Bridging the Gap

CLINICAL PRECEPTORS FOR PHYSICIANS AND ADVANCED PRACTICE REGISTERED NURSES IN UTAH

A brief summary of the clinical preceptor issue and recommendations to strengthen the physician and APRN pipeline in the Beehive State

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BACKGROUND

CLINICAL training is an essential component of preparing a state's health workforce. Members of the Utah Health Workforce Advisory Council (HWAC) have consistently identified clinical preceptor shortages as one of the most pressing challenges impacting health professions education and workforce development. This issue has also garnered prior interest from state legislators (as reflected by the introduction of House Bill 386 in the 2023 session). In direct response, the HWAC prioritized the examination of Utah's clinical preceptors landscape and the development of actionable recommendations as a central focus in its 2024 Action Plan.

Under the authority of the Health Workforce Act and in partnership between the HWAC and Utah Health Workforce Information Center (HWIC), the Department of Commerce's Division of Professional Licensing began collecting supplemental workforce data from Utah's licensed physicians and advanced practice registered nurses (APRNs) as the first professions prioritized for collection and analysis (due to priority establishment by the Legislature and in alignment with professional renewal timelines). The data captured from these professionals during license renewal was prioritized by the HWAC to include professionals' self-reported participation as a preceptor.

Although the HWAC recognizes that a wide range of health professions report difficulties securing sufficient preceptorship opportunities, clearly defining the scope of the study was essential to ensure meaningful analysis and develop feasible recommendations. Therefore, given the data that were available for Utah physicians and APRNs, the initial clinical preceptor study and associated recommendations was focused on these professions. However, the methodology and approach lay the groundwork for expansion to include an assessment and additional professions in future years, if prioritized by the HWAC or other entities.

IN THIS BRIEF

- Review of clinical training needs for physicians and advanced practice registered nurses
- Landscape of the current clinical preceptor workforce

RELATED DOCUMENTS

- HWAC Clinical Preceptor Recommendation
- HWAC Clinical Preceptor Subcommittee: Policy Research and Process

This document outlines the findings from data analyses and stakeholder perspectives to contribute to knowledge on the clinical preceptor landscape within the state of Utah, outlining training needs; current capacity; and perspectives from practicing professionals (both preceptors and non-preceptors), training programs, and other key stakeholders. Accompanying documents have been prepared to outline details about the HWAC's Clinical Preceptor Subcommittee establishment, associated policy research, recommendation development process, and presentation of the HWAC recommendation.

BRIDGING THE GAP

IN CLINICAL PRECEPTORS FOR PHYSICIANS AND ADVANCED PRACTICE REGISTERED NURSES

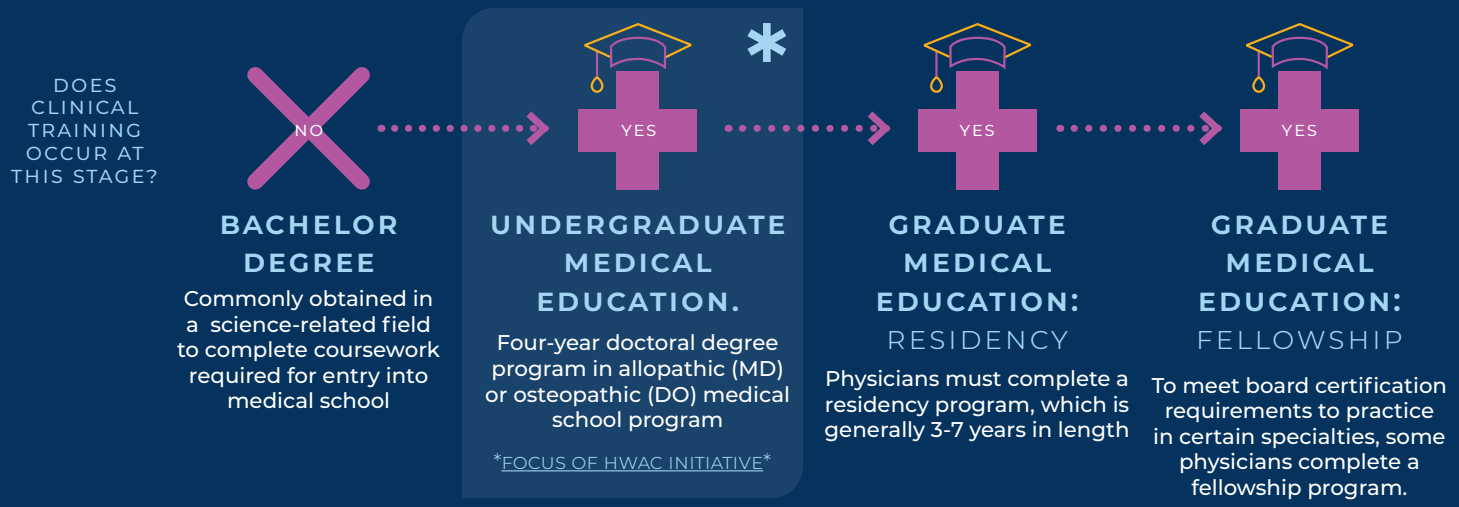
CLINICAL TRAINING NEEDS

WHAT ARE THE CLINICAL TRAINING NEEDS FOR PHYSICIAN AND ADVANCED PRACTICE REGISTERED NURSE STUDENTS?

PHYSICIANS

Physicians are healthcare professionals that diagnose and provide treatment for a variety of health conditions. Physicians are trained with a doctoral degree in medicine and receive specialized post-doctoral training in their desired specialty. Below is a graphic of a common education and training timeline for physicians, including associated clinical training needs and prioritization (identified after conducting interviews with stakeholders as outlined later in report).

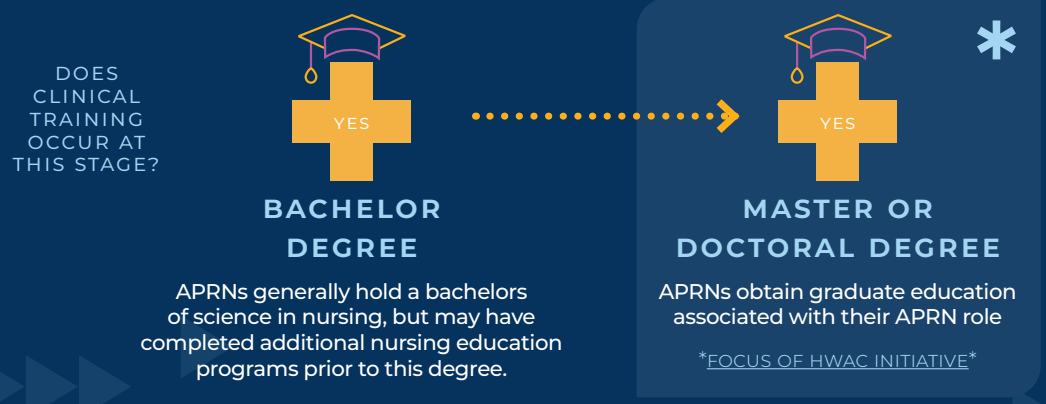
TIMELINE OF PHYSICIAN EDUCATION/TRAINING



ADVANCED PRACTICE REGISTERED NURSES

Advanced practice registered nurses (APRNs) are healthcare professionals that practice an advanced level of registered nursing to provide diagnosis, treatment, and management of diseases. APRNs generally hold a master's degree or higher in an APRN-related field, in addition to the education and training required to obtain their registered nurse license. APRNs practice in one of four APRN roles: Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), and Certified Registered Nurse Anesthetist (CRNA). Below is a graphic of a common education and training timeline for APRNs, including associated clinical training needs and prioritization (identified after conducting interviews with stakeholders as outlined later in report).

TIMELINE OF APRN EDUCATION/TRAINING



A DEEPER DIVE INTO THE CLINICAL TRAINING NEEDS OF UTAH MEDICAL AND APRN STUDENTS

	PHYSICIANS	APRNs
What are the greatest unmet clinical training workforce needs?	**MEDICAL SCHOOL** Utah's physician clinical training workforce needs exist for students enrolled in in undergraduate medical education at a four-year allopathic (MD) or osteopathic (DO) medical school.	**PARTICULARLY ACUTE FOR NURSE PRACTITIONER STUDENTS** There is a significant need for clinical training support for APRN students during their clinicals. Needs exist for all APRN students, but are particularly pertinent for **nurse practitioner (NP)** students.[1]
What clinical training is required for these students?	**CLINICAL ROTATIONS** Medical students complete **clinical rotations** (also referred to as clinical clerkships) in their **third and fourth years of medical school**. Clinical experiences include content related to each organ system. These are commonly conducted in **four to twelve week rotations** in the areas of Emergency Medicine, Family Medicine, Internal Medicine, Neurology, Obstetrics-Gynecology/ Women's Health, Pediatrics, Psychiatry, and Surgery,[2] but may include additional specialties based on medical school curriculum or the student's area of interest. This equates to at least 8 preceptorships (of at least 160 hours, or four weeks) per medical student over the course of their training.	APRN students complete clinical training as a part of their graduate training. The timing and volume of training hours is dependent upon the APRN role and academic program, but **national accreditation requirements also provide insight as to the volume of hours required per student.** This equates to at least 5 preceptorships (of at least 160 hours, or four weeks) per APRN student over the course of their training. **TRAINING HOURS NEEDED** **NP** — **750** HOURS[3] **CNS** — **500** HOURS[4] **CRNA** — **2,000** HOURS + **+600** CLINICAL CASES[5] **CNM** *Clinical experiences are defined by minimum numbers of experiences in certain settings or visit types*[6]

1 *Addressing the Preceptor Gap in Nurse Practitioner Education. Journal of Nurse Practitioners. 2023. Available at: https://www.sciencedirect.com/science/article/pii/S1555415523003203*

2 *2024 Graduation Questionnaire All Schools Summary Report. Association of American Medical Colleges. Available at: https://www.aamc.org/media/78536/download*

3 *The National Task Force for Quality Nurse Practitioner Education outlines 750 direct patient care hours required for NPs. Doctoral level programs may have greater requirements.*

4 *Based on the 2021 American Association of Colleges of Nursing Essentials model, which is a minimum of 500 hours to achieve Level 2 (advanced-level nursing education) sub-competencies for all advanced-level nurses (APRNs.*

5 *CRNA clinical training requirements defined in program accreditation standards (p. 14).*

6 *CNM clinical training requirements include: 10 preconception care visits, 15 new antepartum visits, 70 return antepartum visits, 20 labor management experiences, 20 births, 20 newborn assessments, 20 early postpartum visits, 15 postpartum visits, 10 breastfeeding support visits, 20 family planning visits 40 gynecologic visits, 40 primary care visits.*

A DEEPER DIVE INTO THE CLINICAL TRAINING NEEDS OF UTAH MEDICAL AND APRN STUDENTS

(CONTINUED FROM PREVIOUS PAGE)

	PHYSICIANS CONT.	**APRNs** CONT.
Who provides clinical training?	**PHYSICIANS** Medical student clinical training generally occurs under the supervision and direction of clinical-based physicians (MD and DO), generally referred to as "clinical preceptors." However, institutional policies may vary on other types of providers (such as APRNs or physician assistants) who may also serve as a clinical preceptor to medical students. Given the breadth of clinical training content required by medical school accreditation[7], this workforce **must include providers from a variety of specialties and settings to train each medical student.** The clinical preceptor workforce is generally secured through agreements and affiliations between academic programs and clinical training sites.	**LICENSED AND CERTIFIED APRNS FROM ALIGNED ROLE** Clinical training for APRNs is generally provided by an **APRN that is licensed/certified and practicing in the APRN role that aligns with the academic program** (ex. nurse practitioners serve as clinical preceptors for nurse practitioner students while nurse midwives serve as preceptors for nurse midwife students). However, other health care professionals (including other APRN roles and non-APRNs) may serve as preceptors as well, depending upon program accreditation requirements and program structure.[8]
What resources currently exist to support clinical preceptors for medical and APRN students?	**74% UNCOMPENSATED NATIONALLY** Nationally, most medical student clinical preceptors (74%) are **uncompensated** for their training contributions.[9] Although the current landscape of support for these activities in Utah is grossly unknown, anecdotal reports demonstrate that some physicians preceptors are provided a stipend, adjunct appointment, or other university-based incentives in exchange for their service.	**90% UNCOMPENSATED NATIONALLY** A recent study found that nationally, only 10% of APRN graduate programs are paying for preceptors, meaning that **most APRN clinical preceptors are uncompensated by the academic program**.[10] The current landscape of support for these activities in Utah is grossly unknown.

7 *Functions and Structure of a Medical School. Liaison Committee on Medical Education. 2024. Available at: https://lcme.org/wp-content/uploads/2024/08/2025-26-Functions-and-Structure_2024-08-01.docx*

8 *For example, CNM program accreditation requires that 50% or more of clinical faculty must be CNMs or Certified Midwives (CMs) and 50% of clinical training must be supervised by CNMs/CMs. More specific requirements for NP preceptors can be found here (Table 3).*

9 *Teach Learn Med. 2019 Jun-Jul;31(3):279-287. doi: 10.1080/10401334.2018.1528156. Epub 2018 Dec 31.*

10 *AACN-AONL Clinical Preceptor Survey Summary Report*

LANDSCAPE

WHAT IS THE CURRENT LANDSCAPE OF UTAH CLINICAL PRECEPTORS?

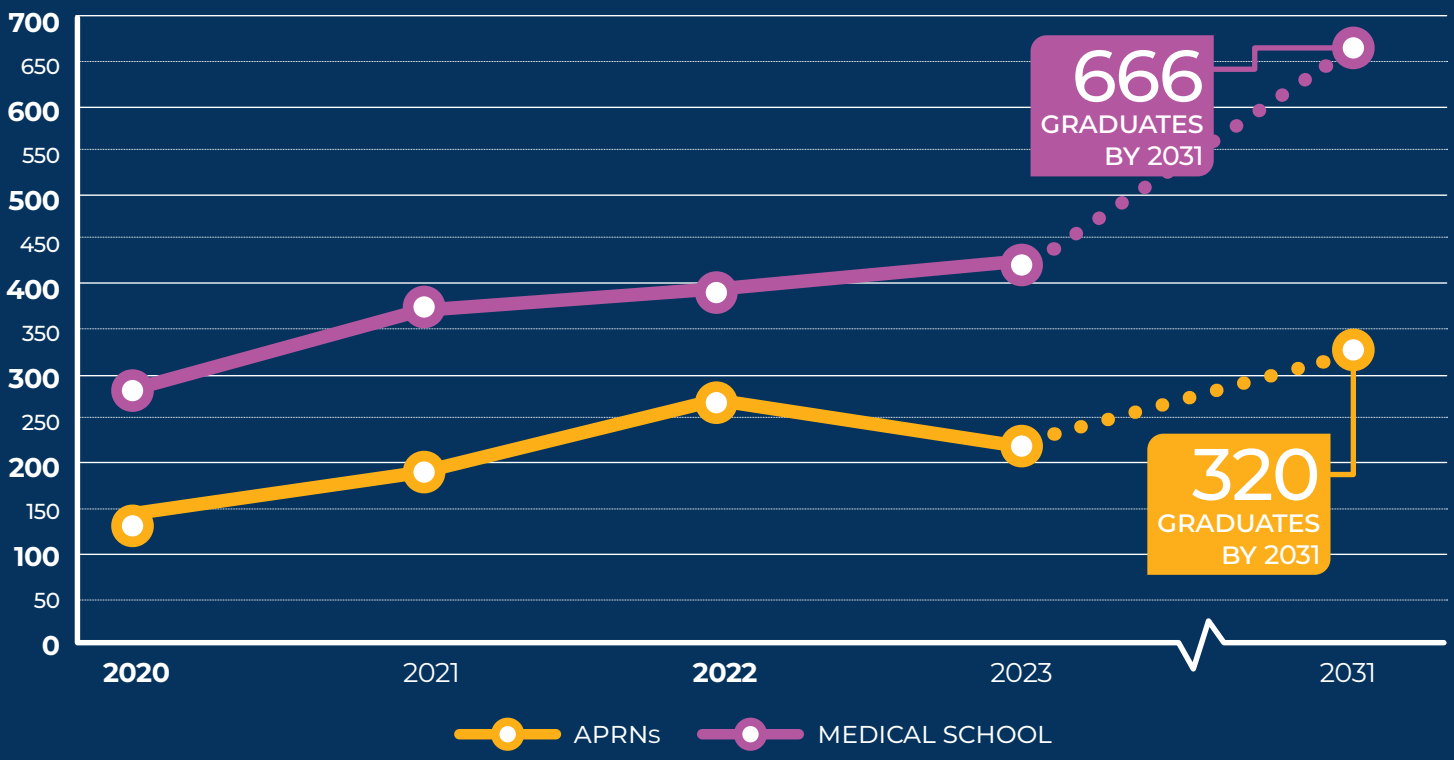
WHAT IS THE NEED FOR CLINICAL PRECEPTORS?

CLINICAL training is a core component of each physician and APRN's training period. Although the specifics of clinical training requirements differ for each profession and program, gross numbers of program graduates provide general information as to how many clinical preceptors are required.

In 2023 (the latest data available), Utah graduated 412 physicians and 216 APRNs from Utah-based programs. The number of graduates has increased over the last three years and is expected to further increase with the establishment of new medical schools (such as Noorda College of Osteopathic Medicine, expected to grade its first class of approximately 75 students in 2025 but growing to a maximum class size of 194 students, and Brigham Young University).

ANNUAL GRADUATES FROM UTAH-BASED PROGRAMS

IN MEDICAL AND APRN PROGRAMS



Sources: *Integrated Postsecondary Education Data System (IPEDS), Education Data Portal (Version 0.22.0), Urban Institute, accessed December, 9, 2024, https://educationdata.urban.org/documentation/, made available under the ODC Attribution License. 2022-2023 graduations data came from the provisional data release by the U.S. Department of Education, National Center for Education Statistics, Integrated Postsecondary Education Data System (IPEDS), Completions component, https://nces.ed.gov/ipeds/SummaryTables/report/360?templateId=3600&year=2023&expand_by=0&tt=aggregate&instType=1&sid=a6cbb1af-02db-4cc1-8864-4f0af6c0c694. National Registry Match Data, 2020-2023. Available at: https://www.nrmp.org/match-data/*

Note: *Includes Rocky Vista University graduates; RVU is based in Colorado and currently has program locations in CO, UT, and MT. While IPEDS state information is specified in Colorado, graduate numbers reflect completions from students across multiple states including Utah. 2031 projections are based on known growth among the medical school enrollment as reported by Noorda and BYU, and an assumed 5% annual growth for APRNs.*

11 https://www.ksl.com/article/51109906/newest-medical-school-expands-to-keep-more-medical-students-in-utah#:~:text=This%20year%20is%20a%20major,our%20next%20class%20of%20students

12 https://news.byu.edu/medical-school/medical-school-announcement

QUANTIFYING PRECEPTOR DEMAND

APPROX. MINIMUM NUMBER OF PRECEPTORSHIPS PER GRADUATE

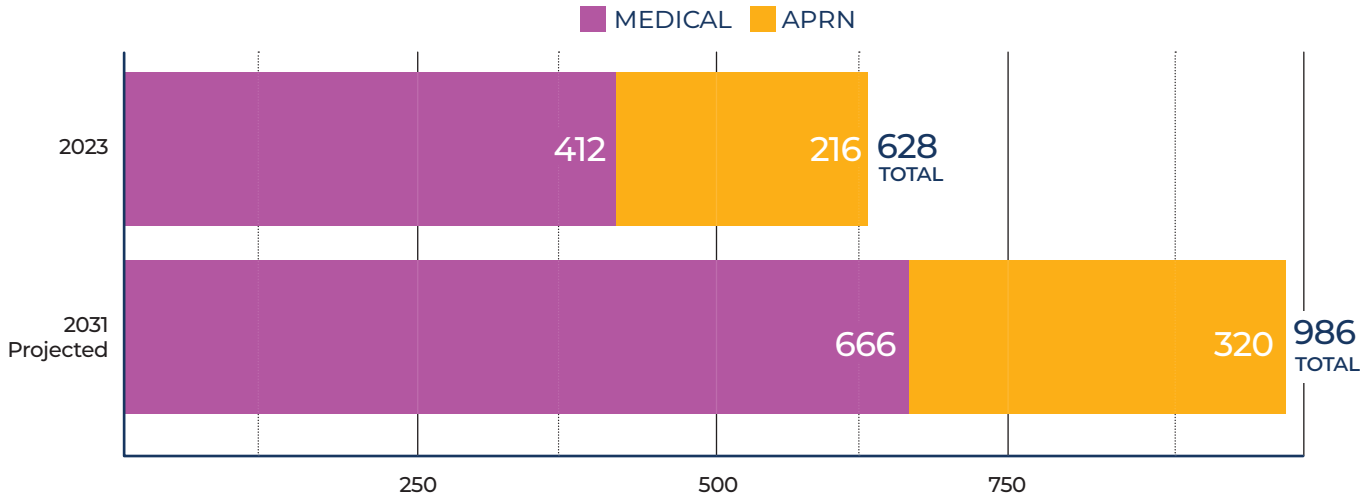
FOR MEDICAL STUDENTS

8

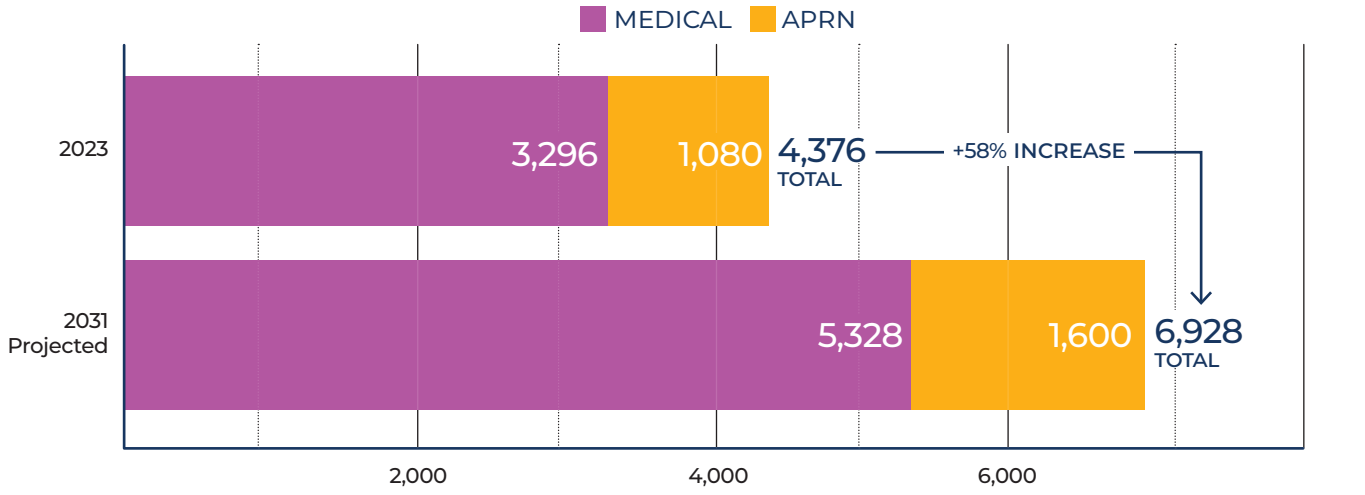
FOR APRN STUDENTS

5

NUMBER OF GRADUATES



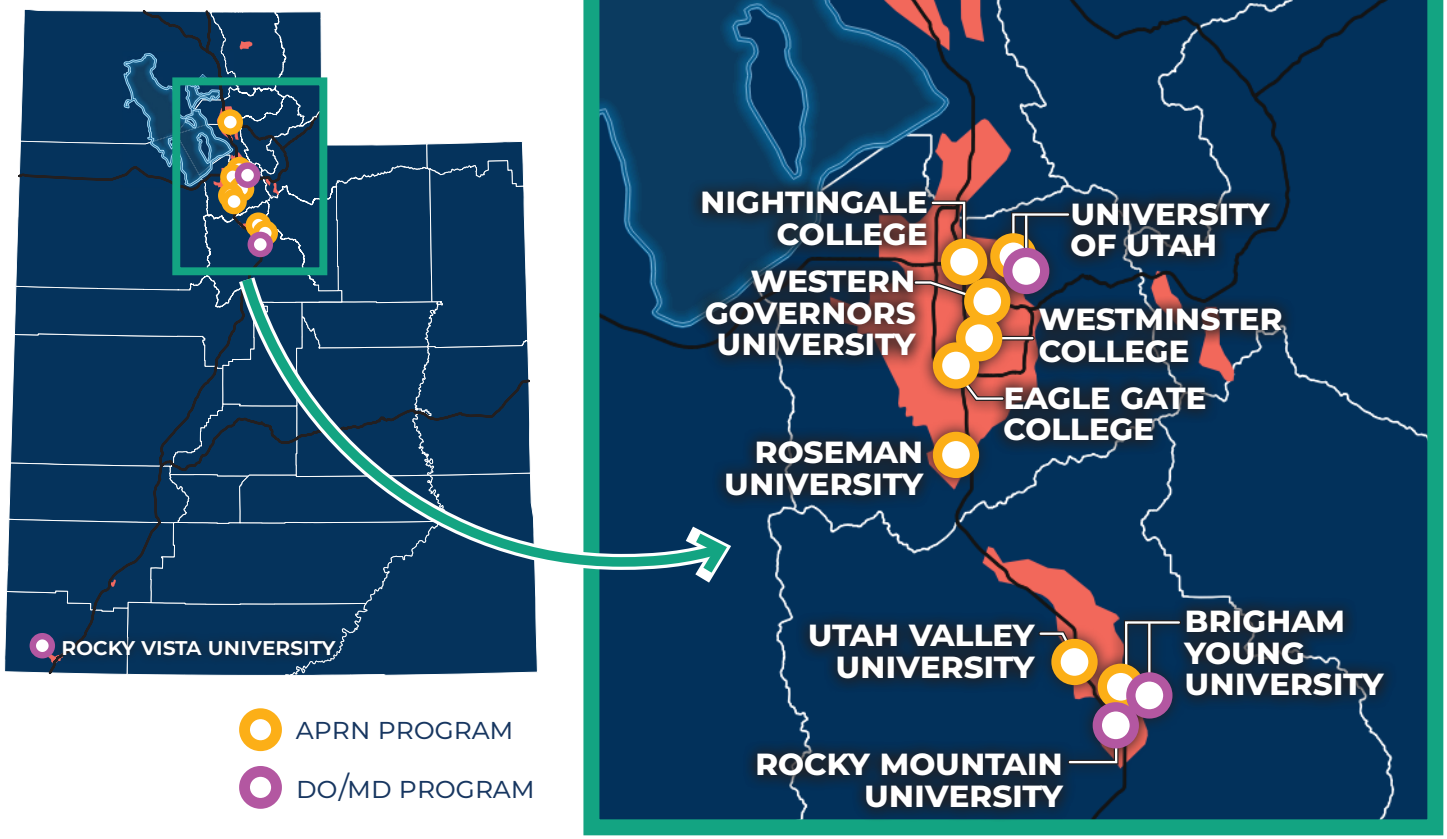
NEED FOR PRECEPTORS



In addition to requiring clinical training during medical school, physician trainees require clinical experiences during residency and fellowship programs. Below is a graphic demonstrating the volume of annual medical residents entering into programs over the last four years, with 216 residents starting their programs in 2023.

UTAH ACADEMIC LOCATIONS

The need for clinical precepting among Utah's medical and APRN students is significant. While most academic programs are centrally located, the hope is that clinical training would occur statewide to support Utah's aim of strengthening the health workforce across all communities.



WHAT IS THE CURRENT KNOWN CLINICAL PRECEPTOR WORKFORCE CAPACITY?

DURING the latest license renewal period for physicians and APRNs, licensees were administered a voluntary survey to provide additional information about their practice characteristics. Among these questions, respondents were asked whether they serve as clinical preceptors. This allows for additional information on current known clinical preceptors to be reviewed and compared to the non-precepting physician and APRN workforces.[13]

GENERAL INFORMATION

Of Utah's 14,324 physicians, 6,940 responded to the survey and 4,155 (59.9%) indicated they serve as a clinical preceptor. Preceptor participation rates are similar among physician license types, with 59.9% of MDs and 64.2% of DOs report serving as a preceptor. Of Utah's 5,818 APRNs, 2,976 responded to the survey and 1,633 (54.9%) reported serving as a clinical preceptor. Most of these precepting APRNs are nurse practitioners (85.6%) because they are the most common APRN specialty, but service as a preceptor is greatest among certified nurse midwives and certified registered nurse anesthetists.

WHAT LICENSURE SURVEY DATA CAN DO

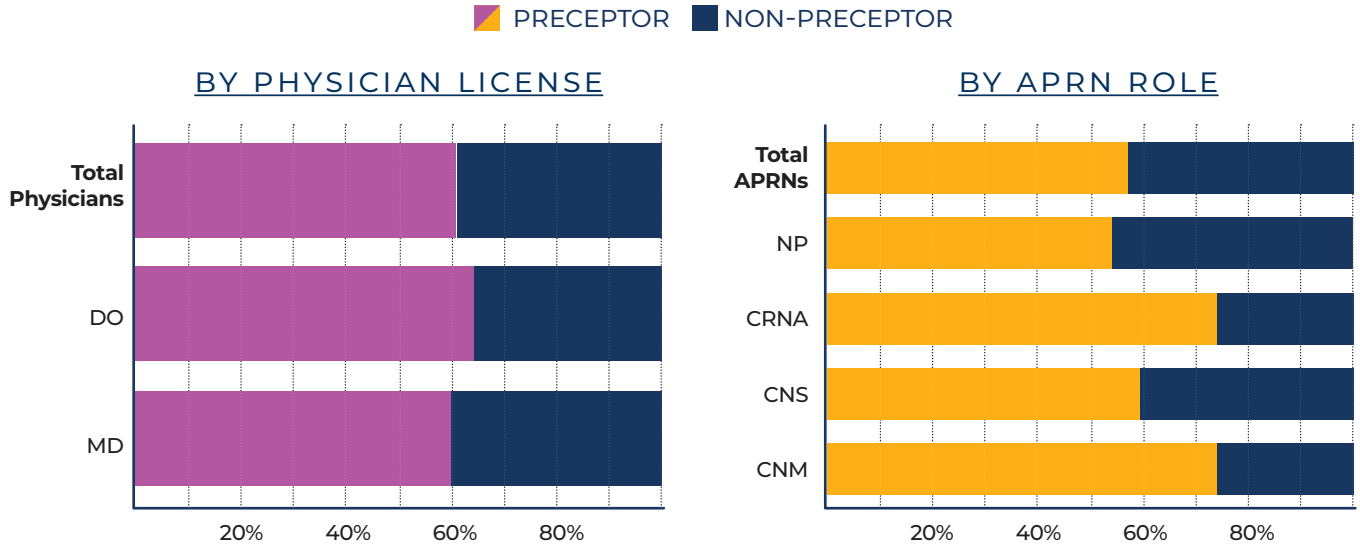
- Provides insight into the known number of clinical preceptors in Utah
- Enables a detailed look at preceptors for certain program types, specialties, settings, and geographies

CONSIDERATION FOR ENHANCEMENT:

All licensure survey data presented below include only survey respondents, which represents about 50% of Utah's physician and APRN licensees. If the survey was migrated from voluntary to required, Utah would have knowledge of the full landscape of clinical preceptors and would be better positioned to monitor the impact of any policy implemented to enhance the clinical preceptor workforce.

PRECEPTOR PARTICIPATION RATES, BY ROLE

AMONG SURVEY RESPONDENTS



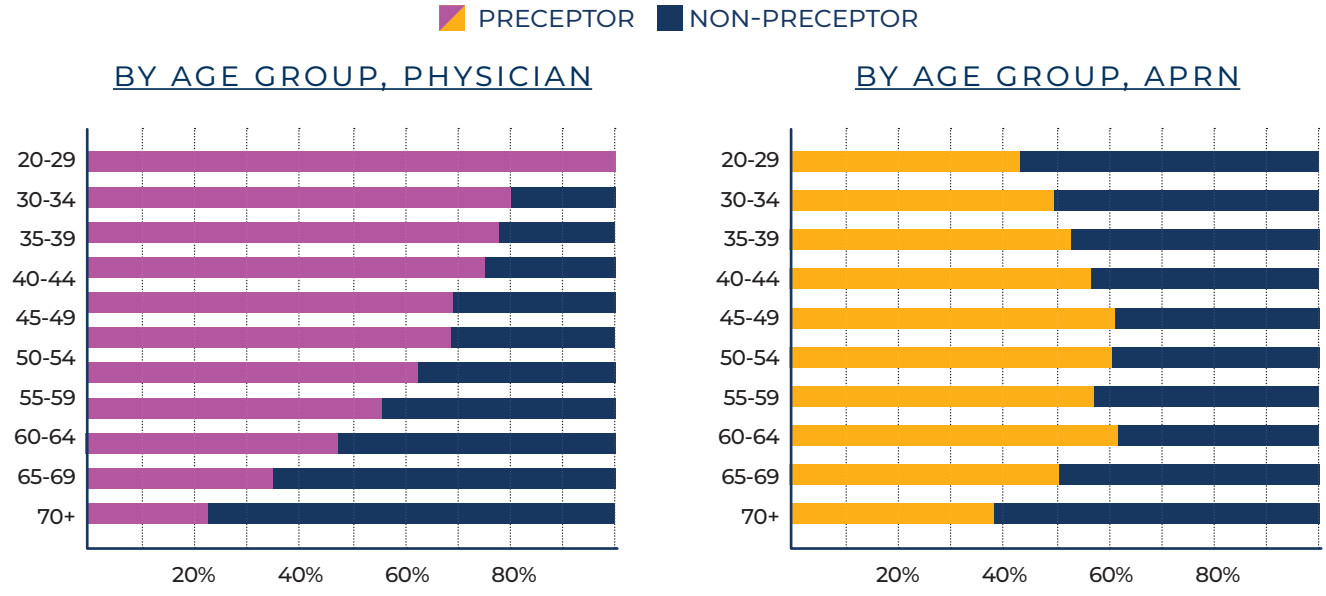
13 *It is important to note that due to the voluntary nature of the survey, the data described below include only the known preceptors, and there are likely additional clinical preceptors that did not respond to the survey.*

DEMOGRAPHICS

Rates of APRN preceptor participation are similar across each age group, but among physicians, there is a greater frequency of participation among younger physicians.

PRECEPTOR PARTICIPATION RATES, BY AGE

AMONG SURVEY RESPONDENTS

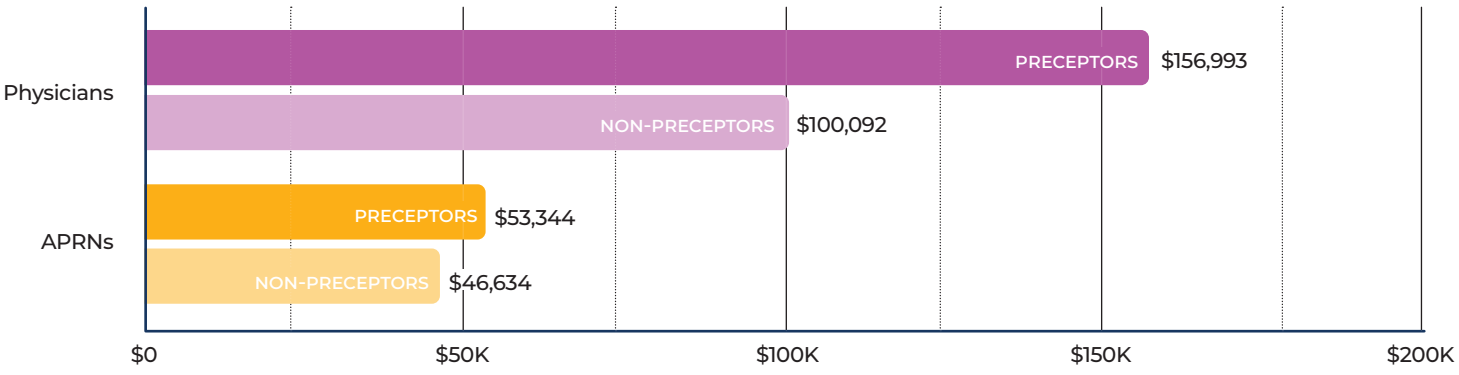


EDUCATIONAL CHARACTERISTICS

Both APRN and physician preceptors report a higher educational debt burden compared to non-preceptors.

AVERAGE EDUCATIONAL DEBT

AMONG SURVEY RESPONDENTS



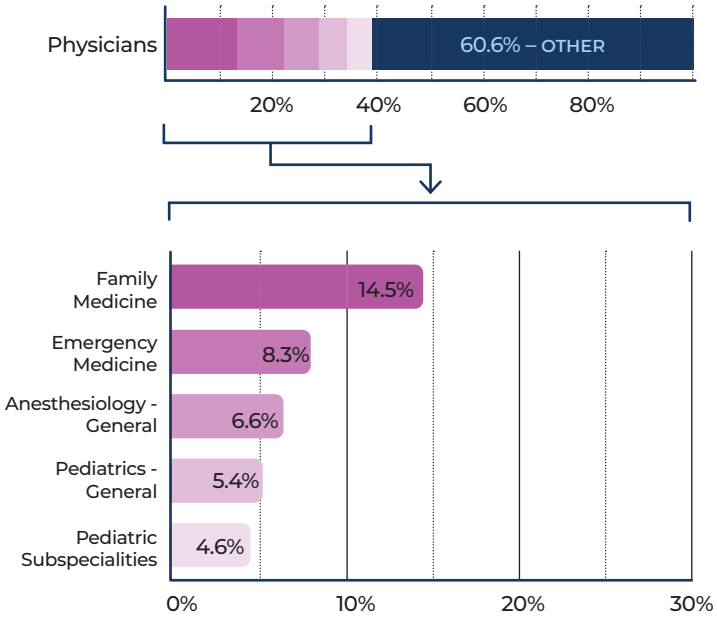
Debt calculations should be considered estimates. Educational debt was calculated using the midpoint of the educational debt range of the response selected by respondents. Calculation excludes non-respondents to this question and suppressed responses.

PRACTICE CHARACTERISTICS

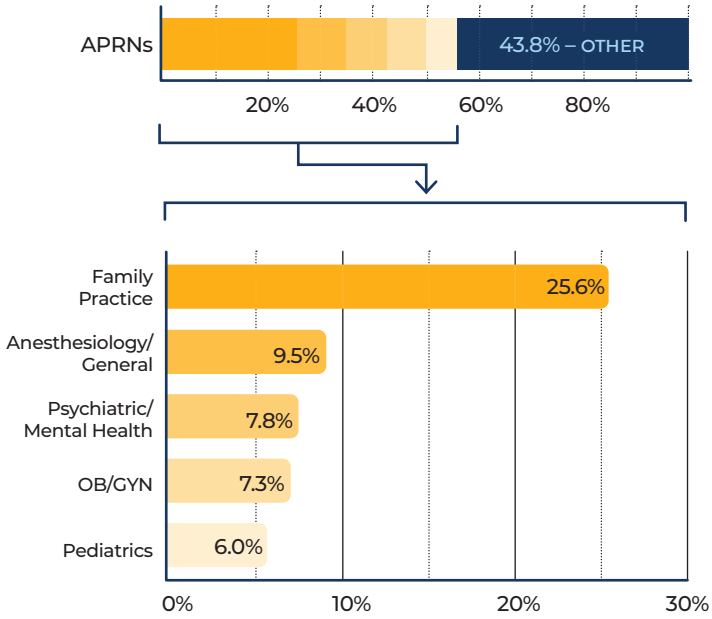
As it relates to roles and specialty, family medicine is the top specialty among both APRN and physician preceptors. APRN preceptors reported hospitals and outpatient clinics as their top practice setting, while the top practice setting among physician preceptors was an academic institution.

PRECEPTOR SPECIALTIES AMONG SURVEY RESPONDENTS

TOP SPECIALTIES: PHYSICIANS

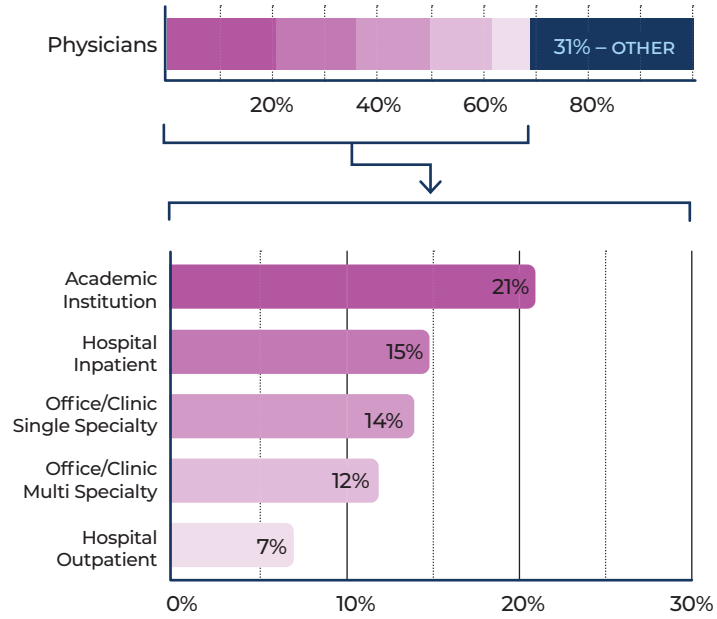


TOP SPECIALTIES: APRNs

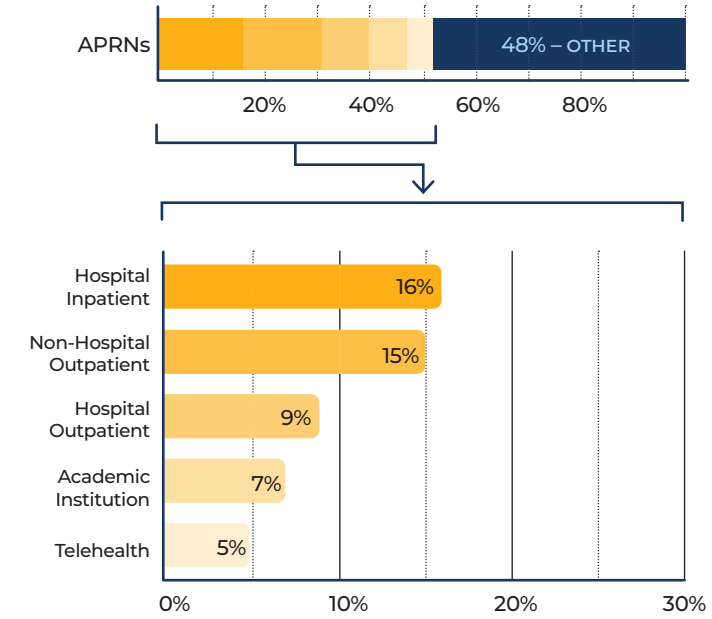


PRECEPTOR SETTING AMONG SURVEY RESPONDENTS

TOP SETTINGS: PHYSICIANS



TOP SETTINGS: APRNs

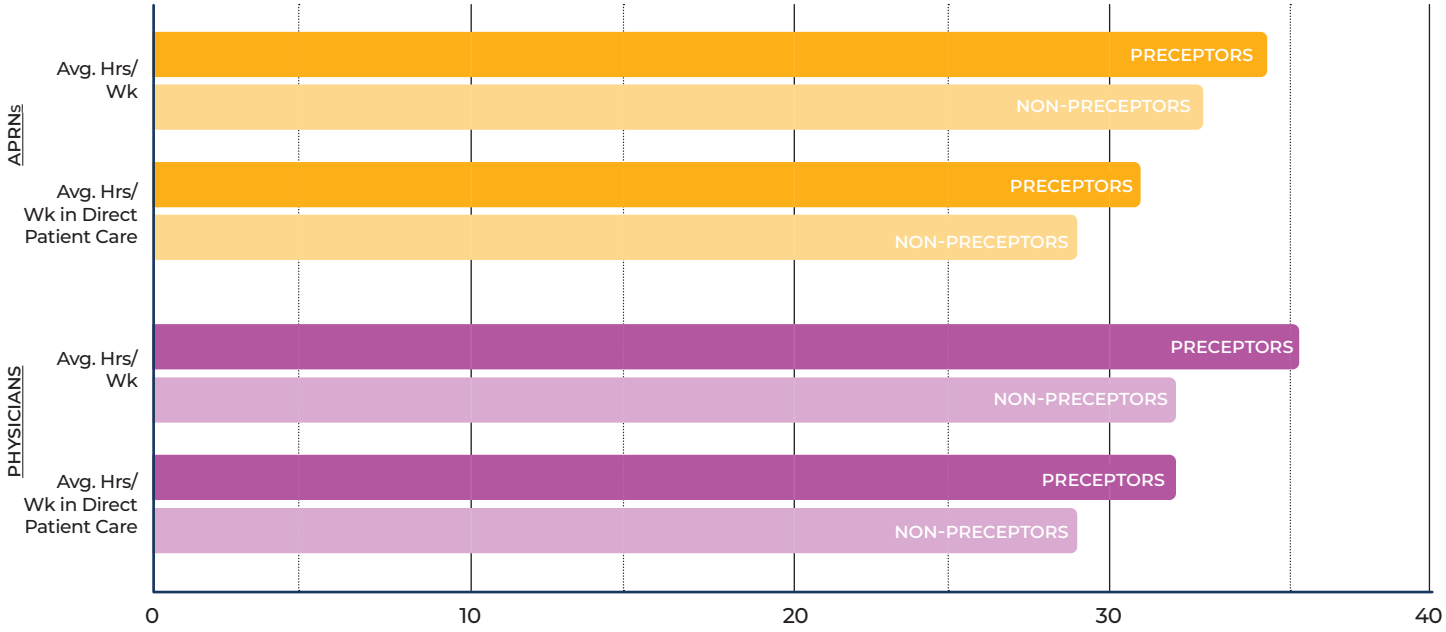


PRECEPTOR SETTING

Although inpatient hospital settings is the most common among preceptors, preceptor participation is greatest among physicians and APRNs working at FQHCs, with nearly 79% of FQHC-based professionals that report serving as preceptors.

As it relates to general time spent in their positions, both APRN and physician preceptors report working more hours per week, including time in direct patient care compared to their non-preceptor peers. However, both preceptors and non-preceptors averaged about a four-hour difference between their reported total hours per week and those in direct patient care.

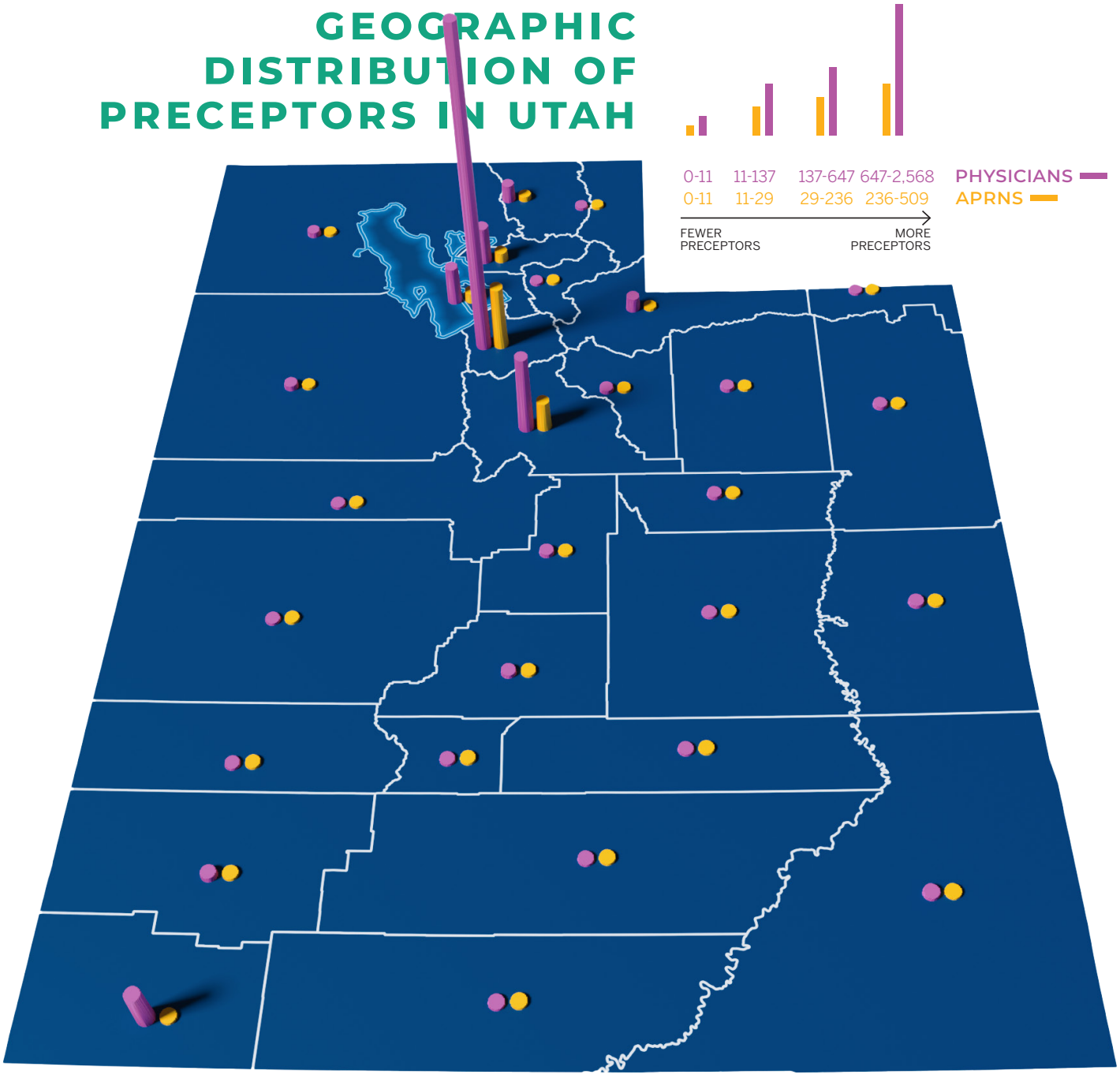
TIME SPENT IN CARE AMONG SURVEY RESPONDENTS
AVERAGE HOURS PER WEEK IN CARE, BY ROLE



Hours per week calculations should be considered estimates. Hours were calculated using the highest integer hour of the response range selected by respondents (making responses conservatively high). Calculation excludes non-respondents to this question, suppressed responses, and those responding "0 hours per week/Not applicable" due to the inability to parse out true zeros.

Utah's APRN and Physician preceptors are serving within many communities across the state. However, they are more concentrated in urban areas like Salt Lake and Utah Counties, which also host many student training programs.

GEOGRAPHIC DISTRIBUTION OF PRECEPTORS IN UTAH



In summary, information provided by licensees during their latest license renewal period provides insights into the characteristics of Utah's known preceptors. Service as a preceptor is more frequent among younger physicians, APRNs or physicians with higher educational debt loads, and those professionals working in a family medicine specialty. Preceptors generally work around three more hours per week compared to non-preceptors, including hours spent in direct patient care.

WORKFORCE REFLECTIONS

In addition to engaging subject matter experts and stakeholders via surveys, key informant interviews, focus groups, and briefings were conducted to share information on the study and capture insights into the challenges and opportunities related to clinical preceptor capacity within the state of Utah. **These sessions were structured to capture the following information regarding clinical preceptors in the state of Utah:**

1 NEED *(current and future projected)*

2 CHALLENGES *(experiences and perceptions)*

3 OPPORTUNITIES *(strategies for strengthening)*

STAKEHOLDER INTERVIEWS

The Process

PARTICIPANTS

Between October and November 2025, over 40 representatives from education (including medical schools, graduate medical education, and advanced practice nursing programs), healthcare employers (such as hospitals, clinics, community health centers, and private practitioners), and practicing professionals (physicians and advanced practice registered nurses) participated in more than 20 meetings. These meetings, which lasted between 30 minutes to 1 hour, aimed to gather structured feedback on Utah's clinical preceptor environment. Consistent questions and prompts were used in each meeting to ensure uniformity (the tool used is available in the Appendix).

Participants included representatives from the following perspectives:

EDUCATORS

- Utah Medical Education Council
- Medical education leaders from each medical school and APRN institution
- Graduate medical education leaders, including residency program directors
- Nursing education leaders, including
  - Family Nurse Practitioner
  - Pediatric Nurse Practitioner
  - Psychiatric Mental Health Nurse
  - Nurse Midwife
  - Nurse Anesthetist

EMPLOYERS/PROVIDERS

- Utah Hospital Association Board
- Hospital administrators
- Utah Association of Community Health Centers
- Private Practice
- Utah Medical Association

DATA COLLECTION

Data were collected through semi-structured interviews using the following pre-defined interview tool. The interview tool was designed to gather comprehensive insights into four key areas: quantifying clinical preceptor needs, describing the current process for securing preceptors, understanding past experiences, and envisioning future solutions. Questions were shared with interviewees prior to the interview.

DATA ANALYSIS

Sessions were transcribed. Thematic analysis was employed to identify common themes and patterns across the interviews. Responses were coded and categorized by two separate health workforce policy researchers to facilitate a comprehensive understanding of the data. This approach allowed for the identification of key insights and themes across participants.

The Findings

NEED
(current and future projected)

Demand for clinical preceptors is outpacing current need. Some educators reported that they are finding clinical preceptors "just in time" but it is very challenging to find them. Some students are reported to travel more than 80 miles one way for their clinical placements. In some cases, students are unable to graduate because they could not complete clinical training requirements.

> *"My son (medical student) needs many types of rotations. He can get specialty rotations but needs primary care and has to go to another state."*

> *"Students are now going up to 80 miles away for their rotations. They give them stipends for travel and try to get them housing but it is so difficult."*

> *"I have previously been in charge of clinical placements. I had to beg, spend my personal funds to convince preceptors to take on students. It is much more difficult today than it was 10 years ago."*

Shortage of preceptors is stunting Utah's education pipeline for health professionals. Some educators state that they are limiting their class sizes due to a shortage of clinical preceptors. They would not be able to guarantee clinical placements for students if they increased their class size.

Concerns regarding the impact new health professions degree programs will have on future clinical preceptor needs. Many educators reported significant concerns regarding the impact new degree programs will have on existing clinical preceptor capacity. Some educators fear they will not be able to find placements for their students in the future.

Physicians serve as preceptors for many types of learners and their capacity is "tapped." Physicians can preceptor medical students, residents, nursing, physician assistants, and others. Some educators suggested that medical students are prioritized for clinical placements because physicians are the primary preceptors. It was suggested that Advanced Practice Registered Nurses may be an untapped resource for clinical preceptor capacity.

Primary care preceptors are the hardest to come by. Educators report significant challenges

identifying primary care clinicians to take on students. Students, including those pursuing primary care practice, are forced to complete additional rotations with specialists and just "scrap by" on primary care hour requirements. This means some students are not getting an ideal amount of exposure and clinical training in primary care.

Rural preceptor shortages limit exposure and clinical training in rural communities. Educators reported a desire to increase clinical training opportunities in rural areas of Utah. They also report that they are unable to find rural professionals willing to precept. Educators suggested that rural professionals may not see value in hosting students and may be concerned about being "told what to do" by academic programs.

> *"I went out to [rural area] to try to get them to take on [learners]. There were two professionals practicing there. One was open, but not excited. The other said 'what is in it for me?'"*

Burnout and overloading is leading to professionals limiting the number of students they are willing to take on. This is reported to be occurring because "some [physicians and advanced practice registered nurses] are doing most of the preceptoring."

> *"We hosted 3-4 students, but ran out of space and energy to accommodate the varying clinical experience needs from students at different institutions (types of cases, scheduling, etc.). We dropped down to 1 student because of this complexity. This experience is similar across another [partner] site.*

CHALLENGES
(experiences and perceptions)

ADMINISTRATIVE DISCREPANCIES

Many different strategies are used by educators to find clinical placements and monitor clinical training. Some degree programs have strong relationships with a clinical partner for their clinical training. Others have dedicated clinical placement coordinators to find clinical preceptors, or encourage students to seek out clinical placements for themselves.

Variations in requirements and processes for reporting clinical training threatens preceptor participation. Employers/providers report that each education program uses a different reporting system for clinical training. Learning and implementing these different systems takes a significant amount of time and effort. Some report discontinuing clinical training or limiting participation due to these complexities and burdens.

INCENTIVE DISCREPANCIES

Incentives are "changing the landscape" of clinical training, discrepancies exist. Some programs offer payments to clinical preceptors. The specific amount varies by program. Selected educators reported that they have been forced to pay preceptors because programs within their own institutions were paying preceptors when they were not. This points to a lack of clinical training coordination within educational institutions. Some employers/preceptors who receive payments report that they highly value them. Others suggested that clinical preceptoring should be a part of one's professional commitment and not require payment. Educators not offering incentives report disappointment and concerns that preceptor payments have negatively impacted their students and threaten quality of clinical training.

> *"When I hosted students, it was an altruistic motivation and I wasn't driven by extrinsic factors. I understand the barriers that exist for other providers. I always felt that I 'get' more than I 'give.' I do understand that the perks may be helpful to some."*
>
> *"We have good-hearted physicians that have generously accepted students without financial compensation. It would be more fair if we were able to offer them something other than adjunct faculty status."*
>
> *"Training is part of the practice of medicine. Instead incentivize all contributions, teaching, services and research. 'What you incentive is what you are going to get.'"*

ORGANIZATIONAL POLICIES

Employer/Provider Group policies and/or practices impact clinical preceptor participation and clinical training availability. Educators report that some healthcare employer/provider groups may not enter into preceptor partnerships (which are recommended by accrediting bodies) "because they don't want to show favoritism to one institution over another." In other instances, educators report shortages of clinical training associated with the models of care delivery in Utah not leveraging professionals to the top of their training and state licensure.

EXTERNAL FACTORS

Out of state programs are placing additional strain on Utah's clinical training capacity. Educators report an increasing number of students from out of state programs are pursuing/completing clinical placements in Utah. They expressed concerns that this is not supporting development of Utah's healthcare workforce citing that these students do not likely intend to practice in the state and are taking clinical training opportunities from Utah based students.

OPPORTUNITIES
(strategies for strengthening)

Expansion of GME will strengthen other clinical training initiatives. Educators and employers/providers report that medical residents increase clinical training capacity because they are additive and "free up" physicians to take on more students. There are more medical graduates than medical residency slots currently available in Utah. Increasing medical education programs in the state will only make this gap bigger. A focus on increasing medical residency capacity would address this gap and may simultaneously help to expand clinical training capacity for other students by freeing up physicians to preceptor.

> *"If you don't have a resident, it's unreasonable to ask an attending to take more than one student at a time."*

New clinical models may help build training capacity. Some educators suggested that expansion of faculty clinics may be a solution to increasing clinical training capacity; however, overcoming physical infrastructure and administrative challenges, and identifying resources to develop such clinics would be needed to explore this strategy. Other educators suggested that mobile health clinics may provide opportunities for students to engage in clinical training in communities across the state. There

were several educators that indicated the presence of gaps between professional scope of training training and licensure and practice/employment opportunities in the state of Utah. In instances where professionals are not practicing to the top of their Utah State licensure they are also not able to engage in associated clinical preceptoring. New clinical models leveraging professionals to the top of their training and licensure may expand clinical training opportunities.

Equitable incentive strategy for clinical training. Although there were differing opinions on incentives for clinical preceptors, the majority of educators and employers/providers indicated that they believed there needed to be a unified state approach in order to stabilize the healthcare workforce pipeline. State income tax credits were cited as a potential incentive approach for Utah to consider, especially for preceptors in primary care specialties and in rural communities.

Unified systems for clinical training reporting. Employers/providers reported administrative discrepancies between programs to be a major barrier to clinical training participation. The development of more unified strategies (systems, requirements, etc.) for reporting clinical training may be helpful to reduce administrative burden and improve preceptor participation.

In addition to the above themes, the inventory below lists all stakeholder-identified solutions for potential state government-supported solutions identified during these stakeholder interviews:

- **Financial Incentives for Preceptors**
  - **State Income Tax Credit:** Offering state income tax credits to preceptors as an incentive.
  - **Funding for Preceptor Stipends:** Providing financial stipends to preceptors to compensate for their time and effort.
- **Regulatory and Policy Changes**
  - **Allow Precepting to Count toward CME/CEUs:** Enabling time spent precepting to count toward state-required Continuing Education Units/Continuing Medical Education (CEUs/CMUs).
  - **Standardized Incentives:** Requiring that all institutions provide a set amount of incentives (such as financial resources or protected time for teaching) to preceptors to ensure a level playing field.
  - **Ban on Incentives for Preceptors:** Prohibiting preceptors from accepting any incentives to ensure a level playing field.
  - **Ban on Out-of-State Precepting:** Prohibiting precepting for students from programs located outside of the state to prioritize local students.
- **Training Support for Preceptors**
  - **Precepting-Related CME:** Requiring Continuing Medical Education (CME) related to precepting for individuals to qualify as preceptors and consider free or no cost options.
  - **Preceptor Training Resources:** Offering free training resources to support preceptor preparedness.
- **Logistical and Structural Support**
  - **State-Defined Templates:** Developing standardized templates for clinical training, such as sign-off forms, skills checklists, preceptor expectations, academic-employer contracts, malpractice coverage, and evaluations.
  - **Housing Cost Support:** Providing support for housing costs for students in preceptor experiences located in remote areas, distant from their school location.
  - **Funding for Faculty-Run Clinics:** Providing funding for academic institutions to create and/or dedicate space for faculty-run clinics, which can serve as training sites.

— **Expand GME Residencies:** Increasing the number of Graduate Medical Education (GME) residencies will expand the pool of precepting staff, as more residents will be available to serve as preceptors.

Although the primary focus of HWAC's work is to provide guidance to state agencies and recommend state government-supported solutions (those that can be adopted, implemented, or otherwise supported by state policies), the feedback provided by stakeholders during these interviews extended beyond this scope. It included ideas for academic institutions and employers as well. These additional ideas are provided within the Appendix.

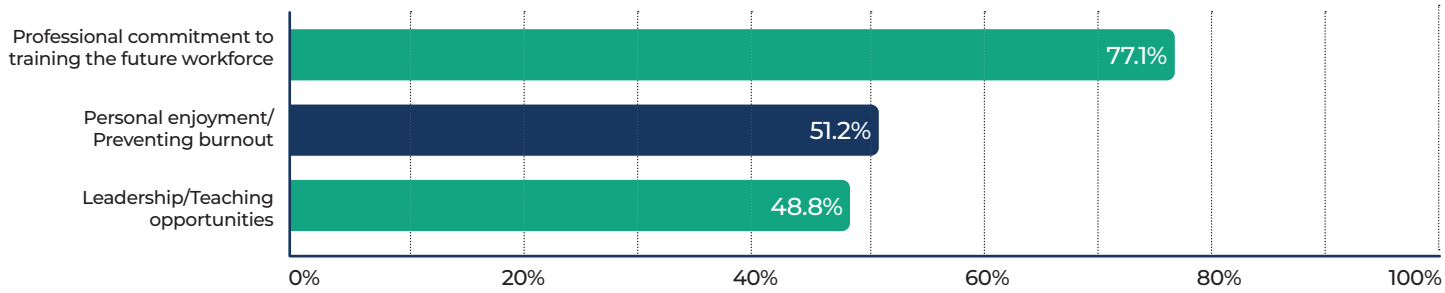
PERSPECTIVES FROM PRACTICING PROFESSIONALS

In order to capture the perspective from professionals (including those who serve as preceptors and those who do not), a brief survey was prepared using Qualtrics. This survey was administered to physicians, APRNs, and PAs through listservs maintained by the Utah Medical Association, Utah Nurse Practitioners, and Association for Utah Community Health. The survey was designed to capture insights from professionals as to their experiences with serving as a preceptor in terms of types of preceptorships offered, current incentives, and future solutions.

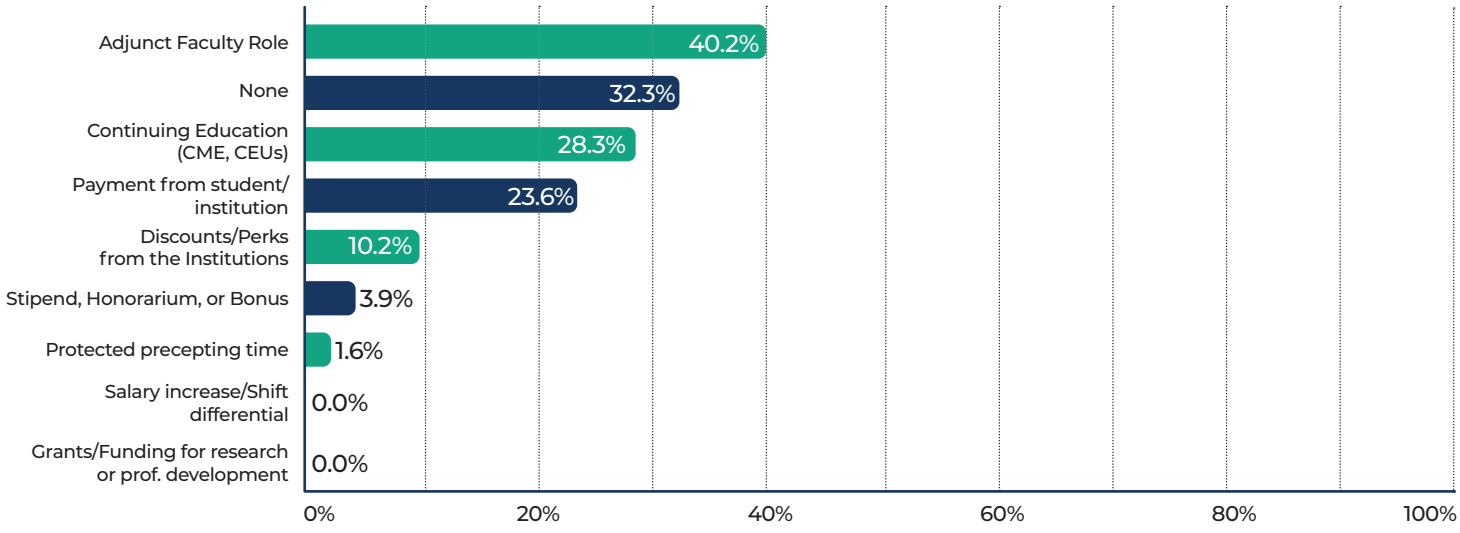
Of the 199 respondents, 67.8% reported they have served as a clinical preceptor within the last year. Most preceptor respondents had a specialty in family medicine (34.3%), working in an urban (82.2%) outpatient (54.8%) setting.

MOTIVATING FACTORS FOR SERVING AS A PRECEPTOR

TOP MOTIVATORS

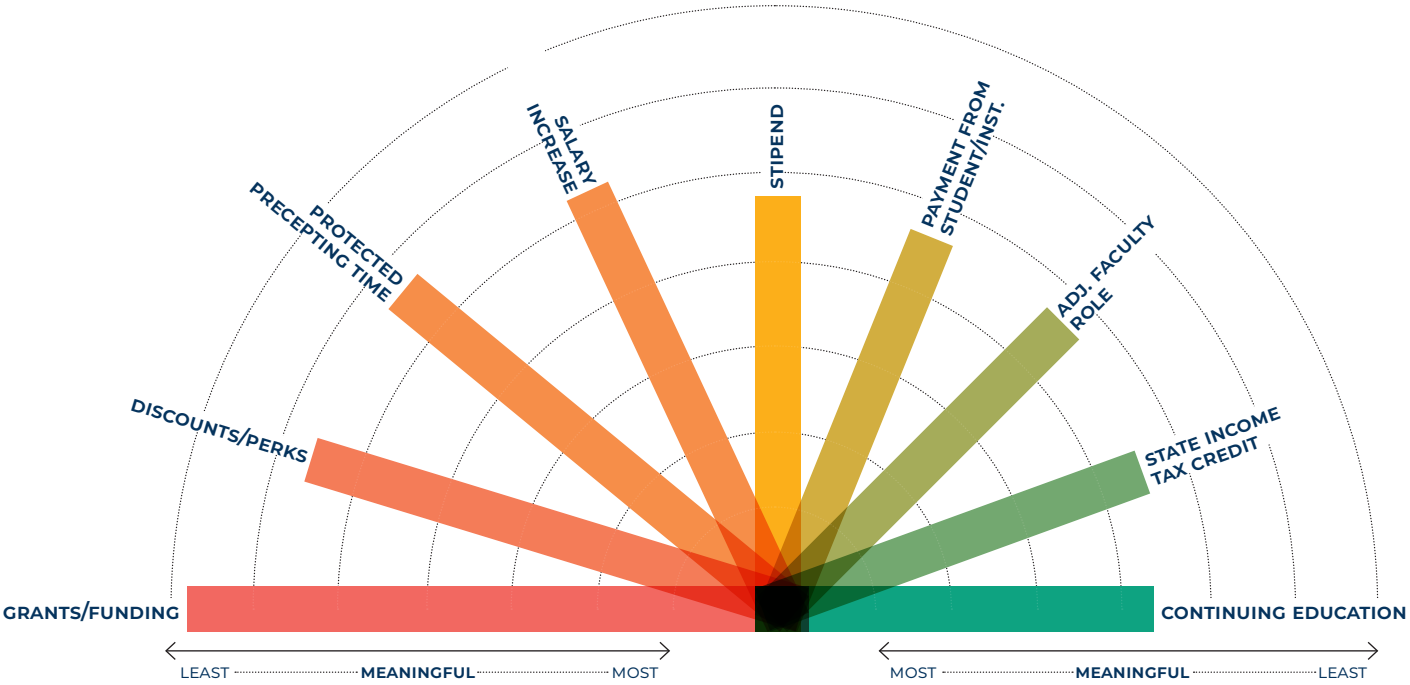


INCENTIVES CURRENTLY OFFERED TO ACTIVE PRECEPTORS



MOTIVATING FACTORS FOR SERVING AS A PRECEPTOR, CONT.

WHAT INCENTIVES WOULD BE MOST MEANINGFUL TO YOU?



Additional thoughts from active preceptors:

ORGANIZATIONAL POLICY INFLUENCING FINANCIAL INCENTIVES

> *"Our organization doesn't allow preceptors to get paid separately. They do it on their own. Any money coming in goes to the organization, not to the preceptor."*
>
> *"The issue with accepting payment is the conflict of interest with the employing organization - do we give it to the organization? to the provider? It gets sticky and challenging."*

ORGANIZATIONAL POLICY INFLUENCING PRECEPTOR SERVICE

> *"It is expected that providers will precept when asked, but everyone can turn that down if they want. Certain personalities are more conducive to be preceptors than others. So, we don't just ask anyone. Also, inefficient providers are not asked to precept, as this tends to make them more inefficient and teach bad habits to students."*

POTENTIAL BENEFITS OF FINANCIAL INCENTIVES:

> *"I preceptor students because that is how they learn and it is how we can attract doctors to rural areas. Creating some incentives would be greatly appreciated as it does slow me down and therefore affects my income and my free time."*

> *"It has been difficult taking students in a fee for service world."*

MISSION COMMITMENT:

> *"I believe teaching the next generation of providers is essential to advance medical practice."*

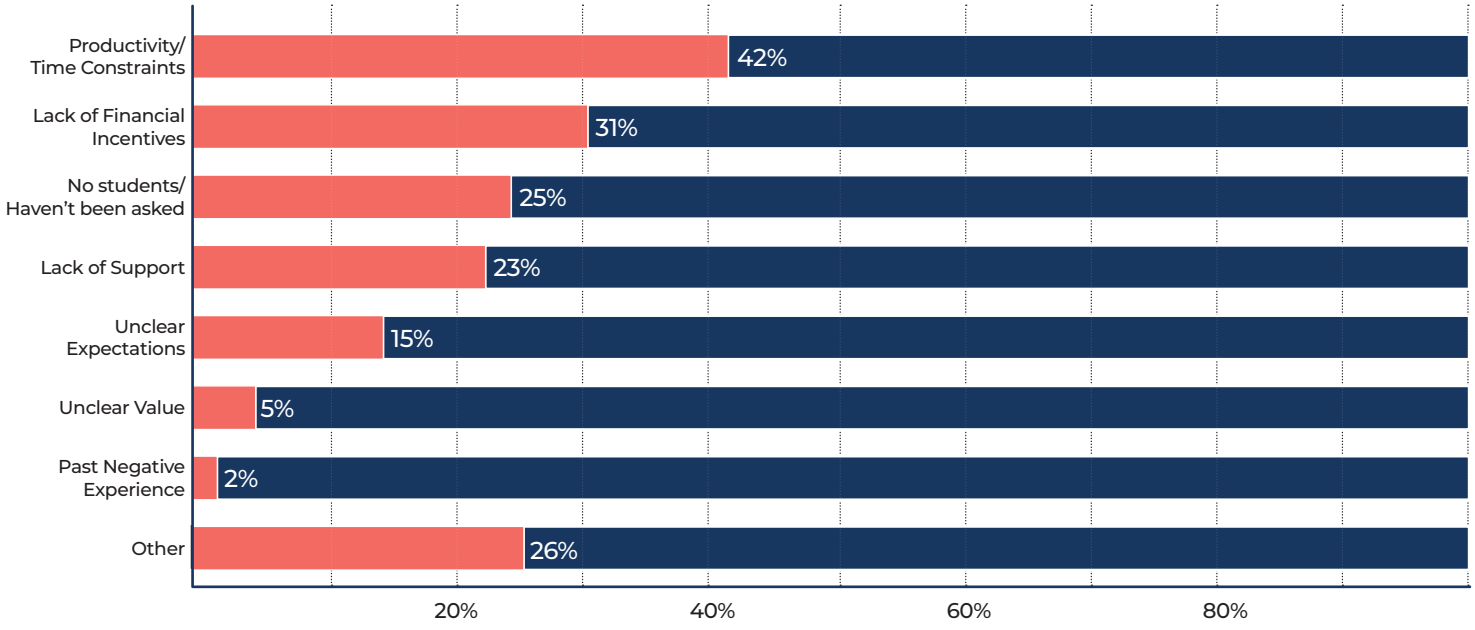
> *"Duty as a Physician"*

OTHER

> *"I also wanted to note that as a tribal organization we often cannot precept students because of institutions unwilling to sign sovereign immunity agreements."*

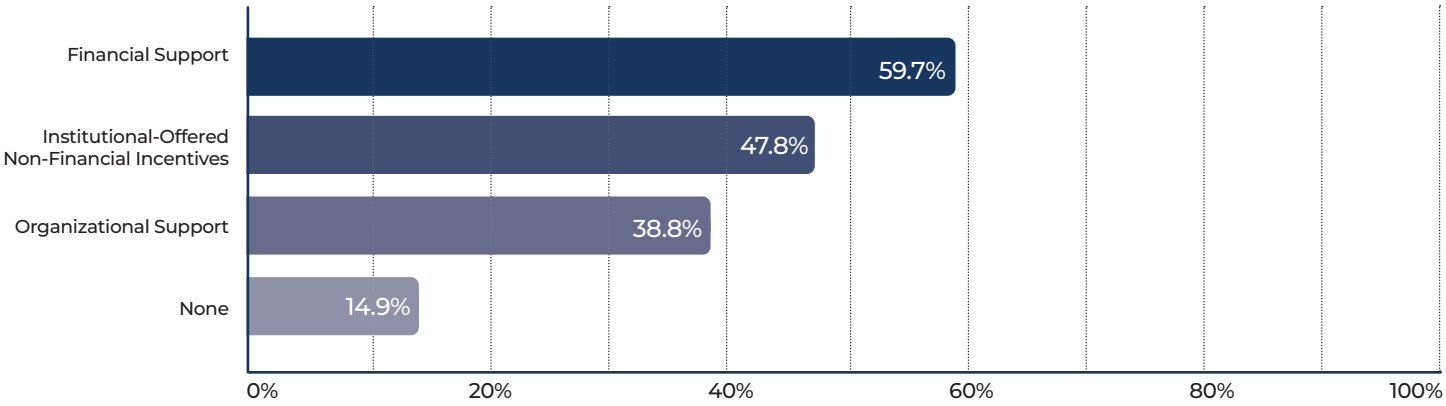
MOTIVATING FACTORS

FOR *NOT* SERVING AS A PRECEPTOR



ENCOURAGING NON-PRECEPTORS TO PRECEPT

WHAT TYPES OF SUPPORT WOULD ENCOURAGE YOU TO SERVE?



Additional thoughts from non-preceptors:

TIME CONSTRAINTS

"I have enjoyed preceptoring in the past. The biggest challenge for me was the time challenges of including student teaching into an already very busy schedule. Preceptoring always adds an hour or more to an already very long day. I found it rewarding, but taxing. I would limit myself to 3 or 4 student rotations per year."

"I have one student every 1-2 years for 2 weeks. That is not a burden. If I had a student frequently, that would change. A student usually adds 1-2 hours of work at the end of the day."

"Between the other admin work that I have to do every spare minute is spent doing something and I don't have the time to adequately teach or precept, if given dedicated admin time to keep up with my other tasks I would consider it."

FINANCIAL INCENTIVES

"Precepting medical students is a great opportunity to help them broaden their exposure to various medical specialties and is an expected part of medical training. Providers typically do this without expectation of compensation but some type of compensation would be appreciated, especially for providers who do this routinely."

"These new DO schools charging exorbitant tuition and then not setting up quality rotations for their students are shameful. The schools should be paying for preceptors, not the state."

CONCLUSION

Utah's healthcare workforce development faces a critical bottleneck in the form of clinical preceptor shortages that threaten the state's ability to train the next generation of healthcare professionals. This comprehensive analysis reveals a complex landscape where demand for clinical training opportunities consistently outpaces supply, threatening the availability of clinical training experiences to meet students' needs for graduation and practice.

The data paints a concerning picture: the growing number of healthcare training programs will place unprecedented strain on an already stretched preceptor workforce. The challenge is particularly acute in primary care specialties and rural communities, precisely the areas where Utah most needs to strengthen its healthcare infrastructure.

Several key themes emerge from the analysis and stakeholder perspectives that demand immediate attention. The inconsistent incentive structures across training programs have created a two-tiered system where some providers receive compensation while others may experience uncompensated productivity losses when taking on clinical training responsibilities. This disparity may have led qualified professionals to avoid precepting altogether, resulting in the concentration of training responsibilities among a small subset of dedicated providers. This uneven distribution has created unsustainable workloads for active preceptors, contributing to burnout and may threaten overall training capacity as experienced preceptors may desire to step back from their roles.

Perhaps most significantly, this analysis demonstrates that clinical preceptor shortages are not merely an educational challenge but a threat to Utah's broader healthcare system. Without adequate clinical training capacity, the state risks constraining its healthcare workforce pipeline precisely when demographic trends and healthcare needs are driving increased demand for services. The ripple effects extend beyond individual students to likely impact healthcare access and quality across communities throughout Utah.

Moving forward, Utah must adopt a coordinated, multi-stakeholder approach that addresses both immediate capacity needs and long-term sustainability. In response to this data insight, the Utah Health Workforce Advisory Council has prepared a recommendation (outlined in an accompanying report) that will provide a foundation for action. Implementation of the recommendation will require sustained commitment from state government, educational institutions, healthcare employers, and individual practitioners. Success will depend on creating systems that support preceptors while maintaining the quality of clinical education that ensures competent, well-trained healthcare professionals.

The stakes are significant. Utah's ability to meet its residents' healthcare needs in the coming decades will be substantially influenced by the actions taken today to strengthen and expand clinical preceptor capacity. The HWAC's work represents a crucial step toward securing Utah's healthcare workforce future and ensuring that all residents have access to high-quality care delivered by well-trained professionals who are prepared to serve their communities.

APPENDIX

A: INTERVIEW TOOL ADMINISTERED TO STAKEHOLDERS:

QUANTIFYING CLINICAL PRECEPTOR NEEDS

Objective: To understand the specific needs for clinical preceptors within each program or organization.

- *Please describe what your program's or organization's clinical preceptor needs.*
- *To what extent does the current capacity meet those needs?*

DESCRIBING THE CURRENT PROCESS FOR SECURING PRECEPTORS:

Objective: To gain insight into the existing methods and strategies used to secure clinical preceptors.

- *Please share the current approach your program or organization uses to secure preceptors.*

UNDERSTANDING PAST EXPERIENCES:

Objective: To learn about the strategies previously implemented to develop clinical training capacity, including successes and challenges.

- *What strategies has your program or organization implemented to develop clinical training capacity?*
- *What has been successful, and where have there been challenges?*

ENVISIONING FUTURE SOLUTIONS:

Objective: To explore potential solutions and innovative ideas to address clinical preceptor needs and enhance training capacity.

- *What do you see as a potential solution to improve clinical preceptor capacity in the future?*

B: ADDITIONAL STAKEHOLDER INSIGHTS ON PRIVATE SECTOR SOLUTIONS TO UTAH'S CLINICAL PRECEPTOR CHALLENGES

Potential Academic Institution Solutions, Identified by Stakeholders during Interviews:

TIERED INCENTIVES

Offering tiered incentives to preceptors, with increased amounts based on their years of experience.

FACULTY PRACTICE POLICIES

Implementing policies that support faculty practice and precepting.

Potential Employer/Organizational Solutions, Identified by Stakeholders during Interviews:

STAFFING STRATEGIES

Adopting new staffing strategies that include clinical preceptor staff rotations at rural or underserved sites, with accompanying preceptor experiences.

POLICY REMOVAL

Removing organizational policies that prohibit staff from participating as preceptors or accepting incentives.

TEAM-BASED CARE

Implementing team-based care models that allow residents and fellows to share the precepting load with staff and attendings.

REMOVE ROTATION CAPS

Removing caps or maximum allowances on the number of student rotations.

EXPAND RELATIONSHIPS

Expanding academic-employer relationships beyond singular or exclusive relationships and allowing staff to develop individual precepting relationships with schools and students.

POLICY REVIEW

Reviewing and expanding policies that govern which academic institutions are permitted to engage in preceptoring experiences.

DEEPER RELATIONSHIPS

Fostering deeper relationships between academic institutions and clinical employers to expand the availability of preceptor experiences.

ACKNOWLEDGMENTS

This brief was commissioned by the Utah Health Workforce Advisory Council and funded by the Utah Department of Health and Human Services (UDHHS). Veritas Health Solutions led the development of this report with input and support from a wide range of stakeholders. We extend our sincere thanks to the individuals and organizations who contributed their time, expertise, and perspectives to inform this work. In particular, we are grateful to the stakeholders that represent Utah academic training programs, employers (clinical training sites), professional associations, and state agencies who offered insight through interviews, meetings, and document review. We also thank the members of the Utah Health Workforce Advisory Council and its Clinical Preceptor Subcommittee, the Utah Medical Education Council, and the UDHHS Primary Care and Rural Health team, for their engagement and guidance throughout this process. Finally, we acknowledge and appreciate the dedicated clinical preceptors across Utah who continue to invest their time and energy into training the next generation of healthcare professionals, often without compensation, and whose commitment to the future health workforce is invaluable.

Authors

- **Hannah Maxey**, PhD, MPH, RDH
- **Courtney Medlock**, MPH

For questions or feedback on this document, reach out to us at admin@veritashealthsolutions.org

Suggested Citation

Maxey H., Medlock C. *Bridging the Gap: Clinical Preceptors for Physicians Advanced Practice Registered Nurses, a Brief Summary of the Clinical Preceptor Issue and Recommendations to Strengthen the Physician and APRN Pipeline*. 2025.

Graphic design by Zachary Ammerman, www.zacharyammerman.com

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