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Strengthening the Nursing Pipeline: Policy and Financial Strategies to Overcome Clinical Placement Barriers

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Abstract: This article examines federal, state, and institutional policy and funding strategies to remove barriers to undergraduate clinical placements, a critical bottleneck in nursing workforce growth. It emphasizes the importance of coordinated, multi-level interventions to address systemic challenges and expand workforce capacity. Clinical placement capacity is a critical constraint on the growth of undergraduate nursing programs and the broader nursing workforce. Despite increasing applications, enrollment is constrained, and many qualified applicants are turned away annually. Barriers include limited clinical sites, faculty and preceptor shortages, staff workload and burnout, and lingering effects of the COVID-19 pandemic. Policy and financial strategies are needed to expand placement capacity and strengthen the nursing pipeline. The Health Policy Triangle framework guided this analysis of federal, state, and institutional strategies to expand clinical placement capacity. A structured review of policies, regulations, accreditation standards, and peer-reviewed literature was conducted, including government reports, institutional policies, professional association publications, and case studies. Documents included focused on addressing placement capacity, preceptor support, simulation use, and policy and financial strategies. Policy and funding strategies to expand nursing clinical placements include direct site reimbursement, per-student fees, regional consortia, federal and state grant programs, preceptor incentives, and regulatory levers. Each approach can increase placement capacity but faces challenges such as unstable funding, workforce constraints, and the need for coordinated implementation. Sustainable, multi-level strategies are essential to address the persistent clinical placement shortage. Expanding the nursing workforce requires coordinated policy and financial strategies to increase clinical placement capacity. Regulatory frameworks that promote transparency, equity, and accountability, combined with coordinated efforts across federal and state agencies, academic institutions, and healthcare systems, are needed to sustain placements and grow the nursing workforce.

Keywords: nursing workforce, clinical placement, policy interventions, preceptor incentives, nursing education.

Clinical placement capacity is widely recognized as the principal bottleneck limiting the expansion of undergraduate nursing education and, by extension, the supply of the nursing workforce. The number of entry-level bachelor nursing applications grew by 8.5 percent between 2023 and 2024, and the enrollment grew by 4.9 percent in 2024 (American Association of Colleges of Nursing [AACN], 2025b). The number of qualified students turned away also grew, with nursing schools

reporting turning away 65,766 qualified applications from baccalaureate and graduate nursing programs in 2023, and by 2024, that number increased to 80,162 (AACN, 2025b).

While applications to nursing programs continue to rise, the number of students admitted is constrained not by interest but by limitations in clinical placement capacity, faculty, preceptors, and budget cuts. The mismatch between student demand and clinical site availability has created a significant educational bottleneck. In fact, a lack of clinical placement settings was cited by 45 percent of baccalaureate programs and 50 percent of associate degree programs as the primary impediment to admitting qualified applicants (National League for Nursing, 2016). Since the COVID-19 pandemic, the clinical placement challenge has intensified (Martin et al, 2023). Several interrelated factors contribute to the ongoing shortage. Healthcare sites face capacity limits due to concerns about patient safety, privacy, and the availability of staff (Copeland, 2020). Competition among nursing, allied health, and medical programs intensifies clinical placement challenges. In urban settings, multiple programs must compete for placement, while rural areas struggle due to the lack of clinical site options and gaps in specialty placements (Martin et al., 2023). Staff workload and burnout further reduce the number of preceptors willing or able to supervise students, while geographic and specialty gaps leave rural areas and high-need fields, such as psychiatry, pediatrics, and community health, underserved (Chan et al., 2025; AACN, 2025a). The lingering effects of the COVID-19 pandemic have also constrained placement access, with some hospitals still restricting student involvement (Copeland, 2020; Martin et al., 2023).

Health systems across the United States continue to face persistent nursing workforce shortages, prompting some to revive hospital-based diploma programs as a means of creating direct pipelines for new nurses. For example, both the West Virginia University Health System (WVU Medicine) and the University of Pittsburgh Medical Center (UPMC) have recently implemented nursing diploma programs to address staffing challenges (Becker's Hospital Review, 2024; Health Leaders Media, 2024). While such initiatives may increase entry points into the profession and help meet immediate workforce needs, they also reduce the availability of clinical placement opportunities for college and university nursing programs. Strengthening partnerships between health systems and academic institutions to expand clinical placement capacity would better align with the national goal of increasing the proportion of baccalaureate-prepared nurses, as recommended by the National Academy of Medicine (2021), rather than reverting to educational models that predate the modern BSN standard.

The consequences of insufficient clinical placement capacity are profound. Thousands of qualified applicants are unable to pursue education despite high demand, exacerbating the national nursing

shortage. Limited placements also slow graduation timelines, preventing the timely entry of new nurses into the workforce.

This paper reviews policies, funding mechanisms, and actionable steps that regions, nursing programs, and health systems can implement to address the clinical placement crisis. Strategies range from pilot programs to scalable statewide initiatives, with a focus on expanding placement availability, improving equity in access, leveraging financial incentives and grant support to recruit and retain preceptors, and developing outcome measures that capture the impact of new graduates on the workforce.

Literature Review

Policies at both the federal and state levels are central to shaping the availability, equity, and quality of clinical placements for nursing students. Clinical placements are essential for preparing a competent nursing workforce, yet capacity limitations, administrative burdens, and regulatory variability often restrict access, particularly for students seeking out-of-state opportunities.

Federal initiatives, such as the National Council State Authorization Reciprocity Agreement (NCSARA), provide a voluntary framework among member states, districts, and territories to establish comparable standards for the approval of interstate postsecondary distance education courses and programs (NCSARA, n.d). While NCSARA facilitates the provision of education across state lines, it does not specifically address clinical placements, which often require state-specific Board of Nursing approval. This limitation creates additional administrative barriers for programs seeking to place students in clinical settings outside their home state, requiring navigation of individual state regulations and approval processes.

The issue of clinical placement across state lines is a significant challenge for nursing program administrators. Programs that are online or close to surrounding states must seek clinical placement in other states, which is a regulatory puzzle. Many Boards of Nursing require programs to be fully approved within their state, and some require annual fees. This ensures that programs meet state standards, do not negatively impact existing placements, and provide annual reports on placement activities. While these policies maintain quality and consistency, they also limit program flexibility to access clinical opportunities across state lines. Examples of the additional requirements are Oregon's Board of Nursing, Texas Board of Nursing, and Massachusetts Board of Registration (Massachusetts Board of Registration in Nursing [MBRN], n.d.; Oregon Laws, n.d; Texas Board of Nursing, n.d)

Federal legislation was introduced to the 118th Congress in May 2023. The bill, S1627 PRECEPT Act, proposed an amendment to the Internal Revenue Service Code of 1986 and standardized tax incentives across the nation. This had the potential to encourage preceptors to work with students of academic institutions as well as newly hired nurses in the first six months of employment. While this act was introduced in the Senate there has been no further action to bring it into law (US Senate, 2023).

In response to these challenges of clinical placement, several states have developed policies and initiatives aimed at increasing transparency, equity, and access to clinical placements. California reported that the inability to secure clinical placements was one of the top reasons for limiting nursing admission. The California Board of Registered Nursing data showed that 92 out of 152 nursing programs reported that they were denied access to clinical placement (California Board of Registered Nursing, 2023). To help combat this issue, California's Senate Bill 1015, enacted in 2024, mandates the Board of Registered Nursing to collect and analyze data on clinical placement arrangements. The legislation seeks to ensure equitable access to placements and curtail practices such as paid "clinical contracts" that may disadvantage certain programs. Additionally, the bill empowers the Board to develop standards that guide fair and consistent placement practices across nursing programs (National Nurses United, 2024).

Similarly, Washington State has approached the issue through targeted funding and collaborative initiatives. Its Clinical Placement Initiative (CPI), supported by the state legislature, seeks to expand placement opportunities, diversify clinical settings, and foster stakeholder collaboration. By providing direct resources to programs and clinical sites, the CPI aims to alleviate placement bottlenecks and enhance student learning experiences, contributing to the development of a robust nursing workforce (Washington Center for Nursing, n.d.).

Many states are seeking financial incentives to increase clinical placement opportunities. In Arizona they appropriated 27 million dollars for student nurse clinical rotation programs to expand the capacity of preceptor training programs (Arizona State Senate, 2022), while legislation in Florida created a nursing education fund which provides matching funds to institutions that partner with health care providers to recruit faculty and clinical preceptors. Many states are reviewing the option of tax credits as a financial incentive to nurses who provide preceptorship (Enlund, 2022, Emonds, 2023). As of 2024, six states had passed tax incentive legislation including Georgia, Hawaii, Maryland, Colorado, South Carolina, and Alabama (South Carolina Senate Bill 314 Tax Incentive Legislation Fact Sheet, n. d.; Goldman, 2018; Newman, 2023).

The effectiveness of these policies varies. California's SB 1015 has been recognized for promoting transparency and equity, but its long-term impact depends on the successful implementation of recommended standards (California Nurses Association, 2024). Oregon, Texas, and Massachusetts approval processes ensure local standards are met but may deter some programs due to administrative burden and cost. Appropriations of funds and incentive programs, such as Washington's CPI, demonstrate the potential for targeted funding and collaboration to expand placements, yet their sustainability is contingent on continued support and engagement from multiple stakeholders (Washington Center for Nursing, n.d.).

In summary, federal and state policies and funding initiatives have made important strides in addressing clinical placement challenges in nursing education. However, gaps remain in coordinating interstate approvals, ensuring equitable access, and sustaining funding for placement initiatives. Coordinated efforts across federal, state, academic, and healthcare systems are essential to scale these strategies effectively, expand clinical capacity, and strengthen the nursing workforce pipeline.

Methods

Policy Analysis Framework

The analysis was guided by the Health Policy Triangle framework, which provides a structured approach to examining policy through the interrelated domains of context, content, process, and actors. The Health Policy Triangle framework enables systematic examination of the contextual factors shaping clinical placement policy, the content of policies designed to address placement shortages, the policy processes through which these policies are developed and implemented, and the actors involved in or affected by policy decisions (Walt & Gilson, 1994). This framework was selected to capture the complexity of clinical placement challenges at the center of education, healthcare delivery, and regulation.

Data Sources

A structured document review was conducted to identify policies, funding initiatives, and related materials relevant to nursing clinical placements. Data sources included institutional nursing program policies related to clinical education; State Boards of Nursing regulations governing clinical hours and supervision; accreditation standards; peer-reviewed literature addressing nursing clinical education capacity and workforce development; and publicly available reports from healthcare organizations, academic–practice partnerships, and governmental agencies. Documents were included if they explicitly addressed clinical placement requirements, capacity

constraints, simulation utilization, preceptorship models, or collaborative clinical placement strategies.

Search Strategy

A structured literature search was conducted to identify peer-reviewed articles, policy reports, and publicly available documents relevant to nursing clinical placement capacity, funding mechanisms, and associated workforce outcomes. Searches were performed in the following electronic databases: PubMed, CINAHL, and Google Scholar, complemented by targeted searches of government, accrediting body, and professional association websites (e.g., Centers for Medicare & Medicaid Services, American Association of Colleges of Nursing, state Boards of Nursing).

Search terms combined three domains: clinical placements (e.g., "clinical education," "clinical placement," "preceptorship"), nursing workforce (e.g., "nursing education," "undergraduate nursing students," "nursing workforce shortage"), and financial support (e.g., "funding," "per-student fees," "Medicare pass-through," "grants," "financial incentives"). Boolean operators and truncation were applied to ensure comprehensive coverage (e.g., "nurs* AND 'clinical placement' AND (funding OR incentive*)").

Inclusion criteria were publications from 2010 onward to capture contemporary post–COVID-19 developments, English-language sources, studies, reports, or policies that addressed clinical placement capacity, preceptor support, simulation utilization, or funding mechanisms, and documents relevant to nursing, allied health, or interprofessional clinical training programs. Exclusion criteria included studies focused exclusively on non-clinical nursing education or international settings with regulatory frameworks not generalizable to the U.S. context, unless findings were illustrative of innovative placement or funding models.

Full-text review was conducted, and key data were extracted on policy type, funding approach, placement strategy, and workforce outcomes. Supplementary sources identified through reference mining and grey literature searches were also included to ensure comprehensive coverage of federal, state, and institutional initiatives.

Data Analysis

Data analysis followed an iterative framework guided approach aligned with the four components of the Health Policy Triangle. Context analysis examined the external and internal factors shaping clinical placement policy, including workforce shortages, regulatory environments, healthcare system capacity, funding mechanisms, and institutional priorities. Content analysis focused on the elements of policies, such as clinical hour requirements, simulation allowances, academic–

practice partnership models, preceptor incentives, and alternative clinical delivery strategies. Process analysis explored how policies were initiated, developed, adopted, implemented, and evaluated, with particular attention to decision-making structures, regulatory approval pathways, and implementation timelines. Actor analysis identified key stakeholders involved in or affected by clinical placement policies, including schools of nursing, clinical partners, faculty, preceptors, students, regulatory bodies, and accreditors; actors were examined in terms of their roles, interests, influence, and capacity to shape policy outcomes. Throughout the analysis, equity considerations were integrated to assess how policies differentially affected student populations, geographic regions, and institutional types. Table 1: Policy and Funding Models to Decrease Clinical Placement Barriers summarizes initiatives from the literature and provides an overview of the mechanism, level, advantages, and challenges of each model.

Table 1

Policy and Funding Models to Decrease Clinical Placement Barriers

Policy and Funding Models	Mechanism	Level Federal, State, Institutional (School/Site)	Key Advantages	Key Challenges
Preceptor Incentives	Tax Incentives	Federal and/or State	Encourages participation; improves retention; promotes high-quality supervision	No federal law has been passed; inconsistent between states; incentives are insufficient alone without workload support.
	Financial incentives: Stipends, honoraria, adjunct appointments, loan repayment	Institution (School)	Encourages participation; improves retention; promotes high-quality supervision	Incentives insufficient alone without workload support; program funding variability
	Non-financial incentives: awards, CE credits, RN clinical promotion	Institution (School and/or Site)	Encourages participation; improves retention; promotes high-quality supervision	Incentives insufficient alone without workload support
Clinical Placement Consortia	Multiple schools and sites pool resources to coordinate clinical placement	State and/or Institutional (School and Site)	Economies of scale; reduces duplication; supports schools and sites.	Requires strong governance and stakeholder buy-in; dependent on pooled funding; complex coordination
Direct Site Reimbursement Hospital incentive	Funding to reimburse clinical sites for preceptor time, orientation, administration, supplies	Federal and/or State	Incentivizes sites to accept more students; compensates sites for costs.	Requires sustained appropriations; vulnerable to budget fluctuations; accountability

				mechanism needed.
	Academic institutions pay clinical sites per student to cover stipends and operational costs	Institution (School)	Incentivizes sites to accept more students; compensates site for costs; standardizes placement process and availability to schools.	May increase student tuition; equity concerns for low-income students; sensitive to institutional budgets.
	Medicaid/Medicare Clinical Training Add-On & Pass-through funding Supplemental payments for hosting students; Medicare reimburses hospitals for educational costs	Federal	Leverages existing financing streams; directly compensates sites	Complex regulatory approval; compliance with billing rules; program limits; historical programs largely phased out
Targeted Grant Pools	Federal and/or state grants to fund stipends, faculty development, clinical training, and site expenses.	Federal and/or State	Supports workforce readiness; increases placement capacity; enhances preceptor/faculty engagement	Time-limited; requires sustainability planning; dependent on funding continuity
Policy & Regulatory levers	Standardizing clinical hour requirements, simulation substitution, cross-state approvals, placement reporting	Federal	Promotes accountability; equitable site distribution; ensures program quality	Variation by state; compliance burden; requires alignment with accreditation
	State oversight of clinical placement availability prior to program approval and/or program growth	State	Promotes equitable distribution of placements, protects students from progression delays due to placement.	Limits agility and adds administrative complexity for schools.

Potential Policy and Funding Models

Expanding clinical placement capacity in nursing education requires a combination of financial incentives, regulatory levers, and strategic partnerships. Several models have been proposed to address the persistent shortage of clinical placement opportunities:

Direct Site Reimbursement

One model is direct site reimbursement, whereby state or federal grants reimburse hospitals or clinics for the documented costs of hosting students—preceptor time, orientation, administrative overhead, and supplies. Although no single U.S. program currently matches all these features, Health Resources and Services Administration (HRSA) emphasizes the need for incentives and compensation to clinical sites to sustain precepting in community settings, especially since many

preceptors receive little or no payment for clinical supervision (Advisory Committee on Interdisciplinary Community Based Linkages [ACICBL], 2018). While this model incentivizes hospitals to accept more students and has been tested in select state-funded initiatives, it requires sustained appropriations and careful accountability mechanisms. Recent decreases in federal funding and unpredictable state budgets threaten the continuity of these reimbursement programs, making it difficult for healthcare institutions to commit resources for student placements without stable financial support.

Per-Student Clinical Placement Fee

Another strategy to expand clinical placement capacity is the implementation of per-student clinical placement fees, paid by academic institutions to clinical sites or regional hubs. These fees are designed to cover preceptor stipends, administrative support, and other operational expenses, creating a direct cost-sharing arrangement that aligns incentives between schools and clinical partners (Copeland, 2020; Chan, 2025). The primary benefit of this approach is an increase in the number of available placements, as financial compensation can encourage clinical sites and preceptors to participate and sustain high-quality training experiences. Structured fee arrangements can also support the development of standardized, equitable clinical education programs.

However, per-student fees may also carry potential drawbacks. If the costs are passed to students, tuition may increase, potentially creating financial barriers and raising equity concerns for students from underserved or low-income backgrounds (Gardenier, Arends, et al., 2019; Edmonds, 2023). These concerns are amplified by the significant financial burdens already associated with unpaid clinical placements. A recent scoping review in Australia reported that students and institutions incur substantial costs for transportation, supervision, and lost income across nursing, allied health, medicine, and dentistry programs, particularly in the post–COVID-19 cost environment (Beks et al., 2024). Such findings underscore the importance of carefully designed funding models that balance the benefits of paid placements with considerations of student affordability and equitable access.

Regional Clinical Placement Consortia & Shared Services

A third strategy involves creating a more centrally organized clinical placement strategy. The ACICBL called for a National Center for Clinical Training Site Development. This is based on the idea of other HRSA centers. They recommend that this center develop best practices, foster research projects, develop non-traditional clinical placement sites, and provide preceptor training. (ACICBL, 2018). While this coordination at a national level could benefit all health

education programs, the potential funding was not identified and given the current strategy to decentralize many aspects of HRSA this does not seem like a feasible option.

Creating a more regionally focused clinical placement consortia and shared services, in which multiple schools and health systems pool resources, employ coordinators, and distribute stipends to support sites may be more feasible. These consortia can yield economies of scale and reduce duplication of effort, but require strong governance and stakeholder buy-in. HRSA's "Enhancing Community-Based Clinical Training Sites" report recommends collaborative models to enable rural and community-based settings to host students by sharing administrative support and reducing burden on individual sites (ACICBL, 2018).

Medicaid/Medicare Clinical Training Add-On and Pass-Through

A fourth option leverages existing health financing streams by creating Medicaid or Medicare clinical training add-on payments. Under this model, providers receive small supplemental payments for hosting students in eligible settings, effectively reimbursing documented training activity. While promising, this strategy requires complex regulatory approval and careful compliance with federal and state billing rules (National Academies of Sciences, Engineering, and Medicine [NASEM], 2021).

Another model is the federal "Medicare pass through funds" which is a funding mechanism that allows Medicare to reimburse hospitals for approved educational costs associated with hospital-based health profession programs. This funding solution started in 1965 when nearly 80 percent of nurses were educated in such hospital-based schools of nursing; most of these hospitals received public funding designed to support the cost of nursing education. In essence, this funding offered an additional subsidy to these hospitals, providing financial support for an unpaid labor force. Today, only a handful of such schools remain, as nursing programs moved to collegiate settings (Chan et.al, 2025). There is a potential policy option to redesign this initiative to support hospitals that support clinical placement.

Targeted Grant Pools for Preceptor Support & Faculty Development

Targeted grant pools that fund preceptor support and faculty development represent a well-established federal strategy for strengthening the nursing workforce. For example, HRSA Nurse Education, Practice, Quality, and Retention (NEPQR) programs provide financial support for preceptor stipends, clinical training, and faculty development initiatives (U.S. Department of Health and Human Services, Health Resources and Services Administration [HRSA], n.d.). At the state level, Maryland has adopted an innovative model through the Maryland Higher Education

Commission's Nursing Support Program II (NSP II), which is funded by Maryland hospital assessment revenues administered through the Health Services Cost Review Commission (HSCRC) and is designed to increase the supply of nurses in Maryland hospitals while expanding the capacity of Maryland universities to educate nurses (Maryland Higher Education Commission, n.d.). While such grant-based mechanisms have proven effective in expanding capacity and enhancing workforce readiness, they are inherently time-limited and depend on sustainability plans to maintain their long-term impact.

Incentives for Preceptors

Preceptor incentives are one initiative to ensure clinical placement capacity. Financial incentives, such as direct stipends or honoraria, have been shown to encourage nurses to precept students (ACICBL, 2018; Copeland, 2020). Non-financial incentives, including continuing education credits, adjunct faculty appointments, access to academic resources, and formal recognition awards, also contribute to recruitment and retention. More innovative approaches, such as loan repayment, state tax credits, or career advancement pathways, have been piloted in several states but require broader policy support to scale effectively.

Evidence from a mixed-methods study in New South Wales, Australia, highlights that incentives alone are insufficient if clinician workload and organizational support are not addressed. In this facility-based model, where each student was assigned to one registered nurse (RN) for the duration of their placement, satisfaction among RNs varied depending on the availability of liaison support and manager engagement (Leon, et al., 2023). This finding underscores that preceptor incentives—both financial and non-financial—must be paired with supportive organizational structures to optimize clinical learning experiences and sustain preceptor participation, even when funding is available.

Policy & Regulatory Levers

Finally, regulatory levers can help create a more supportive environment for clinical placements. Standardizing policies on clinical hour requirements, simulation substitution, and cross-state placement approvals, and oversight of program expansion dependent on clinical capacity are strategies that can strengthen accountability and sustainability. Data transparency mandates, such as California's SB 1015, require reporting on placement agreements to promote equitable distribution (California Nurses Association, 2024). Additionally, this bill reflects the kind of oversight and regulatory requirements that can be tied to program accreditation, funding, or expansion approvals.

Financial Stability of Clinical Placement Models

The financial sustainability of clinical placement strategies is increasingly uncertain due to recent decreases in federal funding and the volatility of state budgets. Direct site reimbursement programs are particularly vulnerable to reductions in federal grants or delayed state appropriations (NASEM, 2021). Without stable funding, healthcare institutions may be reluctant to commit resources, leaving placements underutilized despite high demand.

Per-student clinical placement fees, which facilitate cost-sharing between academic programs and clinical sites, are also sensitive to budget constraints. Schools may struggle to maintain equitable fee structures, especially for students in public or community-based programs, when state support is limited, or federal education funding declines. Similarly, regional consortia and shared service models that rely on pooled resources and seed funding from state or federal sources are at risk; fluctuations in these funds can disrupt operations, hinder long-term planning, and reduce placement capacity, particularly in rural or underserved areas (ACICLB, 2018).

Medicaid and Medicare clinical training add-ons offer a promising mechanism to reimburse clinical sites through existing health financing streams, yet they require complex compliance with federal and state billing regulations and may be constrained by policy changes, program limits, or budget cuts (Chan et al., 2025). Targeted grant pools for preceptor support and faculty development, such as HRSA's NEPQR programs, have successfully enhanced capacity but remain time-limited and dependent on stable allocations (HRSA, n.d.). Instability in these funding streams threatens continuity for preceptor stipends, protected faculty time, and training initiatives, undermining recruitment and retention efforts.

Overall, the financial stability of all clinical placement funding models is highly sensitive to the broader fiscal environment. Reductions in federal education grants, coupled with state budget uncertainty, make it difficult for programs, consortia, and clinical sites to plan and sustain investments in precepting infrastructure. Long-term expansion of nursing placements will require diversified, reliable funding sources, multi-year appropriations, and policy mechanisms that shield these programs from political and economic fluctuations.

Discussion

Financial and policy incentives are central to addressing the clinical placement crisis in nursing education. Without structured funding mechanisms and fair cost-sharing models, hospitals and health systems often view student placements as a net burden rather than a strategic investment in workforce sustainability. To ensure that the expansion of nursing program enrollment

translates into actual workforce growth, clinical training capacity must be intentionally aligned with workforce pipeline policies. Otherwise, the system risks producing more students than it can reasonably train, exacerbating attrition, and delaying workforce entry.

One of the most pressing implications for academic institutions is the shifting role of accreditation in determining program legitimacy. The Commission on Collegiate Nursing Education (CCNE) and other accrediting bodies are increasingly holding programs accountable for demonstrating adequate clinical placement capacity relative to enrollment size. These standards are pushing institutions to be more realistic about the scope of their partnerships and the sustainability of their clinical training models. As a result, programs cannot simply expand admissions without first securing robust and equitable placement arrangements.

Policy oversight also plays an important role, particularly for out-of-state or external programs seeking clinical access across state lines. Regulatory requirements for faculty licensing, clinical site approval, and program authorization vary substantially by state, creating both opportunities and barriers for academic-clinical partnerships. These oversight structures highlight the need for greater coordination and reciprocity agreements among states to reduce administrative barriers while still safeguarding educational and clinical quality standards.

Emerging transparency and equity mandates represent another policy of development with significant implications. For example, California's Senate Bill 1015 requires disclosure of clinical placement agreements to promote accountability and equity in site allocation (National Nurses United, 2024). This measure aims to prevent inequities that occur when well-resourced or private programs outcompete public or under-resourced institutions for site access. While still relatively new, such policies could serve as a model for ensuring that access to clinical placements is not disproportionately skewed toward institutions with more financial leverage, ultimately supporting a more diverse and equitable nursing workforce pipeline.

Finally, the issue of preceptor and faculty funding remains a central and unresolved challenge. Federal programs, such as HRSA's Nurse Education, Practice, Quality and Retention (NEPQR) initiatives, have demonstrated some success in supporting preceptor stipends and clinical faculty development. However, most placements remain under-resourced, leaving both preceptors and academic faculty strained. Sustainable reimbursement models are therefore critical to stabilizing the system. Without this support, the reliance on goodwill and professional duty alone will continue to limit clinical training capacity, undermining national efforts to address the nursing shortage.

Conclusion and Implications

Clinical placement continues to be the critical chokepoint in nursing education, constraining the capacity of programs to enroll qualified students and delaying entry into the workforce. Expanding student slots without parallel investments in clinical sites, preceptors, and faculty risks exacerbating existing nursing shortages rather than alleviating them. The evidence reviewed underscores that financial and policy interventions such as direct site reimbursement, per-student placement fees, regional consortia, Medicaid and Medicare training add-ons, targeted grant pools, and structured preceptor incentives are essential to sustaining and expanding placement capacity.

Equally important are regulatory and legislative frameworks that promote transparency, equity, and accountability. Policies like California's SB 1015 demonstrate how oversight can ensure fair access to placements, while federal initiatives and accreditation standards encourage alignment between program expansion and clinical capacity. Incentives for preceptors, whether financial, professional, or educational, are critical for maintaining engagement and preventing burnout among clinical staff.

Sustainable solutions require coordinated efforts across federal and state agencies, academic institutions, and healthcare systems. Transparent measurements of outcomes, including placement availability, student progression, and workforce impact, will be essential for guiding policy refinements and investment priorities. Only through such coordinated, evidence-informed policy reform can the United States develop a nursing workforce pipeline capable of meeting the growing and evolving healthcare demands of the population.

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