

8-22-2016

Framing the Value of Clinical and Field Education

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Recommended Citation

Richardson, L., McGill, R., Anderson, C., Buxell, L., Harris, L., & Rovick, L. (2016). *Framing the value of clinical and field education*. http://sophia.stkate.edu/ipw_papers/1

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Framing the Value of Clinical and Field Education



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Acknowledgements

The authors are grateful for those who provided critical review of our work: Lisa L. Dutton, PT, Ph.D., Associate Professor and Program Director of the Doctor of Physical Therapy program at St. Catherine University; Carol F. Kuechler, MSW, PhD, LISW, Program Director of the Doctor of Social Work Program at St. Catherine University - the University of St. Thomas School of Social Work; and Penelope Moyers, Ed.D, Dean of the Henrietta Schmoll School of Health and the Graduate College at St. Catherine University. We would also like to thank Dáithí Sproule for his support in editing this paper. Additionally, we are grateful to the St. Catherine University Marketing and Communications staff for the design and production of collateral materials in conjunction with this paper. Our sincere appreciation to the many experts and colleagues who shaped our thinking on clinical/field education and provided encouragement over the past several years.

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Introduction

Community/university partnerships play a critical role in higher education. Community-based research, service learning, guest lectures, internships, and a host of other activities illustrate the shared opportunities for students, educators, practitioners, employers, and consumers, as communities and institutions collaborate to educate the future workforce and develop an informed and engaged citizenry.

Across the spectrum of health and professional disciplines, real world learning through community-based clinical/field education¹ is essential to prepare practice-ready graduates. At St. Catherine University, for example, students complete over 7,000 clinical/field placements annually across multiple degrees and disciplines (see Appendix B). Without community/university partnerships, our universities would not be able to provide high quality learning experiences and educate graduates who are both qualified and competitive in the workforce.

Yet the long-standing model of clinical/field education is faced with pressures and competing demands. While universities strive to increase enrollment and meet rising competition and changing accreditation standards, providers face industry and regulatory reform, economic downturns, reduced funding and reimbursement, productivity demands, a retiring workforce, and a host of other pressures.

This paper is intended to strengthen community/university partnerships by articulating the value that can come from clinical/field education. The authors of this paper serve as clinical/field educators for the Henrietta Schmoll School of Health at St. Catherine University and the School of Social Work at St. Catherine University - University of St. Thomas. We draw from our own experience, conversations with clinical and fieldwork partners, faculty and students, and existing literature to outline this complex issue. The goal of this paper is to provide information, a conceptual framework, and language that can inform stakeholders and foster dialogue as we work collaboratively to address the opportunities and challenges of workforce development.

We particularly want to acknowledge the work of the American College of Clinical Pharmacy (American College of Clinical Pharmacy [ACCP] et al., 2010), who have identified a constellation of values that paid, licensed, pharmacy residents bring to host settings. Our own review of the literature across multiple disciplines (nursing, physical therapy, social work, occupational therapy, medicine, pharmacy, etc.) and our practice experience across educational levels led to similar conclusions. We have organized our findings into five major themes (clinical practice/patient outcomes; professional development; recruitment and retention; organizational capacity; and community/university partnerships), and present those here to advance a comprehensive perspective of the value students bring to clinical/field settings. These findings reinforce those of the ACCP.

¹ A variety of terms are used to describe practical, experiential, and community-based learning designed for students to apply and demonstrate what they learn in the classroom to a real world setting. Terms include fieldwork, clinical education, internships, and practicum experiences. For the purpose of this paper, we will use the term clinical/field education.

Background and Challenges

The design of clinical/field education illustrates common principles across disciplines and contexts. The tradition of clinical teaching reaches back to the very beginning of medical practice, where the spiritual leader and healer were one (Ackerknecht, 1955; Osler, 2009). Disciples and/or offspring of these leaders were shaped through observation and directed practice to carry on the traditions of their preceptors. As education became more formal, institutions and professions developed standards to be used in the design of program curricula and the assessment of student performance. Nursing and medical schools were often housed in hospitals, which provided the clinical portion of the education needed by their students. As hospital-based programs closed and education moved to colleges and universities, the clinical, or hands-on, experience was still necessary. Academic institutions could provide a more structured didactic experience, but were not able to provide the direct practice experience that the hospital or other field settings could provide.

While in years past practice structure could compensate for the extra time required to mentor students, currently many clinical/field settings have high demands for productivity, presenting challenges for students, educators, preceptors, and organizations. Practitioners of many disciplines still wish to provide field education and appreciate its intrinsic value (Globerman & Bogo, 2003; Hanson, 2011; Mason & Bull, 2006; Strydom, 2011). However, organizations tell us that increasing demands in the workplace make it difficult to commit to hosting students. Academic institutions, in assuming that professionals will continue to accept students out of a professional obligation to share their knowledge, may not be attuned to the realities of today's clinical practice.

Shared challenges

Clinical/field education presents challenges for both community and healthcare agencies and schools. Rolenc (2014) asks:

How do hospitals and clinics and other agencies balance the resources required to take on students with the day-to-day reality of operating their institutions? Conversely, faced with the growing demand for capable, trained professionals, how can they afford not to? (p. 27)

Workforce shortages in healthcare put an additional burden on overworked employees to mentor students while also meeting rigorous productivity standards. With the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010, more than 32 million Americans were projected to gain access to healthcare services (Rosseter, 2014). Another factor adding to the current strain and need for increased future capacity of the health system is the increasing number of Americans over age 65 who have complex medical and health needs.

Current projections include expected expansion and replacement of the workforce (see Appendix B). The United States Bureau of Labor Statistics (BLS) identified registered nurses among the top occupations for job growth through 2022 because of a predicted shortage (Buerhaus, Staiger, & Auerbach, 2009; Bureau of Labor Statistics [BLS], 2014; Rosseter, 2014). The number of employed nurses is expected to increase to 3.24 million in 2022, an increase

of 526,800 nurses or 19% (BLS, 2014; Rosseter, 2014). The BLS projections also predicted the need for replacing 525,000 employees in the nursing workforce (Rosseter, 2014).

A second shared challenge is the rapid tempo of internal and external change. One partner described the provider challenges, “From the ACA to our own restructuring to meet the new needs of our communities, to the re-design of care delivery in our clinics we have constant and competing priorities” (A. Yolitz, personal communication, October 14, 2015). Our experience in higher education includes demands of innovation, continuous improvement, accreditation requirements, and the need to meet enrollment and volume projections. These struggles reveal themselves in different ways in academic and community settings, however, remain shared and ongoing challenges which test organizational capacity.

Challenges reported by organizations

Organizations report a number of concerns and challenges that affect their decisions to host students. These include the time required to educate students and the impact on staff productivity; the demands of responding to regulatory and service delivery changes (e.g. implementing an electronic medical record); staffing shortages; and minimal physical space or resources (e.g. access to phone and computer). Barton, Bell, and Bowes (2005) note that agencies are under pressure to account for “their outcomes, efficiencies and use of resources,” and that a “climate of scarcity and uncertainty” can result in fewer placements (Barton et al., p. 301). In their study, Barton et al. identified the primary costs of hosting interns as “supervisor time; agency resources (including vehicle use); consultation time with other agency staff; and orientation and training” (p. 307).

Buck, Bradley, Robb, & Kirzner (2012) note “services provided by students typically cannot be billed, and agencies are increasingly concerned about losing reimbursement as a result of field placements” (p.1). Agency-based clinical/field supervisors report being less able to provide teaching time for students, due to being stretched by other responsibilities, and having to use resources previously allocated to clinical and field education for other financial and monitoring activities. As partners face enormous pressure to keep up with increasing caseloads and financial demands, training students in direct practice settings can be a drain on already stretched resources. Buck et al. (2012) indicate that “agencies want workers, not students” (p. 8).

The Fair Labor Standards Act (FLSA) presents some additional challenges related to the distinction between members of the workforce and students as trainees. Recently, the conditions surrounding unpaid internships have been the subject of several highly publicized lawsuits (Miller & Horn, 2014; Williams, 2014). While these internships have little in common with accredited, highly structured, credit-bearing clinical/field education, they have nonetheless generated concern. There is a wide range of interpretation of the FLSA, with some organizations concluding that the organization cannot benefit in any way from the presence of an intern (Slaymaker, 2014), including through third party billing. The publicity from these legal cases and emerging intern watchdog groups has created another layer of pressure on settings that have historically considered partnering with universities to provide clinical/field education.

Challenges reported by schools

Clinical/field education coordinators face challenges in creating and maintaining community partnerships, particularly when accreditation and program standards and institutional priorities and goals are at odds with industry standards, policies, and economic realities in the practice realm (Frumkin, 1980; Grindel, Patsdaughter, Medici, & Babington, 2003; Gwyer, 1993; Hunter & Poe, 2015; Wayne, Bogo, & Raskin, 2006). With increasing economic pressures in healthcare, the clinical/field education coordinators at our universities have been faced with heightened challenges. Already rigorous on-boarding requirements have increased for universities and students. Some agency partners have instituted payment in exchange for placement. These examples illustrate wider trends, as agencies respond to economic pressures (Buck et al., 2012) and seek to manage costs associated with clinical/field education.

Challenges in creating and maintaining clinical/field placements have evolved in complexity over time (K. Matuska, personal communication, December 6, 2013). Examples of challenges faced by schools include accreditation standards, the changing landscape of educational delivery, state authorization requirements, and the rising cost of higher education. Stressors faced by organizations, such as workforce instability, affect their university partners also. As Buck et al. (2012) highlight:

Field Directors report that programs and workers are turning over more than ever. The primary challenge that Field Directors face, given placement instability, is the time that it takes to develop new placements, including recruiting and orienting field instructors, and negotiating affiliation agreements. (p. 9)

Student-driven educational models, such as online education with around-the-clock access, may be at odds with accreditation requirements for direct patient/client contact. More programs are becoming “hybrid” and it remains a challenge to adapt clinical/field education to a distance learning format. A more geographically diverse student base may mean placements all over the United States, with concurrent challenges in developing site affiliation and meeting state authorization education requirements.

In light of these shared challenges in sustaining clinical/field education, it is imperative that we clearly articulate the values inherent in this critical pathway for workforce development. The value-added framework that follows highlights explicit and implicit benefits that can be gained through high quality, high-value clinical/field education community/university partnerships.

A Value-Added Clinical/Field Education Framework

Stakeholders involved in the clinical/field education of students, including the student, the academic institution, and the clinical/field site, have a reciprocal and symbiotic relationship, with mutual expectations, responsibilities, and benefits. The benefits to the students include real world experience in their field of study, opportunities to learn from experts in their field, and preparation for professional practice. Academic institutions meet the requirements of accreditation and fulfill their responsibility to support students on the pathway toward employment and licensure. Benefits to the clinical/field site include best practices and

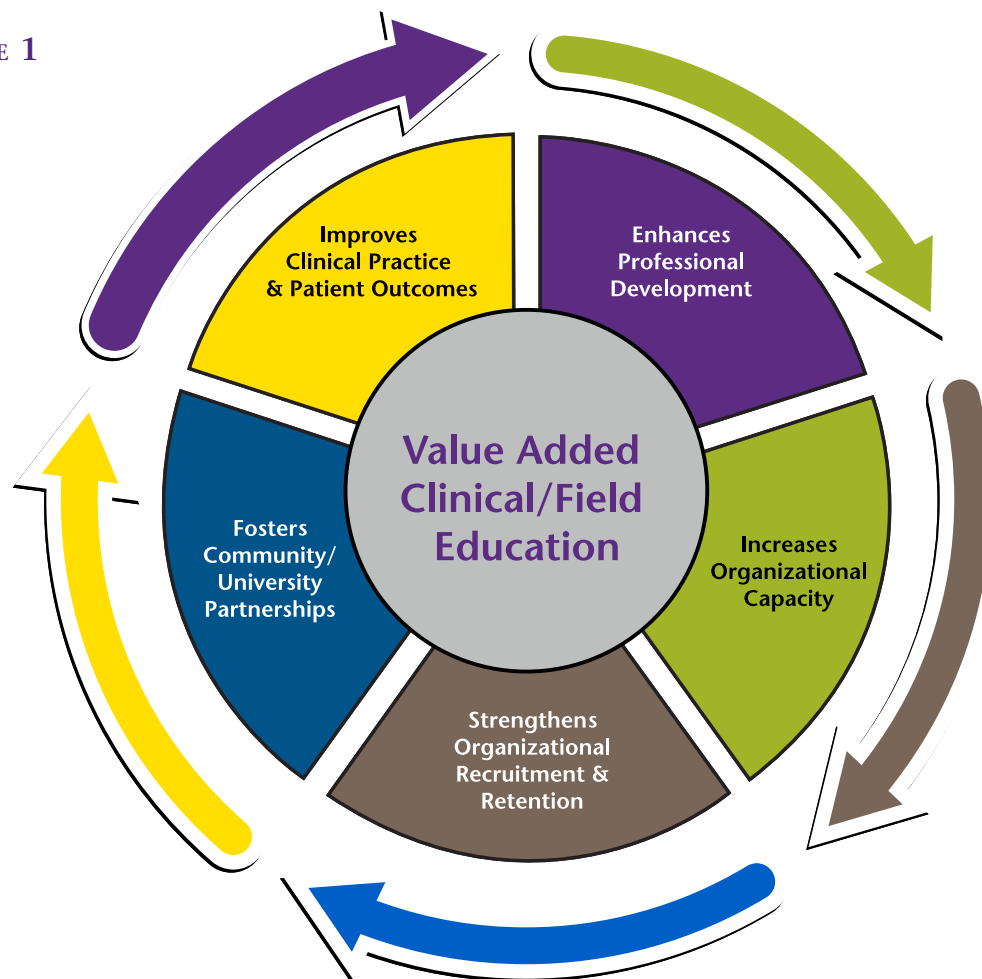
currency of knowledge brought by students (Hanson, 2011; Mason & Bull, 2006; Strydom, 2011; Zendell, Fortune, Mertz, & Koelewyn, 2008). Involvement of clinical partners in professional curriculum development ensures its relevance to the realities of current practice. As recipients of care in the setting where students are placed, consumers gain confidence, not only in the quality of the care they are currently receiving, but also in the care they will receive in the future. In this section, we will frame the value of clinical/field education. We argue that clinical/field education:

1. Improves clinical practice and patient outcomes
2. Enhances professional development
3. Increases organizational capacity
4. Strengthens organizational recruitment and retention
5. Fosters community/university partnerships

Our intention is to articulate concepts, offer language, and foster dialogue that will support high quality, mutually beneficial community/university partnerships for workforce development.

A Value-Added Clinical/Field Education Framework

FIGURE 1



(Richardson, L., McGill, R., Anderson, C., Buxell, L., Harris, L., & Rovick, L., 2016)

1. Improves Clinical Practice and Patient Outcomes

The central goal in our work as health and social service educators and practitioners is to provide excellent care. In our current healthcare environment there is an increasing demand to evaluate the cost-effectiveness and quality of health services (Polgar & Thomas, 2000). In the clinical/field setting, students have the capacity to contribute to the improved quality and delivery of healthcare services by accessing, evaluating and applying knowledge of health science literature and utilizing evidence to inform clinical decision-making.

Students bring new ideas and cutting-edge knowledge to the practice setting (Globerman & Bogo, 2003; Hanson, 2011; Lawson & Ling, 2004; Mason & Bull, 2006; Strydom, 2011; Zendell et al., 2008). Evidence-based literature is the foundation for developing new policy and regulatory statements, clinical practice guidelines, healthcare protocols, consumer materials, and formulating clinical research projects and grant proposals. Clinical practice guidelines, grounded in sound, scientifically based strategies, enable healthcare professionals to deliver the best possible care. Students and faculty play an integral role in the development of practice guidelines. For example, in collaboration with a local medical provider, St. Catherine University's occupational therapy students contributed to the writing of system wide evidence-based clinical guidelines, conducted evidence-based journal clubs, and provided research assistance on a variety of projects.

Research shows that the presence of students can contribute to improved patient outcomes (Strydom, 2011; Talmadge, 2013). A quantifiable example of improved outcomes was seen in the reduction of medication errors correlated with the presence of pharmacy students (ACCP et al., 2010; Fuller et al., 2012). Hospitals that hosted advanced pharmacy interns showed significant decreases in medication errors in the settings where the interns were directly involved (ACCP et al., 2010).

Furthermore, the quality and delivery of healthcare services can be enhanced through the addition of students, who provide "individualized support and care" (Grindel et al., 2003, p. 121). Students provide skilled interventions, beyond the scope of volunteers (L. Anderson, personal communication, February 3, 2014). Talmadge (2013) reports on research that illustrates how increased services provided by students can lead to dramatically better outcomes for patients and cost savings for providers. Perhaps most importantly, clients and families report valuing what students bring in terms of caring and energy (Meyers, 1995), which increases overall client satisfaction.

2. Enhances Professional Development

A second key benefit of clinical/field education is the opportunity for practitioners to grow professionally through the supervision of students. Supervision of students or new practitioners can contribute to the development of the professional self and can positively impact professional demeanor (ACCP et al., 2010; Globerman & Bogo, 2003; Hanson, 2011; Mason & Bull, 2006; Strydom, 2011; Urdang, 2008). Clinical education experiences enable social workers to "feel validated in their clinical abilities...develop deeper reflective skills...[and] review, consolidate, and integrate their own learning" (Urdang, 2008, p. 88).

CRITICAL THINKING AND REFLECTIVE PRACTICE. The presence of students in the clinical/field setting can stimulate critical thinking. Students' fresh perspectives can contribute to a climate of questioning, fostering clinical reasoning and evaluation of program methods (Barton et al., 2005; Grindel et al., 2003; Strydom, 2011). In an ideal learning environment, reciprocal learning occurs between the student and the instructor. Barton et al. (2005) found that field instructors see students "contributing both by bringing new ideas and perspectives, as well as by challenging agency practice" (p. 307).

Urdang (2008), in her study of first-time MSW student supervisors, noted that not only are students' interventions with clients strengthened through field-based supervision, the supervisors' practice is also strengthened. Subjects in the study reported that they "learned from what they taught their students, using the guidance they gave to students to 'rethink' their own practice with clients" (p. 93). Furthermore, "the student often serves as a catalyst for the supervisor, prompting the latter to think, analyze, process, and reflect in new and deeper ways" (p. 95-96). As students share new knowledge and ideas, practitioners have the opportunity to evaluate their own practices and develop them further.

As S. Ochocki, lead social worker for a school district, notes:

Field placement opportunities provide a symbiotic relationship in which both the student and professional can take advantage of new opportunities to grow professionally. Supervisors are challenged to uphold and model sound ethical decision making and evidence-based practices. Beyond demonstrating competent practice, supervisors must also master the ability to deconstruct the practices they have modeled in order to propel student learning. This requires higher levels of metacognition and self-reflection on one's practice, followed by purposeful discussions with the student in order to provide the student context for the practice in their learning environment (personal communication, June 5, 2014).

In a study by Barton et al. (2005), respondents identified "increased reflection" and "shared ideas and new knowledge" as benefits of working with students (p. 309). This perspective is further supported by the American Occupational Therapy Association (2009) in their reference document for fieldwork education, stating "supervising students enhances fieldwork educators' own professional development by providing exposure to current practice trends, evidence-based practice and research" (p. 393). Grindel et al. (2003) claim that "working with students exposes staff to different perspectives; working with students stimulates staff intellectually; working with students allows for reciprocal learning" (p. 121).

FOSTERS THE PROFESSION AND PROFESSIONAL IDENTITY. Supervised clinical experiences serve to define a profession, to shape the practice methods of the next generation, and create a bond and sense of loyalty between the student and the clinical/field educator. This fosters the student's process of socialization and development of a professional identity. According to Globerman and Bogo (2003), social work field instructors encourage the promotion of social work knowledge, skills, and a professional identity. Providing supervision to social work students in field placements "bands all the social workers together" into a "collective sense of being of the profession" (Globerman & Bogo, 2003, p. 68). Lawson and Ling (2004) reported that family physicians felt enriched by mentoring students, thus solidifying their

own identity as physicians and teachers. Family practitioners list several benefits to teaching, including the joy they experience in sharing their knowledge with the next generation (Lawson & Ling, 2004).

Clinical/field education is crucial to developing student competency. Practitioners acknowledge that they were mentored by professionals and recognize the importance of their own participation with students (Globerman & Bogo, 2003; Gwyer, 1993; Hanson, 2011; Lawson & Ling, 2004; Mason & Bull, 2006; Strydom, 2011). A 2011 study by Hanson illustrated the following incentives for occupational therapy field supervision: “professional values, opportunities for continued professional development, recruitment of future employees, and pride in learning experiences available” (Hanson, 2011, p. 164). This was consistent with the earlier work (2006) of Mason and Bull identifying the decision making determinants of “professional responsibility, personal rewards and demands, and support needs” (p. 22) in whether or not to accept a field student. By serving as clinical/field educators, current practitioners are able to share their knowledge while refreshing their own understanding and learning about new developments from students (Hanson, 2011; Lawson & Ling, 2004; Mason & Bull, 2006; Strydom, 2011).

CONTINUING EDUCATION. Formal professional development events provide additional opportunities for growth for practitioners. Academic institutions often provide low-cost to no-cost continuing education for affiliated clinical/field educators, a valuable resource for professionals who need to meet ongoing requirements for licensure and credentialing (Hanson, 2011; Hunter & Poe, 2015; Strydom, 2011). Practitioners may also have the opportunity to earn continuing education credits through direct supervision of students. Access to affordable training to meet professional requirements represents a significant cost saving to practitioners and their employers (see Appendix B).

3. Increases Organizational Capacity

Over the past decade, we have seen a rapid evolution of healthcare and social service trends that impact service delivery, increasing pressure for settings to “do more with less.” Healthcare practitioners are increasingly being called upon to use evidence to inform their clinical reasoning, engage in reflective, ethical, and efficient care practices, and create innovative delivery care models. Cherry and Shefner (2004) noted “academic institutions bring substantial intellectual, technical, and technological resources to community problem solving” (p. 222). There are several ways in which university/community partnerships for clinical/field education can increase the capacity of organizations to promote quality, efficiency, problem solving potential, expansion of services, professional development and education, as well as possible revenue generation.

INCREASED SERVICE CAPACITY. Students can contribute to an expansion of services. Zendell et al. (2008) described the increase in health screening and education services provided by social work students, with one student’s efforts reaching more than 100 individuals and families. Pharmacy interns were able to provide services at the basic level, freeing the preceptors to work on more complex orders (ACCP et al., 2010). In addition to medication error reduction noted from this study, above, this program increased the volume of services provided and increased revenues for the hospitals where the interns were placed (ACCP et al.,

2010). In a study by Dillon, Tomaka, Chriss, Gutierrez, and Hairston (2003), the productivity of physical therapists working with students was significantly higher than those without students as measured by the number of patients seen per day and the number of charges billed per day.

Additional studies provide evidence that students in the clinical setting neither diminish productivity nor outcomes (Cobb, Jeanmonod, & Jeanmonod, 2013; Hake, Glickman, King, & Hollman, 2015; Hiller et al., 2014; Ozelie, Janow, Kreutz, Mulry, & Penkala, 2015). Ozelie et al. (2015) measured the productivity of occupational therapists with and without students based on the percentage of time spent on direct patient care. The study found no significant difference in productivity between clinicians working with a student and those not working with a student. Hake et al. (2015) examined patient outcomes and efficiency of care delivery for patients in an acute care setting following total knee arthroplasty. Patient outcomes, as measured by the level of assistance for functional mobility, were similar for patients treated by staff physical therapists and those treated by student physical therapists. At the same time, staff physical therapists and student physical therapists demonstrated the same level of efficiency of care delivery, as measured by functional gains and the amount of therapy provided during the hospital stay.

PROFESSIONAL AND PROGRAM DEVELOPMENT. Student special projects and presentations benefit the professional development of agency staff (L. Anderson, personal communication, February 3, 2014; Hunter & Poe, 2015; Mertz, Fortune, & Zendell, 2008). Examples include program development and evaluation projects, satisfaction questionnaires, and presentations on practice theory and methods. Mertz et al. (2008) claim data gained from students' professional development projects can lead to expanded services within agencies, and the development of tools for accessing funding for services.

Presentations completed by students support the learning of both staff and clients/constituents (L. Anderson, personal communication, February 3, 2014). Anderson notes that clinical/field education student research can lead to changes in how the organization assesses its programs and services. Frumkin (1980) also notes the value that students can provide through analysis of an organization's operations.

Barton et al. (2005) note that students complete research and literature reviews, providing this information to settings. Students' formal and original research informs the emerging understanding of populations served and methods and models of treatment. Student research is disseminated on campus, at the clinical field site, in public presentations at local, state and national conferences, and in publications.

INCREASED REVENUE. Under certain conditions students provide billable services for the facility (Gandy & Sanders, 1990; Meyers, 1995). Revenue generation through third-party billing can provide tangible value to an organization, while not jeopardizing the educational experience for the student.

In certain cases there may be opportunities for revenue enhancement through grants related to clinical/field education partnership. Public and private funding may support professional education, fostering workforce development and a well cared for population ACCP et al., 2010). As an example, the Minnesota legislature provides grants for practice settings that host

practicum students and medical residents, in order to offset the costs of training, through the Medical Education and Research Costs (MERC) program (Minnesota Department of Health, n.d.). MERC was recently expanded to include clinical social work, community health workers, and psychology trainees in a growing pool of eligible provider types (see Appendix B).

Grants may also be available to support clinical education in areas that represent local, regional and national priorities. For instance, in recent years funding has been awarded to community/university partnerships which offer placements in gerontology or oncology for Master's level clinical social work students (Council on Social Work Education Geront-Ed Center, 2014; American Cancer Society, 2014). Other national grants have provided funds to both agencies and students for clinical/field education in integrative healthcare settings (Council on Social Work Education, 2014). The Department of Human Services in Minnesota recently prioritized minority participation in the behavioral health workforce, offering grants to agencies to support immigrant and refugee students on the pathway from clinical/field education to licensed practice (Minnesota Department of Human Services, 2015).

Finally, the resources non-profit organizations allocate to fostering student development in clinical/field education placements can be included in the annual community benefit calculation, supporting renewal of tax-exempt status. What may appear in the short term as lost revenue from time reallocated to student supervision has a hidden benefit, contributing to the organization's long-term tax-exempt sustainability.

4. Strengthens Recruitment and Retention

A critical aspect of organizational capacity is the creation of a workforce pipeline. A widely recognized benefit of hosting students is the potential to recruit new employees (Gandy & Sanders, 1990; Globerman & Bogo, 2003; Grindel et al., 2003; Hanson, 2011; Hunter & Poe, 2015; Jensen and Daniel, 2010; Mason & Bull, 2006; Meyers, 1995). Globerman and Bogo (2003) recognize that students form a pool of potential employees, and in a study by Barton et al. (2005) 60% of respondents noted that students were hired from clinical/field education placements.

Gandy and Sanders (1990) identify three benefits for recruitment from a pool of students including "1) access to an applicant pool with minimal advertising; 2) fewer personnel required to interview because the applicant may already be personally known; and 3) a shorter staff orientation time, allowing the new staff to be more productive earlier" (p. 72). Our clinical partners regularly affirm these benefits for recruitment of new employees. Students and staff can determine if the student is a good fit in the work environment during the clinical/field education period (Barton et al., 2005; Jensen & Daniel, 2010), while the employer can assess the student's values and work ethic as well as their skills. According to a recent *Time* magazine article, the average cost for recruitment and hiring of an external candidate is 1.7 times more than an internal candidate (Schawbel, 2012). Internships are a "proven, cost-effective way to recruit and evaluate potential employees" (L. Anderson, personal communication, February 3, 2014). Partners report the conversion to hire ratio is an increasingly important metric to track given the escalating workforces shortages (L. Beeth, personal communication, October 8, 2015).

The new employee orientation for a student who is hired can be streamlined. The student has already had training in organizational practices, policies and procedures, documentation, and specific practices related to the management of the patient/client. The student can hit the ground running more quickly (Barton et al., 2005). The result of this decreased time for orientation is dollars saved (see Appendix B).

In addition to efficiencies in recruitment and orientation, the rate of retention is higher for new employees who were students in the facility. Research shows that individuals who were students in a facility remain in their first job longer than those who were not (Gandy & Sanders, 1990), and that employee satisfaction and retention rates were higher at institutions where students were placed (ACCP et al., 2010).

Employers also benefit from the interest students develop in a specific population, need, type of service, or a specific agency as a result of their clinical/field education experience (Mason & Bull, 2006; Strydom, 2011; Zendell et al., 2008). In a study by Brown et al. (2003) student learning experiences led to an increase in serving underserved communities upon graduation.

5. Fosters Community/University Partnerships

Community/university educational partnerships provide opportunities for mutually beneficial and transformative learning processes. Faculty strive to create a rich and collaborative environment with organizational partners that fosters intellectual exchange. In turn, as Anderson notes, both the visibility and image of an organization benefit as it engages in the “educational enterprise” (personal communication, February 3, 2014).

STATUS AND RECOGNITION. Organizations that partner with universities identify “increased status in the community” (Zendell et al., 2008, p. 168). Faculty can partner with clinical/field educators to provide academic, professional, and local and global community educational opportunities. The American Occupational Therapy Association (2009) indicates clinical/field education partnerships create a “progressive, state-of-the art image to the professional community, consumers, and other external audiences” (p. 394).

Universities place high value on the partnership and expertise of clinical/field educators. Partners can contribute to curriculum design, provide input into the articulation of student educational competencies, and ensure that the curriculum is current, relevant, and responsive to the realities of practice (Mertz et al., 2008). Clinical/field educators have opportunities to guest lecture, assist in labs and facilitate group activities, and participate in accreditation processes, contributing to the university’s mission while gaining valuable skills for career enhancement.

University recognition and appreciation of clinical/field educators provide value. Globerman and Bogo (2003) found that social workers perceived that “they achieved or acquired a special status because the university valued them” (p. 68). In some cases, and upon nomination from a university’s faculty, clinical educators are eligible for receiving adjuvant faculty status, an official recognition acknowledging the unique contribution of educational partners.

RESOURCES. According to Gwyer (1993), clinical/field educators in partner organizations “can benefit from utilizing faculty as resources” (p. 65). Hanson (2011) emphasized that community educators expect university support providing ongoing education, preparation

and communication with field supervisor and student. Faculty may assist clinical/field educators in developing improvement strategies for enhancing student supervision, promoting problem solving and dialogue when challenges emerge, and facilitating optimal student learning experiences. Academic and clinical educators collaborate in establishing site-specific learning objectives and maintain communication regarding a student's progress during clinical experiences, including site visits.

A community-wide learning environment is created during clinical/field educational opportunities as students and clinical/field educators have access to academic institutions' library, media services, and archives. Clinical/field educators have exposure and access to the latest theoretical and research publications in scientific journals, reference books, textbooks, government reports, policy statements, and other materials specific to each profession. Partnerships with academic institutions can provide broad opportunities for clinical/field educators to be involved in research and scholarly activities. Whereas professionals may lack the time, resources, and mastery of current scientific inquiry methods to undertake extensive research projects, leveraging organizational partnerships brings together the skills and resources of both education and practice. Developing meaningful working relationships between academic institutions and clinical/field educators sustains excellence in clinical/field education.

Distinguishing Values

Thus far, this paper has focused on a value framework for clinical/field education that can be applied across institutions, disciplines, and practice settings. In addition, it is important to consider the unique values that are rooted in a specific academic institution and its partners. The mission and vision as well as strategic directions are guides for the work of each institution. This section will offer examples of institutional distinctions that enhance value in the clinical/field education partnership.

Mission and Vision

The priorities and themes declared in an organization's mission statement may hold specific relevance for a strategic university/community partnership. As an example, the St. Catherine University and the University of St. Thomas mission and vision statements share themes of leadership, critical thinking, and serving the common good (see Appendix A). The development of leadership skills prepares students to serve as emerging leaders in their professions. Students are trained to think critically and develop a commitment to lifelong learning. Across programs and disciplines, students administer care to underserved/ uninsured community members in a wide range of practice settings. On and off campus, students live the mission by initiating events which respond to critical social justice issues (e.g. health disparities, human trafficking, institutional racism, poverty). They organize community-based service activities, attending to emerging as well as endemic needs in their communities.

The liberal arts focus of our universities further prepares students for work in healthcare and social service professions. The study of the liberal arts adds the human dimension to all areas of specialization, laying the foundation for critical thinking, problem solving, and respect for

diverse and varied experiences and perspectives. Clinical/field education partnerships create an opportunity for further development and exploration of factors such as race, ethnicity, gender, age, education, and class that intersect with population health and the care delivery system.

Strategic Directions and Goals

An organization's strategic directions and goals can also add value to university/community partnerships. Both St. Catherine University and the University of St. Thomas articulate the centrality of clinical partnerships and community engagement to student learning and institutional purpose. Faculty and students participate in research initiatives and innovative practice pilots, exemplifying the reciprocity and synergy that is a result of our clinical partnerships. Clinical/field education faculty serve on task forces and steering committees with legislators, policy makers, providers, practitioners, and consumers to consider regional responses to public health and workforce development needs. Our strong partnerships with community organizations help to ensure that our students receive the best educational experiences possible and, in return, can offer the most benefit to facilities during their clinical/field education and as future employees.

INTERPROFESSIONAL PRACTICE. A major focus of our curriculum is interprofessional education and interprofessional practice. Within the changing healthcare system, patients/clients are best served when their healthcare providers work within a team. We offer many opportunities for our students to learn interprofessionally in order to prepare them for collaborative practice.

Community Partner Distinctions

Institutional priorities can be served by the distinctions of partners, the university, and the community. Community organizations and providers that lead the country in adopting new and emerging practice methods offer extraordinary learning opportunities for students. Partners on the front edge of health industry reforms, for instance, Accountable Care Organizations and Medical Homes, serve universities' efforts to prepare students for the future of healthcare. Organizations that are recognized for practice innovation, research, or fidelity models of care offer students exposure both to treatment delivery and program development and evaluation. Organizations with an educationally focused mission have a deep commitment to sustaining learning opportunities and partnerships.

These examples illustrate how factors unique to each institution's identity can enhance the value of community/university partnerships, further serving strategic priorities and goals.

Next Steps - Call to Action

By articulating the value that can come from clinical/field education, this paper encourages next steps for multiple stakeholders. We must work collaboratively to improve clinical/field education processes and systems and to strengthen community/university partnerships.

TABLE 1 HIGHLIGHTS THE NEXT STEPS FOR UNIVERSITY AND COMMUNITY SETTINGS.

VALUE ADDED CLINICAL/FIELD EDUCATION	UNIVERSITY SETTING	COMMUNITY SETTING
Improves Clinical Practice & Patient Outcomes	<ul style="list-style-type: none"> • Model and facilitate the development of strategies to promote effective and innovative learning opportunities 	<ul style="list-style-type: none"> • Function as a practice resource for universities to enhance clinical/field collaboration and outcomes
Enhances Professional Development	<ul style="list-style-type: none"> • Develop collaborative strategies to improve site and clinical/field educator preparation 	<ul style="list-style-type: none"> • Nurture and develop providers who have an interest in teaching • Promote the qualitative and quantitative benefits that enhance the professional growth of self and students
Increases Organizational Capacity	<ul style="list-style-type: none"> • Collaborate to simplify and streamline processes with regard to student placement 	<ul style="list-style-type: none"> • Advocate for broad staff participation in clinical/field education • Model excellence and commitment to clinical/field education
Strengthens Organizational Recruitment and Retention	<ul style="list-style-type: none"> • Nurture stakeholder partnerships 	<ul style="list-style-type: none"> • Recognize and articulate the role of clinical/field educator in position descriptions and professional development goals • Identify the competency and skills needed for the role
Fosters Community/University Partnerships	<ul style="list-style-type: none"> • Generate a clinical/field education research agenda • Model and facilitate development of strategies to promote effective and innovative learning opportunities • Encourage the exploration of new models in partnership with universities 	

Need for Future Research

Opportunities abound for on-going innovation and collaborative research in the area of clinical/field education. Examples of questions that bear further exploration include:

- What is the perceived value of student participation by community partners in today's healthcare environment?
- What metrics should be used to measure qualitative and quantitative value in clinical/field education?

- How can organizations develop structures to support their educational mission?
- How can individual practitioners advocate for student education within their care environment?
- What is the actual cost of clinical/field education for both the university and the practice site?
- How does payment of students/residents during learning experiences affect perceived value?
- What is the correlation of student outcomes (e.g. student success, student competence, student satisfaction) to this value-added framework?
- What is the impact of students on practitioner productivity?
- What is the impact of clinical/field education on patient outcomes?
- How does the organizational capacity change with student involvement?

Conclusion

Community/university partnerships form the context for developing the next generation of a productive and engaged citizenry. This shared education of new professionals, skilled workers, and future leaders is entering an era of urgency. The combined pressures of an aging workforce and industry overhauls, such as healthcare reform, demand collaborative responses. Healthcare and social assistance are projected to be the largest employment sector in 2022, accounting for a third of US job growth over the next decade (Henderson, 2013). Replacing a retiring workforce while meeting the needs of an aging population requires robust pathways for workforce development. Only together can communities and universities meet these challenges.

This paper offered a framework for articulating value in clinical/field education for multiple stakeholders. Through literature and practical examples, we, as academic leaders of clinical and field education, have communicated ways in which clinical/field education remains an excellent value for stakeholders and strengthens the community/university partnership. It is critical that stakeholders understand both the challenges and opportunities for organizations in working with students. The ability to convey accurately the value, both intrinsic and explicit, will help organizations realistically and holistically determine costs and benefits.

In the environment of scarcity and shrinking resources, this is a call for practitioners and educators to collaborate on a sustainable solution. Using an appreciative approach, we have articulated the value of students in the clinical/field setting and highlighted the importance of learning and professional development for our partners through a value-added framework.

Through our work as an interprofessional team of academic leaders in clinical and field education, we have come to realize that we share common concerns and face similar

challenges in this area of curriculum. We see the necessity to articulate the status of clinical/field education by shining light on the positive values and re-framing the message and existing perceptions. We come together to share our collaborative work with the ultimate goal of preparing a practice-ready workforce, well positioned to meet society's needs.

We invite our community partners and clinical/field educators to review, test, explore, and apply this framework. We look forward to discussion and dialogue about how together we can foster mutual benefit of clinical/field education. Our collaboration is essential as we work to develop tomorrow's workforce in the health and social services professions.

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Appendix A

University Mission and Vision Statements

St. Catherine University

Mission Statement

St. Catherine University educates students to lead and influence. Inspired by its visionary founding in 1905 by the Sisters of St. Joseph of Carondelet, more than a century later the University serves diverse students, with a baccalaureate college for women at its heart and graduate and associate programs for women and men. (St. Catherine University, n.d., Mission statement, para. 1)

At all degree levels, St. Catherine integrates liberal arts and professional education within the Catholic tradition, emphasizing intellectual inquiry and social teaching, and challenging students to transformational leadership. Committed to excellence and opportunity, St. Catherine University develops ethical, reflective and socially responsible leaders, informed by the philosophy of the women's college and the spirit of the founders. (St. Catherine University, n.d., Mission statement, para. 2)

Vision Statement

To be a leading Catholic university distinguished by its innovative spirit and premier baccalaureate college for women. (St. Catherine University, n.d., Vision statement, para. 1)

University of St. Thomas

Mission Statement

Inspired by Catholic intellectual tradition, the University of St. Thomas educates students to be morally responsible leaders who think critically, act wisely, and work skillfully to advance the common good. (University of St. Thomas, n.d., Mission, para. 1)

Vision Statement

The University of St. Thomas, a Catholic comprehensive urban university, is known nationally for academic excellence that prepares students for the complexities of the contemporary world. Through disciplinary and interdisciplinary inquiry and deep intercultural understanding, we inspire students to lead, work and serve with the skill and empathy vital to creating a better world. (University of St. Thomas, n.d., Vision, para. 1)

Appendix B

By the Numbers - The Value of Clinical/Field Education

21,965,900	Number of jobs in healthcare/social assistance projected by 2022 ¹
4,994,100	Growth of jobs in healthcare/social assistance sector between 2012 and 2022 ¹
13.6	Percentage of healthcare/social assistance in total US employment in 2022 (the largest individual sector) ¹
32,000,000	Number of Americans projected to gain access to healthcare through the Patient Protection and Affordable Care Act (PPACA) ²
3,238,400	Number of nurses employed by 2022 (rising 19% from 2012) ²
525,000	Number of nurses who will be replaced in the workforce from 2012–2022, due to retirements ²
\$6,332	Savings from hiring an internal candidate instead of an external candidate (\$8,676 vs. \$15,008) ³
\$400–\$700	Estimated annual savings to clinical/field supervisors receiving university-provided low-cost to no-cost continuing education training required for maintaining professional licensure and credentialing ⁴
120 to 1,840	Range of required clinical/field education hours for students in our universities' healthcare and social work programs ⁴
7,000	Number of clinical/field education placements completed annually at St. Catherine University ⁴
\$58 million	Dollars dispersed annually by the Minnesota Education and Research Costs (MERC) program to sites hosting healthcare trainees ⁵
\$2,639,088	Example of compensation equivalent for hours students from one academic program spent in one year in clinical/field education (using 2013 volunteer hours calculation of \$22.14/hour wage) ⁶

¹Henderson (2013)

²Rosseter (2014)

³Schwabel (2012)

⁴Based on authors' experience

⁵Minnesota Department of Health n.d.

⁶Independent Sector (2013)

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