by DOPL.[6]

At the time of OPLR's review, there were 95 MACs licensed in Utah.[7] Uptake of the license started slowly; DOPL issued the first license in 2013. However, between 2017 and 2024, the

[1] Utah Code Ann. § 13-1b-203(2).
[2] Utah Code Ann. § 13-1b-302.
[3] Vogelsmeier, "Medication Administration in Nursing Homes."
[4] Audio Recording of the House Health and Human Services Committee Meeting, January 31, 2006.
[5] Audio Recording of the House Health and Human Services Committee Meeting, February 13, 2008.
[6] H.B. 399 passed in 2008.
[7] DOPL Licensee Data, accessed January 2025.

number of licensees grew 34% annually (see Appendix 2.1).[8] MACs work overwhelmingly in SNFs and ALFs.[9] MACs are also authorized to work in "small health care facilit[ies]," "intermediate care facilit[ies] for people with an intellectual disability," and "designated swing bed unit[s] in a general hospital."[10] OPLR focused its review on medication administration in SNFs and ALFs because they represent the primary setting for MACs. See Appendix 2.2 for a description of the differences between SNFs and ALFs.

To become a MAC in Utah, an applicant must have a high school diploma or equivalent and 2,000 hours of experience as a certified nursing assistant (CNA).[11] Applicants must then complete 100 hours of approved training (60 classroom hours and 40 practical training hours), pass the Medication Aide Certification Examination (MACE) created by the National Council of State Boards of Nursing (NCSBN), and pass a background check.[12] MACs must renew their license every two years by showing proof of eight hours of continuing education.[13]

There are presently some ill-defined areas of MAC practice and their use by facilities.

The first area concerns whether a MAC's scope of practice includes dispensing controlled substances. The scope of practice for MACs in Utah includes both 1) "providing direct personal assistance or care" and 2) "administering routine medications" defined by DOPL rule, but not helping a resident self-administer medication.[14] Per DOPL rules, MACs can administer over-the-counter and prescription medication, but are prohibited from administering medication via certain routes, such as subcutaneously or intravenously.[15] However, there are varying interpretations among regulators about whether MACs can administer controlled substances.[16] There is also varying practice in this regard. OPLR's research revealed that even workers without a MAC working in ALFs are passing controlled substances to residents.[17]

The second area concerns whether the MAC is a mandatory license. The Nurse Practice Act, which regulates MACs, does not clarify whether workers *without* a MAC can pass medications in any long-term care setting when delegated to by an RN. Presently it is the view of both regulators and the industry that workers without a MAC cannot pass medications in SNFs but can pass medications in other long-term care settings, such as ALFs.[18] This may be due, in part,

[8] DOPL Licensee Data, accessed January 2025.
[9] HWIC/DOPL 2025 Medication Aide Workforce Survey, January 2025: 62% of respondents reported working in a nursing home, long-term care facility, or skilled nursing facility and 12% reported working in an assisted living facility.
[10] Utah Code Ann. § 58-31b-102(10)(a)(ii); Utah Code Ann. § 58-31b-102(8).
[11] Utah Code Ann. § 58-31b-302(1). To become a CNA, an individual must receive 100 hours of approved training and pass both a multiple-choice and practical examination (Utah Nursing Assistant Registry, "Become a CNA in Utah").
[12] Utah Code Ann. § 58-31b-102(9); Utah Code Ann. § 58-31b-302(6); Utah Code Ann. § 58-31b-302(1); The NCSBN no longer administers the MACE. It is now run by an organization called Credentia (NCSBN, "NNAAP & MACE"; Credentia, "MACE").
[13] Utah Code Ann. § 58-31b-305(1)(a); Utah Admin. Code R156-31b-303(3)(c).
[14] Utah Code Ann. § 58-31b-102(10)(b).
[15] Utah Admin. Code R156-31b-801.
[16] OPLR Stakeholder Series.
[17] OPLR Field Research.
[18] OPLR Stakeholder Series; Federal regulations (42 C.F.R. § 483.45) say "The [long-term care] facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse." Regulators appear to interpret federal and state regulation as requiring the MAC in SNFs but not in ALFs. From interviews this appears to be well known in the industry.

to ALF facility rules from the Utah Department of Health and Human Services (DHHS), which allow workers to pass medication in an ALF (with or without the MAC license) after receiving 16 hours of training from the facility (required of all caregivers) in addition to whatever training the delegating RN feels is necessary for safe medication passing.[19] However, there is evidence in the audio recordings of legislative discussions on the original MAC licensure bills that it was intended to be a requirement for medication passers in all long-term care settings, including in ALFs.[20]

Given that MACs are authorized to work in ALFs and that there is evidence to suggest the license was meant to be mandatory in ALFs, OPLR considered a review of medication passers in ALFs within the scope of this review.

Approaches in Other Jurisdictions

States regulate medication passing in long-term care settings in various ways. More than half of states (37) require some form of government-issued credential (e.g., license, certification, registry) to pass medications in SNFs, while just under half (23) require a government-issued credential to pass medications in ALFs. Among the states that do not require a government credential, 7 require training to pass medications in SNFs and 16 require training to pass medications in ALFs.[21]

Unlike Utah, a majority of states (28) allow their equivalent of medication aides to administer insulin in at least one long-term care setting.[22] In 10 of these states, this insulin authorization is limited to specific devices (e.g., prefilled pens), and 14 of these states allow insulin as an optional scope expansion only after the completion of additional insulin-specific training.[23]

Regulatory Model Assessment and Recommendation

Framework

In an effort to standardize how appropriate regulatory models are determined for each profession (e.g., license, registry, no regulation), OPLR developed a framework which

[19] Utah Admin. Code R432-270-18(7)(c); Utah Admin. Code R432-270-8(9)(a)(iii); Utah Admin. Code R156-31b-701a.
[20] The sponsor of the bill framed the need for the MAC license in terms of the lack of constant RN presence in ALFs and the inconsistent training happening in these facilities (Audio Recording of the House Health and Human Services Committee Meeting, January 31, 2006). When presenting the bill that would make the MAC license a permanent program, the sponsor stated that the bill "*allows* nurses aides to receive this training to *enable them* to assist patients with their medications in *assisted living homes* and long-term care facilities" (Audio Recording of the House Health and Human Services Committee Meeting, February 13, 2008; emphasis added).
[21] OPLR Policy Scan utilizing AI tools from Westlaw and Vulcan (Justinian). See Appendix 2.3 for more information.
[22] OPLR Policy Scan utilizing AI tools from Westlaw and Vulcan (Justinian). Fifteen (15) states allow insulin administration in both SNFs and ALFs, 4 states allow insulin administration in SNFs but not ALFs, and 9 states allow insulin administration in ALFs but not SNFs. See Appendix 2.3 for more information.
[23] OPLR Policy Scan utilizing AI tools from Westlaw and Vulcan (Justinian). See Appendix 2.3 for more information.

incorporates its statutory review criteria.[24] 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.

Potential for Harm

While medication errors can be common, they typically do not result in serious harm. Residents of long-term care facilities tend to be, but are not always, older with a variety of physical and mental conditions and comorbidities. They require medication with differing levels of risk. In Utah, an error is broadly defined as a medication pass which includes the wrong drug or dosage, occurs at the wrong time, is given to the wrong patient, is given at the wrong rate, utilizes medications not properly prepared, or includes giving a patient a drug they are allergic to.[25] This definition is roughly aligned with measures in academic studies that suggest these types of errors are commonplace. There is a potential for error when administering any kind of medication but, while the consequences of medication errors can be severe, most errors do not result in serious harm.[26] The potential for harm can be particularly high, however, when controlled substances are involved.

The U.S. Department of Labor's O*NET Consequence of Error Ranking, which estimates the severity of harm that could come from different professions, places the consequence of error from a personal care aide (OPLR's proxy for medication aide) as 69 out of 100. This score is between that of licensed practical nurses (LPNs) at 61 and registered nurses (RNs) at 74.[27] This likely reflects, in part, the involved role an aide plays in the day-to-day care of a long-term care facility resident.

Other Factors Related to Harm

The potential for harm from medication administration is exacerbated by a lack of robust consumer choice. Residents in long-term care facilities have little choice regarding who helps administer their medications. While residents can choose a facility, once admitted they are cared for by the available staff. Changing facilities is possible, but not easy.

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[24] 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." See Utah Code Ann. § 13-1b-302.
[25] See Utah Admin. Code R429-1-2(10) for the full definition of a medication error.
[26] Young et al., "Types, Prevalence, and Potential Clinical Significance of Medication Administration Errors in Assisted Living," found a relatively high rate of medication errors (28%) in studied ALFs in Oregon, Washington, and New Jersey, most of which (>99%) were not clinically significant. Additionally, Zimmerman et al., "Medication Administration Errors in Assisted Living," found a 42% error rate in studied ALFs in South Carolina and Tennessee, but only a 7% error rate when only considering errors with a "moderate or high potential for harm." In both studies, errors of timing were the most common type of error.
[27] O*NET, "Work Context - Consequence of Error." OPLR used the ranking for 'Personal Care Aides' as a proxy for medication aides because a related job title is 'Certified Medication Aide' (O*NET, "Personal Care Aides"). The consequence of error analysis for 'Personal Care Aides' includes personal care tasks besides medication administration, but these are also in the scope of practice of a MAC in Utah (see Utah Code Ann. § 58-31b-102(10)(b)(i)(A)).

Additionally, workers passing medications in some facilities receive little in-person oversight from licensed RNs on a day-to-day basis. SNFs are required by federal rule to have an RN on-site every day for a minimum of eight consecutive hours,[28] but in other long-term care facilities, such as ALFs, there is no requirement for continuous nurse oversight. In these settings, it is possible for workers passing medications to do so without an RN or LPN at the facility to step in immediately if needed.

Limited academic research on this topic suggests that potential for harm is mitigated through training. For example, a study of ALFs in South Carolina and Tennessee found a 42% medication error rate, though this was reduced to 7% when confined to errors of either moderate or high risk of harm. Importantly, this study found evidence that unlicensed medication passers with less training were more likely to make errors than trained medication aides and LPNs.[29]

Potential for harm is also mitigated by the fact that workers passing medications in long-term care are always employees of state-regulated facilities. Facilities have incentives to mitigate medication errors through training and processes, given that DHHS sets facility requirements in rule and may cite facilities for not meeting those requirements.[30] Employer oversight alone may not prevent harm entirely, nor prevent bad actors from switching employment between facilities. DHHS oversight helps in other ways. For example, it requires employees of long-term care settings who have direct access to patients to undergo a background check through the department's Direct Access Clearance System (DACS), and an individual's ability to provide direct care (including passing medications) can be removed by DHHS for certain offenses.[31] However, the types of offenses that put someone's direct patient care access in jeopardy are criminal charges and convictions, so quality issues regarding medication errors would likely not be considered.[32]

For more detail on OPLR's analysis of medication aides according to the framework, see Appendix 3.2.

Recommendation

When there is potential for harm to vulnerable individuals exacerbated by low levels of consumer choice and varying degrees of effective direct oversight, it becomes more important for the state to set minimum competency standards for, and oversight of, a profession to help mitigate harm. However, a government credential that can be revoked may not be necessary, and may be overly burdensome, if the seriousness of potential harm is typically low to

[28] 42 C.F.R. § 483.35(b).
[29] Zimmerman et al., "Medication Administration Errors in Assisted Living."
[30] SNFs are required to ensure that medication error rates do not exceed 5% and that there are no "significant medication errors" (Utah Admin. Code R432-150-14(14)). ALFs are required to report medication errors and to make plans for improvement (Utah Admin. Code R432-270-18(14)-(16)).
[31] See Utah Admin. Code R432-35.
[32] See Utah Code Ann. § 26B-2-120; Utah Admin. Code R432-35-8.

moderate, if workers within that profession are always employed by regulated facilities with state-mandated minimum requirements, including training requirements, and if there are other preventative mechanisms in place to flag bad actors.

OPLR analysis indicates that, despite medication errors being common in these settings, DOPL rarely receives complaints about individuals administering medications (see the 'Model Adjustment Assessment and Recommendation' section below for more details). This suggests that these safety issues are being handled at the facility level and that individual-level licensure is not an effective enforcement tool for this profession.

As a result, OPLR recommends removing the MAC license and instead requiring medication passers in all long-term care settings to be trained as part of facility licensing requirements.

This regulatory change would represent a decrease in regulation on the SNF side (no longer requiring a license) and an increase in regulation on the ALF side (requiring standardized training).

Model Adjustment Assessment and Recommendation

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 4.1).

Safety

Limited quantitative evidence suggests that medication passers in long-term care settings (including MACs) are generally practicing safely, though medication errors do occur.

Since issuing the license, DOPL has received only one substantiated complaint against a licensed MAC, which was not related to resident safety.[33] DOPL received one other substantiated complaint, but this was against an individual who was not licensed.[34] See Appendix 4.2 for information on how OPLR uses DOPL complaint data.

However, data provided by DHHS indicates that medication-related citations are among the most frequently issued disciplinary actions in long-term care settings, though harm is not typically severe. In 2025, DHHS issued 64 citations to ALFs for violations of medication delegation and passing provisions, three of which involved a high risk of harm and 17 of which

[33] DOPL Complaint Data. The complaint against a licensed MAC was categorized as "Falsification of Application."
[34] DOPL Complaint Data. The individual claimed to be, and was practicing as, a MAC but did not have a license.

involved a moderate risk of harm.[35] During the same period, DHHS issued 9 citations to SNFs for failing to keep medication errors below 5% or keep residents free from serious medication errors.[36]

Currently, MAC training is relatively standardized in SNFs due to the license requirements (CNA prerequisite, 100-hour curriculum, required exam).[37] However, because individuals can pass medications in ALFs without the MAC license, training for these individuals is likely highly variable and dependent on the facility. This opens the door for someone to pass medications in an ALF with very little relevant training, which likely increases the risk of medication errors.[38]

Access

The current supply of MACs is likely not enough to meet all long-term care facility needs, given that the number of MACs (95) in Utah is dwarfed by the number of skilled nursing (90) and assisted living (225) facilities.[39] This means that, at most, only a quarter of facilities have access to a MAC. The number of MACs is likely low because they are mainly used in SNFs. ALFs are not required to hire direct patient care workers with a CNA credential and, as mentioned above, generally rely on medication passing to residents in those facilities under nurse delegation.[40]

Additionally, ALF administrators expressed difficulty accepting and caring for diabetic residents because in Utah insulin administration cannot be delegated to someone without a nursing license in that setting.[41] These facilities may be unable to administer insulin to residents on a daily basis because they are not required to have an RN on-site at all times. For this reason, ALFs may be unable to provide consistent diabetic care, which may lead residents with diabetes to 1) stay in an ALF and self-administer insulin, even if their condition makes it risky to do so; 2) stay in an ALF but pay for a home health nurse to administer their insulin; or 3) enter an SNF, which may not be ideal given their acuity level.[42] OPLR's rough calculations suggest that more than 1,500 ALF residents have diabetes, a subset of which may be affected negatively by this current regulation.[43]

Experience requirements (e.g., prerequisite of 2,000 hours as a CNA) may inhibit some workers

[35] Data provided by DHHS; the 64 citations were given in the course of 109 inspections, meaning there was less than one medication delegation and administration citation per inspection. There are other medication-related provisions for which DHHS cited ALFs, but these are related to medication error reporting and resident self-administration.
[36] Data provided by DHHS. There are other medication-related provisions for which DHHS cited SNFs.
[37] See Utah Code Ann. § 58-31b-302(3) and Utah Admin. Code R156-31b-802.
[38] See Zimmerman et al., "Medication Administration Errors in Assisted Living," discussed previously.
[39] Utah Department of Health and Human Services, Office of Licensing, List of "Regulated health facility programs," accessed September 2, 2025.
[40] OPLR Stakeholder Series: The requirement that all individuals giving direct care in ALF Type II facilities be on the CNA registry was removed in 2019. See Utah Office of Administrative Rules, "Section R432-270-8 Rule Analysis DAR File No. 43773."
[41] OPLR Stakeholder Series; DHHS "Assisted Living Nursing Guidelines."
[42] OPLR Stakeholder Series.
[43] OPLR Analysis. Based on the number of ALF beds in the state (Utah Department of Health and Human Services, Office of Licensing, List of "Regulated health facility programs," accessed September 2, 2025), an 85% ALF occupancy rate (estimate provided by the Utah Assisted Living Association), and estimates of diabetes prevalence in this setting (Caffrey et al., "Variation in Residential Care Community Resident Characteristics, by Size of Community").

from becoming licensed due to the high turnover of staff in long-term care settings.[44] Beyond the time required, a MAC qualification represents a modest but not insignificant cost given the low wages of this occupation.[45] It costs approximately $1,400–$2,200 to become a CNA and then obtain a MAC license in Utah, although some employers help pay for the cost of this training.[46] There are six approved MAC courses in Utah, although only one (administered by the Utah Healthcare Association) actively promotes its program throughout the state.[47]

Recommendations

1) Require individuals passing medications in SNF or ALF settings to complete a DHHS-approved certification course and have at least six months of prior setting-specific experience

As discussed in the 'Regulatory Model Assessment and Recommendation' section, OPLR recommends replacing the DOPL MAC license with training requirements for those passing medications under DHHS's SNF and ALF rules.

In lieu of a DOPL license, OPLR recommends that DHHS require medication passers in SNFs and ALFs to complete an approved medication aide certification course. While there are differences in the acuity level of residents in SNFs and ALFs, research indicates that a similar proportion of residents in each facility type either take five or more medications, take ten or more medications, and/or take antipsychotic medications and benzodiazepines.[48] Additionally, the resident population in both settings may include individuals who are elderly, infirm, and cognitively impaired. Requiring a standardized training course for both settings would address the variability in training between different ALFs and would be administratively more efficient for both DHHS and long-term care facilities.

DHHS should set minimum requirements for this training, covering both qualifications and content. Qualifications of, say, six months of patient care experience in the relevant setting, ensure medication passers are familiar with the context of their setting and with individual residents. Training requirements should specify the number of hours of didactic and clinical training, the topics covered, and a required examination. The state could simply require the course to be 100 hours, to reflect current MAC requirements. However, this would represent a significant increase in the training requirements for those passing medications in ALFs, who currently do not have any medication-related training requirements beyond what the delegating nurse feels is appropriate. Twelve states have the same training requirements for medication

[44] Gandhi et al., "High Nursing Staff Turnover in Nursing Homes Offers Important Quality Information," found that nationally, on average, nursing homes experienced a turnover rate of 129% per year.
[45] The median hourly wage for a CNA in Utah is $19.15: Utah Department of Workforce Services, "Occupation Details: Nursing Assistants." MACs likely make a couple of dollars more an hour than CNAs, though OPLR was unable to find concrete reported wage data for MACs.
[46] OPLR Stakeholder Series and OPLR analysis. CNA training cost of $440–$955 and MAC training cost of $920–$1,220 based on a review of three Utah CNA programs, one active MAC program, and exam fees for CNAs and MACs. DOPL, "Division of Professional Licensing Fees"; DOPL charges $50 for an initial application and $42 for a renewal application.
[47] DOPL, "Medication Aide-Certified Utah Approved Programs."
[48] Lei et al., "Medication Costs and Use of Older Americans in Assisted Living Settings."

passers in SNFs and ALFs. Among these states, the hour requirements range from 30 to 124, with an average of 72 hours and a median of 60 hours.[49] OPLR recommends requiring between 50 and 100 hours. All 12 of these states also require individuals to pass an examination.[50] OPLR recommends requiring certification courses to administer a standard examination that an individual must pass before being issued a certificate of completion.

Rather than develop the content of the training internally, DHHS could leave that to private groups (e.g., industry associations). However, DHHS would need to develop rules and processes for approving programs and overseeing facility compliance with this new training requirement.

2) Allow medication passers in SNFs and ALFs to administer long-acting insulin in a limited capacity (e.g., via a preloaded pen) with training

OPLR recommends allowing approved medication passers to administer insulin, limited to long-acting insulin via a preloaded insulin pen, in SNFs and ALFs. To facilitate this scope expansion, OPLR recommends that DHHS include insulin-specific training in the requirements of an approved medication aide certification course.

The inability of some ALFs to care for a segment of diabetic residents likely constrains access to care for those individuals. The administration of insulin, if performed improperly, can lead to serious complications, including hyper- or hypoglycemia,[51] and insulin administration is common among more serious medication errors.[52] However, long-acting insulin represents a consistent dose each day that does not require calculations, and administration from a preloaded pen is a relatively non-complex task.[53] Additionally, it is likely safer for an individual who has completed an approved medication aide certification course with some insulin-specific education to administer insulin than for an elderly patient to continue self-administering as their physical and mental capacities decline.

Allowing medication passers in SNFs and ALFs to administer insulin is not without precedent. Twenty-eight (28) states allow their medication aides to administer insulin in at least one long-term care setting. Ten of these states explicitly limit the device that a medication aide can use. The insulin-specific training required in these states ranges from 4 to 24 hours (see Appendix 2.3).[54]

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[49] OPLR Policy Scan utilizing AI tools from Westlaw and Vulcan (Justinian). See Appendix 2.3 for more information. These hour estimates include any additional hours required for individuals to be able to administer insulin. OPLR did not include Georgia in this analysis because analysts were unable to find concrete training hour requirements.
[50] OPLR Policy Scan utilizing AI tools from Westlaw and Vulcan (Justinian).
[51] Trief et al., "Incorrect Insulin Administration."
[52] McKay et al., "Review of Medication Error Sources Associated with Inpatient Subcutaneous Insulin"; errors associated with insulin administration make up an estimated 11-16% of "harmful medication errors."
[53] See UCLA Health, "Type I Diabetes Treatment." The process of administering insulin via a preloaded pen is relatively routine. It includes washing your hands, removing the pen cap, attaching a clean needle to the tip of the pen, dispensing a small amount of insulin to ensure it's working, dialing the pen to the correct dose, and quickly inserting the needle into the body. Proper disposal of the needle after use is vital; Cleveland Clinic, "Insulin Pens."
[54] OPLR Policy Scan utilizing AI tools from Westlaw and Vulcan (Justinian). See Appendix 2.3 for more information.

Other Considerations

Along with the stated recommendations, OPLR considered the following policies:

Requiring Separate Licenses for Medication Aides in SNFs and ALFs

An alternative approach to standardize the regulation of medication passers in SNFs and ALFs would be to require a license in both settings. OPLR considered recommending two separate licenses, one for medication passers in SNFs and one for medication passers in ALFs. OPLR ultimately decided against this approach due to the conclusions outlined in the 'Regulatory Model Assessment and Recommendation' section above.

Creating an Additional Insulin-Specific Add-On Credential

OPLR considered recommending the creation of an insulin administration credential that would be separate from the base medication aide training. Fourteen states similarly require additional training for insulin scope expansion.[55] However, OPLR favors including insulin training in the base medication aide certification training course. This avoids an overly complex regulatory environment and creates a workforce familiar with this very common medication. Additionally, the insulin-specific training is unlikely to add too much time to the certification course requirements.

Rule Review

In accordance with Utah Code Ann. § 13-1b-203(5), OPLR conducted an in-depth review of DOPL's nursing rules, which include rules related to Medication Aides Certified (MACs), found in Utah Admin. Code R156-31b.

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) 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 Utah Admin. Code R156-31b found:

1. no rules that are overly burdensome for licensees;
2. one rule misaligned with statutory language. This is outlined in Appendix 5.1;
3. no incorrect references to statute, but two instances of outdated language. These are outlined in Appendix 5.2; and

[55] OPLR Policy Scan utilizing AI tools from Westlaw and Vulcan (Justinian). See Appendix 2.3 for more information.

4. if OPLR's recommendation to replace the DOPL license with certification requirements in DHHS rule is adopted by the Legislature, all of the rules in R156-31b that reference MACs would need to be removed. This would include all of R156-31b-801.

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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 Division 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 Workforce Services, Health Resources and Services Administration, National Practitioner Data Bank)
- 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 Medication Aide Certified Licensee Renewal Survey

Survey overview

OPLR utilized a DOPL survey available to medication aides certified 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**.

Survey Limitations

The survey was available to all medication aides certified during the license renewal process, so results were not affected by sampling bias. The survey had a moderately high response rate of 45%. 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).

Other possible limitations include measurement error (which occurs when questions do not accurately measure the variable of 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. All of these potential errors may cause some variability or systematic bias.

OPLR uses this 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 Medication Aide Certified Literature and Policy Scans

To better understand the academic literature and regulatory environment for medication aides, OPLR utilized several AI tools (Gemini, Westlaw, and Vulcan's Justinian). OPLR analysts validated results produced by these AI tools. The validated sources were then used to evaluate research findings, 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.

OPLR used the following basic prompt to search for literature:

"*Please research any academic literature there is on medication aide certified (MAC) or unlicensed assistive personnel (UAP) and being delegated medication administration by a nurse. I want to see if any articles or research have been done on potential harm and/or medication errors through MAC or UAP administering medication. Please make me a chart that has 1. Name of the article 2. author(s) 3. Year published 4. Does the article mention MAC, UAP, or both MAC & UAP 5. Key Findings from the article 6. full url to the article"*

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 these tools to research how jurisdictions differ regarding specific policies, such as whether they have a licensure/certification for medication aides and the requirements for licensure/certification. The following is an example of a prompt used to research medication aide requirements in other states:

"*Could you pull information from each state regarding whether or not they have a license for someone to be able to pass medications? Put the information into the following table format: In column 1, put the name of the state, in column 2 indicate whether or not the state has a license for someone who passes medication (Yes or No), in column 3 indicate whether the license is mandatory or voluntary (Mandatory, Voluntary, or NA if there is no license), in column 4 list the required qualifications for the license (put NA if there is no license), in column 5 please put links for the exact sites you used to get the information. Please only use official government sources for this research."*

OPLR analysts then verified the AI tool's output.

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 AI that were not caught by OPLR's manual verification.

2 Background

2.1 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 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.

2.2 Difference Between Skilled Nursing and Assisted Living Facilities

Skilled nursing facilities (SNFs) provide constant nursing care to residents whose conditions do not warrant hospitalization but still require extensive care. SNFs are subject to extensive federal regulations that mandate training requirements for staff and staffing ratios, in addition to facility regulation by the Utah Department of Health and Human Services (DHHS).[56]

Assisted living facilities (ALFs) provide less intensive care to older or disabled residents whose conditions are less acute and who are able to function with greater independence. In Utah, an ALF's ability to accept a resident depends on the level of assistance that individual needs with activities of daily living (ADLs), and also their ability to exit the building independently in an emergency.[57] ALFs are not subject to federal regulation, but they are regulated as facilities by DHHS.[58]

2.3 Medication Aide Regulation in the U.S.

OPLR utilized AI tools from Westlaw and Vulcan (Justinian) to pull information on the regulations for non-nurse medication passers in long-term care facilities in each state. Analysts verified each result.

[56] 42 C.F.R. § 483; Utah Admin. Code R432-150.
[57] Utah Admin. Code R432-270-10.
[58] Utah Admin. Code R432-270.

Medication Passing in Long-Term Care Regulations by State*

	Skilled Nursing Facilities		Assisted Living Facilities	
State	*Regulatory Model***	*Insulin Allowed*	*Regulatory Model*	*Insulin Allowed*
Alabama	Govt. Credential	No	Not allowed	NA
Alaska	Training Requirement	No	Training Requirement	No
Arizona	Govt. Credential	No	Training Requirement	Unclear
Arkansas	Govt. Credential	Yes	Not allowed - assistance only	NA
California	Training Requirement	No	Not allowed - assistance only	NA
Colorado	Govt. Credential	Yes	Govt. Credential	No
Connecticut	Not allowed	NA	Not allowed - assistance only	NA
Delaware	Not allowed	NA	Training Requirement	Unclear
Florida	Training Requirement	Yes	Training Requirement	No
Georgia	Govt. Credential	Yes	Govt. Credential	Yes
Hawaii	Training Requirement	Unclear	Delegation	Unclear
Idaho	Govt. Credential	Unclear	Training Requirement	Unclear
Illinois	Govt. Credential	No	Govt. Credential	No
Indiana	Govt. Credential	Yes	Govt. Credential	Yes
Iowa	Govt. Credential	No	Training Requirement	No
Kansas	Govt. Credential	No	Govt. Credential	No

Kentucky	Govt. Credential	Yes	Govt. Credential	Yes
Louisiana	Govt. Credential	No	Govt. Credential	No
Maine	Govt. Credential	Yes	Training Requirement	Yes
Maryland	Govt. Credential	No	Govt. Credential	Yes
Massachusetts	Govt. Credential	No	Not allowed - assistance only	NA
Michigan	Govt. Credential	No	Training Requirement	Unclear
Minnesota	Training Requirement	No	Training Requirement	Unclear
Mississippi	Not allowed	NA	Not allowed - assistance only	NA
Missouri	Govt. Credential	Yes	Govt. Credential	Yes
Montana	Govt. Credential	Yes	Govt. Credential	Yes
Nebraska	Govt. Credential	Yes	Govt. Credential	Yes
Nevada	Govt. Credential	No	Training Requirement	Yes
New Hampshire	Govt. Credential	Yes	Govt. Credential	No
New Jersey	Delegation	Unclear	Govt. Credential	Yes
New Mexico	Govt. Credential	Yes	Govt. Credential	Yes
New York	Not allowed	NA	Govt. Credential***	Unclear
North Carolina	Govt. Credential	No	Govt. Credential	Yes
North Dakota	Govt. Credential	Yes	Govt. Credential	Yes
Ohio	Govt. Credential	Yes	Govt. Credential	Yes
Oklahoma	Govt. Credential	Yes	Govt. Credential	Yes
Oregon	Govt. Credential	No	Training	Unclear

			Requirement	
Pennsylvania	Govt. Credential	No	Training Requirement	Yes
Rhode Island	Govt. Credential	No	Govt. Credential	No
South Carolina	Govt. Credential	Yes	Training Requirement	Yes
South Dakota	Govt. Credential	Yes	Govt. Credential	Yes
Tennessee	Govt. Credential	No	Govt. Credential	No
Texas	Govt. Credential	No	Delegation	Yes
Utah	Govt. Credential	No	Training Requirement	No
Vermont	Govt. Credential	No	Delegation	Yes
Virginia	Govt. Credential	Yes	Govt. Credential	Yes
Washington	Govt. Credential	No	Delegation	Yes
West Virginia	Training Requirement	No	Training Requirement	Yes
Wisconsin	Training Requirement	Yes	Training Requirement	Yes
Wyoming	Unclear	Unclear	Not allowed - assistance only	NA

* OPLR Policy Scan utilizing AI tools from Westlaw and Vulcan (Justinian)
** The “Govt. Credential” label was applied to states that had a license, certification, or registry. States use these terms interchangeably, but in most cases this represents the government setting training requirements and maintaining the ability to revoke someone’s ability to practice, either through licensure or certification revocation or striking an individual from a government registry.
*** New York has an Advanced Home Health Aide that can pass medications in an “enhanced assisted living residence” (New York State Education Department, “Advanced Home Health Aides”).

Medication Aide Insulin Administration Policies in States Which Allow It*

State	Setting authorized	Specific insulin device	Additional training beyond MAC required	Required insulin-specific training
Arkansas	SNF	No	No	15 hours
Colorado	SNF	Yes	No	Unspecified
Florida	SNF	Yes	No	Unspecified
Georgia	SNF and ALF	No	No	Unspecified
Indiana	SNF and ALF	No	Yes	6–12 hours
Kentucky	SNF and ALF	Yes	Yes	24 hours
Maine	SNF and ALF	No	Yes	Unspecified
Maryland	ALF	No	No	Unspecified
Missouri	SNF and ALF	No	Yes	4 hours
Montana	SNF and ALF	Yes	No	Unspecified
Nebraska	SNF and ALF	No	No	Unspecified
Nevada	ALF	Yes	No	Unspecified
New Hampshire	SNF	Yes	No	Unspecified
New Jersey	ALF	Yes	No	Unspecified
New Mexico	SNF and ALF	Yes	Yes	16 hours
North Carolina	ALF	No	Yes	Unspecified
North Dakota	SNF and ALF	No	No	Unspecified
Ohio	SNF and ALF	Yes	Yes	Unspecified
Oklahoma	SNF and ALF	No	Yes	16 hours
Pennsylvania	ALF	No	Yes	Unspecified
South Carolina	SNF and ALF	No	No	Unspecified
South Dakota	SNF and ALF	No	Yes	10 hours
Texas	ALF	No	Yes	Unspecified

Vermont	ALF	No	Yes	Unspecified
Virginia	SNF and ALF	No	No	8 hours
Washington	ALF	No	Yes	Unspecified
West Virginia	ALF	Yes	No	Unspecified
Wisconsin	SNF and ALF	No	Yes	Unspecified

* OPLR Policy Scan utilizing AI tools from Westlaw and Vulcan (Justinian)

OPLR, with the assistance of Westlaw and Vulcan AI tools, identified 12 states that have the same requirement for medication passers across both SNFs and ALFs. A description of each of these states' requirements and scope of practice is below.

Training Requirements in States with Identical Regulations in SNFs and ALFs*

State	Hours Required	CNA Required	Insulin Allowed
Louisiana	120 hours (45 clinical, 75 didactic)	Yes, with one year of experience	No
Illinois	100 hours (40 clinical, 60 didactic)	Yes, with 2,000 hours of experience	No
Indiana	100 hours (40 clinical, 60 didactic)	Yes, with 1,000 hours of experience	Yes, optional add-on with an additional 4--8 didactic hours and 2–4 clinical hours
Kentucky	100 hours (60 clinical, 40 didactic)	CNA for 6 months or unlicensed direct care worker in setting other than SNF	Yes, optional add-on with an additional 16 didactic hours, 8 clinical hours, and 20 supervised injections
Kansas	75 hours (25 clinical, 50 didactic)	Yes	No
Tennessee	60 hours (20 clinical, 40 didactic)	Yes, with one year of experience	No
Rhode Island	45 hours	Yes	No

Nebraska	40 hours	No	Yes, if found competent and for specific patients
Oklahoma	40 hours (16 clinical, 24 didactic)	Must be a home health aide, long-term care aide, or ICF/IID care aide	Yes, optional add-on with an additional 12 didactic hours and 4 clinical hours
Ohio	30 hours (16 clinical, 14 didactic)	No	Yes, if trained by employer
South Dakota	20 hours (4 clinical, 16 didactic)	No	Yes, optional add-on with an additional 10 hours of training
Georgia	Unspecified	Yes	Yes

* OPLR Policy Scan utilizing AI tools from Westlaw and Vulcan (Justinian).

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.[59]

3.2 Model Assessment of Medication Aides Certified

The following table summarizes OPLR's analysis of medication aides certified (MACs) 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 MACs are highlighted in bold.

Model Assessment of Medication Aides Certified (MACs)	
Harm Factors	
Mechanism of Harm	If MACs administer the wrong medication, to the wrong patient, and/or at the wrong time/dosage, a resident can have an adverse reaction.*

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

Severity, Permanence, and Likelihood of Harm	**Research indicates that medication errors are not rare. However, most are not of serious consequence.** There is potential (though small) for more serious adverse reactions, especially when dealing with controlled substances.**
Consequence of Error	**69 out of 100*** **
Downstream Impact	Medication errors, if serious enough, can lead to the need for more urgent care, including hospitalization.
Consumer & Setting Factors	
Patient Vulnerability	**MACs frequently work with residents who are older or require additional care, many of whom have complicating conditions or comorbidities.**
Frequency of Physical Touch	MACs touch patients frequently as they help with personal care. The medication administration element of their job does not necessitate patient touch, though this would change if they were allowed to administer insulin.
Frequency of Private Setting	MACs are frequently alone with a resident in their room as they help administer medication, though these incidents are usually of short duration. They may spend more time alone with a patient when performing personal care tasks, such as helping to dress.
Information Asymmetry	MACs deal with routine medications. Residents may have been taking these medications for years and have an understanding of them, though this is not guaranteed.
Related Factors	
Independence	**MACs are not solo practitioners, and they do not exercise independent judgment. Rather, they follow orders from nurses or physicians in dispensing medications.**
Patient Choice	**MACs are assigned to residents, so residents do not choose the individual helping administer their medications.**
Information Availability	Residents do not generally receive information about the person who would administer their medications when choosing a long-term care facility.
Level of Oversight	*Employers:* **MACs are employees of long-term care facilities. They do not work independently.** MACs in SNFs likely receive higher levels of oversight from RNs, given these facilities are required to have an RN on-site for at least eight hours a day.**** ALFs do not have this requirement, so workers passing medications in these facilities may not always have an RN on-site. *Government:* The federal government has regulations for SNF staff,

	including that nurse aides must be certified, but leaves the question of whether those aides can administer drugs to states.^ **The Utah Department of Health and Human Services (DHHS) licenses SNFs and ALFs, issues rules these settings must abide by (including staff qualifications and medication error reporting), and inspects facilities to ensure compliance with statute and rule.^^** *Private Bodies:* MACs do not hold a credential from any private body, though their required training can be provided by a "health care association."^^^

*See Utah Admin. Code R429-1-2(10) for definition of a medication error.
** For example, Young et al., "Types, Prevalence, and Potential Clinical Significance of Medication Administration Errors in Assisted Living," found a relatively high rate of medication errors in ALFs, most of which were not clinically significant.
*** O*NET, "Work Context - Consequence of Error." OPLR used the ranking for 'Personal Care Aides' as a proxy for medication aides because a related job title is 'Certified Medication Aide' (O*NET, "Personal Care Aides"). The consequence of error analysis for 'Personal Care Aides' includes personal care tasks besides medication administration, but these are also in the scope of practice of a MAC in Utah (see Utah Code Ann. § 58-31b-102(10)(b)(i)(A)).
**** 42 C.F.R. § 483(b).
^ Relevant federal regulations include 42 C.F.R. § 483.35(d); 42 C.F.R. § 483.45.
^^ A license is required to operate a long-term care facility by Utah Code Ann. § 26B-2-206, and DHHS is required to inspect these facilities by Utah Code Ann. § 26B-2-202. DHHS's SNF and ALF rules can be found in Utah Admin. Code R432-150 and Utah Admin. Code R432-270, respectively.
^^^ Utah Admin. Code R156-31b-802(2): Training programs can also be offered by an "educational institution" or "health care facility."

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.[60]

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."[61] Violations that meet the criteria for investigation are then prioritized and assigned to an investigator. DOPL may resolve investigations in a variety of

[60] The document is also available on OPLR's website in the "About OPLR" section, accessible here: https://commerce.utah.gov/oplr/about/.
[61] DOPL, *An Explanation of the Complaint Handling Process for the Division of Occupational and Professional Licensing.*

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) and Salesforce to access closed complaints investigated by DOPL. MLO was used to analyze complaints between 2017 and 2022, while Salesforce was used for complaints between 2023 and 2024. 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

There was only one complaint brought to DOPL against a licensed medication aide certified during this period, and it appears related to falsifying an application. OPLR did not find it necessary to review the details of this case. OPLR did read notes from the case brought against an individual who was not licensed as a MAC but was acting as one.

Limitations

There are significant limitations to this analysis, and the information collected should not be interpreted as a precise estimate of harm caused by medication aides certified. 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 potential for harm and may generate more complaints. For example, surgeons have a higher likelihood of causing severe harm to a patient than medication aides certified because surgery is inherently far riskier, not because surgeons are "less safe" or less competent than medication aides.

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.

5 Rule Review

5.1 Rule Language Misaligned With Statutory Language

According to Utah Admin. Code R156-31b-801(1)(e), medication aides certified (MACs) are allowed to help patients self-administer medications. However, the Nurse Practice Act expressly prohibits MACs from helping a patient self-administer (see Utah Code Ann. § 58-31b-302(3)(d)). Thus, it appears that Utah Admin. Code R156-31b-801(1)(e) is not aligned with statute and should be removed.

5.2 Outdated Rule Language

OPLR found two instances of outdated language in the provisions of the Nurse Practice Act Rule that need to be updated.

First, Utah Admin. Code R156-31b-302g(2) requires MACs to pass the Medication Aide Certification Examination (MACE) administered by the National Council of State Boards of Nursing (NCSBN). However, the MACE is now administered by an organization called Credentia rather than NCSBN.[62] Rule language should be updated accordingly.

Second, Utah Admin. Code R156-31b-802(3)(a) requires MAC training programs to utilize the model curriculum adopted by the NCSBN in 2007. However, OPLR was unable to find this curriculum on NCSBN's website.[63] It is possible, given that the NCSBN no longer administers the MACE, that their model training program curriculum no longer exists, or at least has not been updated recently. DOPL should consider removing references to the NCSBN curriculum and either finding an alternative or developing its own.

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.

[62] NCSBN, "NNAAP & MACE."
[63] OPLR did find a copy of the NCSBN model MAC curriculum through the Washington State Board of Nursing's website (NCSBN, "Medication Assistant-Certified (MA-C) Model Curriculum").

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 medication aides, 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 medication aides certified). 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 medication aides certified (patients and residents), so their perspectives were not incorporated into this review. Thus, the stakeholder engagement and findings from these interviews should not be understood to be 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 Ann. § 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 those OPLR engaged with throughout the review of nursing and related professions. Professional credentials (such as MD and DNP) were omitted for simplicity. Those who contributed to the medication aide review specifically are highlighted in gray.

Stakeholder Engagement Summary	
Utah State Legislature	
Legislative Working Group	**Rep. Bridger Bolinder** **Rep. Katy Hall** **Rep. Cory Maloy** **Rep. Logan Monson** **Rep. Angela Romero** **Rep. Raymond Ward** **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	**Josip Ambrenac,** Director, Office of Long Term Services and Supports **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, Coordinate Care, and 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, and Audit **Jessica Fiedel,** Licensing Manager, Office of Licensing **Heather Flint,** Licensing Manager, Office of Licensing **Teri Garfield,** Senior Registered Nurse, Integrated Healthcare **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 **Marisol Lobo,** Manager, New Choices Waiver Program **Kyle Lunt,** Director, Office of Data, Systems & Evaluation **Daphne Lynch,** Director, Office of Background Processing **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 **Alianne Sipes,** State of Utah Long-Term Care Ombudsman **Alyssa Smailes,** Director, Office of Legislative and Government Affairs **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 **Shannon Thoman-Black,** Director, Division of Licensing and Background Checks **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
Utah Department of Workforce Services	**Ben Crabbe,** Chief Economist **Dave Forgerty,** Assistant Director, Division of Workforce Research & Analysis **Chris Williams,** Director, Division of Workforce Research & Analysis
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