

TWO GAPS, ONE CRISIS:

A Framework for Building Clinical Pipelines

How Paid Training, Employer Investment, and Strategic Partnerships Can Close the Gap

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and

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EXECUTIVE SUMMARY

America's clinical pipeline is breaking in multiple places at once. By 2032, the U.S. will need to fill nearly 2 million healthcare roles every year, but the pressure keeps compounding, driving clinicians away at key moments, preventing them from ever establishing themselves within the workforce.

Clasp's [School Deserts Index](#) documented one part of the failure: training programs are absent from the communities that need clinicians most. But geography alone doesn't explain the shortage. Even where accredited programs exist, the financial reality of training itself blocks potential clinicians before they can start.

Across allied health, behavioral health, and nursing, becoming a licensed clinician requires hundreds to thousands of hours of supervised clinical training—hours that are almost never paid. Students still owe rent, groceries, and tuition during those rotations. Many take out additional student loans to fill the gap. By graduation, they are carrying layered debt: the cost of their education, plus whatever they borrowed just to survive the unpaid hours that were part of earning it. That combined weight shapes every decision they make about where they can afford to work.

This white paper presents the case for a different approach: one that invests in clinicians across the full arc of their training and early career, from the moment they step into a practicum through the launch of their career and multi-year success within a healthcare organization.

The full continuum this paper addresses:

During training: Stipends and external supervision keep students in the pipeline through unpaid practicum hours → [HealthForce](#)

Before graduation: Employer connections built early reduce pre-graduation attrition and expand the pool of people pursuing clinical careers → [Clasp](#)

After graduation: Employer-sponsored loan repayment relieves financial pressure, builds loyalty, and helps clinicians put down roots in the communities they serve → [Clasp](#)

HealthForce Partners California has built a model that addresses the training gap directly. By serving as a regional workforce intermediary, HealthForce Partners California supports California-based employers with providing external clinical supervision to behavioral health interns, and pays them stipends for practicum hours that would otherwise go uncompensated. More students complete training. More clinicians enter the workforce. More communities get care.

Clasp addresses the pipeline from a complementary direction. By connecting health systems with clinical students before they graduate, Clasp reduces the attrition that happens when students lose confidence, lose momentum, or simply lose sight of who's waiting for them on the other side of licensure. And through employer-sponsored student loan repayment, Clasp

enables these systems to help clinicians actually thrive after graduation—relieving the financial pressure that so often drives early career turnover—so they can invest fully in the patients, the teams, and the communities that need them.

The logic for pairing these approaches is compelling, and the moment is right. Health systems that invest in both—stipends that keep students in the training pipeline, and loan repayment that helps new graduates stay and grow—are not simply being generous. They are being strategic. They are building a pipeline of driven clinicians who are rooted in their communities, relieved of financial pressure, and motivated to stay.

I. TWO GAPS, ONE CRISIS

The clinical workforce shortage is most commonly framed as a supply problem: not enough people choosing clinical careers, not enough training programs to prepare them, not enough incentive to work in the settings where they are needed most. All of that is true. But the pipeline breaks at two specific points that are both underinvested and addressable.

The Training Gap: When Students Can't Afford to Finish

Physical therapy doctoral programs require 1,600 hours of full-time clinical rotations.¹ Master of Social Work (MSW) programs require a minimum of 900 hours of supervised field education, followed by 3,000 additional post-degree hours for licensure in California.²³ Respiratory therapy, nursing, radiologic technology—virtually every clinical discipline embeds hundreds of required clinical hours in the degree. In most cases, those hours are unpaid.

For students who are already borrowing to cover tuition and living expenses, an extended period of uncompensated required work is not a minor inconvenience. It is the moment many leave the pipeline, because they simply can't make the numbers work. The students most likely to leave are disproportionately from the communities where clinical shortages are most severe: low-income households, first-generation college students, students of color. In turn, the training system as currently designed limits who can reach the workforce, and what communities are represented by the teams providing their care.

The Post-Graduation Gap: When Debt Drives the Decision

For students who do make it through, a new pressure begins at graduation. Layered debt—tuition loans plus whatever they borrowed to survive unpaid clinical rotations—comes due. In clinical fields, early career compensation is often modest, particularly in community health settings, county agencies, and rural or underserved regions.

Healthcare's love for degree inflation compounds this challenge. Physical therapists and nurse anesthetists now require doctorate degrees (versus their prior Masters-level requirement),

¹Commission on Accreditation in Physical Therapy Education (CAPTE). "Evaluative Criteria for PT Programs." Available at: <https://www.capteonline.org>

²Council on Social Work Education (CSWE). "2022 Educational Policy and Accreditation Standards." MSW field education minimum: 900 hours. Available at: <https://www.cswe.org>

³California Board of Behavioral Sciences (BBS). Supervision requirements for LCSW, LMFT, and LPCC licensure (3,000 post-degree supervised hours each). Available at: <https://www.bbs.ca.gov>

and recent policy changes limit the amount students in these fields can borrow in Federal funding,⁴ forcing them to rely on other means of financing such as private loans to cover the costs of the additional required schooling.

Physical Therapy is a prime example: The American Physical Therapy Association reports that the average physical therapy graduate carries ~\$150,000+ in student debt, while starting salaries are often in the \$70K–\$80K range. That's a ~2:1 debt-to-income ratio—before someone has even started working. For many students, that math alone makes a career in physical therapy feel financially impossible.

This is one of the most significant and least-discussed drivers of early career turnover in clinical fields. Clinicians leave not because they don't love their work—but because their debt load makes lower-paying community settings untenable.⁵

Why Current Approaches Fall Short

Government programs can help newly minted clinical workers stay the course over time, but they don't address the immediate financial weight that shapes where — and whether — clinicians choose to work. Without adequate supply of talent, health systems are left to lean on costly workarounds that strain already tight budgets:

- Even with standard clawback clauses, sign-on bonuses generate roughly 28 cents of retention value for every dollar spent⁶ and require an upfront cash hit that many systems can't absorb.

Note: California recently implemented limitations on the use of clawbacks⁷, and other states like New York are following suit.

- Contract labor that covers gaps without closing them at ~2x the cost of in-house clinicians.⁸
- Recruitment cycles that start again when the next departure happens, costing roughly \$56,300 per attrited clinician.⁹

⁴Association of American Universities (AAU). "Proposal to Implement Loan Caps Threatens Access." Available at: <https://www.aau.edu/newsroom/leading-research-universities-report/proposal-implement-loan-caps-threatens-access>

⁵U.S. Department of Education Federal Student Aid resources and National Association of Social Workers (NASW) policy updates on federal loan limit impacts on professional degree programs.

⁶Laudio. "The Cost of RN Signing Bonuses Is Far Higher Than Their Impact on Retention." Analysis of 50+ US hospitals. Average signing bonus: \$10,000+; estimated retention value per employee retained: \$2,800—generating approximately 28 cents of measurable retention return per dollar spent. Available at:

<https://laudio.com/insights/the-cost-of-rn-signing-bonuses-is-far-higher-than-their-impact-on-retention>

⁷Greenberg Traurig. "California Claws Back: New Limits on Stay-or-Pay Contracts Starting Jan. 1, 2026." November 2025. Available at:

<https://www.gtlaw-laborandemployment.com/2025/11/california-claws-back-new-limits-on-stay-or-pay-contracts-starting-jan-1-2026/>

⁸Becker's Hospital Review. "The Cost of Hospital Contract Labor in 22 Numbers." Available at:

<https://www.beckershospitalreview.com/finance/the-cost-of-hospital-contract-labor-in-22-numbers/>

⁹NSI Nursing Solutions, Inc. 2025 NSI National Health Care Retention & RN Staffing Report. March 2025. Available at: https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf

The approaches described in this paper are different in kind. They address both gaps—investing in students during training so more make it through, and supporting clinicians after graduation so they can plant roots in the workforce.

II. HEALTHFORCE PARTNERS' MODEL: CLOSING THE TRAINING GAP

The Model

External Clinical Supervision

Rather than relying on host agencies to provide supervision, HealthForce Partners California employs or contracts **licensed supervisors who provide external clinical oversight** for interns across multiple placement sites. This unlocks agencies that would otherwise be closed to the training pipeline—a community nonprofit serving unhoused individuals, a rural FQHC, a school-linked service—because they no longer need a licensed supervisor on staff to participate.

Community Placement

Interns are placed at community-based organizations, county behavioral health departments, FQHCs, and others. The diversity of sites is intentional: interns train in settings that reflect the communities they will serve, and host agencies gain real service capacity without the full administrative burden a traditional internship would require.

Student Stipends

Students receive stipends for practicum hours that would otherwise go uncompensated. For students from low-income backgrounds, this changes the calculation. It means no sleeping hours lost to a second job during field placement. It means showing up fully as a developing clinician rather than managing financial survival. It keeps the pipeline open for people who would otherwise be pushed out—including the people most likely, once licensed, to stay in the communities that shaped them.

HealthForce Partners California has also built pathways for incumbent workers—community health workers, peer support specialists, and case managers who want to pursue licensure while continuing to work. Their upward trajectory is grow-your-own in the most direct sense.

Maurice Troy Peoples, Jr. grew up in Stockton, served in the U.S. Air Force, and is now completing his MSW at University of the Pacific, training in the same community he's spent his life in. His paid practicum placement with San Joaquin County Behavioral Health Services has deepened his skills in assessment, care coordination, and trust-building with clients who often arrive at their hardest moments. Without the stipend that came with that placement, staying in the program full-time would have been far harder to sustain.

"I want to be part of the solution and help individuals navigate their circumstances with dignity and hope," Maurice says. "Social work is about meeting people where they are and understanding their needs without judgment."

Maurice plans to focus his career on youth and veterans, two populations he knows from the inside. He is exactly the kind of clinician San Joaquin County needs, and exactly the kind the current training system too often loses.

"Maurice's story is why we do this work. He has the lived experience, the community roots, and the commitment to serve, everything you'd want in a behavioral health clinician," says Dr. Paul Lanning, President & CEO of HealthForce Partners California. "Our job is simply to make sure the financial reality of training doesn't push people like him out of the pipeline before they get the chance to prove it."



Maurice Troy Peoples

Geographic Footprint & Partnerships

HealthForce Partners California's work currently spans four regional footprints: the Northern San Joaquin Valley, Contra Costa/Tri-Valley Region in the East Bay, Solano County, and portions of the Sierra Region. The Northern San Joaquin Valley is both the organization's birthplace and its anchor, a region that includes San Joaquin, Stanislaus, and Merced Counties and where the Behavioral Health Workforce Partnership first launched. From here, measurable results have taken root, prompting neighboring counties to explore replication and expansion of the model.

Across these regions, board commitments from Stanford Health Care and Kaiser Permanente, and ongoing discussions with Sutter Health and John Muir Health, reflect growing alignment among major health systems around the value of coordinated regional workforce development. Education partnerships with institutions including Chabot Las Positas Community College District, Saint Mary's College, and Cal State East Bay are deepening the reach of the pipeline and expanding clinical training capacity in the communities that need it most.

The regional education ecosystem is responding in kind. Stanislaus State's return to Stockton has expanded MSW training capacity directly in the communities where clinicians are needed most. University of the Pacific and San Joaquin Delta College have strengthened training pipelines across behavioral health disciplines. These aren't parallel developments. They reflect the coordination infrastructure HealthForce Partners California has built and continues to lead.

Funding

The model is funded through a combination of state behavioral health workforce investments, county contributions including direct support from the San Joaquin County Board of Supervisors, and philanthropic grants, including a nearly \$900,000 award from Health Career Connection, supported by The California Endowment, to expand clinical placements across the Northern San Joaquin Valley. HealthForce Partners California serves as a regional conduit, directing these funds toward supervisor salaries, intern stipends, and scholarship support.

Outcomes to Date

The results in San Joaquin County are concrete and measurable. Through the Behavioral Health Workforce Partnership, HealthForce Partners California has placed and supervised 96 paid internships to date, more than double the original program goal of 40. More than \$1 million in scholarships has been awarded to local students pursuing degrees in social work, counseling, marriage and family therapy, and related disciplines. Training opportunities have expanded through San Joaquin Delta College, University of the Pacific, and Stanislaus State.

The workforce impact is visible at the system level. Two years ago, San Joaquin County Behavioral Health Services carried a clinician vacancy rate of 24%. Today it stands at 4%, a reduction that reflects both new clinicians entering the pipeline and the retention of those who trained and chose to stay.

The model is now expanding. Stanislaus and Merced Counties have joined the partnership, with new investments supporting Peer Support Specialists, Substance Use Disorder Counselors, and Psychiatric Technicians, disciplines where community need is acute and the incumbent worker pathway is particularly powerful.

"What we've learned in San Joaquin County is that workforce shortages are the predictable result of a system that asks too much of people who have too little runway. When you change the conditions, you change the outcomes. The question we're focused on now isn't whether this works. It's how fast we can bring it to the regions that are still waiting."

— Dr. Paul Lanning, President and CEO, HealthForce Partners California

The behavioral health supervision and stipend model is currently operating in two California counties, with significant interest from additional regions. Host agencies report expanded service capacity and stronger relationships with education partners. Students report being able to persist through training without working a second job. The requests for replication are themselves evidence of impact.

III. CLASP'S ROLE: FROM TRAINING TO THRIVING

Stipends keep more students in the pipeline during training. Because the pipeline doesn't end at graduation—and neither does the financial pressure—Clasp's approach addresses what comes next: connecting health systems with clinical students before they graduate, and helping new clinicians thrive in the communities where they choose to build their careers.

Engaging Students Before They Graduate

Pre-graduation attrition is an underexamined leak in the clinical pipeline. Students who enroll in clinical programs don't always finish. Financial stress compounds. The path to licensure is long and uncertain. And without a clear sense of who is waiting for them on the other side—without an employer who has already said “we want you here”—it is easy to lose momentum.

Clasp connects healthcare employers like Boston Children’s, Confluent Health, and Northwestern Medicine with clinical students while they’re still in school. These early relationships change the equation: Clasp has seen a **99% graduation rate to date** for students in these programs). A student who has already heard from a mission-aligned employer that has expressed interest in her is more likely to finish training. She graduates with confidence, not just credentials—with a clearer sense of where she belongs and what comes next. Early engagement also expands the pool of people pursuing clinical careers. When students can see themselves in the workforce they’re training to join, with a clear path to financial stability, some who might have walked away instead stay in. That is how you grow the pie.

Helping Clinicians Thrive Through Loan Repayment

Employer-sponsored student loan repayment—administered through Clasp’s platform—changes the post-graduation dynamic. When a health system says “we will help you pay down your loans,” they are making a sustained, concrete demonstration of investment in a clinician’s success. This, in stark contrast to transactional sign-on bonuses, is what builds real loyalty.

Clinicians who are financially supported can show up fully for their patients and their communities. They are not calculating whether a competing offer makes more financial sense. They are building careers. And clinicians who stay long enough to build careers become something else: the mentors, supervisors, and community champions that the next generation of interns will need. The investment compounds.



“Instead of constantly worrying about how I will manage my debt as I start my new career, I’m able to focus fully on starting my new career and giving the best to my patients.”

~ Darby, CRNA



“I had the hardest time starting, because of the cost of going back to school. I was living paycheck to paycheck, barely able to make the minimum payments on the student loans I already had. This has removed such a burden from my life and my family.

~ Matthew, OD



“Having a big financial burden is definitely something that concerned me throughout school, and when I was deciding to go to PT school. This program allows me to put that concern to the side.”

~ Sutton, PT

The results are measurable. Talent placed through Clasp's platform see Year 1 turnover rates of approximately 5%¹⁰—compared to an industry average of more than 20%. That gap is not incidental. It reflects the difference between a clinician who was recruited with a check and a clinician who was supported into a career.

The Business Case

Health systems already spend heavily on the workforce gap—through sign-on bonuses that generate roughly 28 cents of retention value per dollar spent,¹¹ through contract and travel labor at premium rates, through the recurring cost of recruitment cycles every time a clinician leaves. Investing in stipends and loan repayment is not an additional expense, but a smarter allocation of money health systems are already spending.

A clinician who completes training with financial support, enters their employment relationship with genuine institutional investment in their success, and stays because they can actually thrive in the community they love: that is a fundamentally different return than any sign-on bonus delivers. Health systems that invest across the full continuum—from training through post-graduation support—are not choosing between financial sustainability and doing right by their communities. In the long run, those are the *same* choices.

IV. WHAT INVESTING IN BOTH CAN LOOK LIKE

The clinical workforce challenge doesn't have a single breaking point. Students leave training programs before they finish. New graduates take jobs based on who showed up at the right moment, not who invested in them over time. Clinicians carry debt into roles that don't pay enough, and leave within two years. Each of those moments is a place where an intervention could have changed the outcome.

Addressing the full arc means investing at each juncture. HealthForce Partners California's model holds students in the pipeline during the hardest stretch—unpaid practicums, financial pressure, an uncertain road to licensure. Clasp's model picks up where that ends: connecting health systems with students before they graduate, and extending that investment through employer-sponsored loan repayment after hire.

A model for the full clinician journey:

In training: HealthForce Partners California provides external supervision and stipends, keeping students in the pipeline through unpaid practicum hours

¹⁰Clasp internal data. Year 1 turnover rate for employees supported through Clasp's platform (~5%) vs. healthcare industry average (>20%).

¹¹Laudio. "The Cost of RN Signing Bonuses Is Far Higher Than Their Impact on Retention." Analysis of 50+ US hospitals. Average signing bonus: \$10,000+; estimated retention value per employee retained: \$2,800—generating approximately 28 cents of measurable retention return per dollar spent. Available at: <https://laudio.com/insights/the-cost-of-rn-signing-bonuses-is-far-higher-than-their-impact-on-retention>

Before graduation: Clasp connects regional employers with graduating students, reducing pre-graduation attrition and building relationships before the job search begins

After graduation: Employers provide loan repayment through Clasp, helping new clinicians thrive financially and build long-term careers

The arc matters. A student who moves through this pipeline gets something rare: sustained investment at every phase. They enter the workforce with relationships already in place, financial pressure that isn't catastrophic, and a genuine reason to build a career where they trained. For health systems, this pays. Turnover drops. Contract labor spend drops. Culture stabilizes. Sign-on bonuses become less necessary. The investment returns on itself.

This architecture applies across disciplines. The pressure points—unpaid practicums, post-graduation debt, early attrition—show up in behavioral health, allied health, nursing, and beyond. The interventions work wherever the problem does.

V. RECOMMENDATIONS

For Health Systems and Employers

The clinicians you need in five years are in training programs today. Some are on the verge of leaving because the math doesn't work. Others will graduate and be gone within two years because their debt load makes certain settings untenable, despite passion or values alignment. There is still time to change those outcomes—but only if the right investment starts now.

Invest upstream through regional partnerships and stipend models that expand the supply of trained clinicians in your region. Organizations like HealthForce Partners California provide the coordination infrastructure that individual health systems can't build alone.

Engage students before they graduate — the relationship that begins during training is the foundation for a career. Partner with platforms like Clasp to connect with clinical students early, reduce pre-graduation attrition, and build genuine institutional investment in the people you want to hire.

Invest in the post-graduation arc via employer-sponsored loan repayment that helps new clinicians thrive, build loyalty, and retain long term. Measure the return in reduced turnover, and reduced reliance on transactional tools like contract labor and sign-on bonuses.

For State and County Policymakers

Rebalance clinical workforce investment toward the front end of the training pipeline—paid practicums, external supervision infrastructure, and regional intermediary organizations that can coordinate what individual institutions cannot.

Fund intermediary organizations as core infrastructure, not overhead. HealthForce Partners California’s model works because there is an organization holding the relationships and managing the logistics. That organization needs sustained funding.

Complement government loan repayment programs with support for employer-sponsored models that provide immediate, reliable relief rather than future promises.

VI. CONCLUSION

The clinical workforce shortage will not be solved by competing harder for the same pool of graduating clinicians. It will be solved by growing more of them—and by supporting them well enough to stay.

HealthForce Partners California has shown what it looks like to keep more students in the training pipeline. Clasp has shown what it looks like to help clinicians in training build employer relationships early, and thrive in long-term careers post-graduation. Together, these approaches represent a fundamentally different theory of workforce development: one that invests in people rather than simply incentivizing them, and that builds pipelines rather than competing over them.

The communities that need this most already know it. The students are in training right now. The health systems that will lead on this are the ones that understand, now, that investing in their workforce and investing in their communities are not competing priorities. They are the same priority.

Let’s build the pipeline that proves it.

ABOUT THE AUTHORS

HealthForce Partners California

HealthForce Partners California brings together top executives and operational leaders from healthcare, education, and workforce development to craft innovative programs and systems-change strategies that address the staffing priorities of employers while expanding career opportunities for community residents. Originally focused on the Northern San Joaquin Valley, the organization has since broadened its reach to additional regions across California. Since launching its Behavioral Health Workforce Partnership in 2023, HealthForce has placed and supervised 96 paid interns, awarded more than \$1 million in scholarships to local students, and helped reduce clinician vacancy rates at San Joaquin County Behavioral Health Services from 24% to 4%. Learn more at healthforcepartners.net.

Clasp

Clasp is the retention-driven recruiting platform for hard-to-hire clinical talent. Trusted by leading health systems including Boston Children's Hospital, Novant Health, and Northwestern Medicine, Clasp helps organizations replace transactional tools like sign-on bonuses, allowing them to engage with talent early, while they are still in school, and secure a 3+ year work commitment (similar to ROTC). With more than 10,000 students supported across hundreds of universities and first-year turnover rates of ~5%, Clasp is building a smarter, more sustainable approach to clinical workforce development.

Visit clasp.com to learn more.