EXPERIENCE EXCHANGE

Outside track: A new alternative for prelicensure nursing clinical

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ABSTRACT

Background: Due to the dwindling number of acute care facilities, and the rising number of patients requiring care, the healthcare arena is changing. Patients require care in the outpatient arena. Nursing academia needs to retool future caregivers to provide prelicensure outpatient clinical sites to resemble the changing healthcare landscape.
Results: Eight prelicensure nursing students (n = 8) were selected to have the majority of their clinical in the community. Clinical formats differed per course based on availability of clinical partner settings. This program was successful in graduating 7/8 students in the first cohort. Overall satisfaction was achieved in the first cohort leading to program continuation and increased student interest.
Conclusions: Although successful, challenges in operating this program remain relative to the clinical format, availability of clinical placements and student satisfaction.

Key Words: Ambulatory setting, Clinical, Nursing students, Outpatient, Prelicensure

1. INTRODUCTION

As the world surrounding patient care changes, education for nurses must change as well. In looking at today's healthcare environment, there is a growing demand for nursing care in the community setting. Individuals are older, are aging in place, and have multiple chronic and complex conditions paired with decreasing physical abilities. At the present, 17.1% of Americans are 65 or older, and the median age is increasing.[1] Similarly, there is patient complexity across all age levels and Americans are having to manage healthcare in their homes or outpatient settings. Systematic complexity exists thanks to shorter hospital stays, shrinking acute care facilities, and limited nurses working in community settings. Patients requiring care are turning to residential, ambulatory, respite, hospice, and long-term care options. These care options require nursing care, coordination, and management. Nursing students looking to work in these non-acute care areas need clinical training in these expanding arenas. Hence, this article will outline: 1) a new clinical program, where the majority of all clinical is in the community setting, and 2) the benefits and challenges of starting this innovative program.

2. BACKGROUND

2.1 Defining community practice

Community Practice, for the purpose of our project, is defined as any setting outside of inpatient care. These settings may include, but are not limited to, home care, hospice, public schools, assisted living, and outpatient clinics. Traditional nursing clinical experiences, anchored in the acute inpatient hospital setting, are valuable because they provide patients in a structured patient environment. US Bureau of Labor and Statistics[2] identifies that 58% of nurses work in hospi-

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tals and 30% of registered nurses work in ambulatory care, residential care and government positions. However, using the acute care setting, as the only model for patient care, is short sighted due to the broadening base of community needs. Acute care hospitals are declining from 7,156 in 1975 to 6,120 in 2022;[3] while the population mean age is increasing.[1] Anecdotally, our clinical partners indicate that new nursing graduates need the ability to function within a community or ambulatory setting. As outlined by American Association of Colleges of Nursing,[4] gaps in nursing education in areas such as disease prevention/health promotion, chronic care, restorative/regenerative care and hospice/palliative care should be addressed. Thus, the addition of clinical experiences, in a community setting, will provide experienced nurses while reducing dependency on hospital units.

2.2 Literature review

Curriculums that include community-based clinical rotations in nursing education can help to serve as a vital bridge between theoretical knowledge and practical application. Historically, it is well known that academic programs have focused on acute care settings, as noted by The Institute of Medicine's, Future of Nursing Report in 2010.[5] Academic usage of acute care facilities for nursing training does focus on disease management; and arguably, there is less focus on disease prevention and health promotion.[6] Exposing students to the community setting can foster interdisciplinary skills, increase focus on health promotion and help integrate theory and practice.[6,7] In 1993, the National League for Nursing (NLN) started a campaign encouraging community-based nursing education in undergraduate nursing schools to support the shift to community-based healthcare.[8] Research consistently supports the need for nursing students to have community experience and engagement.[6–8] One study by Zeydani and others, in 2023,[9] found that these community clinical experiences gave students a firsthand glance at chronic disease management that impedes disease management, often resulting in a hospital stay. Pijl-Zieber, Barton, Awosoga and Konkin, in 2015,[10] found that there is a major practice gap in the community, and undergraduate nurses are not prepared to work in the community health setting.

Some concerns with community-based nursing education are developing competence with physical skills, the lack of adequate support and supervision, and variability in the quality of learning experiences at different sites.[8,9] These same studies found that while tackling community-based nursing challenges proved difficult; community experiences were valuable. Focus on community-based care didactic and clinical experiences did not negatively impact NCLEX® (National Council Licensure Examination) pass rates; and student evaluations demonstrated they were acquiring new knowledge, skills and critical thinking abilities.[6] Instead, community experiences provided interest in community-based settings. Students consistently reported enjoying the community experiences and community experiences; such experiences fostered interest in primary care and community setting work.[6–12]

This community exposure is beneficial in developing a collaborative mindset and understanding how different services intersect to support patient care. Such experiences can lead to improved teamwork skills and a greater appreciation for the integrated nature of modern healthcare delivery, ultimately preparing students to contribute effectively in a variety of healthcare environments.[6,7,9,12]

3. Outside track clinical and lessons learned

Based on growing job availability in outpatient care, there is a need to provide more clinical experience in community or outpatient setting. An alternative clinical option (Outside Track) was created with the objective to provide most of the experience in the community setting. Having clinical outside of acute care facilities is not a new idea.[8,13] Most recently, Hawkins et al. (2023),[15] threaded primary care across all semesters. Remarkably, the Outside Track provides curricular innovation where the majority of the experience resides in an outpatient setting, not acute care.

3.1 Outside track students

The first cohort (N = 8 students) was selected from a convenience sample of interested students. Inclusion criteria included ability to provide transportation and initial commitment to the remaining semesters in the pre-licensure program (Semester 2, 3, 4 – see Figure 1). Of 24 students, eight students were chosen based on their application and student written interest in the program. The group comprised of seven females and one male. All students successfully completed their first semester with an inpatient acute care setting. The current pre-licensure program includes five semesters for all students with the last semester consisting of a practicum in which students can choose their clinical placement.

Starting with the second semester, the eight students were placed in community settings in both urban and suburban settings in the MidAtlantic region (The first semester is an in-patient medical surgical rotation focused on refinement of assessment skills, technical nursing skills, communication and organization, see Figure 1). Site selection criteria included the following: availability during the scheduled clinical day, a nurse or clinical instructor availability, and stu-

dent ability to participate (not observe) in the clinical setting. All community sites must also allow students to meet clinical course competencies expected in the course (ie administering of medications).

Three clinical teaching modalities were utilized: preceptor, group or hybrid (see Table 1). Preceptor modality provided instruction "at the elbow;" hence, students were able to increase their scope of practice. Preceptors were chosen by the clinical site and must be a Registered Nurse. Students were permitted to perform more skills, such as draw blood, start intravenous lines, and perform advanced wound care on patients, due to this high level of oversight by a registered nurse. All feedback relative to the student was directly given to the university clinical instructor (CI). Other courses, like psychiatric mental health, students operated in an outpatient setting as a group with oversight by a traditional psychiatric instructor. The hybrid modality combined traditional group format with a precepted format. For instance, in child health, a hybrid format was used. The hybrid format allowed students to participate in inpatient pediatric sites with a traditional group for three weeks; ending the last three weeks students were precepted within a community school clinic.

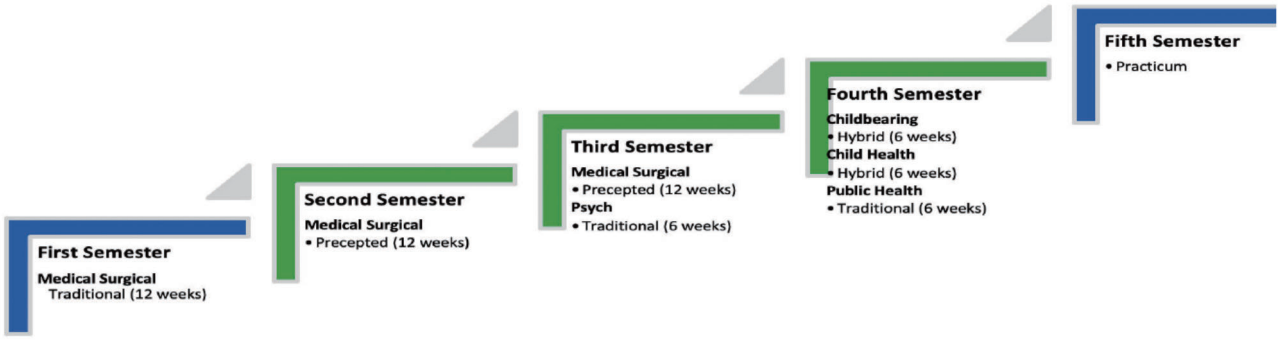

Figure 1. Teaching format per semester per clinical course

Prior to any clinical rotation, the student scope of practice, clinical requirements and clinical competencies were defined by academia and communicated to the clinical site. For instance, students are expected to administer medications with the oversight of a nurse, perform full assessments on their patients and chart clinical findings. Attention to leveling the community clinical sites/experiences to ensure students accomplished course objectives was key.[16] All Outside Track students completed the same projects and deliverables as their traditional peers. Clinical partners enthusiastically wanted to provide a clinical site, while finding the staff capacity to participate in this new program. Issues that impacted capacity included: staff absences relative to vacation, staff vacancies, new staff orientation needs, and the geographical size of the ambulatory/outpatient site. Based on these factors, a large clinical group was not ideal in many ambulatory settings; instead, students would be better served to go to sites individually (and opt for a preceptor modality).

Table 1. Sites and teaching modality per clinical course

Course	Teaching Modality	Clinical Site/s
Medical Surgical II	Precepted 1 preceptor:1 student	Elder Care
		Hospice
		Assisted Living/Long Term Care
		Heart Failure Clinic
		Wound Care
Medical Surgical III	Precepted 1 instructor:1 student	Infusion Sites
		Outpatient Clinic
Psychiatric, Mental Health	Traditional Group (1 instructor with 6- 8 students)	Outpatient Psychiatric Day Clinic
Pediatrics	Hybrid (3 weeks inpatient Acute Care 1 instructor - 6 students; 3 weeks School Clinic, 1 preceptor: 1 student)	Inner City School Clinics
Childbearing	Hybrid (majority inpatient obstetric care, 1 instructor- 6 students; outpatient ambulatory experience 1 preceptor: 1 student)	Ambulatory High Risk Maternal Clinic
Public Health Nursing	Traditional Group 1 instructor: 6-8 students	Outpatient Community Site

3.2 Outside track clinical instructor

The role of the Outside Track Clinical Instructor (CI) was redefined. With all precepted students, the nurse preceptor would oversee the direct activity of the student in the clinical area, with the CI serving as liaison. The CI would provide oversight and redirect as necessary. The CI visited all clinical sites weekly and met with the Outside Track group virtually to debrief each week. Any remediation or skill practice has been provided by the CI. As a link to the clinical course, the CI graded all clinical assignments per each clinical class. The CI also served as an important gatekeeper. Day one of the new clinical program, students were given opportunities to perform advanced skills like drawing blood. These "new experiences" led to "homework" where all group members were required to review material based on this new skill (that was not previously covered in class). All new skills are compiled so that future groups can prepare before clinical begins in future semesters.

4. Benefits and challenges

4.1 Benefits

After each clinical rotation, a survey was conducted. Each preceptor and student was asked for the strengths and weaknesses of the clinical site and rotation. In general, feedback relative to clinical sites was positive. Outside Track students liked the varied sites because the sites differed from the traditional clinical sites. Students liked being pioneers and felt energized by the experience. This clinical format provided a holistic view for students to see the entire spectrum of patient care, as experienced in other programs with community settings.[8,13,14,17,18] Community precepted modalities offered unique skill opportunities, like drawing blood. Skill acquisition is improved via participation in a community based program as shown via systematic review by Zeydani et al. (2021)[11] The CI provided a positive gatekeeper for all clinical courses – in all teaching modalities. This preceptor teaching model can translate into academic savings for the university since traditional student limits per clinical site can be expanded (from the traditional one instructor per 6-8 students).

Clinical partners enthusiastically offered clinical spots to showcase their settings and expose nursing opportunities and roles that exist beyond acute care settings. Per the US Chamber of Commerce, current turnover rates vary from 8.8 to 37% in some settings with new nurses planning to leave their position in two years.[19] Arguably, showcasing workplace flexibility may prevent nurses from leaving the profession altogether by offering a different career path.[20] Community partners also fostered a sense of belonging by requesting that students remain at one setting for at least six weeks and discouraged one day observational clinical opportunities. Success was measured by student pass rate and attrition in the Outside Track program. All students passed their clinical courses and only one student opted out of the program.

4.2 Challenges

Challenges also exist (see Table 2). Individual placement within a setting requires administrative oversight to provide a beneficial experience – leading to increased communication within our academic and community partners. The CI provides the planning and mediation with all clinical issues that arise. Consequently, in the beginning of the semester, this process is a large burden administratively.[6,21] As mentioned prior, some sites, although enthusiastic, are unable to offer spots due to staff variability (ie vacation, etc). Additionally, some clinical sites required specific "homework" to prepare students for their rotation (ie hospice or cancer care).

As mentioned prior, the student's scope of practice must be defined before each new site. A detailed list of what students can and cannot do was provided before each clinical experience. The clinical setting must define daily workflow with the student to ensure understanding of the student role at the community site. This often requires follow up by the CI with managers and preceptors. Adjusting to each new community setting requires each student to be self-directed, organized, and eager to take advantage of clinical opportunities. Some students found it challenging to find purposeful work during slow clinical timeframes. The CI must guide students in fostering opportunities in each new clinical setting during periods of downtime.

Another challenge was preparation and planning to have relevant materials during simulation days. Each clinical course has a simulation day embedded in the schedule. The group identified that the simulation scenarios were based on the needs of a patient in a hospital environment. This highlighted the need for more scenarios that offer a component of community based care. The need for more community scenarios that incorporate outpatient issues is supported by literature.[22,23] Having the CI at simulation days helped to bridge the gap for students in community settings.

The greatest challenge, for the Outside Track students, was self-imposed. Students expressed a fear of "missing out." Although gaining unique clinical experience, students compared their clinical experience to acute care clinicals of their peers. Students often asked for "skill practice" – similar to their peers. This phenomenon has been documented in another study of 19 prelicensure nursing students placed in primary care settings.[24] To help off-set this issue, students were offered the opportunity to work an inpatient day during

their third semester (Medical Surgical III class) and practice common skills, if necessary. Additionally, students can opt out of this program at the end of each semester. One student did drop out citing transportation issues.

Table 2. Benefits and challenges of the outside track

Benefits	Challenges
Positive student feedback	Heavy administrative burden
Variety of clinical sites/experiences	Limited site availability relative to lack of staff or space
Holistic view of nursing	Homework prior to rotation; downtime
Cost savings with precepted students in hiring CI	Lack of community simulations relative to clinical course
Student pass rate	Fear of missing out
Limited attrition	Limited community settings in specialty areas

Last, not all clinical areas have community clinical opportunities. Recognition of this issue is best highlighted in the childbearing class. Lack of outpatient birthing settings led to a hybrid format, where students visited in a specialty outpatient obstetrical setting that met expectant mothers with unique genetic needs. Hence, most of the student experience was fostered in an inpatient setting.

4.3 Limitations

At the present, only one cohort has graduated. As a small cohort, it is difficult to generalize to larger student cohorts. Increased information and formal study needs to be collected relative to the graduates of this program and their preparedness for the workforce moving forward. Data relative to their National Council Licensure Examination (NCLEX) pass rate, and workforce retention (compared to traditional students) needs to be collected and evaluated. Additionally, more data needs to be collected relative to the burden on the practice partners and their ability to train and precept students.

5. Summary

Needs of our changing population is exploding. Acute care settings are decreasing – along with changing workforce opportunities for the new nurse. These trends have led to the need to explore increased collaboration with community partners. As community partners welcome the addition of nursing students, we need to refine and study this collaboration to optimize this clinical experience for students and sites alike. In sum, the Outside Track is one new option for all schools of nursing to utilize in the retooling of future nursing students.

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Authors contributions

Dr Hudson, Dr Muratore and Dr Lucas were responsible for program design and revising. Dr Hudson, Muratore and Lucas drafted the manuscript and Dr Hudson revised it. All authors read and approved the final manuscript.

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Obtained.

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Data sharing statement

No additional data are available.

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REFERENCES

[1] US Census Bureau. Quick Facts. 2023 [cited 2025 October 1] Available from: https://www.census.gov/quickfacts/fact/table/US/AGE775223

[2] US Bureau of Labor and Statistics. Nursing Workforce. 2023. [cited 2025 October 1] Available from: https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-3

[3] Yang J. Number of All Hospitals in the U.S. 1975-2023. [Internet]. 2025 Statista. [cited 2025 October 1] Available from: https://www.statista.com/statistics/185843/number-of-all-hospitals-in-the-us/#statistic

[4] Association of Colleges of Nursing. The Essentials: Core Competencies for Professional Nursing Education. [Internet] 2021 [cited 2025 October 25] Available from: https://www.aacnnursing.org/Portals/0/PDFs/Publications/Essentials-2021.pdf

[5] Institute of Medicine. The Future of Nursing: Leading Change, Advancing Health. [Internet] Institute of Medicine 2010. [cited 25 October 2025] Available from: Available from: https://www.ncbi.nlm.nih.gov/books/NBK209881/

[6] Morton JL, Weierbach FM, Sutter R, et al. New education models for preparing pre-licensure students for community-based practice. J Prof Nurs. 2019 Nov-Dec; 35(6): 491-498. PMid:31857060 https://doi.org/10.1016/j.profnurs.2019.05.004

[7] Nuuyoma V, Munangatire T, Nghiweni N. Nursing students' experiences of community-based learning in an undergraduate programme at a Namibian University. Int. J. Afr. Nurs. Sci. 2022. https://doi.org/10.1016/j.ijans.2022.100458

[8] Hamner J, Wilder B. A new curriculum for a new millennium. Nurs Outlook. 2001 May-Jun; 49(3): 127-31. PMid:11416814 https://doi.org/10.1067/mno.2001.112791

[9] Zeydani A, Atashzadeh-Shoorideh F, Hosseini M, et al. Community-based nursing: a concept analysis with Walker and Avant's approach. BMC Med Educ. 2023 Oct 12; 23(1): 762. PMid:37828504 https://doi.org/10.1186/s12909-023-04749-5

[10] Pijl-Zieber EM, Barton S, Awosoga O, et al. Disconnects in pedagogy and practice in community health nursing clinical experiences: Qualitative findings of a mixed method study. Nurse Educ Today. 2015 Oct; 35(10): 43-8. PMid:26346374 https://doi.org/10.1016/j.nedt.2015.08.012

[11] Zeydani A, Atashzadeh-Shoorideh F, Abdi F, et al. Effect of community-based education on undergraduate nursing students' skills: a systematic review. BMC Nurs. 2021 Nov 18; 20(1): 233. PMid:34794436 https://doi.org/10.1186/s12912-021-00755-4

[12] Clark KM, Tadé I, Gibson S, et al. Evaluating Student Learning: Community-Based Nursing Education as Action to Address Inequities. J Nurs Ed. 2022; 61(9): 525. PMid:36098541 https://doi.org/10.3928/01484834-20220705-07

[13] Gauthier MA, Matteson P. The role of empowerment in neighborhood-based nursing education. J Nurs Educ. 1995 Nov; 34(8): 390-5. PMid:8558288 https://doi.org/10.3928/0148-4834-19951101-13

[14] Wink DM. Developing a community nursing center. Nurse Educ. 2001 Mar-Apr; 26(2): 70-4. PMid:16372629 https://doi.org/10.1097/00006223-200103000-00011

[15] Hawkins JE, Wiles LL, Martin J, et al. Creating a Primary Care Track in Prelicensure Nursing Education. J Nurs Educ. 2023 Mar; 62(3): 171-174. PMid:36279563 https://doi.org/10.3928/01484834-20220912-14

[16] Witwer S, Fritz E, Antol S, et al. In Search of the Evidence: Informing Academic-Practice Partnerships in Ambulatory Care. Nurs Econ. 2022; 40(3): 146–155. https://doi.org/10.62116/NEC.2022.40.3.146

[17] Jeffrey C, Quayle T, Rindlisbacher D. Harnessing the Untapped Potential of Ambulatory Clinical Placements in Prelicensure Nursing Education. J Nurs Educ. 2025 Jun; 64(6): 381-384. PMid:39177207 https://doi.org/10.3928/01484834-20240429-03

[18] Fleming L, Lorenzen R, Stanek J, et al. Transitions in Care Model for a Senior-Level Clinical Immersion Experience. Nurse Educ. 2020 Jan/Feb; 45(1): 39-42. PMid:30801418 https://doi.org/10.1097/NNE.0000000000000657

[19] Hoover M, Lucy I. Mahoney K. Data Deep Dive: A National Nursing Crisis. [Internet] US Chamber of Commerce; 2024 [cited 2025 October 25] Available from: https://www.uschamber.com/workforce/nursing-workforce-data-center-a-national-nursing-crisis

[20] American Nurses Association. Nurse Retention Strategies: How to Combat Nurse turnover. [Internet]; May 19, 2023 [cited 2025 October 25]. Available from: https://www.nursingworld.org/content-hub/resources/nursing-leadership/nurse-retention-strategies/

[21] Williamson TW, Hughes S, Flick JE, et al. Clinical Experiences: Navigating the Intricacies of Student Placement Requirements. J Allied Health. 2018 Winter; 47(4): 237-242.

[22] Kindi ZA, Jabri WA, Zadjali MA, et al. Utilizing simulation in community health nursing education: a scoping review of current trends and applications. BMC Nurs. 2025 Aug 12; 24(1): 1055. PMid:40796842 https://doi.org/10.1186/s12912-025-03718-1

[23] Aslan F. Use of simulation practices in public or community health nursing: findings from mixed-methods systematic review. Scand J Caring Sci. 2021 Dec; 35(4): 1050-1056. PMid:33354784 https://doi.org/10.1111/scs.12946

[24] Hooper-Arana ED, Li JN, Borges WJ, et al. Clinical Training Innovation for Prelicensure Graduate Nursing Students to Expand Roles in Primary Care. Nurse Educ. 2020 Jan/Feb; 45(1): 25-29. PMid:30865150 https://doi.org/10.1097/NNE.0000000000000664