UTAH HEALTH WORKFORCE ADVISORY COUNCIL
CLINICAL PRECEPTOR STIPEND PROGRAM RECOMMENDATION

BUILDING THE BRIDGE

RECOMMENDATION DEVELOPMENT PROCESS AND SUPPORTING RESEARCH

JUNE 2025

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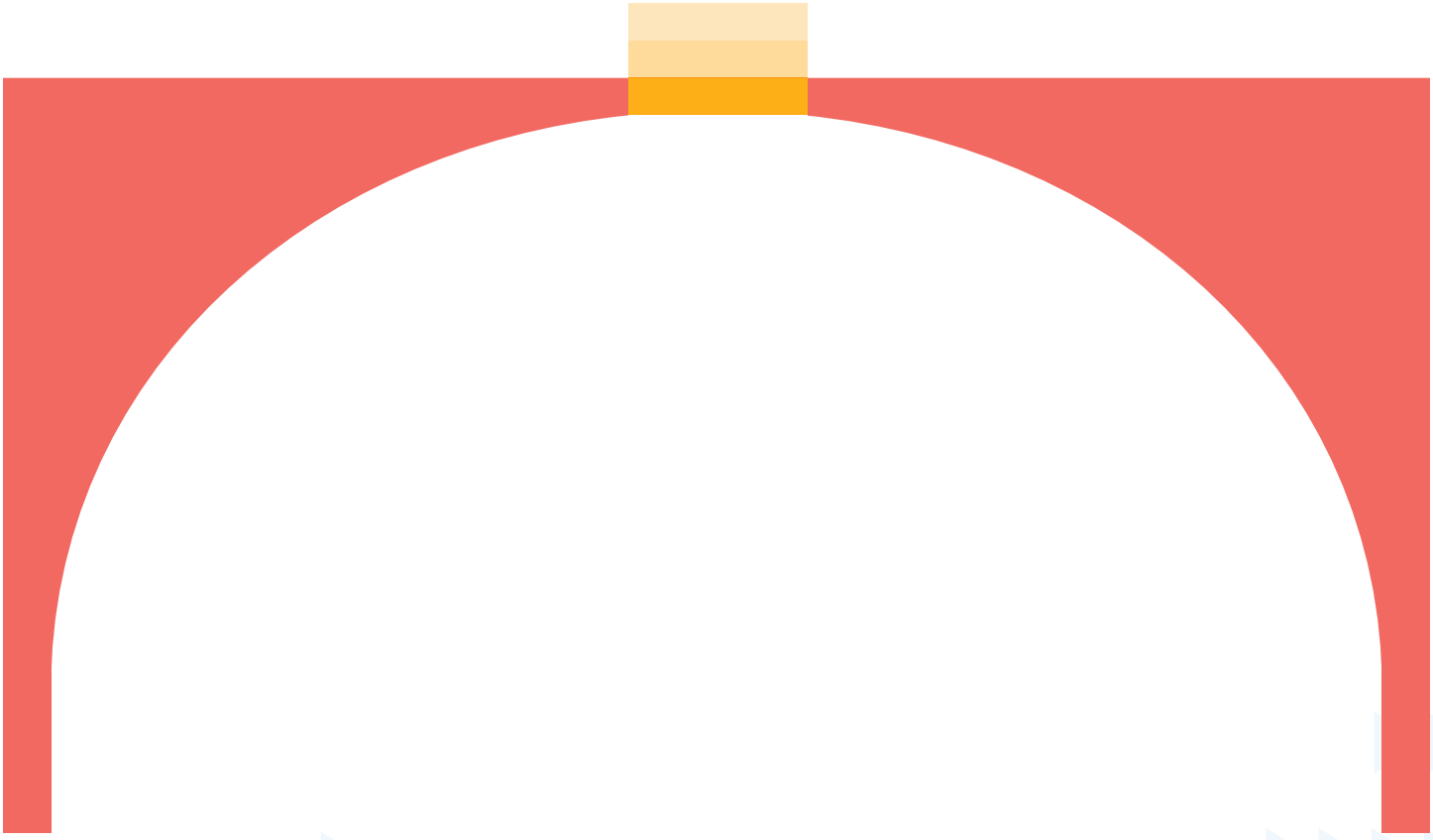
INTRODUCTION

BUILDING THE BRIDGE

This document summarizes the policy research, deliberative process, and key decisions that led to the development of the Utah Health Workforce Advisory Council's (HWAC) recommendation to establish a Clinical Preceptor Stipend Program.

This report is part of a companion series alongside the Bridging the Gap: Clinical Preceptors for Physicians and Advanced Practice Registered Nurses in Utah report, which provides a comprehensive overview of input gathered from practicing professionals, academic institutions, employers, and organizational leaders. The landscape report captures detailed perspectives on existing incentives, barriers, and potential solutions to Utah's preceptor capacity challenges.

Together, these documents offer a holistic understanding of Utah's clinical preceptor environment and present a coordinated approach to strengthening this critical component of Utah's healthcare training infrastructure. The recommendation presented herein directly responds to the top challenges identified through extensive stakeholder engagement and research.



BACKGROUND

UTAH CLINICAL PRECEPTING: THE CHALLENGE

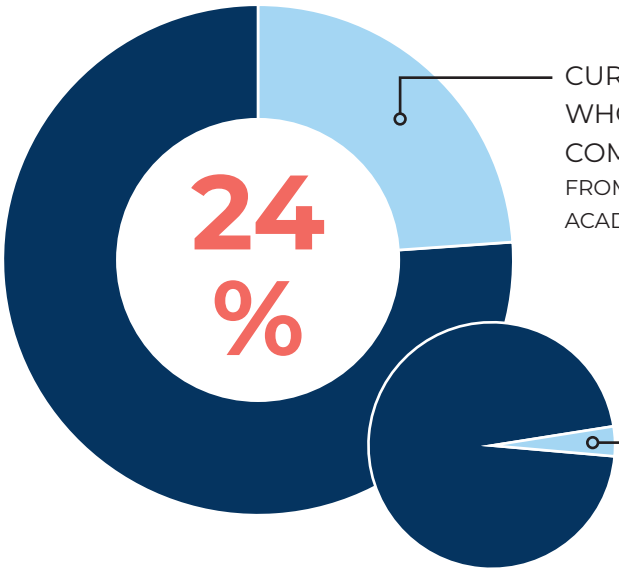
UTAH faces a growing crisis in training healthcare students that threatens the state's ability to meet future workforce demands. The scale and urgency of this challenge became clear through comprehensive stakeholder research conducted by the Utah Health Workforce Advisory Council. Although the HWAC recognizes 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.

The Problem is Getting Bigger

Utah's healthcare training needs are expanding rapidly. By 2031, the state will require 3,000 additional preceptorships annually, representing a 57% increase from 2023 levels. This dramatic growth reflects Utah's expanding population, increased class sizes and programs, and the state's commitment to ensuring Utah-based health professions students can receive clinical training within Utah.

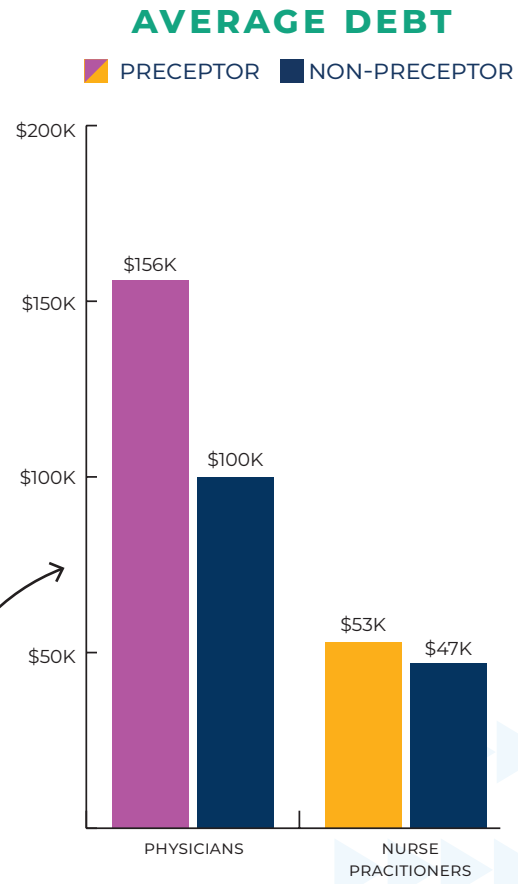
Financial Barriers Dominate the Challenge

The companion Bridging the Gap report revealed that financial constraints represent the primary obstacle



CURRENT PRECEPTORS WHO RECEIVE COMPENSATION FROM STUDENTS OR ACADEMIC INSTITUTIONS

4% PRECEPTORS WHO RECEIVE BONUSES OR STIPENDS



CURRENT PRECEPTORS CARRY **SIGNIFICANTLY HIGHER EDUCATIONAL DEBT BURDENS** COMPARED TO THEIR NON-PRECEPTING COLLEAGUES

to expanding preceptor participation:

- Only 24% of current preceptors receive any compensation from students or academic institutions
- Just 4% receive bonuses or stipends for their precepting work
- Current preceptors carry significantly higher educational debt burdens compared to their non-precepting colleagues:
  - **Physicians:** $156,000 vs. $100,000 average debt
  - **Nurse practitioners:** $53,000 vs. $47,000 average debt

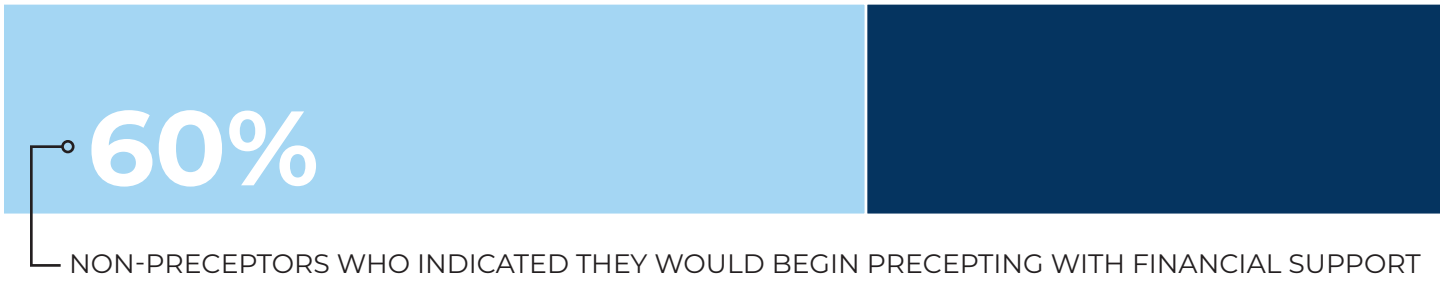
These findings suggest that those already committed to training the next generation of healthcare providers are disproportionately bearing both the time burden of precepting and higher personal financial strain: a concerning combination that may limit long-term sustainability of volunteer-based precepting models.

Additional Barriers Compound the Challenge

Beyond financial constraints, stakeholder research identified other significant deterrents to preceptor participation, including time demands, lack of protected precepting time within work schedules, administrative burden, and organizational policies that fail to recognize or support precepting activities.

The Solution Pathway is Clear

Despite these challenges, the research revealed strong potential for expanding preceptor capacity: 60% of non-preceptor survey respondents indicated they would begin precepting students if they received financial support. This finding suggests that targeted financial incentives could substantially increase Utah's preceptor pool and help meet the state's growing training demands.



The Need for Coordinated Action

Recognizing that addressing Utah's clinical preceptor challenges would require focused expertise and detailed policy development, the HWAC established a time-limited Clinical Preceptor Subcommittee during its March 12, 2025 meeting. The Subcommittee was charged with developing actionable recommendations for HWAC consideration in June 2025, with the goal of creating state-supported solutions that could meaningfully expand Utah's clinical training capacity.

THE PROCESS

OVERVIEW

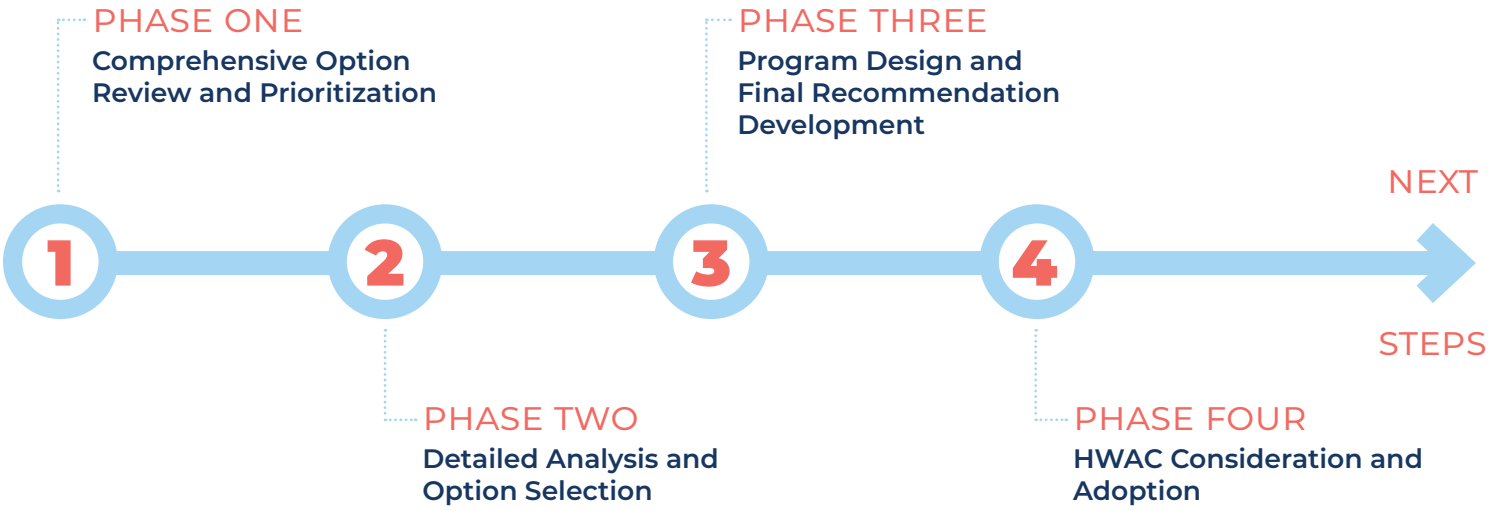
The Utah Health Workforce Advisory Council (HWAC) Clinical Preceptor Subcommittee was formed to develop actionable, state-supported policy recommendations that strengthen the availability, quality, and capacity of clinical preceptors for physicians (MD/DO) and advanced practice registered nurses (APRNs) across Utah.

The subcommittee brought together representatives from education, healthcare delivery, professional associations, and other sectors with direct interests in clinical education and workforce development. Operating under HWAC's authority, the subcommittee was supported by Council staff and Veritas Health Solutions.

Dr. Sarah Woolsey, HWAC member and medical director at the Association for Utah Community Health, chaired the subcommittee. A complete list of subcommittee members is provided in Appendix A, and the subcommittee's formal charter is included in Appendix B.

To inform its recommendations, the Subcommittee:

- Reviewed preceptor policy documents and case studies from other states.
- Analyzed structured input from more than 40 stakeholders across clinical education, health systems, and professional practice
- Compared the feasibility, scalability, and appropriateness of various policy options, focusing on state government-supported solutions
- Developed an actionable recommendation for HWAC consideration



PHASE ONE

Comprehensive Option Review and Prioritization

The subcommittee began with an expansive brainstorming process, considering all potential policy options to address preceptor capacity challenges. This initial review included high-level research on successful implementations in other states. A complete list of policy options considered is presented in Appendix C.

Following feasibility and impact discussions, the subcommittee selected three policy options for in-depth research and consideration:

- **Stipends for Clinical Preceptors**
- **State Income Tax Credit for Clinical Preceptors**
- **Housing Support for Students during Clinical Rotations**

PHASE TWO

Detailed Analysis and Option Selection

During the second subcommittee meeting, members conducted thorough analysis of the three prioritized options. This research encompassed: (1) any related current or historical programs in Utah, (2) implementation experiences in other states, and (3) Utah-specific implementation considerations. Complete research findings are available in Appendix D.

The subcommittee quickly identified that Housing Support for Students during Clinical Rotations was a lower priority option because:

- It focuses on students rather than directly addressing preceptor capacity
- Existing programs already address some housing needs (such as Area Health Education Centers support)
- Implementation feasibility concerns related to securing and managing student housing
- Success depends on the unverified assumption that adequate numbers of potential preceptors exist in remote and rural settings

Extensive discussion focused on the remaining options: stipends versus tax credits for clinical preceptors. While tax credits are more commonly implemented across states, research revealed mixed utilization and benefit reports. Most existing tax credit programs have not distributed all available credits, with evaluation reports attributing underutilization in part to coordination complexities between state revenue departments and administering agencies. The subcommittee also identified concerns about delayed financial recognition with tax credits compared to direct stipends.

Based on these considerations, the subcommittee recommended stipends as the preferred approach.

PHASE THREE

Program Design and Final Recommendation Development

An initial recommendation draft was developed with structured decision points for subcommittee consideration (Appendix E). During the final formal meeting, members reviewed each program component and voted on preferred options. A summary of subcommittee decisions and supporting rationale is available in Appendix F.

The subcommittee's final recommendation was shared as pre-reading material for the June 18, 2025 HWAC meeting.

PHASE FOUR

HWAC Consideration and Adoption

The subcommittee chair presented the recommendation to the full HWAC during its June 18, 2025 meeting, leading to further discussion and refinement to develop the final adopted recommendation that contains detailed program cost estimates.

To align with Governor Cox's second-term strategic priorities to improve healthcare access for rural Utahns and maximize public benefit from taxpayer investments, the HWAC incorporated prioritization language for rural clinical preceptors and preceptorships associated with public institutions.

The final cost estimates represent substantial research incorporating data from other states' stipend programs and current Utah workforce counts (detailed calculations available in Appendix G). The recommended investment represents the minimum funding level needed to align Utah's program with comparable stipend programs in other states.

NEXT STEPS

The timing of the HWAC's Clinical Preceptor Recommendation was strategically planned to meet state agency deadlines for inclusion in executive branch legislative request packets. However, the recommendation is also designed for independent advocacy use by HWAC members, subcommittee members, or other stakeholders in their legislative engagement efforts.

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.

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

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APPENDICES

APPENDIX A

HWAC CLINICAL PRECEPTOR SUBCOMMITTEE MEMBERSHIP

Chair

Dr. Sarah Woolsey, Association of Utah Community Health, HWAC Member

Members:

- **Rosemary Bowden**, Revere Health
- **Dr. Amber Collins**, Utah Academy of Physician Assistants
- **Dr. Sam Finlayson**, University of Utah Dean, UMEC Chair
- **Sunil Gollamudi**, Intermountain Health
- **Dr. Melissa Hinton**, Utah Nurse Practitioners Association
- **Dr. Carrie Jeffrey**, Weber State University
- **Dr. Beth Luthy**, Brigham Young University
- **Michelle McComber**, Utah Medical Association
- **Dr. Mark Ott**, Brigham Young University
- **Dr. Michael Rhodes**, Noorda COM
- **Dr. Laura Rosch**, Rocky Vista University
- **Carrie Torgersen**, Utah Center for Rural Health
- **Dr. Emily Winn**, University of Utah

APPENDIX B

UTAH HWAC CLINICAL PRECEPTOR SUBCOMMITTEE CHARTER

A Time-limited Subcommittee of the Utah Health Workforce Advisory Council (HWAC)

Subcommittee Purpose

The Utah HWAC Clinical Preceptor Subcommittee is established to develop actionable recommendations aimed at strengthening the availability, quality, and capacity of clinical preceptors in Utah for physician and advanced practice nursing students. The subcommittee will address challenges, identify opportunities, and propose solutions that align with the broader goals of the HWAC.

Scope of Solutions

Given that the primary focus of HWAC's work is to provide guidance to state agencies, the subcommittee's recommendations will be targeted to include state government-supported solutions (i.e. those that can be adopted, implemented, or otherwise supported by state policies; an example of state government-supported solutions is included below).

Authority

The subcommittee operates under the authority of the HWAC, with a mandate to provide recommendations for Council review and consideration.

Membership

- Membership will consist of stakeholders with expertise in clinical education, workforce policy, healthcare, and related fields.
- Members will include representatives from the Council, healthcare organizations, academic institutions, professional associations, and other relevant perspectives.
- The subcommittee will also include a chairperson appointed by the Advisory Council who will invite Committee members to participate.
- Membership terms will conclude upon the completion of the subcommittee's objectives.

Roles and Responsibilities

- **Subcommittee Members:** Contribute expertise, review data, and participate in discussions to shape policy recommendations. Review content, share content and solicit feedback from their represented group or organization.
- **Chairperson:** Facilitate meetings, guide discussions, and ensure timely delivery of recommendations.
- **Council Staff and Veritas Health Solutions:** Provide logistical, research, and administrative support to the subcommittee.

Meetings

- The subcommittee will meet monthly or as needed to achieve its objectives.
- Meetings will be conducted virtually or in person, with agendas distributed at least two business days prior.
- Minutes will be recorded and shared with members.

Decision-Making Process

- Decisions will be made by consensus whenever possible.
- If consensus cannot be reached, decisions will be made by a majority vote of members present.

Deliverables

- A comprehensive set of state government-supported policy recommendations addressing clinical preceptor challenges and opportunities in Utah.
- A final report summarizing findings and recommendations, delivered to the Utah Health Workforce Advisory Council.

Resources and Support

The subcommittee will receive support from the Utah Health Workforce Advisory Council, including:

- Access to relevant workforce data and research.
- Administrative and logistical assistance.
- External consultation provided by Veritas Health Solutions.

Term and Review

The subcommittee will operate until the completion of its mandate, with an anticipated end date of June 2025. Progress will be reviewed periodically, and the subcommittee may be dissolved earlier if objectives are met.

State Government-Supported Solutions (In Scope)

These are examples of strategies that fall within the state's authority which fund, regulate, or facilitate health workforce development:

- **Financial and Programmatic Support:** Implementing tax credits, stipends, loan repayment programs, or expanding funding for workforce training and education.
- **Policy and Regulatory Changes:** Establishing standardized guidelines, legislative provisions, or reimbursement mechanisms to support workforce engagement.
- **Public-Private Collaboration:** Facilitating partnerships between state agencies, educational institutions, and employers to strengthen workforce pipelines.
- **Training and Workforce Development:** Providing state-funded continuing education, certification programs, or standardized agreements to streamline workforce participation.
- **Data and Workforce Planning:** Investing in statewide data collection and analysis to inform policy decisions and address workforce gaps.

Private Sector Solutions (Out of Scope)

These are examples of health workforce initiatives that are typically led by private organizations, employers, or industry groups without a role for state oversight or support:

- **Employer-Led Incentives and Programs:** Organizations offering financial incentives, workplace training, or mentorship programs to support workforce engagement.
- **Institutional and Industry-Led Support:** Educational institutions, nonprofits, or businesses independently funding scholarships, tuition discounts, or workforce initiatives.
- **Commercial and Proprietary Solutions:** Private companies developing and selling workforce development tools, training platforms, or recruitment services.

APPENDIX C

COMPLETE LIST OF POLICY OPTIONS CONSIDERED BY THE SUBCOMMITTEE

- Allowing Precepting to Count Toward State Continuing Medical Education/Continuing Education Requirements
- Ban, Limit, or Regulate Precepting of Out-of-State Students
- Expand Graduate Medical Education (GME) Residencies*
- Funding for Faculty Practice
- Housing Cost Support for Students in Clinical Rotations
- Loan Repayment for Preceptors (Ex. Adding Preceptor Requirement to Existing Programs)
- Preceptor Stipends
- Preceptor Training Resources
- Provide HOV Lane Pass to Clinical Preceptors
- Regulation of Preceptor Incentives
- Requiring Preceptor-related Continuing Education
- State Income Tax Credit for Preceptors
- State-defined Guidance Documents
- Waive Licensing Fees for Preceptors

**Note: There was substantial discussion that GME residency expansion is critical. However, the Utah Medical Education Council has a separate, concurrent initiative to explore GME expansion for Utah. As such, this was de-prioritized for the Clinical Preceptor Subcommittee.*

APPENDIX D

DETAILED RESEARCH ON THREE PRIORITY POLICY OPTIONS

Policy Option: State Stipends for Clinical Preceptors

ABOUT THIS STRATEGY:

> Several states have implemented stipend programs that offer direct financial payments to eligible clinical preceptors. These stipends serve as a tangible form of recognition, helping to support retention and potentially attract new preceptors by offsetting the time and productivity costs associated with supervision. This brief provides an overview of state strategies related to stipends and presents considerations for Utah.

CONSIDERATIONS FOR UTAH:

BENEFITS:

- **Near immediate financial recognition of preceptor service.** Unlike other approaches, this strategy results in a faster response and perceived outcome from preceptor service. Most states implementing this strategy provided the stipend quarterly or at the end of an academic semester.
- **Opportunity for determination of preferred administrative mechanism.** Although there were only four states with active preceptor stipend programs, there were three different program administration approaches. One state partnered with professional associations for distributions, another structured the stipend as an employer reimbursement, the final two provided direct payment from the state to the preceptor.
- **Opportunity for private sector matching contributions**: One state requires employers to match funding in order to participate. This public private partnership helps to extend public investments and impact.

CHALLENGES:

- **Requires financial commitment.** In order to establish the program, upfront funding is required.
- **Grant programs require administration**. Some options for program administration may be more accessible than others (ex. public/non-profit collaboration for awarding is less administratively burdensome to the state compared to direct review and award).
- **Impact has not been fully measured or publicly reported.** Although some programs have specific reporting to the legislature and/or forthcoming plans for report and evaluation, the information that is publicly available to date is limited.

TABLE D1 STATE STIPENDS STRATEGY IN ACTION

STATE	PROGRAM NAME	ELIGIBILITY DETERMINED BY	KEY ELIGIBILITY CRITERIA	INDIV. AWARD AMOUNT	STATE AWARD LIMIT (Total Fiscal Impact)	COST SOURCE	PROGRAM OBJECTIVES	OUTCOMES
ARIZONA Bill text	Arizona State Preceptor Grant Program	The state provided subawards to professional associations for program administration.[1]	- Licensed healthcare professionals (e.g., physicians, APRNs, PAs, dentists) who serve as preceptors for students in approved training programs. - Preceptorship must be at least four weeks long.	$1,000 per calendar year, regardless of the number of preceptorships provided. (Unknown taxability)	$500,000 annually (FY23-37), unclear the exact amount allocated to each profession	General fund *No specifications as to costs for program administration.*	- Increase placements of student nurses and nursing assistants in clinical settings. - Support preceptors in providing quality clinical training.	Information on specific outcomes is not readily available.
VERMONT Bill text (2022) Bill text (2023)	Nurse Preceptor Incentive Grants Program	Vermont Agency of Human Services	- Nurses (inc. APRNs) providing student preceptor supervision in Vermont's Critical Access Hospitals and other healthcare settings. - Serving in-state students only.	Preceptors awarded up to $5 per preceptor hour (paid by employer, reimbursed through grant to employer). (Taxable)	$2.38 million available for the program.	ARPA *No specifications as to costs for program administration*	Increase compensation for nurse preceptors. - Enhance student supervision in critical healthcare settings.	As of December 2023, the Vermont Auditor reported on various nursing incentive programs but did not provide specific outcomes for this program.
VIRGINIA (fiscal FY21-22; 2021 budget, ; FY23-24 budget; FY25-26 budget)	Nursing Preceptor Incentive Program (NPIP)	Virginia Department of Health	- Uncompensated practitioners serving as preceptors for APRN, RN, LPN students. - Must commit to a service obligation. - Priority to Preceptors in HPSAs. - No cap for rotations in Psych/Mental Health, Nurse Midwives, OB/GYN, and Pediatrics if funding is available.	Awards per semester based on clinical hours: - 25-70 hours: $500 - 71-115 hours: $1,625 - 116-160 hours: $2,750 - 161-205 hours: $3,875 - 206-250 hours: $5,000. (Tax-free)	$500,000 allocated for first three program years; $3.5 million approved since FY24 and through FY26.	General fund *No specifications as to costs for program administration.*	(Per budget bill) "Provide financial incentives for practitioners who serve as otherwise uncompensated preceptors for Advanced Practice Nurses (APRN), registered nurse (RN), and licensed practical nurse (LPN) students to help increase access to care, address the primary care shortage, handle mental health crises, and manage chronic diseases."	Specific outcomes data is not readily available.
WASHINGTON (Statute)	Washington State Student Nurse Preceptorship Grant	Washington Board of Nursing	- Licensed nurses (inc. APRNs) serving as preceptors for nursing students in approved Washington State nursing programs. - Clinical practice hours must occur in facilities approved by Washington State nursing programs. - Preceptors can apply for up to two students per term, with a maximum of eight payments per year.	Up to $900 per preceptor per payment cycle. (Taxable)	$6 million allocated, split between fiscal years 2022 and 2023.	State funds	(Per statute) "Reduce the shortage of health care training settings for students and increase the numbers of nurses in the workforce."	Not yet available; In 2023, a requirement for an outcomes report to be completed by September 2025.

1 *Subawardees include: Arizona Medical Association, Arizona Osteopathic Medical Association, Arizona Nurses Association (APRNs), and Arizona State Association of Physician Assistants, and Arizona Dental Association.*

ADDITIONAL INFORMATION

ARIZONA:

> The program was structured with a limited recurring appropriation and is set to sunset when the funds are depleted or by June 2028. This program aims to expand preceptor training capacity for graduate students pursuing degrees in allopathic or osteopathic medicine, advanced practice registered nursing, physician assistant studies, or dentistry. The appropriated funds are legislatively allocated to the five largest statewide nonprofit organizations representing these professions, which in turn provide grants of up to $1,000 to eligible preceptors. The professional associations must meet legislative criteria but can add additional program requirements (ex. The PA association requires the precepting be provided for PA students and requires service with the association). Organizations are legislatively required to report the number of applications received and awarded back to the Arizona Department of Health Services.

VERMONT:

> The Vermont Agency of Human Services administers the state appropriation to health care employers for further allocation to employees serving as nurse preceptors ($380,000 is specifically carved out for critical access hospitals). The incentive pay provides up to $5 per preceptor hour. Employers seeking this appropriation submit an application seeking incentive pay reimbursement to the Agency. This application includes details about the nurse preceptors/experiences (name, dates, amount of incentive pay provided); priority is given to those employers who have committed matching funds. Employers submit semi-annual reports on the number of nurse preceptors (inc. new nurse preceptors) back to the Agency. Reimbursement funding must be used for preceptor incentive pay; there is no carve out for employer administrative costs.

VIRGINIA:

> The Virginia Department of Health (DOH) administers the program. Clinical preceptor applicants must upload a form completed by the nursing program to their application. Payment is made directly from the DOH to the preceptor at the end of each academic semester. The program is funded through a general fund appropriation and currently receives $3.5 million per year. There is no statute or rules on the program outside of the biannual budget bills.

WASHINGTON:

> This program provides a grant stipend per qualifying rotation per student (up to 2 students per term). In order to access the stipend, preceptors must register as a state vendor and submit all associated documentation via an online form to the Board of Nursing. An evaluation of program outcomes will be published in September of 2025.

Policy Option: State Tax Credits for Clinical Preceptors

ABOUT THIS STRATEGY:

State tax credits for clinical preceptors are financial incentives provided to healthcare professionals who serve as preceptors for students in clinical training programs. These tax credits aim to recognize the uncompensated service of preceptors by offering monetary compensation in the form of state tax burden reductions. In order to implement this strategy, a state must

- Clearly define what types of professionals will qualify (ex. Provider types, amount of precepting hours contributed, setting/locations)
- Set a cap on the tax credit amount per person and/or per year,
- Develop a process to confirm preceptor eligibility, and
- Process the tax credit for qualified taxpayers.

CONSIDERATIONS FOR UTAH:

BENEFITS:

- **Financial recognition for preceptors.** This policy option reduces the state tax burden for unpaid preceptors.
- **Could be budget-neutral.** Could be designed to be budget neutral to the state if another source of funding was identified (ex. licensing fee surcharge).
- **Opportunity for targeted policy design.** Can be legislative or administratively designed to meet a state's targeted needs (ex. Specialty areas, license types, in-state programs, rural areas, HPSAs, etc.).

CHALLENGES:

- **Financial incentive is a delayed benefit.** For example, if an individual served as a preceptor in January, they would not feel the effect (receive the tax benefit) of this policy option until April of the following year.
- **Tax credit utilization is a mixed bag.** Program auditing/evaluation is limited among participating states. One state has assessed credit utilization and found that over $2.1 million in credits were issued (Georgia). However, two other states have had low-uptake of credit utilization, attributed to administrative complexities.
- **Effectiveness has not been well-demonstrated.** The two states with more robust evaluations (Colorado, Hawaii), demonstrated limited impact on recruitment of new preceptors, but that credited awardees did perceive value in the credit (suggesting it might be a helpful program for retention of preceptors).
- **Program administration is challenging and generally requires two state agencies'/ entities' efforts.** In the majority of states who have adopted this strategy, one entity is responsible for creating and implementing a certification process for eligible preceptors, while the state Department of Revenue is responsible for updating state tax return documents, developing associated guidance, and processing credits.

RELATED HISTORICAL UTAH INITIATIVES:

A bill was proposed in the 2020 legislative session (House Bill 351) to provide a tax credit of up to $2,000 to health care professionals that provide personal instruction training, or supervision to Utah-based health professions students. The bill passed the house Revenue and Taxation Committee (6 yes, 5 no, 4 absent) but failed to pass in its third reading on the House floor (19 yeas, 49 nays, 7 absent or not voting).

TABLE D2 **STATE TAX CREDITS STRATEGY IN ACTION**

STATE	PROGRAM NAME	ELIGIBILITY DETERMINED BY	KEY ELIGIBILITY CRITERIA	INDIV. AWARD AMOUNT	STATE AWARD LIMIT (Total Fiscal Impact)	COST SOURCE	OUTCOMES
 ALABAMA Bill	Alabama Preceptor Tax Incentive Program	AHEC	Unpaid, community-based, rural; in-state students	Physicians: $500/ rotation, up to $6,000/ year APRN: $425/$5,100	$780,000	Education Trust Fund Rolling Reserve *Specific amounts for administrative costs are unknown.*	Not yet available; An evaluation will be completed in 2030
 COLORADO (Bill; Fiscal Note)	Rural and Frontier Healthcare Preceptor Tax Credit Program	Department of Revenue	Primary care, rural, unpaid, in-state students	$1,000/year	$300,000	General Fund *Impact on DOR for program administration expected to be negligible.*	86 preceptors were approved to claim the credit in 2022, resulting in only a 29% usage of available tax credits. 80% of 2017 survey respondents were already precepting before they received the credit.
 GEORGIA (2014 original legislation; Fiscal note unavailable before 2017) (2019 Updated Bill), (2019 FN)	Preceptor Tax Incentive Program	AHEC	Unpaid; in-state students	Physicians: $8,500/yr APRN: $6,375/yr	Unclear	General Fund *Administrative costs not enumerated but were covered by the Medical College of Georgia; $40,000 for initial Department of Revenue information system changes*	In its first year as a tax credit (as opposed to the original program which was a dedication), $2.1 million was claimed.
 HAWAI'I (Bill)	Health Preceptor Tax Credit	Department of Health, Preceptor Credit Assurance Committee	Unpaid, primary care, in-state students	$1,000/rotation, up to $5,000/yr	$1,500,000	General Fund *Specifics on administrative costs are unknown.*	Since program establishment, 2,657 tax awards have been provided to 1,243 unique preceptors. Only 45% of available tax credits were claimed in 2023.

TABLE D2 **STATE TAX CREDITS STRATEGY IN ACTION** CONTINUED

STATE	PROGRAM NAME	ELIGIBILITY DETERMINED BY	KEY ELIGIBILITY CRITERIA	INDIV. AWARD AMOUNT	STATE AWARD LIMIT (Total Fiscal Impact)	COST SOURCE	OUTCOMES
 MARYLAND (Bills)	Income Tax Credit for Preceptor in Areas with Health Care Workforce Shortages Program	Department of Health: Office of Population Health Improvement	Unpaid, designated shortage areas, Department-approved training programs	$1,000/rotation, up to $10,000/yr	$100,000 per profession type	Licensing board fees and general fund *Specifics on administrative costs are unknown.*	Unable to identify
 MISSOURI (Bill; Fiscal Note)	Community-based Faculty Preceptor Tax Credit	Department of Health and Senior Services	Unpaid; family medicine, peds, psych, OB/GYN	$1,000/rotation, up to $3,000/yr	$200,000 1.0 additional FTE was required to administer the program (est. $51,828 per year); Estimated $3,596 to add the tax credit onto state tax forms	Licensing board fees without impact to general revenue *Note: Bill accompanied a $7 increase in licensing fee for physicians and $3 increase for physician assistants to offset revenue loss, deposited into a state-established "Medical Preceptor Fund". Staffing for program administration (1.0 FTE) comes out of this fund.*	Not available

ADDITIONAL INFORMATION

ALABAMA:

> The AHEC administers the program to certify preceptor eligibility. Educational institutions must register with the AHEC using a form. Preceptors must also register. Academic programs report information within an information management system that matches student rotations and associated precepting hours to the individual preceptor. Once a qualifying rotation is verified by AHEC, the preceptor will receive a Certification Letter that is used during state tax preparation. Academic programs may provide compensation to the employer to cover administrative costs of precepting without disqualifying preceptors from program participation. In addition to hosting the platform which enables documentation of existing precepting experience, the AHEC also serves as a coordinator and matchmaker for interested individuals not currently serving as a preceptor by connecting them with academic programs. No information is currently available on outcomes, but the legislation tasks the AHEC to develop performance metrics published in an annual report and requires a state evaluation in 2030.

COLORADO:

> Colorado: The Department of Revenue serves as the certifying body, which differs from other state approaches. Evaluations of this program were performed by the state auditor in 2017 and 2023 to determine the impact of the policy on its original intent. Although the program's authorizing statute did not outline evaluation measures, the Colorado Office of the State Auditor put forth outcome measures within the 2017 and 2023 Tax Expenditure Evaluation Reports.

TABLE D3 COLORADO'S 2017 EVALUATION OF THE RURAL AND FRONTIER HEALTHCARE PRECEPTOR TAX CREDIT PROGRAM

STATE AUDITOR'S OFFICE-DETERMINED OUTCOME MEASURE	EVALUATION FINDING
The extent to which eligible healthcare providers working in rural and frontier areas have been approved by the Department of Revenue to claim the credit.	■ **Most of the tax credits went unused.** "Although statute authorizes up to 200 Preceptor Credits to be claimed each tax year, the Department of Revenue approved only 87 preceptors (44 percent of the credits available) to claim the credit in Tax Year 2017." ■ **The tax credit may not have been an effective mechanism to recruit new preceptors.** A survey issued to approved preceptors found that many of the preceptors (25/31 survey respondents) shared that they were already precepting prior to establishment of the tax credit program. ■ **Only approximately 20% of the approved preceptor credits went toward frontier areas**. Although the policy intended to target frontier areas, this represented only a small proportion of the preceptor credit requests received by the DOR. ■ **There were errors in the approval process.** Out of those 87 preceptors/credits that were initially approved, 14 were identified to be issued erroneously to individuals that did not qualify based on the location or student eligibility.
The extent to which the Preceptor Credit provides a sufficient financial incentive for preceptors in rural and frontier areas of the state	■ **Awarded preceptors were generally pleased with the amount, as they saw it as an incentive, not as wage replacement**. "We found [via survey] that the credit amount may be a sufficient financial incentive for many preceptors, though the relative incentive varies based on the extra time they spend instructing students and their typical hourly wage."

TABLE D4 COLORADO'S 2023 EVALUATION OF THE RURAL AND FRONTIER HEALTHCARE PRECEPTOR TAX CREDIT PROGRAM

STATE AUDITOR'S OFFICE-DETERMINED OUTCOME MEASURE	EVALUATION FINDING
The extent to which the credit encouraged eligible preceptors to offer preceptorships to students enrolled at Colorado institutions of higher education.	■ **Despite expansion to include additional eligible professions and rural settings, most of the tax credits still went unused.** Only 92 taxpayers were approved and only 83 taxpayers claimed the credit out of the 300 possible credits. Therefore, "the Preceptor Credit has not encouraged a substantial number of providers in rural and frontier areas of the state to become preceptors." ■ **Less than 2 percent of Colorado's eligible physician, dentist and advanced practice nurse providers claimed the tax credit.** ■ **A lack of awareness of the program may be contributing to low tax credit usage.** Educational institutions may not have been aware of the preceptor program. Similarly, active providers/professionals may not be aware of this program.
The extent to which the credit provides tax relief to preceptors in rural and frontier areas of the state.	■ **Despite preceptors being satisfied with the tax credit amount in the 2017 evaluation report, the calculated amount of the tax relief provided by this program may be less than the hourly wage of many eligible practitioners, and the impact of this credit may vary based on the type of preceptorship offered.** "The extent of the tax relief provided by the credit varies depending on how many extra hours per day a provider spends training students and the type of provider the preceptor is." The credit equates to a $50 per hour monetary benefit if a preceptor spends 20 hours per week for 4 weeks, which is generally less than the hourly wage of many eligible practitioners. ■ The tax credit is seen by educational representatives as a helpful incentive to support clinical placements for Colorado students, **by providing a competitive advantage to public programs over out-of-state programs for the same pool of perspective preceptors.**

GEORGIA:

> The administrative program structure is similar to Alabama's approach. Preceptors must register through the AHEC. Academic programs submit completed rotation dates and hours to the AHEC and match rotations to the preceptor license number. Preceptors receive a letter by mail at year end outlining the amount of tax credit received. The tax credit is included in the Georgia Department of Revenue Tax Return Form (p. 24). The Medical College of Georgia provided resources (undisclosed amount) to the AHEC to provide administrative support to this program. Costs associated with Department of Revenue process changes were a one-time $40,000. In addition to hosting the platform which enables documentation of existing precepting experience, the AHEC also serves as a coordinator and matchmaker for interested individuals not currently serving as a preceptor by connecting them with academic programs.

HAWAI'I:

> This program is structured to utilize a statutorily established guiding committee to verify registered preceptors. They have developed an academic subcommittee that works with institutions to develop a list of eligible academic programs. The committee issues a certification document that can be used for accessing the tax credit. The lack of tax credit utilization inspired the state to recommend expansion to participation requirements within the 2023 evaluation.

MARYLAND:

> The Department of Health provides a certification letter to preceptors in order to claim the credit(s). The Department also determines areas of workforce shortages (in consultation with the Governor's Workforce Development Board) and approves training programs for qualification (which includes both in-state and out-of-state programs[2]). We were unable to find any publication of outcomes or associated administrative costs.

MISSOURI:

> Missouri's tax credit program is unique from other state approaches because it is supported by a licensing fee surcharge to a Medical Preceptor Fund. This Fund is used to fully fund the Medical Preceptor Tax Credit Program: covering the cost of tax credits issued to eligible preceptors and funding administrative expenses, including a full-time equivalent (FTE) at the Department of Health and Senior Services (DHSS) responsible for determining applicant eligibility. Qualifying preceptors complete an application (signed by preceptor employer and/or student university) and submit to the Department. Awards are on a first-come, first-serve basis (with HPSA score of employer geography considered for any same-day applications). The department provides certification letters for taxpayers to submit with tax returns.

ADDITIONAL SOURCES AND REFERENCES

- Exploring Opportunities to Support Clinical Preceptors through Tax Credits
- Exploring Preceptor Tax Credits in Michigan and Nationwide
- Although this research focused on specific tax credits for preceptors, tax credits have been provided for health professionals with other goals. Below is a list of the tax credits available in other states and some highlighted outcomes:

STATES WITH MEASURED OUTCOMES:

- New Mexico Rural Health Care Practitioner Tax Credit Program: The program was initially established in 2007. A proposed 2025 legislative expansion of qualifying practitioners included a summary of current tax credit utilization, stating that "For tax year 2023, a total of 2,061 eligible health care practitioners received a Certificate of Eligibility from the

2 *See here for approved out-of state programs for Nurse Practitioners and here for registered nurses. No out-of-state programs are approved for medicine or physician assistants.*

Department of Health (DOH), a number that remains consistent with previous years. For the current 2024 tax year, 10 new health care practitioners have been deemed eligible. As of February 18, 2025, 3,079 health care practitioners have received a Certificate of Eligibility. This represents a significant increase compared to previous years, with the tax season still at its mid-point, highlighting the growing impact of this direct incentive. (Source: DOH Rural Practitioner Tax Credit Program Online Application System)".

- Oregon Rural Medical Practitioner Tax Credit: This program offers rural health professionals to receive a tax credit. A recent evaluation demonstrates that the number of individuals who sought and were certified as eligible for the tax credit have declined over recent years. (Evaluation, p. 36-38)

OTHER STATES WITH TAX CREDIT PROGRAMS:

- Alabama Rural Physician Tax Credit
- Georgia Rural Physician Tax Credit
- (Historical) Louisiana Small Town Health Care Professionals Tax Credit (ended in 2020)
- (Historical) Montana Rural Physician Tax Credit (phased out in 2008, transitioned to a loan repayment program)

Policy Option: Housing Supports to Expand Clinical Preceptors

ABOUT THIS STRATEGY:

Expanding access to clinical training opportunities in communities experiencing workforce shortages is a key strategy to expose students to the opportunities that exist and support recruitment. Unfortunately, while practicing health professionals in rural communities may be willing to serve as clinical preceptors for health professions students, these professionals are generally located many miles from degree/training programs. Lack of short-term, affordable housing options is a significant barrier to leveraging some clinical preceptors in rural communities. To address this barrier, some states have implemented financial support to reduce the housing cost burden for students completing required clinical rotations in rural communities. These efforts aim to improve access to clinical preceptorship experiences and ultimately strengthen the pipeline of healthcare workers entering the field.

State approaches may include:

- **AHEC-facilitated Housing through Stipends, Reimbursements, or Placements in AHEC-leased/owned Properties:** State-funded AHECs may provide stipends or reimbursements to students completing rotations with clinical preceptors in rural underserved areas or away from their primary residence. Alternatively, AHECs may secure housing for students by purchasing or leasing properties to be used during clinical training experiences with rural preceptors.
- **State Funding to Employers for Workforce Development:** One state strategy is to channel workforce development funds directly to healthcare employers, especially in rural and underserved communities. These funds could support organizations that serve as clinical rotation sites by helping cover student housing, program administration, and/or preceptor-related costs such as lost productivity. This approach allows employers to design rotation experiences that align with workforce recruitment strategies, while also reducing barriers for students.
- **State Appropriation to University for Clinical Rotation Support:** State legislatures may appropriate funds directly to universities or specific health profession programs to support rotations with clinical preceptors in rural and underserved areas. These appropriations could then be used to support administrative costs, housing stipends, university-facilitated housing, or could be used for preceptor stipends. This strategy allows states to scale clinical training capacity while tailoring programs to meet specific regional or specialty workforce needs.
- **Medicaid Managed Care Funding for State Workforce Development:** Innovative partnerships with Medicaid Managed Care Organizations (MCOs) are emerging as a mechanism for supporting workforce development, including student housing during clinical training. In this approach, states or associations facilitate agreements in which MCOs contribute a portion of profits or reinvestment dollars into health workforce pipelines. These flexible funds could then be used by clinical training sites to expand placement capacity, including by providing housing support to students on rotations.

CONSIDERATIONS FOR UTAH:

Current Utah Programs that Support Student Housing:

- **Utah AHEC:** Utah's AHEC program currently provides support to students seeking housing support for clinical rotations.
    - About the Utah AHEC: The Utah AHEC network has a program office at the University of Utah, and regional centers in Northern Utah (host institution: Weber State University), Crossroads Utah (host institution: Salt Lake Community College), and Southern Utah (host institution: Southern Utah University with satellite offices at Utah Tech University and Snow College). The University of Utah received a federal award of $482,316 in FY2024 for AHEC Point of Service Maintenance and Enhancement. The Utah AHEC receives a

state appropriation of $800,000 which is distributed evenly across the three regional centers and Program Office.

- **Current Student Housing Initiatives:**
  - The Southern Utah AHEC administered a program that provided funding for housing and travel expenses for students undergoing rotations in Utah's rural communities. Through the state appropriation, salary support is available to assist with coordinating clinical rotations. Direct support for housing stipends/payments is provided by the individual program/school or the student and none of the state appropriation is utilized directly for housing.
  - The Crossroads Area AHEC has historically provided housing and mileage subsidies for students completing clinical training in medically underserved areas. The exact amount of funding allocated for this initiative is unknown. However, this funding and program is no longer available or active.

- **Rural & Underserved Utah Training Experience (RUUTE):** This program seeks to increase the number of physicians practicing medicine in rural and underserved areas of Utah and the Intermountain West. To achieve this, they create and support opportunities for clinical training in these communities. The program is supported by $1.5 million annually in state appropriations ($750k for undergraduate medical education efforts through RUUTE, $750k for graduate medical education efforts). As a part of these activities, some funding is available to support lodging and travel assistance (mileage stipends) for University of Utah medical and pharmacy students. This funding supports accommodations in Utah, and additional non-state government funds (private philanthropy, HRSA, and non-Utah contractual funds) support placements in the Intermountain West (Idaho, Montana, Wyoming). In 2024, 64 students completed rural clinical rotations through this support.
- **University of Utah School of Medicine - Psychiatry Residency Idaho Rural Training Track:** Their website states that for the Idaho Rural Training Track, housing is provided through a university-secured Airbnb in Pocatello, Idaho. It should be noted that this rural track program is funded by the Idaho State Legislature at $60,000 per resident per year and $250,000 per year for program administration. In addition to receiving state appropriation, this track is supported by employer funded (hospitals and c
- **(Historical) Utah Medical Education Council (UMEC) Rural Rotation Program:** The UMEC previously developed and administered a rural rotation program for health professions trainees. As a part of this program, students from Utah-based training programs (and a small number of out-of-state students) completed clinical training rotations in rural Utah. In the latest report in 2020, 1,103 students had completed a rural rotation since the program's inception in 2007. It is unclear at this time whether this program was directly supported by state funding or is still operational.
- **Partners in Medicine - Utah Housing:** The Partners in Medicine is a group of individuals composed of spouses and significant others of physicians associated with the University of Utah and surrounding area. This group has developed a website containing information on housing for physician trainees who are coming into the SLC area for training. There is no current established role for state policy or funding of this program.).

BENEFITS:

- **Reduces Financial Barriers for Students:** Housing assistance alleviates one of the most significant out-of-pocket costs for students completing rotations away from their home institution, making rural or underserved placements more accessible.
- **Increases Clinical Placement Capacity:** By supporting students' logistical needs, housing support enables more sites to participate as clinical training locations, especially in rural areas.
- **May Improve Workforce Recruitment and Retention in Rural Areas:** There is some self-reported evidence from the included programs that the programs are satisfied with the outcomes associated with recruitment/retention of those students into practice.
- **Eases Preceptor Burden:** In some approaches, housing support is bundled with other resources (like stipends or admin coordination), helping reduce logistical and financial burdens on preceptors and encouraging continued participation.
- **Fosters Institutional Partnerships:** These programs often strengthen collaboration between universities, employers, and state agencies, aligning educational pathways with workforce needs.

CHALLENGES:

- **Does Not Directly Compensate Preceptors:** While housing support benefits students, it may not sufficiently incentivize preceptors who also face time and productivity constraints when taking on learners.
- **Funding Sustainability:** Many programs rely on discretionary funding, appropriations, or grant dollars, making long-term sustainability and scalability a challenge.
- **Administrative Complexity:** Coordinating housing, especially in geographically dispersed or short-term placements, can be logistically complex and require dedicated staff or infrastructure.
- **Measurement and Evaluation Gaps:** Outcomes data related to housing support (e.g., long-term retention or workforce impact) is often limited and therefore reliant on self-report, making it challenging to objectively evaluate return on investment or inform continuous improvement.

TABLE D5 **STATE HOUSING SUPPORTS STRATEGY IN ACTION**

STRATEGY	STATE	PROGRAM NAME	PROGRAM ADMIN.	ABOUT THE PROGRAM(S)	STATE FUNDING	COST SOURCE	PROGRAM OBJECTIVES	OUTCOMES
AHEC-facilitated Housing	 including Utah	Area Health Education Center activities	Area Health Education Center	Many AHEC provide housing support through stipends, reimbursements, owning/ leasing properties that host students, or developing a network of private residential homes with space for hosting	Varies by state	Federal grant, state appropriation	Varies by state	Varies by state
State Funding to Employer for Workforce Development		Horizon Health (Community Health Center) Dental Rotations	South Dakota Department of Health, Office of Rural Health	Horizon Health serves as a clinical rotation site for the University of Minnesota's dental program. Horizon's staff coordinates and pays for housing for students on rotation under a grant received from the state. The state funds cover housing, program administration, and lost productivity costs.	Amount not disclosed	State grant through discretionary funds	Provide rural training experience for dental students as early investment in dental workforce recruitment (South Dakota does not have a dental program)	Approximately 37% of students that completed a rotation in South Dakota through this program have gone on to practice within the state at some point following graduation. In fact, 12 of the students either worked or currently work at Horizon Health.
State Appropriation to University for Clinical Rotation Support	 (2025 budget request)	University of Utah Psychiatry Resident Rural Idaho Track	University of Utah School of Medicine, Department of Psychiatry	Idaho state appropriations to support a cooperative agreement between the University of Utah and Idaho State University to host Utah psychiatry residents in Idaho.	$250,000 per year for program administration plus $60,000 per year per resident	State appropriation	Train community-centered psychiatrists	Unable to identify
	 (Bill - 2024 Budget)	Regional Initiatives in Dental Education (RIDE)	University of Washington School of Dentistry	State appropriations are directed to this program to support a dental educational track in rural and underserved rotations. As a part of this program, a stipend for housing is provided to dental students.	$2,505,000 (2024)	State appropriation from the workforce education investment account	Increasing the number of dentists trained to meet the needs of rural and underserved populations	"Over 70 percent of [program] graduates [have returned] to practice in rural and underserved areas of Washington and the region."

TABLE D3 **STATE HOUSING SUPPORTS STRATEGY IN ACTION** CONTINUED

STRATEGY	STATE	PROGRAM NAME	PROGRAM ADMIN.	ABOUT THE PROGRAM(S)	STATE FUNDING	COST SOURCE	PROGRAM OBJECTIVES	OUTCOMES
Medicaid Managed Care Funding for State Workforce Development		Health Center Association of Nebraska: Project Access	Health Center Association of Nebraska	Project Access was established to provide Nebraska FQHCs with flexible funding to expand and enhance access to quality, community-responsive care unique to their Communities. This funding can and has been used to support student housing during clinical rotations at health centers.	Undisclosed amount	Medicaid Managed Care partnerships	Increasing patient access by addressing provider shortages, improving clinic operations, expanding capacity, and enhancing the workforce pipeline	"Midtown Health Center rented an apartment for students and residents to stay at while completing clinical rotations. The apartment is walking distance to the clinic and located in the heart of Norfolk's business district, surrounded by restaurants and other attractions. Midtown is planning to house their first student in Spring 2025."

ADDITIONAL INFORMATION

- **AHEC-facilitated Housing through Stipends, Reimbursements, or Placements in AHEC-leased/owned Properties.** AHECs are programs designed to support the supply and distribution of a state's health workforce. These programs are generally funded by a variety of sources, including federal grants, state appropriations, and local support. Many state AHEC programs provide support for student housing during clinical rotations. Some examples include:

ARIZONA:

- The AHEC administers the Rural Health Professions Program (RHPP) (legislatively established) to place students at rural rotations and with mentors. According to the 2024 Annual Report, some RHPP trainees received housing, travel, and related expense support.
- The AHEC leases a modular home that accommodates trainees during clinical rotations. In 2024, 533 nights were provided for trainees.
- One regional AHEC supported 270 students with travel, meals, and housing in FY24.
- Another regional center has 11 housing units with space for 20 learners at any given time.

COLORADO:

- AHEC arranges housing with private homeowners, dorms, or COAHEC owned properties near the rotation site or reimburses students at $23 per night if they find their own housing.

NEVADA:

- One regional AHEC has apartments available to support housing students during rural rotations.

State Funding to Employers for Workforce Development

SOUTH DAKOTA

- Horizon Health (Community Health Center): Horizon Health partners with a dental school program to provide rural dental student rotation experience. Horizon Health receives a grant from the state Office of Rural Health to administer the program, offset lost productivity, and secure housing for dental students on rotation. This has resulted in 37% in-state retention for students that rotated in-state, and 50% of the health center's staff were once student trainees on-site. Note: the state does not have its own dental program, so students are from a contiguous state's dental school.

State Appropriation for Rural Clinical Training

IDAHO

- The Legislature appropriates funds directly to support the University of Utah programming to train psychiatrists in rural Idaho. The University of Utah Psychiatry Residency offers an Idaho Rural Track where three University of Utah residents will spend their first two years in Salt Lake City, and their final two years in Pocatello, Idaho. During their time in Idaho, housing support is provided to residents completing one rotation per year at an Idaho hospital.

WASHINGTON

- The Legislature appropriates funds to support a rural dental training program. A portion of the funds (unknown specific amount) are used to provide housing and travel stipends or secure university/clinic-owned housing for students during their rotations.

Medicaid Managed Care Funding for State Workforce Development

NEBRASKA:

- Nebraska's health center association has established a program, Project Access, where state Medicaid Managed Care Organizations pledge a portion of their profits toward health center workforce development. The funds have a dedicated steering committee that accepts and awards applications from health centers for funding use. Health centers can use funds to support student housing during clinical rotations as a part of their broader pipeline development and long-term recruitment strategies. Other examples of allowable activities include: clinic optimization, capital improvements, sign-on bonuses, retention bonuses, wage support or incentives, loan repayment matches/programming, and other workforce educational needs.

APPENDIX E

SUBCOMMITTEE INITIAL RECOMMENDATION WITH DETAILS ON DECISION OPTIONS

DRAFT Recommendation: Utah Clinical Preceptor Stipend Program

EXECUTIVE SUMMARY RECOMMENDATION

> The Utah Health Workforce Advisory Council Clinical Preceptor Subcommittee recommends the following:
>
> Establish a Utah Clinical Preceptor Stipend Fund and [Decision 1: Pilot] Program to provide financial support for clinical training of healthcare students in priority disciplines.

FUND ADMINISTRATION

> The Fund will be established within the Utah Department of Health and Human Services. It will be funded by [**Decision 2 - Funding Source: 1**) a modest surcharge on license fees for eligible licenses, 2) general fund appropriation, 3) other] and the Fund [**Decision 3 - External Fund Contributions: 1**) will 2) will not] accept contributions from other sources, including donations, gifts, and money received from any other source, such as private foundations, health systems, or other. The Fund will be [**Decision 4 - Stipend Distribution Approach: 1**) state-administered directly to individual preceptors and employers, 2) state-administered directly to individual preceptors, 3) state administers to the Utah Area Health Education Center network for distribution to preceptors, 4) state administers to the major professional associations for distribution to preceptors]. Permissible administrative costs should be in alignment with similar programs.

AWARD DETAILS

> Eligible preceptors include those [**Decision 5 - Qualifying License Types: 1**) MDs, DOs, APRNs, PAs; 2) MDs, DOs, NPs, PAs; 3) MDs, DOs, NPs; 4) Other] who hold active licenses in good standing [**Decision 6 - Specialty/Practice Area: and 1**) All specialties qualify 2) Only those practicing in primary care specialties qualify 3) Other] [**Decision 7 - Geography/Setting: and 1**) All geographies and settings qualify, 2) Must work in a rural or frontier area of Utah as defined by the Utah Office of Primary Care and Rural Health, 3) Must work in a rural or underserved area of Utah as defined by the Utah Office of Primary Care and Rural Health, 4) Other] who provide an uncompensated qualifying preceptorship experience. Qualifying preceptorship experience are those provided to students in the following Utah-based academic programs: [**Decision 8 - Qualifying Students: 1**) medical school, APRN, or PA program 2) medical school or APRN program, or 3) Other]. Qualifying preceptorship experiences should have a minimum duration of [**Decision 9 - Preceptorship Duration: 1**) 40 hours, 2) 80 hours, 3) 120 hours, 4) 160 hours or four weeks, or 5) Other] spent providing personalized instruction, training, and supervision to qualifying students. The award amount will be [**Decision 10 - Award Amount: open for discussion**] and the amount will be [**Decision 11 - Award Amount Structure: 1**) Tiered by profession, with physicians receiving the highest award or 2) a flat rate per qualifying rotation] up to a maximum amount per preceptor.

VERIFICATION PROCESS

> To qualify for the award, qualifying entities (as determined by **Decision 4**) must submit an application to the stipend administering entity detailing the preceptorship experience provided. In order to verify the preceptorship experience, one of the following options will be implemented, 1) the administering entity will then manually confirm the details of the preceptorship experience with the academic institution through a designated point of contact at each qualifying educational institution,

2) the preceptor submits a signed form from the institution alongside their application to certify the experience, 3) academic institutions will supply a list of preceptors and preceptorship details to the administering entity for use to individually certify preceptors, or 4) a state preceptor verification system should be developed to allow prospective awardees to enter their hours and academic institutions to upload preceptorship experience details, facilitating the certification process done by the administering entity.

(If **Decision 4: 1**) Employers would receive funds on behalf of eligible preceptors, for the purpose of providing financial recognition to employees who serve as preceptors through wage increases or bonuses, and retaining a portion to support administrative costs (such as onboarding the student to the organization/electronic health records, loss in productivity that may be associated with training, etc.). Awarded employers must comply with data reporting requirements.

Awards will be issued based on priority determined by the Utah Department of Health and Human Services until the funding maximum is reached. Any unused awards will remain in the fund for future distribution.

DATA REPORTING AND EVALUATION

Qualifying entities must submit the following information to the Department of Health and Human Services. Such information should include, at minimum:

- **Preceptor Practice Information:**
  - License number
  - Practice specialty
  - Practice location (address)
  - Practice setting type
- **Preceptorship Experience Information:**
  - Student type
  - Student educational institution
  - Number of hours
  - Number of students
  - Dates of preceptorship experience
- **Preceptor Perspective:**
  - Was the stipend a significant factor in your decision to precept? (Likert scale)
  - Would you precept again in the future? (Yes/No)
  - What barriers (if any) continue to prevent you from precepting more often?
  - Open-ended feedback on stipend process

The Administering Entity should provide regular updates to the Health Workforce Advisory Council during their quarterly meetings. After one year of implementation, an evaluation should be conducted by the Health Workforce Advisory Council through the Health Workforce Information Center to describe, at minimum, the following:

- Total number of applicants per year
- Total awards distributed

- Total dollars disbursed
- Percent of total applicants who received awards
- **Award distribution by:**
  - License type
  - Student type
  - Geography
  - Institution
  - Practice setting
- Self-reported preceptor perspective findings

ADDITIONAL DETAILS

Specific details about the award should be outlined clearly on the administering entity's website. Upon implementation, the administering entity should develop basic marketing materials and distribute information about the program through the trade associations of qualifying license types, employer trade associations, the Division of Professional Licensing, and the Utah System of Higher Education. This will assist in information dissemination and ensure awareness of the Program.

Decision 1 — Pilot

- **What is this decision?**
  - *To determine whether or not this recommendation should be term-limited or ongoing.*
- **What are the options?**
  - *Yes, pilot.*
    - *For how long?*
  - *No, ongoing.*
- **What are some considerations?**
  - *A pilot program may be more politically feasible.*
  - *Ongoing may lend to sustainability, but be more challenging to implement.*

Decision 2 — Funding Source

- **What is this decision?**
  - *Determination of how the Fund would be funded.*
- **What are the options?**
  1. *A modest surcharge on license fees for eligible licenses*
  2. *General fund appropriation*
  3. *Other*
- **What are some considerations?**

TABLE E1 **LICENSE RENEWAL FEES BY STATE**

STATE (Utah and neighboring)	PHYSICIAN (Biannual)	APRN (Biannual)	PHYSICIAN ASSISTANT (Biannual)
UTAH (2025)	$193	$78	$133
ARIZONA	$500 MD $636 DO	$160	$500
COLORADO	— UNABLE TO IDENTIFY —		
NEVADA	$750 MD $700 DO	$200	$375
NEW MEXICO	$600 (Triennial)	$110	$150
WYOMING	$155	$180	$80

Decision 3 — External Fund Contributions

- **What is this decision?**
  - *Determination as to whether the fund would accept external funding contributions from a non-government or other funding source.*
- **What are the options?**
  1. *The Fund will accept contributions from other sources*
  2. *The Fund will not accept contributions from other sources*
- **What are some considerations?**
  - *If private funds are accepted, would need to decide what, if any, impact this would have on awarding.*

Decision 4 — Stipend Distribution Approach

- **What is this decision?**
  - *This impacts how the Fund ultimately trickles down to preceptors; whether that is provided directly from a state government entity to preceptors, or through a pass-through entity that handles award administration. The award administering entity would be responsible for creating an application process, certifying preceptors/preceptorships, determining awardees, and processing awards.*
- **What are the options?**
  1. *State-administered directly to individual preceptors and employers*
  2. *State-administered directly to individual preceptors*
  3. *State administers to the Utah Area Health Education Center network for distribution to preceptors*
  4. *State administers to the major professional associations for distribution to preceptors*
- **What are some considerations?**
  - ***Option 1:** Employers may easily integrate fund disbursements with payroll. This strategy could align with employer-based recognition strategies. If paired with allowable administrative costs, could provide resources to encourage employer participation.*
  - ***Option 1 and 2:** Higher administrative burden on the state: Requires tracking, verifying, and paying individuals.*
  - ***Option 3:** Leverages existing infrastructure; the AHEC has already provided stipends to students historically, and has a network of schools/employers already established with trusted relationships. Additionally, since the AHEC already receives state funding, this could potentially be done through an existing or amended statement of work.*
  - ***Option 4:** Allows for targeted outreach by professional discipline, which may increase uptake of stipends among professionals that regularly receive communications from professional associations. Unclear whether professional associations would be interested in this approach or capable of disbursing funds at this scale.*

Decision 5 — Qualifying License Types

- **What is this decision?**
  - *Determination of which license types would qualify for the preceptor stipend. Note: This is NOT equivalent to the student types that qualify as an eligible preceptorship experience.*

- **What are the options?**
  1. *MDs, DOs, APRNs, PAs*
  2. *MDs, DOs, NPs, PAs*
  3. *MDs, DOs, NPs*
  4. *Other*
- **What are some considerations?**
  - *Currently DOPL only licenses APRNs and does not provide a specific designation for NPs. If NP is selected separately, how would APRNs submit proof of eligibility as an NP?*

TABLE E2 **QUALIFYING PRECEPTOR LICENSE TYPES**

CATEGORY	STATE	QUALIFYING PRECEPTOR LICENSES
States with Preceptor Stipends	Arizona	MD, DO, PA, APRN, Dentists **Note student must be in the same discipline as the preceptor.*
	Vermont	APRN, RN
	Virginia	MD, DO, PA, APRN, RN, LPN
	Washington	MD, DO, PA, APRN, RN, LPN
States with Preceptor Tax Credit *(Referenced for Policy Design Learning Only)*	Alabama	MD, DO, APRN
	Colorado	MD, DO, PA, APRN, Dentist, RN, Pharmacist, and more
	Georgia	MD, DO, PA, APRN
	Hawai'i	MD, DO, APRN, Pharmacists
	Maryland	MD, DO, PA, APRN-NP
	Missouri	MD, DO, PA

Decision 6 — Specialty/Practice Area

- **What is this decision?**
  - *An opportunity to determine specific specialties or roles for targeted recruitment/retention.*
- **What are the options?**
  1. *All specialties qualify*
  2. *Only those practicing in primary care specialties qualify*
  3. *Other*

- **What are some considerations?**
  - *Primary care training is considered foundational to many, if not all provider training programs.*
  - *The Landscape Report identified that primary care preceptorships are the hardest to secure.*
  - *Educational institutions have a strong interest in expanding rural training, but report difficulty finding available and willing preceptors.*
  - *Limiting eligibility by specialty could reduce the overall pool of eligible preceptors, thereby decreasing program uptake and potentially undermining the perceived success of the program.*
  - ***Eligibility Criteria established by other states:***

TABLE E3 **PRECEPTOR SPECIALTY AND GEOGRAPHY**

CATEGORY	STATE	SPECIALITY	GEOGRAPHY/SETTING
States with Preceptor Stipends	Arizona	"Grant priority shall be given to preceptorships in primary health care"	"Grant priority shall be given to preceptorships in … rural areas of this state."
	Vermont	N/A	N/A
	Virginia	N/A	All sites. Prioritization given to the following practice site types located in a health professional shortage area, medically underserved area, or working with medically underserved populations: Community Mental Health, Facility, Critical Access Hospital, Hospital, Federally Qualified Health Center, Free Clinic, Long-Term Care Facility, Private Practice, Rural Health Clinic, Health Department, Other
	Washington	N/A	N/A
States with Preceptor Tax Credit *(Referenced for Policy Design Learning Only)*	Alabama	A professional "who provides medical services in a health care facility that is physically located in this state and not owned or operated by a [health professions] school and who, through an agreement with a qualified [health professions] school physically located in this state, provides one or more clinical preceptorships for students in [eligible health professions training programs."	Preceptorship experience must be in a Medically Underserved Rural Area, defined as "a primary care service area with a deficit, or surplus of less than 2.0 primary-care physicians, as shown by the most-recent Status Report of the Alabama Primary Care Physician Workforce from the Office for Family Health Education and Research at the UAB Huntsville Regional Medical Campus."
	Colorado	'"Primary health-care" means the provision of integrated, equitable, and accessible health-care services provided by clinicians who are accountable for addressing a large majority of personal health-care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Integrated health-care encompasses the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care."	'"Rural area" means an area listed as eligible for rural health funding by the federal office of rural health policy.'
	Georgia	N/A	N/A
	Hawai'i	"Preceptor means a [professional] who is a resident of Hawaii and who maintains a professional primary care practice in this State. Primary care means the principal point of continuing care for patients provided by a healthcare provider, including health promotion~ disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses, and coordination of other specialist care that the patient may need."	N/A
	Maryland	N/A	"in an area of the State identified as having a health care workforce shortage by the Department."
	Missouri	Preceptorship instruction categories: Family medicine, internal medicine, pediatrics, psychiatry, or obstetrics and gynecology	N/A

Decision 7 — Geography/Setting

- **What is this decision?**
  - *Whether or not the award should prioritize or be limited to preceptors in certain geographies or clinical settings.*
- **What are the options?**
  1. *All geographies/settings qualify (No geographic or setting-based prioritization)*
  2. *Work in a **rural or frontier** area of Utah as defined by the Utah Office of Primary Care and Rural Health*
     - *Note: This is geography based only.*
  3. *Work in a **rural or underserved** area of Utah as defined by the Utah Office of Primary Care and Rural Health*
     - *Note: This could be interpreted to include both geography and other areas with defined shortages.*
  4. *Other*
- **What are some considerations?**
  - *The Landscape Report identified that educational institutions have a strong interest in expanding rural training, but report difficulty finding available and willing preceptors.*
  - *Targeting awards geographically could help address maldistribution of training opportunities and contribute to long-term recruitment strategies.*
  - *Limiting eligibility by geography/setting could reduce the overall pool of eligible preceptors, thereby decreasing program uptake and potentially undermining the perceived success of the program.*
  - ***See research in Table E3 above***

Decision 8 — Qualifying Students

- **What is this decision?**
  - *The types of student preceptorships that qualify for stipend support*
- **What are the options?**
  1. *Medical school (MD/DO), APRN, or PA students*
  2. *Medical school or APRN students only*
  3. *Other*
- **What are some considerations?**
  - *The Utah Medical Education Council provided feedback that preceptors for students in medical residencies can be excluded.*

TABLE E4 QUALIFYING STUDENT ROTATIONS

CATEGORY	STATE	QUALIFYING STUDENT ROTATIONS
States with Preceptor Stipends	Arizona	MD, DO, PA, APRN, Dentists **Note student must be in the same discipline as the preceptor.*
	Vermont	APRN, RN
	Virginia	APRN, RN
	Washington	APRN, RN, LPN
States with Preceptor Tax Credit *(Referenced for Policy Design Learning Only)*	Alabama	MD, DO, PA, APRN, Dentistry, Optometry, Anesthesia Assistant
	Colorado	'"Health professional student" means an individual matriculating at any accredited colorado institution of higher education seeking a degree or certification in a primary health-care field.'
	Georgia	MD, DO, APRN, PA
	Hawai'i	MD, DO, APRN, Pharmacists
	Maryland	MD, DO, PA, APRN-NP
	Missouri	MD, DO, PA

Decision 9 — Preceptorship Duration

- **What is this decision?**
  - *To determine the minimum length of a preceptorship required to qualify for the stipend.*
- **What are the options?**
  1. *40 hours*
  2. *80 hours*
  3. *120 hours*
  4. *160 hours (Four weeks)*
  5. *Other*
- **What are some considerations?**
  - *Training programs likely use varying definitions and structures for preceptorship experiences; it would be prudent to utilize a duration that captures most.*

TABLE E5 **QUALIFYING STUDENT ROTATIONS**

CATEGORY	STATE	CLINICAL PRECEPTORSHIP DURATION
States with Preceptor Stipends	Arizona	Four (4) weeks
	Vermont	Not outlined
	Virginia	250 hours
	Washington	80 hours
States with Preceptor Tax Credit *(Referenced for Policy Design Learning Only)*	Alabama	160 hours
	Colorado	Not less than four (4) consecutive or nonconsecutive working weeks or twenty (20) consecutive or nonconsecutive business days per calendar year
	Georgia	160 hours
	Hawai'i	80 hours
	Maryland	Minimum of 3 100-hour rotations
	Missouri	120 hours* **"A community-based faculty preceptor may add together the amounts of preceptorship instruction time separately provided to multiple students in determining whether he or she has reached the minimum hours required under this subdivision, but the total preceptorship instruction time provided shall equal at least one hundred twenty hours."*

Decision 10 — Award Amount

- **What is this decision?**
  - *The specific dollar value awarded per qualifying preceptorship experience*
- **What are the options?**
  - *Open for discussion*
- **What are some considerations?**
  - *See amounts in Table E6 and corresponding duration in Table E5.*

TABLE E6 **PRECEPTOR AWARD**

CATEGORY	STATE	AWARD AMOUNT
Current Utah Academic Institution Stipends (Anonymized)	Institution A (Physician)	$500
	Institution B (APRN)	$200-250
	Institution C (APRN)	$500-1,000
	Institution D (APRN)	$600
States with Preceptor Stipends	Arizona	$1,000
	Vermont	Up to $5 per preceptor hour
	Virginia	Up to $5,000, based on clinical hours: 25-70 hours: $500, 71-115 hours: $1,625, 116-160 hours: $2,750, 161-205 hours: $3,875, 206-250 hours: $5,000.
	Washington	Up to $900 per student per payment cycle ($7,800 per year)
States with Preceptor Tax Credit *(Referenced for Policy Design Learning Only)*	Alabama	Physicians: $500/rotation, up to $6,000/yr; APRN: $425/rotation, up to $5,100/yr
	Colorado	$1,000/year
	Georgia	Physician: $500 each for rotations 1-4, $1,000 each for rotations 5-8 APRN/PA: $375 each for rotations 1-4, $750 each for rotations 5-8
	Hawai'i	$1,000/rotation, up to $5,000/yr
	Maryland	$10,000 ($1,000 per student, up to $10,000)
	Missouri	$1,000 per rotation, up to $3,000/year

Decision 11 — Award Strategy

- **What is this decision?**
  - *How stipend amounts should be structured across eligible preceptorships.*
- **What are the options?**
  1. *tiered by profession, with physicians receiving the highest award, up to a cap*
  2. *Flat rate per rotation, up to a cap*
- **What are some considerations?**
  - *Two states utilize a tiered model by license type of the preceptor.*

APPENDIX F

SUBCOMMITTEE DECISION SUMMARY AND RATIONALE

DRAFT Recommendation: Utah Clinical Preceptor Stipend Program

EXECUTIVE SUMMARY RECOMMENDATION

> The Utah Health Workforce Advisory Council (HWAC) Clinical Preceptor Subcommittee recommends the establishment of a **Utah Clinical Preceptor Stipend Program** (the Program) to provide financial recognition and support for Utah's clinical preceptors who train healthcare students in priority disciplines.
>
> This Recommendation reflects the extensive review and consideration by the Health Workforce Advisory Council Clinical Preceptor Subcommittee. The Subcommittee was established by the HWAC under its authority from Utah Code 26B-1-425. According to the Subcommittee charter, this body was tasked with "develop[ing] actionable recommendations aimed at strengthening the availability, quality, and capacity of clinical preceptors in Utah for physician and advanced practice nursing students. The Subcommittee will address challenges, identify opportunities, and propose solutions that align with the broader goals of the HWAC". The prepared recommendation below offers guidance as to program structure and approach, but is not intended to incorporate the specifics required for a full legislative policy design.

FUND ADMINISTRATION

> The Program should be established within the Utah Department of Health and Human Services (UDHHS). Initial funding should come from a General Fund appropriation, with long-term sustainability supported by a modest surcharge on licensure fees for eligible license types. The fund should also be structured to accept contributions from private foundations, health systems, donations, and other sources. UDHHS will administer the Program and distribute awards directly to individual preceptors. Allowable administrative costs should align with similar programs.

GUIDANCE

ELIGIBILITY

> Eligible preceptors include physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) who provide uncompensated, qualifying preceptorship experiences. The Program should be designed to allow all licensees in these categories to participate, while giving UDHHS flexibility to prioritize specific needs during implementation.
>
> **A qualifying preceptorship experience must be:**
>
> - Conducted with a student enrolled in a Utah-based medical school, APRN program, or PA program.
> - A minimum of 160 hours in duration, including direct instruction, training, and supervision.
>
> Preceptors may combine hours across multiple students to meet the 160-hour threshold.

AWARD DETAILS

> The base award amount will be $1,000, with a tiered structure by profession, with physicians receiving the maximum award. The maximum number of awards per preceptor will be determined by UDHHS.

To qualify for the award, eligible preceptors must submit an application to UDHHS detailing the preceptorship experience. UDHHS will establish a process to verify the preceptorship experience. Awards will be issued based on available funds and priority determined by UDHHS. Any unallocated funds awards will remain in the fund for future distribution.

DATA REPORTING AND EVALUATION

Upon completion of a qualifying preceptorship experience, eligible preceptors must submit the following information to the UDHHS within their application. Such information should include, at minimum:

- **Preceptor Practice Information:**
  - License number
  - Practice specialty
  - Practice location (address)
  - Practice setting type
- **Preceptorship Experience Information (by student/rotation):**
  - Student type
  - Student educational institution
  - Number of hours
  - Dates of preceptorship experience
- **Preceptor Perspective:**
  - Did you serve as a preceptor prior to this experience? (Yes/No)
  - Was the stipend a significant factor in your decision to precept? (Likert scale)
  - Would you precept again in the future? (Yes/No)
  - What barriers, if any, limit your ability to precept more often?

UDHHS should provide regular updates on the Program to the Health Workforce Advisory Council during their quarterly meetings. After one year of implementation, an evaluation should be conducted by the Health Workforce Advisory Council through the Health Workforce Information Center to describe, at minimum, the following:

- **Total number of applicants per year**
- **Total awards distributed**
- **Total dollars disbursed**
- **Percent of total applicants who received awards**
- **Award distribution by:**
  - License type
  - Student type
  - Geography
  - Institution

- Practice setting
- Summary of preceptor feedback

ADDITIONAL DETAILS

Program details should be published clearly on UDHHS's website. Upon program launch, UDHHS should develop and distribute basic marketing materials through trade associations, the Division of Professional Licensing, health systems, and the Utah System of Higher Education to ensure broad awareness.

ADDITIONAL CONTEXT AND RESEARCH ON THE SUBCOMMITTEE RECOMMENDATIONS

The following provides additional context and relevant research considered by the Subcommittee in developing recommendations on key design elements for the proposed Utah Clinical Preceptor Stipend Program.

PROGRAM DURATION

The Subcommittee considered whether the Program should be operated as a pilot or ongoing. The Subcommittee generally acknowledged that although a pilot program may be more politically feasible, the intent of a pilot is generally to demonstrate effectiveness of a program prior to scaling. The Subcommittee acknowledged that while pilot programs can support demonstration and evaluation, existing use of stipends by some Utah institutions provides a tested foundation. As such, the Subcommittee recommends establishing the program as ongoing, with built-in evaluation requirements.

FUNDING SOURCE

In considering funding options, the Subcommittee reviewed regional comparisons and acknowledged that Utah's professional licensing fees are generally lower than neighboring states (Table 1). Based on this review, the Subcommittee determined that a **modest licensing fee surcharge could be a reasonable and sustainable funding source.**

Recognizing that licensing renewal occurs on a fixed biennial schedule, the Subcommittee also recommends a **one-time General Fund appropriation to launch the program.** This startup investment would provide immediate support while allowing time for the fee-based funding mechanism to be phased in.

Specific surcharge amounts were not determined, and further analysis would be needed to set those levels. While not all licensees may directly receive a stipend, the Subcommittee acknowledged that all licensees benefitted from clinical preceptors during their own training. As such, the program can be viewed as a shared investment in maintaining the pipeline of qualified health professionals.

TABLE F1 **LICENSE RENEWAL FEES BY STATE**

STATE (Utah and neighboring)	PHYSICIAN (Biannual)	APRN (Biannual)	PHYSICIAN ASSISTANT (Biannual)
UTAH (2025)	$193	$78	$133
ARIZONA	$500 MD $636 DO	$160	$500
COLORADO	— UNABLE TO IDENTIFY —		
NEVADA	$750 MD $700 DO	$200	$375
NEW MEXICO	$600 (Triennial)	$110	$150
WYOMING	$155	$180	$80

EXTERNAL CONTRIBUTIONS TO THE FUND

To enhance long-term sustainability and support program flexibility, the Subcommittee recommends structuring the fund **to allow contributions from both governmental and non-governmental sources.** There was shared agreement that while broad participation in funding should be encouraged, contributions should not come with stipulations tied to institutional affiliation or intended beneficiaries.

STIPEND DISTRIBUTION APPROACH

The Subcommittee recommends that the **Utah Department of Health and Human Services (UDHHS) administer the stipend program directly to eligible preceptors.** UDHHS has existing infrastructure and experience managing similar workforce incentive programs, such as the Health Care Workforce Financial Assistance Program and Rural Physician Loan Repayment Program.

While the Subcommittee considered pass-through models (e.g., via Area Health Education Centers or trade associations), it was determined that direct administration by UDHHS would likely result in greater efficiency and lower administrative costs.

There was extended discussion on whether stipends should flow directly to preceptors or through employers. Recognizing the diversity of employment models and the importance of minimizing administrative complexity, the Subcommittee recommends distributing stipends directly to eligible preceptors. This approach also provides more transparency and accountability in how funds are used.

QUALIFYING LICENSE TYPES

The Subcommittee recommends including **physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs)** as eligible preceptor license types. This reflects the interprofessional nature of many clinical training environments and aligns with approaches in other states (Table 2).

TABLE F2 QUALIFYING PRECEPTOR LICENSE TYPES

CATEGORY	STATE	QUALIFYING PRECEPTOR LICENSES
States with Preceptor Stipends	Arizona	MD, DO, PA, APRN, Dentists **Note student must be in the same discipline as the preceptor.*
	Vermont	APRN, RN
	Virginia	MD, DO, PA, APRN, RN, LPN
	Washington	MD, DO, PA, APRN, RN, LPN
States with Preceptor Tax Credit *(Referenced for Policy Design Learning Only)*	Alabama	MD, DO, APRN
	Colorado	MD, DO, PA, APRN, Dentist, RN, Pharmacist, and more
	Georgia	MD, DO, PA, APRN
	Hawai'i	MD, DO, APRN, Pharmacists
	Maryland	MD, DO, PA, APRN-NP
	Missouri	MD, DO, PA

SPECIALTY/PRACTICE AREA AND GEOGRAPHY/SETTING FOCUS

The Subcommittee discussed the potential benefits of prioritizing certain specialties, settings, or geographic areas in program design. While these approaches may support targeted goals, they can also limit participation in areas where clinical placement capacity is already constrained.

Rather than imposing restrictions upfront, the Subcommittee recommends an inclusive program design that allows all specialties and practice settings to participate. Over time, UDHHS may refine implementation to align with evolving workforce needs and placement patterns.

TABLE F3 **PRECEPTOR SPECIALTY AND GEOGRAPHY**

CATEGORY	STATE	SPECIALITY	GEOGRAPHY/SETTING
States with Preceptor Stipends	Arizona	"Grant priority shall be given to preceptorships in primary health care"	"Grant priority shall be given to preceptorships in … rural areas of this state."
	Vermont	N/A	N/A
	Virginia	N/A	All sites. Prioritization given to the following practice site types located in a health professional shortage area, medically underserved area, or working with medically underserved populations: Community Mental Health, Facility, Critical Access Hospital, Hospital, Federally Qualified Health Center, Free Clinic, Long-Term Care Facility, Private Practice, Rural Health Clinic, Health Department, Other
	Washington	N/A	N/A
States with Preceptor Tax Credit *(Referenced for Policy Design Learning Only)*	Alabama	A professional "who provides medical services in a health care facility that is physically located in this state and not owned or operated by a [health professions] school and who, through an agreement with a qualified [health professions] school physically located in this state, provides one or more clinical preceptorships for students in [eligible health professions training programs."	Preceptorship experience must be in a Medically Underserved Rural Area, defined as "a primary care service area with a deficit, or surplus of less than 2.0 primary-care physicians, as shown by the most-recent Status Report of the Alabama Primary Care Physician Workforce from the Office for Family Health Education and Research at the UAB Huntsville Regional Medical Campus."
	Colorado	'"Primary health-care" means the provision of integrated, equitable, and accessible health-care services provided by clinicians who are accountable for addressing a large majority of personal health-care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Integrated health-care encompasses the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care."	'"Rural area" means an area listed as eligible for rural health funding by the federal office of rural health policy.'
	Georgia	N/A	N/A
	Hawai'i	"Preceptor means a [professional] who is a resident of Hawaii and who maintains a professional primary care practice in this State. Primary care means the principal point of continuing care for patients provided by a healthcare provider, including health promotion~ disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses, and coordination of other specialist care that the patient may need."	N/A
	Maryland	N/A	"in an area of the State identified as having a health care workforce shortage by the Department."
	Missouri	Preceptorship instruction categories: Family medicine, internal medicine, pediatrics, psychiatry, or obstetrics and gynecology	N/A

QUALIFYING STUDENTS

The Subcommittee recommends limiting the stipend program to preceptors who train Utah-based medical, APRN, or PA students. Preceptors for residents and fellows were not prioritized due to lower unmet need (as advised by the Utah Medical Education Council). Additionally, there was strong support for focusing eligibility on students enrolled in Utah-based academic institutions, in alignment with state investment goals.

TABLE F4 **QUALIFYING STUDENT ROTATIONS**

CATEGORY	STATE	QUALIFYING STUDENT ROTATIONS
States with Preceptor Stipends	Arizona	MD, DO, PA, APRN, Dentists **Note student must be in the same discipline as the preceptor.*
	Vermont	APRN, RN
	Virginia	APRN, RN
	Washington	APRN, RN, LPN
States with Preceptor Tax Credit *(Referenced for Policy Design Learning Only)*	Alabama	MD, DO, PA, APRN, Dentistry, Optometry, Anesthesia Assistant
	Colorado	'"Health professional student" means an individual matriculating at any accredited colorado institution of higher education seeking a degree or certification in a primary health-care field.'
	Georgia	MD, DO, APRN, PA
	Hawai'i	MD, DO, APRN, Pharmacists
	Maryland	MD, DO, PA, APRN-NP
	Missouri	MD, DO, PA

PRECEPTORSHIP DURATION

The Subcommittee reviewed common rotation lengths across student types and recognized the need for a flexible model that allows preceptors to accumulate qualifying hours across multiple students or rotations. To ensure broad applicability and administrative simplicity, the Subcommittee recommends a threshold of 160 hours, which may be met through a combination of training experiences. It should be noted that there was discussion as to whether defining the duration in "hours" vs. "weeks" was more appropriate; academic representatives reported that hours is the most common measure of student training and weeks could be interpreted ambiguously.

TABLE E5 **QUALIFYING STUDENT ROTATIONS**

CATEGORY	STATE	CLINICAL PRECEPTORSHIP DURATION
States with Preceptor Stipends	Arizona	Four (4) weeks
	Vermont	Not outlined
	Virginia	250 hours
	Washington	80 hours
States with Preceptor Tax Credit *(Referenced for Policy Design Learning Only)*	Alabama	160 hours
	Colorado	Not less than four (4) consecutive or nonconsecutive working weeks or twenty (20) consecutive or nonconsecutive business days per calendar year
	Georgia	160 hours
	Hawai'i	80 hours
	Maryland	Minimum of 3 100-hour rotations
	Missouri	120 hours* *"A community-based faculty preceptor may add together the amounts of preceptorship instruction time separately provided to multiple students in determining whether he or she has reached the minimum hours required under this subdivision, but the total preceptorship instruction time provided shall equal at least one hundred twenty hours."*

AWARD AMOUNT

After deciding the preceptorship duration, the Subcommittee reviewed the corresponding award amounts in other states (referenced in Table 5) and provided their open-ended feedback on the stipend amount that would correspond to that duration. After assessing individual member feedback, the average response was **$1,000 for the 160-hour rotation**. This amount is designed to be meaningful without being overly complex to administer. It reflects a middle ground that acknowledges the time and mentorship provided by preceptors, while also recognizing that stipends are a supplemental incentive rather than a replacement for intrinsic motivations or employer compensation.

AWARD STRATEGY

The Subcommittee acknowledged the critical role that clinical preceptors play across all disciplines and recognized that physician preceptors are particularly difficult to recruit, due to their capacity to precept a broader range of students, including medical, APRN, and PA students. While some APRNs and PAs may also serve as preceptors, especially for students in their own disciplines, it was noted that medical students are typically required to be precepted by physicians, although institutional policies regarding non-physician preceptors vary by medical school.

In light of this, the Subcommittee recommended a **tiered stipend structure by preceptor license** type. In this approach:

- **Physicians** would qualify for the **highest award amount,**
- **Other qualifying license types,** including APRNs and PAs, would be eligible for a **reduced award amount.**

This tiered strategy is consistent with models used in states such as **Alabama and Georgia** (see Table 5), which differentiate award amounts based on the preceptor's license type. The specific dollar amounts for each tier was not discussed, deferring that determination to a future implementation planning phase.

APPENDIX G

PROGRAM COST CALCULATIONS AND SUPPORTING DATA

The Clinical Preceptor Subcommittee recommended a one-time appropriation for capital investment in the program, and sustained funding through a biennial program fee assessed during license renewal.

To calculate a reasonable program funding amount, research in other states with preceptor stipend programs was reviewed. The below Table G1 outlines those states by the stipend-eligible professions (which varies in each state), the counts of practicing professionals that are eligible for award, and calculates a by-eligible individual investment. Utilizing this information, the annual $225,000 funding request aligns with the most conservative investment in other stipend issuing states.

TABLE G1 CALCULATIONS OF STATE INVESTMENT BY ELIGIBLE INDIVIDUAL

STATE	STIPEND-ELIGIBLE PROFESSIONS	— COUNTS OF LICENSEES FOR AWARD-ELIGIBLE PROFESSIONS — Physicians[3]	APRNs[4]	Phys. Assistants[5]	Other[6, 7]	TOTAL	ANNUAL AWARD State Total	AMOUNT PER LICENSEE
ARIZONA	Physicians, PAs, APRNs, Dentists	34,547	6,240	4,152	Dentists: 4,368	**49,307**	**$500,000**	$10.14
VERMONT	APRNs, RNs	—	800	—	RN: 23,869	**24,669**	**$2,380,000**	$96.48
VIRGINIA	Physicians, PAs, APRNs, RNs	48,918	7,040	5,180	RN: 142,961	**204,099**	**$500,000 (pilot)** **$3,500,000 (current funding)**	$2.45 $17.15
WASHINGTON	APRNs, RNs	—	4,150	—	RN: 137,584	**141,734**	**$3,000,000**	$21.17
UTAH[8]	Physicians, APRNs, PAs	16,082	2,740	3,266	—	**22,088**	**Proposed: $225,000**	Proposed: $10.18

3 *Sourced from Federation of State Medical Board's Physician Data Center.*

4 *No national data exists to quantify the licensed APRN workforce by state. Therefore, these counts represent the U.S. Bureau of Labor employment from May 2022 for nurse practitioners. It is recognized that these counts exclude other APRN roles (such as certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists). However, given that nurse practitioners are the largest APRN role, this data is used for estimate purposes.*

5 *Represents the number of Certified PAs as reported by the National Commission on Certification of Physician Assistants in their 2024 Statistical Profile.*

6 *Registered Nurse (RN): National Council of State Boards of Nursing Number Of Active RN Licenses By State, 2022.*

7 *Dentist supply data sourced from the American Dental Association's Health Policy Institute data tables.*

8 *Although specific license counts are available through the Utah Division of Professional Licensing, counts in this table are sourced from the above mentioned datasets so that Utah's data would be comparable to other states referenced within this table.*

In order to maintain annual funding of approximately $225,000, a 10% surcharge (stipend program fee) is recommended to be assessed on qualifying license types. The assumptions and calculations for estimated revenue are presented below in Table G2.

TABLE G2 **ESTIMATED STIPEND FUND REVENUE GENERATION BY PROGRAM FEE APPROACH**

	PHYSICIAN		APRN		PHYS. ASST.			
Count of Licensees (2025)*	17,261**		8,428^		3,266			
Utah Current Biennial License Fee (2025)	$193		$78		$133			
POTENTIAL SCENARIOS	PROGRAM FEE	EST. BIENNIAL FUND AMOUNT	PROGRAM FEE	EST. BIENNIAL FUND AMOUNT	PROGRAM FEE	EST. BIENNIAL FUND AMOUNT	EST. TOTAL BIENNIAL AMOUNT	EST. TOTAL ANNUAL AMOUNT
Current Recommendation (10% surcharge)	$19.50	$336,589	$8.00	$67,424	$13.50	$44,091	**$448,104**	**$224,052**

**Sourced from https://db.dopl.utah.gov/licensee_count.html on 5/28/2025*

***Includes Physician & Surgeon, Physician & Surgeon MB, Osteopathic Physician & Surgeon, Osteopathic Physician & Surgeon MB*

^Includes A.P.R.N, APRN-CRNA Controlled Substance, APRN-CRNA without PP, Certified Nurse Midwife

Given the varying timelines associated with professional license renewal (outlined in Table G3), the HWAC recommends a one-time program investment by the Utah Legislature. This one-time investment would kickstart the program while program fees are being collected from qualifying license types. Following this approach, the program would be fully funded for State Fiscal Year 2029 and could be sustained from license renewal program fee revenue.

TABLE G3 **UTAH LICENSE RENEWAL SCHEDULES**

	PHYSICIAN AND SURGEON	OSTEOPATHIC PHYSICIAN AND SURGEON	APRN	PA
Expiration Dates	January 31 of even years	May 31 of even years	January 31 of even years	May 31 of even years
Upcoming Renewal Periods	11/30/25-1/31/26 11/30/27-1/31/28*	3/31/26-5/31/26 3/31/28-5/31/28*	11/30/25-1/31/26 11/30/27-1/31/28*	3/31/26-5/31/26 3/31/28-5/31/28*

**Indicates the likely earliest renewal period where the program fee could be assessed.*

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