

Working remotely: Innovative allied health placements in response to COVID-19

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Faced with broad scale cancellation of allied health student placements due to COVID-19, placement coordinators at The University of Melbourne Department of Rural Health established remote, online work-integrated learning placements across a range of settings, including a primary school, specialist school, kindergarten association and a homelessness sector organization. To ensure safe and high-quality placements, the evidence for telepractice and placement innovation was reviewed and integrated with existing knowledge of developing quality service-learning placements and COVID-safe guidelines from professional associations. This paper describes how placements were established, how student learning needs were aligned with host site objectives, and critically analyses the benefits and challenges of the online placement format. Partnerships, communication, and planning with all stakeholders were critical in placement redesign. The outcome is that students have enhanced their clinical and professional skills and provided community services to clients that would otherwise not have been provided during a pandemic.

Keywords: COVID-19, allied health, telepractice, clinical education, service-learning, rural health

Health disparities between rural and metropolitan-based Australians are well documented (Australian Institute of Health and Welfare [AIHW], 2019). Access to health services is a key factor leading to poorer rural health outcomes, in part due to workforce shortages (AIHW, 2019). Recruiting and retaining an appropriately skilled health workforce commensurate with community needs is a key component of rural health policies and programs globally (Wakerman & Humphreys, 2012). Clinical placements are an essential component of health training programs (Quail et al., 2016; Bowles et al., 2014) and a source of staff recruitment. There are a range of efforts to increase the number of students undertaking rural placements in order to prepare students for rural practice and increase rural allied health recruitment.

The Australian Government's investment in a network of University Departments of Rural Health (UDRH) is a focused effort to address rural health recruitment and retention (Department of Health, 2019). The Rural Health Multidisciplinary Training (RHMT) Program promotes innovative, high quality rural training experiences with a focus on Aboriginal and Torres Strait Islander health and local partnerships (Department of Health, 2019). The University of Melbourne's Going Rural Health team has sites based at the three rural campuses, namely Ballarat, Shepparton, and Wangaratta in the state of Victoria.

Going Rural Health focuses on clinical learning for nursing and allied health students, where students complete their placement in a rural area and are encouraged to immerse themselves in the rural setting. Students are supported with subsidized accommodation, financial bursaries, education, and mentoring by the Going Rural Health team. These kinds of placement experiences are similar across Australian University Departments of Rural Health, who have demonstrated that these rural learning opportunities boost students' intentions to work rurally after graduation (Smith et al. 2018; Wolfgang

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et al., 2019). Included in the Going Rural Health team are Community Placement Coordinators who are allied health professionals with the role of developing and coordinating placements in community settings, including primary care and non-health settings. Part of this role is the development of service-learning placements.

Prior to the COVID-19 restrictions implemented in Australia in March 2020, Going Rural Health had been facilitating service-learning placements for five years. These placements incorporated a variety of elements reported in the rural clinical education literature, such as collaborative learning, occasions of remote supervision, project placements, and role-emerging placements. In addition, the three sites had been connecting via online platforms over this time.

When restrictions began to impact clinical placements, Going Rural Health was able to adapt to online placement models with little lead-time, allowing the continuation of eleven placement types for twenty-three students. Placement organizations included a primary school, a specialist school, a regional kindergarten network, and a homelessness community organization. This paper presents a detailed discussion of these placements, beginning with a review of relevant concepts, an overview of the placements, and a reflection of the strengths, challenges, and factors for success. The authors assert that the Community Placement Coordinators' experience working in work-integrated learning (WIL) placement models, community relationships and willing university coordinators allowed for quick adaptation to clinical placements with students working mostly from their own homes.

PLACEMENT INNOVATION IN RURAL CONTEXTS

A changing health service environment, dramatic increase in allied health courses and need for clinical placements has called for innovative models of clinical education to provide valuable learning experiences for students and contribute positively to health organizations (Rodger et al, 2008). Placement innovation is not new to those operating in rural contexts, although a review of the literature in this area was necessary at the outset to ensure an evidence-based approach to the placement adaptations.

Some of these innovations, such as telesupervision, are particularly pertinent to addressing geographical distance, whereas concepts such as service-learning, collaborative learning and supervision could be applicable in a variety of placement contexts. These kinds of work-integrated learning placements have the common aim of facilitating the transfer of theory into practice in the workplace through situated and experiential learning (Held et al, 2019). The immersive aspect of these placements is an intention to increase student understanding of rural health issues and improve their appreciation of rural practice (Brown et al., 2015; Wolfgang et al, 2019).

Service-Learning

Service-learning placements, as a component of WIL, are equally concerned with student learning and work readiness (Jones et al., 2015) as well as achieving outcomes for host organizations and their clients (Furco, 1996). Students undertake a service-learning placement work to address pre-identified community needs by providing a service or completing a project that would otherwise be unavailable to the community (Lyle et al., 2006).

Incorporating service-learning within a WIL framework is a University Department of Rural Health requirement. It is asserted as wise practice because it meets objectives from multiple perspectives, including; (i) personal growth, development of networks and professional experience for students; (ii)

academic rigor, student education and progress, and service to community from a university perspective; and (iii) enhanced services for the community (Valencia-Forrester et al., 2019). A review of service-learning in Australia identified that although service-learning is a less common form of WIL, it is growing in popularity among institutions of higher education and is becoming increasingly sought after by the non-profit sector (Patrick et al., 2019). Key characteristics identified for successful service-learning partnerships and outcomes include responsiveness, trust, innovation, community leadership, consistency, flexibility, reciprocity, and knowledge sharing (Jones et al., 2018; Power & Bennett, 2015).

Telesupervision

The requirement for alternative and innovative methods of providing clinical learning opportunities has led to the adoption of a range of strategies, one of which is telesupervision (Chipchase et al., 2014). Telepractice is the application of telecommunications technology to deliver clinical services at a distance by linking clinician to client, caregiver, or any person(s) responsible for delivering care to the client, for the purposes of assessment, intervention, consultation and/or supervision (AHPRA, 2020; Speech Pathology Australia, 2014). Telesupervision offers a viable solution to geographical challenges by allowing student placements at locations that cannot provide the necessary support through on-site supervision, if planned appropriately (Carlin, 2012; Dudding & Justice, 2004; Harris et al., 2020; McCarthy & Crutchley, 2011; Rule & Kelchner, 2017). Studies report enhanced student learning experiences with clinical educators by providing opportunities to reflect on performance, debrief whilst still in the clinical setting, discuss novel or challenging situations when they arose, and enhancing a sense of connection and belonging (Barnard-Ashton et al., 2018; Nagarajan et al., 2016). Students also valued working with clients who had difficulty accessing care as well as working with fellow students (Serwe et al., 2020). Laughran and Sackett (2015) concluded that a hybrid model of face-to-face and telesupervision would allow for the most effective clinical supervision in regard to speech pathology competencies, however other studies have found that telesupervision-only was able to adequately meet the learning needs of students (Carlin, 2012; Dudding & Justice, 2004; Nagarajan et al., 2016). Regardless of the hybrid versus pure debate, telesupervision can be a powerful tool in providing meaningful learning opportunities to students and early career professionals (Rule & Kelchner, 2017).

Whilst technology-related barriers are cited in most telesupervision studies, key considerations in using telesupervision effectively include: investing in and distributing high quality equipment (Grady, 2011; Dudding & Justice, 2004); collaboration with shared goals (Boisvert & Hall, 2019); implementing appropriate security and confidentiality measures (Carlin, 2012; Grady, 2011); embedding scheduled telesupervision sessions (Chipchase et al., 2014); and ethical considerations such as consent (Cohn, 2012).

Collaborative Learning and Supervision

As opposed to individual or apprentice models of clinical education, many studies have been published internationally regarding the value of collaborative models of fieldwork supervision for helping students obtain the skills needed for working in a team-based environment (Hanson & Deluliis, 2015). However, there are many terms used to describe the collaborative peer learning approach, all with slight differences (Bartholomai & Fitzgerald, 2007; Ladyshevsky, 2000). In essence, collaborative learning acknowledges that the students capitalize on one another's knowledge and skills as well as monitoring and evaluating each other's work (Hanson & Deluliis, 2015). To align with Going Rural Health placement practices, peer learning and collaborative supervision models are specifically explored.

Group supervision, where one supervisor oversees the clinical education of multiple students at once, has been found to be as effective in supporting students' clinical growth as individual supervision (Atik & Erkan Atik, 2019; Bhagwat et al., 2018; Provident & Colmer, 2013). Group supervision also addresses service gaps (Currens, 2003) and is more supportive of adult learning principles (Martin et al., 2004). Peer-learning benefits include enhanced learning opportunities and student autonomy, improved self-reflection and feedback skills, and increased student confidence via the mutual support of a peer. Perceived disadvantages are reduced ability to deliver quality individualized supervision, increased time burden associated with administration, and negative peer relationship issues (Sevenhuysen, Thorpe, Molloy, et al., 2017). Clinical educators, whilst supportive of the model, request more practical information and strategies to facilitate the group supervision process (Currens, 2003; Lynam et al., 2015), which helps to improve confidence and placement outcomes (Sevenhuysen, Thorpe, Barker et al., 2017).

A combination of the collaborative supervision framework proposed by Bartholomai & Fitzgerald (2007) and the capacity development facilitator model (Fairbrother et al., 2016) closely represents the model embedded by Going Rural Health. The collaborative model of fieldwork education shares the support of students across the multidisciplinary team, although has the clinical educator responsible for key assessment and learning outcomes of the students (Bartholomai & Fitzgerald, 2007). The Capacity Development Facilitator supports both clinical educators and students by providing both groups with training and education as well as liaising with the organization, identifying opportunities and conducting evaluations. Learning resources and support were identified as being superior to other placements when using this model (Fairbrother et al., 2016).

Successful collaborative models require advanced preparation involving all stakeholders (Hanson & Deluliis, 2015), including training in the theoretical model, planning meetings, timetabling and clear communication (Bartholomai & Fitzgerald, 2007; Fairbrother et al., 2016). Going Rural Health drew on the concepts of service learning, telesupervision and collaborative learning to adapt placements during the COVID-19 pandemic. This provided new learning experiences for students as well as for supervisors, the Going Rural Health team, the organizations, and the clients involved in these placements.

GOING RURAL HEALTH COVID-19 PLACEMENT ADAPTATIONS AND INNOVATIONS

Due to restrictions from COVID-19, some planned student placements could not proceed due to the closure of sites/organizations as well as the reduced capacity of some supervisors. Some placements were able to be adapted and some new placements were created during the physical distancing restrictions. Incorporating key aspects of the evidence-based literature, four clinical placements are described. The authors do not refer to these as "virtual" placements, as the health literature tends to use this term to describe online simulation experiences (Lucas et al., 2019; Banzski et al., 2018; Phillips et al., 2018; Quail et al., 2016). The placements described did not involve any simulation but rather connected students with real clients and service settings through online methods. It is worth mentioning that many studies of telesupervision are focused on students being in the placement environment and the supervisor linking in from another location. In the case studies here, the situation was either reversed or both the supervisor and the students were engaged in the placement from their own homes.

There were common factors across these four placements that integrated evidence in regard to service learning, collaborative supervision and peer assisted learning. All placement learning objectives were

focused on pre-identified community need and provided services that would otherwise not exist or expanded/extended service provision. All supervisors had been provided with training in supervision prior to the placement and were supported by the placement coordinators for the duration of the placement. All placements integrated service improvement initiatives and were not purely clinically focused.

Specialist School Placement - Physiotherapy

Based at a rural specialist school, a physiotherapy placement was adapted requiring the undergraduate students to complete their placement entirely online due to restrictions inhibiting face-to-face interactions. Students received supervision via videoconferencing facilities and placement objectives were adapted to align with the online format.

As COVID-19 restrictions were approaching and school closures were imminent, supervisors communicated with students to confirm their placement, minimizing any fears of cancellation. Pre-placement planning was critical; supervisors collaborated with each other to ensure that the delivery of telehealth physiotherapy services and telepractice procedures aligned with the undergraduate curriculum needs, discipline specific scope of practice and the needs of end users. Onsite staff and students prioritized their time to collect data in preparation for the shift to telepractice. Agreement was made regarding assigned roles within the supervision team, preferred teleconferencing platforms, data storage and privacy measures for implementation.

As per routine procedures, a pre-placement briefing was facilitated for the undergraduate students to inform them of the specific details of their upcoming placement, including pre-reading topics and the shift to an online format. Due to the rural origin and technology basis of the placement, supervisors identified the equipment needs of each student in order to optimize their participation.

Usual operations were transformed. A password protected and time-specific OneDrive file was set up to enable the storage of confidential documentation and information sharing. In addition to executed privacy agreements, a virtual assessment of each student's remote workspace was completed by a supervisor. Students completed an online telehealth module to facilitate their translation of practice and prompt operational considerations. Students disseminated detailed weekly schedules to meet occupational health and safety requirements and supervisors monitored these to assess student performance (e.g., time management, communication, and task delegation). Students relied on on-site staff to upload/communicate site specific information to them due to their remote nature and responded to family requests regarding intervention frequency. Other innovative supervision strategies included the use of feedback (from end users and peers), intervention plans and session recordings. The expertise within the team was utilized at all placement stages via the delivery of tutorials (discipline specific and interprofessional), the facilitation of fortnightly peer assisted learning discussions and twice-weekly stakeholder meetings.

The undergraduate students on this WIL placement developed a site-specific telehealth policy, a student profile detailing allied health information and implemented home-based exercise programs to school students via telehealth to counteract suspended hydrotherapy programs. Beyond this student-led physiotherapy telehealth model, the site's allied health staff also actively promoted the telehealth service during times of remote learning and plan to offer their telepractice services beyond COVID-19. The realignment of this placement resulted in the maintenance of a rural placement for two physiotherapy students, who both passed the placement. Another key outcome included the implementation of an information management initiative to support service coordination and

telepractice exposure. This has enabled the host site to expand their service delivery options to promote service access for their end users.

Mental Health/Homelessness Placement - Occupational Therapy

Pandemic restrictions also impacted upon a rural community organization working with homeless people. The organization was unable to host students onsite due to infection control requirements for their clients. This organization had been hosting service-learning placements for the previous three years. Within this time, occupational therapy students had developed and implemented a life-skills program for people who were homeless and who had mental health conditions. Naslund et al.'s (2015) review identified that telehealth is a viable means of providing services and that these services can benefit clients who are at high risk in the community. The Going Rural Health Community Placement Coordinator worked with the in-house occupational therapist to develop an online student placement and this began with identifying whether the placement would meet the academic goals set by the university. Clients who would be appropriate for students to engage with were identified by the occupational therapist and referred to the students for telehealth services. During the first week of placement, students had the opportunity to develop an understanding of safe telehealth practices, professional boundaries in mental health and the context of clients. This first week of placement also provided additional mentoring to support the students in adjusting to the online placement format.

Supplementary education was developed to ensure students were developing their knowledge of the role of the therapist in mental health, despite their reduced time with the clinician. Role plays, relevant videos along with education on the mental state examination allowed for students to begin to understand professional language in the area of mental health. A weekly check-in was developed with the students' supervisor to identify if any challenges with the online format needed to be addressed. Students conducted formalized assessments of leisure, community participation and occupational performance with individual clients and then formulated treatment plans for these clients. A challenge for the students was to persist in making contact with clients who sometimes were not able to engage in telehealth at the set appointments times. Students needed to assign additional time to developing rapport with clients over the phone. Treatment intervention for clients included developing work ready skills, budgeting and expanding their clients' engagement in meaningful leisure activities. Students employed cognitive behavioral therapy and motivational interviewing as they worked with clients living in the organization's modular units to prepare them for independent housing.

In addition to client contact, students engaged with project work by developing a presentation and accompanying brochure, which contained current support services available to homeless people in the area. This placement has allowed the host organization to explore how to best deliver telehealth to this particular client group, resulting in them purchasing additional telehealth equipment and ensuring in-house staff support the facilitation of students providing telehealth. The two students on this placement both passed the placement and have offered to return as volunteers (COVID-19 permitting) later in the year, which the host organization has welcomed.

Primary School Placement – Speech Pathology

This speech pathology placement was undertaken at a rural primary school. The student completed their placement online from home for the first four weeks, then came to the school for the final three weeks after schools had reopened. Going Rural Health had an existing partnership with the school, which had employed a full-time speech pathologist at the beginning of 2019 to work within a response to intervention framework (see Fuchs & Fuchs, 2006). The speech pathologist had been supervising

students each school term for the 12 months prior to the COVID-19 pandemic and was provided with training in supervision and peer-assisted learning. It was agreed with the student's university prior to the placement that if any competency areas could not be achieved due to the online format, the university would help to supplement this via simulation or other means. The CPC and supervisor worked together to implement appropriate supports for the student to complete their placement in this format. Orientation was delivered via Zoom and relevant links and resources were sent via email to the student, such as webinars on telehealth and guidelines for telehealth practice from Speech Pathology Australia. A secure share drive was set up to store all relevant documents, accessible only by the student and the supervisor. The student was provided with data and demographic information relevant to the rural town and meetings with key stakeholders were arranged for the student via Zoom to provide context for the placement, including a cultural orientation.

The supervisor and student interacted briefly via WebEx (a video conferencing platform) most mornings and afternoons, with the student working independently during the day on various activities identified by the supervisor and participating in planning meetings with teachers. The student contributed ideas to plan online learning tasks for reading and writing and helped select focus texts for the week as well as developing videos focusing on oral language. Whilst it was hoped that individual telehealth sessions with school students could be conducted, the increased demands on parents in supporting their children to complete remote learning tasks meant this did not eventuate. Instead, the student focused more on individual assessment and intervention when they came to the school for the final weeks of their placement.

The student was also linked in via Zoom to fortnightly interprofessional learning sessions with other students completing service-learning placements online, providing an opportunity to share experiences with others in a similar situation, and discuss useful resources, techniques, and approaches. The student passed their placement and achieved all of their learning objectives, although they only had the opportunity to do individual assessment and intervention in the face-to-face component of the placement. Placement outcomes included increased capacity of the speech pathologist to provide online materials and resources for teachers during the home learning period, school student access to speech pathology services and embedded oral language lessons and systems approaches to supporting speech pathology interventions.

Intergenerational Kindergarten Project – Occupational Therapy

Going Rural Health collaborated with a local, rural pre-school association to develop an intergenerational kindergarten placement for two final-year occupational therapy students, which arose as an opportunity during pandemic restrictions. As intergenerational practice aims to facilitate reciprocal learning between generations, students on this placement were assigned the task of developing a program to promote skill development and social connectedness between the kindergarten and residential aged care settings (Airey & Smart, 2015).

As no allied health staff were employed by the preschool association, Going Rural Health met with association staff and tertiary academics to ensure the placement's design and project objectives aligned with the undergraduate curriculum needs, supervision requirements and online format. Consensus was reached that students would utilize the placement site's preferred teleconferencing platform, Zoom, with advanced security settings enabled to meet privacy requirements. The use of a password protected OneDrive file was employed to facilitate data management and information sharing. Stakeholders agreed that the student's execution of a privacy agreement prior to placement

commencement and the provision of evidence to supervisors confirming that they were completing their placement from a confidential workspace met privacy requirements.

Pre-placement material and placement details were disseminated to both occupational therapy students via their university, outlining pre-placement requirements (i.e., Working with Children Check), placement objectives, orientation schedule, contacts, placement expectations and outlined the collaborative supervision model in place. Orientation was delivered via Zoom and screen sharing functions were utilized to facilitate information sharing, interaction and orientation to the OneDrive file, which included placement and site-specific information. Time was dedicated on the first day of placement for students to meet association staff, undertake site orientation, participate in a Zoom tutorial, embed advanced security settings within online platforms and to develop their individual learning objectives with their clinical supervisor.

Time-specific deliverables were communicated within a placement schedule. Students received clinical supervision, interprofessional mentoring and stakeholder consultation online via Zoom throughout the placement. Students were required to complete online education modules regarding telehealth, rural health and resilience. Peer assisted learning sessions were embedded into their placement schedule fortnightly to encourage information sharing, interprofessional learning and the development of a community of practice. Students met with site staff twice weekly to ascertain the work done regarding intergenerational programs by association staff, details regarding the proposed pilot site (i.e., timelines), program goals (long and short) and to guide placement directions.

A placement experience was created for two undergraduate students who successfully met all their learning requirements and passed the placement. Despite the challenges of not being able to consult with stakeholders from the aged care sector due to Covid-19, a valuable pilot program was developed to promote meaningful engagement between elderly and pre-school members of the community that otherwise would not have been available. Items in this kit included: risk management tools, a goal setting proforma, information handouts, training materials for staff and session plans with embedded therapeutic goals.

DISCUSSION

The ability to be responsive and adaptable in the changing environment wrought by COVID-19 restrictions in Victoria allowed the continuation of several placements that would otherwise have been cancelled, as well as the creation of new placements. In order to learn from these experiences, this section reflects on the strengths and challenges of the realigned placements and then identifies the critical factors enabling the shift to remote, online learning.

Strengths

An obvious strength was that all students were able to complete their placements during high rates of placement cancellation. Students passed their curriculum and clinical learning needs whilst contributing positively to clients and organizations. The successful clinical and end user outcomes of telesupervision placements is reflected in some studies (Chipchase et al., 2014; Harris et al., 2020; Lee & Billings, 2016; Nagarajan et al., 2016) whilst other studies recommend placements involve a mix of face-to-face and online supervision (Carlin, 2012; Boisvert & Hall, 2019; Martin et al., 2018). With three placements occurring completely online and one placement having a mix, no major difference was noted in student outcomes. The collective willingness of all stakeholders generated placements that were mutually supportive; they worked together to accommodate, adapt and complement the work of

one another, creating a sense of connectedness (see also Barnard-Ashton et al., 2018; Nagarajan et al., 2016). This reflected the pandemic era when most organizations worked enthusiastically to share, support, and connect for the benefits of their clients. Allied health students showed their adaptability by implementing a similar approach to developing partnerships and working with others despite differing discipline, clinical learning outcomes and supervision models.

This pandemic has driven broad implementation of telepractice, which has proven advantageous and even critical to service delivery (Boyages, 2020). Technological adjustments enabled by the Going Rural Health team resulted in all stakeholders being better equipped to use technology and several of the host sites reporting that they would embed telehealth in their ongoing practice. Although initially hesitant about their capacity to successfully engage in telepractice, students were able to gain experience providing these services, which they identified would be an important skill in the future, as supported by Serwe et al. (2020). The positive shift in attitude towards telepractice is also evident in other studies (Grady, 2011; Martin et al., 2018; Nagarajan et al., 2016).

Due to the reduction of travel, students had time to receive additional education and support relevant to their specific placement area, along with increased access to expertise and supervision, which was also reflected in the studies of Inman et al. (2019) and Nagarajan et al. (2016). Supervisors had more flexibility to conduct shorter, but more frequent supervision sessions with students (as recommended by Chipchase et al., 2014, and Martin et al., 2018) and supervisors who would not have been able to attend the placement if it was face-to-face (due to distance from placement site) were able to be involved (see Dudding & Justice, 2004).

The collaborative learning and supervision implemented for all placements was another strength. All but one placement involved students working in a peer assisted learning model, which allowed them to create their own small community of practice. Mackenzie et al. (2019) also found that students appreciated having peers with whom they could discuss experiences, examine their reactions and support each other through challenges. Students indicated that the interprofessional learning sessions, facilitated for three of the four placements, also promoted this sense of connection and assisted in feeling less isolated. Collaborative supervision meant that the responsibility was shared by a number of people and not reliant on one supervisor (see Bartholomai & Fitzgerald, 2007; Fairbrother et al., 2016). A key enabler of the collaborative supervision model was the involvement of the Community Placement Coordinator role, which, through the Rural Health Multidisciplinary Training program, was able to coordinate the placement as well as mobilize funds to purchase equipment for student use.

A final strength was a consistent focus on health and wellbeing. Students were encouraged to engage in proactive self-care, including taking regular breaks, exercising and identifying with their peers or supervisors if they were finding the placement format challenging. There was also more focus on students and supervisors' personal lives than would be the case in a face-to-face format, which seemed to build empathy and compassion.

The positive outcomes of the online placements mean that Going Rural Health will integrate more elements of telesupervision into future clinical education to provide more flexibility for supervisors, more services for clients, and arguably more learning opportunities for students.

Challenges

As an organization focused on a rural health workforce, there were limited opportunities for students to benefit from the immersive experience that is promoted by University Departments of Rural Health (see Frewin, 2015); Wolfgang et al., 2019. Students were unable to embed themselves in and engage informally with the community and organizational staff, which is identified as a key element in rural placements (Furness et al., 2020). Whilst this may have some impact on some students' intentions to practice rurally, students did indicate that the online experience still gave them valuable insights into the varied scope of practice in rural communities.

The online placements did place some restrictions on students that may not have occurred in a face-to-face context. The online format tended to limit the scope of the placement as well as hampering some creativity that comes from being immersed in the daily placement setting. Waiting for the host site to respond to questions via email also lessened productivity and some autonomy, as the students were more reliant on information that they could access themselves if onsite. Host sites were understandably under pressure from navigating their own organization through the pandemic, and so the student placements did impact capacity. One student, who did a combination of online and face-to-face placement, would likely have missed out on doing individual assessment and intervention had they not had the face-to-face component.

Students needed to ensure privacy and confidentiality measures were adhered to in their homes as well as across multiple online platforms, which was sometimes challenging. Technological issues are almost universal in telepractice service delivery models (Boisvert & Hall, 2019; Carlin, 2012; Chipchase et al., 2014; Nagarajan et al., 2016). Going Rural Health placement challenges included limited practical guidelines and experience regarding telesupervision; addressing cybersecurity and online privacy issues; establishing appropriate data storage; and managing connectivity issues. However, by following recommendations of ensuring high quality software and equipment (Grady, 2011; Wolfer et al., 2002) and posting necessary equipment to students, these issues were mitigated as much as possible. Managing client relationships and the development of rapport in a virtual space required concerted effort due to the lack of face-to-face interaction. Another difficulty was that clients were not always available for their telehealth appointment, were overwhelmed with remote work and learning, or did not optimally engage in the online session. Hines et al. (2019) indicate that significant effort is generally required of the clinician to support the family in initially engaging in the telepractice process and this is time that students did not necessarily have within a five to seven-week placement block. Dudding and Justice (2004) outline the challenges of telesupervision, including limited opportunities to observe supervisors modelling practice and observations of different clinical contexts, while Grady (2011) noted the biggest drawback of telesupervision to be the lack of hands on experience and limited access to the client. These challenges also applied to Going Rural Health's WIL placements.

From a Community Placement Coordinator perspective, setting up and supporting the online placements involved more work and time than a standard service-learning placement, although once the initial measures were implemented, efficiencies were gained with repetition. Having put all these adaptations in place it is foreseen that this will allow for easier transition to online placements in the future.

Key Factors for Adapting Placements

A key foundation across the adapted, online placements was an established relationship with the host sites and supervisors. The enabling factors that arose from these relationships included a reputation of

being reliable, supportive and committed, and ensuring reciprocal benefit for the host organization and students, which fostered trust to trial the online format. The establishment of trust prior to online formats is supported by Martin et al. (2018) and extended by Jones et al. (2018). Clear roles and responsibilities within a collaborative supervision model that existed prior were reinforced and developed, driven by effective communication. An attitude of learning together and nobody being the expert of facilitating an online placement created a safe space for mistakes and promoted greater flexibility from all parties. Key to the success of these partnerships was being transparent, communicating regularly and supporting each other to make the placements work. For most stakeholders, this often-meant extra effort to pick up responsibilities that they might not otherwise.

Orientation procedures were a critical component of all placements. As per Hanson and Deluliis' (2015) recommendation, orientation to the host site, the technologies, policies and procedures, expected outcomes and learning objectives were provided for students via online methods. The availability of online resources, such as webinars on telehealth, also provided information useful to the placement success. Universities were willing to support students with anticipated learning gaps arising from the adapted format, for example, through simulation or other experiences post-placement (if needed). Students, while initially concerned that a lack of face-to-face client contact would limit their learning (as per Panos, 2008), approached their placement cooperatively and positively.

Learning

The models and concepts that framed the development of these WIL online placements (and that guide all placements developed by Going Rural Health placement coordinators) were affirmed during this pandemic era. Collaborative learning environments have been particularly beneficial during an isolating time. With the ongoing uncertainty created by COVID-19, Going Rural Health are actively implementing online contingencies in placement planning to minimize further disruptions, whilst maximizing WIL opportunities for students. With hindsight, it would have been sensible to delay the start of some early placements to allow the time to plan and implement the necessary requirements for an online placement, with involvement from the students.

Limitations

It is acknowledged that while a critical analysis of the placements has been attempted, the authors were the placement coordinators of the case studies which creates issues of bias. Due to the quick implementation of these placements, it was not possible to gain ethics approval to seek the perspectives of students or placement organizations. Further, having only four case studies may limit the conclusions that can be drawn about the impact of this placement model. Despite these limitations, these case studies highlight the utility of online service-learning placements to assist students to progress their studies and for rural communities to gain enhanced services.

CONCLUSION

Driven by ever-changing COVID-19 restrictions, Going Rural Health's adoption of online WIL placements was responsive, individualized, and strengthened by having partnerships in place. While imperfect, the routine integration of innovative elements into Going Rural Health student placements, including service-learning models, collaborative supervision, and peer-assisted learning, enabled the team to adapt to an online format. Adaptations minimized pandemic disruptions, ensuring ongoing service delivery for end users and achievement of learning objectives for students. As clinical placement needs continue to increase and rural communities continue to experience health workforce

shortages, the pandemic has highlighted the power of partnerships between universities and the community sector. This perhaps lays down a challenge to universities engaged in clinical education— with their increasing reliance on community-based organizations to provide quality learning opportunities for allied health students, universities are encouraged to invest in reciprocal relationships that benefit communities.

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