Utah Department of Health & Human Services

Utah Health Workforce Advisory Council (HWAC)
Wednesday, September 17, 2025
Multi-Agency State Office Building (MASOB)
1:00 – 3:00 p.m.
Meeting Minutes

Council Members Present: Heather Borski, Mia Nafziger, Igor Limansky, Chris Williams, Sue Jackson (virtual), Teresa Garrett, Carrie Torgersen, Kristina Callis Duffin, Michelle Hofmann, and Tyler Goddard (virtual).

Council Members Absent: Vic Hockett, Kendra Muir, Francis Gibson, Mark Steinagel, Tyler Goddard, and Sarah Woolsey.

HWAC Staff Present: Ashley Moretz, Marc Watterson, Kendyl Brockman, and Michelle Geller.

HWIC Staff Present: Holly Uphold, Matt Cottrell, and Julie Olson.

This meeting was recorded per the Open Public Meetings Act.

Welcome, Roll Call, and Approval of Meeting Minutes: Heather Borski
Heather welcomed everyone and introduced two new HWAC members: Igor Limansky, the new director of the Utah Division of Multicultural Affairs, and Dr. Kristina Callis Duffin, the Interim Dean of the Spencer Fox Eccles School of Medicine at the University of Utah. Heather then proceeded with a roll call of the voting members.

Michelle Hofmann moved to approve the 6/18/2025 Meeting Minutes. Teresa Garrett seconded. **Motion passed to approve the 6/18/2025 Meeting Minutes.**

Administrative Update: Kendyl Brockman
Kendyl announced that DHHS has renewed its contract with Veritas Health Solutions (Dr. Hannah Maxey and Courtney Medlock), who will continue to collaborate on the Behavioral Health Workforce Strategic Plan, a recommendation from the May 2025 OLAG audit report.

Kendyl also shared that the HWAC charter has been updated to clarify proxy voting. The updated charter states that while proxies can attend HWAC meetings, they are not allowed to vote, as the HWAC statute does not permit proxy voting. The HWAC may consider requesting a statutory change later.

Mia Nafziger moved to adopt the updated HWAC charter. During the discussion, Teresa Garrett questioned why proxies could count toward quorum but not vote. Kendyl explained that the HWAC statute does not restrict proxies from counting toward quorum, but acknowledged that the charter could be adjusted. Michelle Hofmann raised a concern about proxies counting towards quorum but not enabling a vote. Mia Nafziger then amended her motion to remove the line "Proxy members shall count toward a quorum" from the charter.

Igor Limansky asked for clarification on what the HWAC can and cannot do without a quorum. Heather Borski clarified that the HWAC can hold updates and presentations without a quorum, but cannot vote or take action. Michelle Hofmann added that knowing if a quorum will be met helps staff decide whether to proceed with a meeting or reschedule if action is required. Heather noted that the quarterly meeting schedule makes quorum particularly important to avoid delays in voting.

Michelle Hofmann seconded the amended motion.
Motion passed to adopt the HWAC charter and strike the language around proxy members counting toward quorum.

Data Subcommittee Update: Kendyl Brockman
Kendyl shared that the Data Subcommittee is updating its membership and will be meeting shortly. The Data Subcommittee will be working with the HWIC and DOPL on doing a full review of the health professional surveys.

Teresa Garrett asked whether the Data Subcommittee membership is missing any areas of expertise. Kendyl noted that the subcommittee could use one more person from higher education and potentially another health profession.

OPLR Update: Jeff Shumway
Jeff introduced the Office of Professional Licensure Review (OPLR) to new HWAC members, explaining its task of periodically reviewing regulated occupations in the state every 10 years. This year, OPLR is focusing on nursing and allied health professions. Jeff highlighted the statutory criteria used in their review: safety, access, and affordability.

Michelle Hofmann requested more detail on two recommendations:

- **Re-align clinical experience requirements across APRNs, CRNAs, and PAs:** Jeff explained that current clinical hour requirements vary significantly across advanced practice professions due to historical trends. OPLR is concerned about a "loophole" where individuals might open independent practices with insufficient clinical experience outside of schooling. They recommend setting a minimum clinical experience requirement for APRNs and reducing it for PAs to achieve better alignment, acknowledging that PA requirements might remain slightly higher due to differences in didactic paths. The proposed requirement would include precepted or workforce experience and should not impact demand for preceptors. OPLR is addressing concerns from the Utah Nurse Practitioner's Association and schools regarding the accuracy of clinical hour counts and the value proposition for incoming students. They are open to suggestions for post-licensure restrictions.
- **Incremental changes to streamline entry requirements, improve supervision, or expand scope of practice:** Jeff provided examples of proposed adjustments to keep professions current with technological advancements. These include issuing guidance to DOPL regarding NPs in ketamine/IV environments (like med spas), proposing rights for PTs and OTs to prescribe durable medical equipment and order imaging, and aligning unprofessional conduct standards for SLPs and audiologists. OPLR also suggests streamlining training pathways for hearing instrument specialists.

Regarding next steps, Jeff indicated that the Business & Labor Committee has opened a bill file, and

OPLR is working with a drafting attorney to incorporate these recommendations. The committee's intent is to address these changes in one bill.

Legislative Review Subcommittee Update: Teresa Garrett
Teresa reported that the subcommittee has been meeting monthly to review study items for the Business & Labor and Health & Human Services Committees. They are also working to advance the Clinical Preceptorship Stipend Program. However, stakeholders from UNP, the PA association, and UMA have raised two "showstoppers": UNP and PA stakeholders oppose prioritizing publicly-funded schools, and UMA stakeholders oppose the modest licensing fee. As a result, Teresa, Sarah Woolsey, and Veritas are re-evaluating funding options, with Teresa having requested funding through the Rural Health Transformation Fund.

Teresa moved to rescind the HWAC's previous stipulation that publicly-funded schools be prioritized in the program. During the discussion, Mia Nafziger questioned whether the state setting tuition for publicly-funded schools was considered. Teresa clarified that the focus was on private schools already paying preceptors, and the issue was how the prioritization would appear given that much of the state's precepting capacity comes from private institutions. Michelle Hofmann asked if private schools would stop paying preceptors and rely on the program, to which Teresa noted the stipend is a small amount. No public comments were made.

Teresa believes this change will make the program more acceptable to stakeholders, helping to advance the overall initiative. Holly Uphold suggested that the HWAC subcommittees could discuss collecting data through health professional surveys to measure the program's success, for example, by adding a question about its impact. Michelle Hofmann highlighted that Utah-licensed physicians are committed to medical education under the AMA code of ethics, yet only about 60% are precepting. She emphasized that all licensed physicians should engage in some form of medical education as part of their commitment.

Kristina Callis Duffin seconded Teresa's motion.
Motion passed to rescind the public-school prioritization from the Clinical Preceptorship Stipend Program.

Utah Medical Education Council (UMEC) Update: Kristina Callis Duffin
Kristina announced the upcoming UMEC meeting on September 29th, 2025, from 12:00 - 2:00 p.m. in MASOB Rooms 1019A and 1019B. Mr. Charlie Alfero, a consultant hired by UMEC, will present his research and findings on Graduate Medical Education (GME) expansion in Utah. Kristina will share any key takeaways or action items at the next HWAC meeting.

Health Workforce Information Center (HWIC) Update: Holly Uphold, Matt Cottrell
Holly presented a high-level overview of RN and LPN data from health professional surveys, with more technical findings to be released in upcoming reports. Matt detailed the presentation, covering methodological considerations, survey response rates, average wage data, long-term care wage differences, and urban vs. rural responses.

Methodological considerations included the use of convenient sampling, limiting broad generalizations, and the need for supplemental data. The RN survey response rate was 62% (above average), while the LPN rate was 44% (below average), raising concerns about LPN data reliability

due to only 59% of active LPN licenses being eligible for renewal. Matt suggested linking surveys to active licenses rather than just those eligible for renewal for future random sampling.

Analyzing employment and wage trends from 2018-2023 using unemployment insurance data, Matt noted a slower growth rate for RNs from 2022-2023, and while LPN numbers increased, employer numbers and growth rates were significantly smaller, suggesting a cooling demand. The importance of distinct employers for reducing gatekeeping and increasing opportunities was also highlighted.

Significant wage discrepancies were found between RNs and LPNs in long-term care (LTC) settings versus non-LTC settings. RN wages in LTC grew from $37,474 in 2018 to $44,195 in 2024, while non-LTC RN wages grew from $56,691 to $74,134. Only 10% of RN respondents worked in LTC. For LPNs, LTC wages grew from $29,657 to $36,647, and non-LTC wages from $33,702 to $45,243. Nearly 48% of LPN respondents worked in LTC.

Mia Nafziger and Michelle Hofmann suggested exploring characteristics of those working in LTC, such as years of experience, to see if it's perceived as an entry-level stepping stone. Teresa Garrett noted the recent trend of hospitals hiring LPNs since the pandemic. Matt clarified that the data reflects employer and wage demand, not patient demand.

For RNs, rural and urban workers showed similar full-time equivalency and plans to maintain hours. DWS job posting data indicates a general decline in demand for new RN hires from 2025-2026, with a more rapid decline for LPNs. Teresa suggested changing the survey's "plan to keep working" question, as its current two-year projection is not significant. Matt agreed, also noting the confusing wording. Mia asked about comparing Utah's RN and LPN demand to other states, but Matt explained that survey wording challenges full comparisons, though some national average wage and education level comparisons exist.

Utah Rural Health Transformation Program Update: Ashley Moretz, Dr. Ronak Iqbal, Nate Checketts

Nate introduced the Utah Rural Health Transformation Program (RHTP), created through the federal "One Big Beautiful Bill Act" (OBBA). Governor Cox designated the Department of Health and Human Services (DHHS) to apply for these funds. Dr. Ronak Iqbal (Medical Director of Utah Medicaid) and Nate Checketts (Deputy Director of DHHS) were introduced. Ashley Moretz and Brittney Okada (project manager for RHTP) explained that the federal government has committed $50 billion through FY 2026-2030, with half as baseline funding for all states and the other half allotted based on rural factors defined by the OBBA.

The program's three primary objectives are: (1) improving financial sustainability, (2) increasing access to care, and (3) improving health outcomes, with a focus on technology (AI, telehealth, robotics), preventative care, and chronic disease management. To gather public and stakeholder input, the team conducted a webinar, a survey (receiving 106 responses from every rural Utah county), and three listening sessions across the state.

Four strategic buckets were created to prioritize and structure the use of Utah’s RHTP funds, encompassing the nine authorized OBBA actions: (1) Health Rural Utahns, (2) Workforce Development, (3) Innovation and Access, and (4) Technology Innovations. Survey responses ranked these actions. Each bucket has a workgroup with internal DHHS and external organization co-leads

to foster collaboration. The Utah application is due November 5th, with workgroup feedback requested by October 17th to ensure timely completion and adherence to CMS criteria. CMS will announce awards on December 31st. To learn more or contact the RHTP team, please reach out to ruralht@utah.gov or visit www.dhhs.utah.gov/ruralhealth

Maternity Care Report Update: Melanie Beagley, Anna West
Melanie, a Senior Health Research Analyst from the Kem C. Gardner Policy Institute, presented research on maternal health outcomes, risk factors, care access, and workforce in Utah.

Maternal Health Outcomes: Utah generally fares better than the national average for maternal mortality and severe maternal morbidity. However, disparities exist for racial and ethnic minority groups and older mothers. Leading factors for mortality include mental health conditions, substance use disorder, and obesity, with over 70% of mortalities considered preventable. Nearly 30% involved healthcare access barriers, primarily financial and transportation-related.

Risk Factors: The report identified broader risk factors such as intimate partner violence, insurance, and poverty. Notably, Utah women reported higher rates of postpartum depression (4th highest among 27 reporting states) and diagnosed depression symptoms (6th highest among all US states) compared to the national average. Poor mental and physical health among Utah women of reproductive age also increased between 2012 and 2022.

Access and Workforce: Average travel time to the nearest birthing hospital exceeds 60 minutes in 5 counties, with some communities reporting 4-6 hour travel times. In 2021, 13 counties lacked an OB-GYN, 12 lacked a Certified Nurse Midwife (CNM), and 4 lacked a family physician. Family practice physicians are crucial in rural areas, often being the sole providers of maternal care. Interviews suggested that increasing OB-GYNs isn't always the solution for rural communities, with telehealth consultation emerging as an innovative insight. Carrie Torgersen noted that many rural counties lack birthing hospitals, making increased workforce less effective without facilities. Melanie added that some providers travel to secondary locations in rural counties, and low birth rates in these communities can impact providers' ability to maintain current training levels.

Maternal health workforce projections for 2021-2036 in Utah anticipate slight growth or stability for CNMs, but worsening shortages for OB-GYN and family medicine physicians at the state level, not accounting for geographic distribution. Mental health care barriers persist, with long waitlists, limited insurance acceptance, and 6-8 month appointment delays for those with postpartum depression.

Anna West, a Health Workforce Development Coordinator, partnered on the report and emphasized the need for a roadmap to address maternal health access challenges, which will be shared with the HWAC for next steps.

Wrap-Up
Heather concluded the meeting and noted that the next HWAC meeting is scheduled for Wednesday, December 17th from 1:00 to 3:00 p.m.

Ashley shared an update that the Built Here Workgroup met and revised the target metric. The previous target goal was to reduce the number of rural counties in Utah that were in a Health

Professional Shortage Area (HPSA) from 79% to 66%. With the help of the HWIC team, the Built Here Workgroup went back to Gov. Cox and got a revised metric, which is to increase the number of primary care providers working in rural counties by 5% over the next 4 years.

Michelle Hofmann moved to adjourn the meeting.
Meeting adjourned by 3:00 p.m.

Respectfully submitted,
Michelle Geller