COVID-19 PANDEMIC HEALTH CARE

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Case Study

Riding the waves: lessons learnt from Victoria's COVID-19 pandemic response for maintaining effective allied health student education and clinical placements

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Abstract. Victoria was the Australian state most significantly affected by the COVID-19 pandemic in 2020, which caused significant disruption to Victorian health services. The aim of this case study is to describe the experience of the Victorian public health system in adapting to support allied health student education during the pandemic. Factors that affected student education were complex and dynamic, and included a decrease in traditional face-to-face learning opportunities due to a transition to telehealth, social distancing requirements, furlough of staff and travel restrictions. Impacts on placement capacity across allied health professions were highly variable. Strategies used to enable the continuation of student work-integrated learning (WIL) (also referred to as clinical placements or fieldwork) included an increase in remote placements and the use of technology. Enhanced communication between government and health service educators enabled rapid sharing of information and problem solving. At this time, the impacts on student preparedness for practice are unclear but may include deficits in interprofessional learning, clinical skills, increased levels of agility and enhanced resilience. This case study highlights the need for the health system to be adaptable and innovative to maintain the quality of student education, and the future allied health workforce, through the pandemic and beyond.

What is known about the topic? The COVID-19 pandemic caused significant disruption to Victorian health services and consequently their ability to support WIL for students during this time. The pandemic created risks for continuity of student learning and future allied health workforce supply.

What does this paper add? The challenges that Victorian public health services faced to support student education during the pandemic were complex and dynamic. This paper describes the ways in which health services adapted to optimise the capacity and quality of student education.
What are the implications for practitioners? This case study highlights that a focus on student well-being and a high level of problem solving for health services were required to support student learning during the pandemic, and that enhanced communication between government and health services supported the rapid sharing of innovations. These strategies can be used to support quality student WIL through the pandemic and beyond.

Keywords: allied health, COVID-19, education and training, health services, pandemic, public health, risk management, student education, workforce.

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Introduction

Work-integrated learning (WIL) clinical education for entry-level allied health (AH) students (also referred to as placements or fieldwork) provides essential experience for students to develop clinical skills and a greater understanding of the health system. Public health services are the largest provider of WIL for AH in Victoria, encompassing 27 professional groups across 59 public health services in 2019–20. Public health services in Victoria operate in a devolved-governance model whereby the central government agency, the Department of Health (DH), cedes operational control to the health service board. In the context of workforce pipelines, DH maintains strategic oversight for WIL to ensure future workforce supply and quality, and provides funding to incentivise engagement in student training. Within this model, placement offers are negotiated between individual health services and tertiary education providers, and then documented via Placeright, a web-based portal that records Victorian student education activity.[1] Health services are responsible for the management of their own student education programs, typically via the appointment of a lead AH educator. Collectively, Victorian health service education leads engage in the Victorian Allied Health Clinical Educators Network (AHCEN), which is a sector-led community of practice (CoP). The AHCEN membership works collaboratively with DH and other stakeholders to enhance state-wide approaches to AH clinical education and training.

In 2020, coronavirus (COVID-19) public health directives significantly affected access to WIL in Australia. WIL across public, private and not-for-profit sector agencies was affected, with Victoria experiencing higher infection rates than other Australian states and some of the most stringent public health restrictions globally.[2] Victoria's public health response focused on reducing community transmission risk while maintaining health system operations during pandemic waves. In this context, AH WIL was pivotal to ensure adequate future workforce supply. It also supported the potential need for student engagement as a substitute surge workforce.

Objective

This case study describes the experience of Victorian government and public health services in managing AH WIL during the COVID-19 pandemic. The paper presents an overview of Victoria's experience in managing competing demands of community transmission risk, healthcare worker safety and maintenance of allied health WIL. Key learnings relating to sector-wide communications and consistent strategy and response across multiple stakeholders are highlighted.

Setting and participants

This paper reflects the collective experiences of AHCEN and the DH allied health leads supporting AH students during 2020. Drawing on student placement data sourced from Placeright, placement activity included 6824 individual placements from 21 AH disciplines, encompassing 17 tertiary education providers and 59 fieldwork partnerships across metropolitan ($n = 16$) and regional/rural ($n = 43$) public health services.[3]

Sequence of events and outcomes

The COVID-19 pandemic resulted in two waves of transmission in Victoria in 2020. An overview of the key dates and events and daily COVID-19 case rates during the first and second wave responses are provided in Fig. 1.

First wave response: March–April 2020

After the first Victorian case of COVID-19 was confirmed, measures to 'flatten the curve' required an increase in critical care capacity and preparation for predicted health workforce disruptions. Health services observed a drop in emergency and outpatient presentations as individuals stayed home due to fear of exposure to COVID-19 and because of government directives Elective surgeries were cancelled and resources diverted to COVID-19-specific units. Social distancing increased pressure on space within health services and necessitated a rapid transition to telehealth. Despite a direction from DH to prioritise placements for final-year students, these issues, coupled with safety concerns, resulted in widespread placement cancellations. As case numbers increased, alternative student roles supporting 'surge' capacity were considered. A timeline outlining public health restrictions and effects on AH service provision during the first wave of transmission is provided in Table 1.

After the peak of the first wave, focus shifted to placement continuity to minimise future workforce disruption. Safety remained key, with the movement of placements from areas of high risk to remote placement models using telehealth. These changes, and subsequent reduced direct learning opportunities,

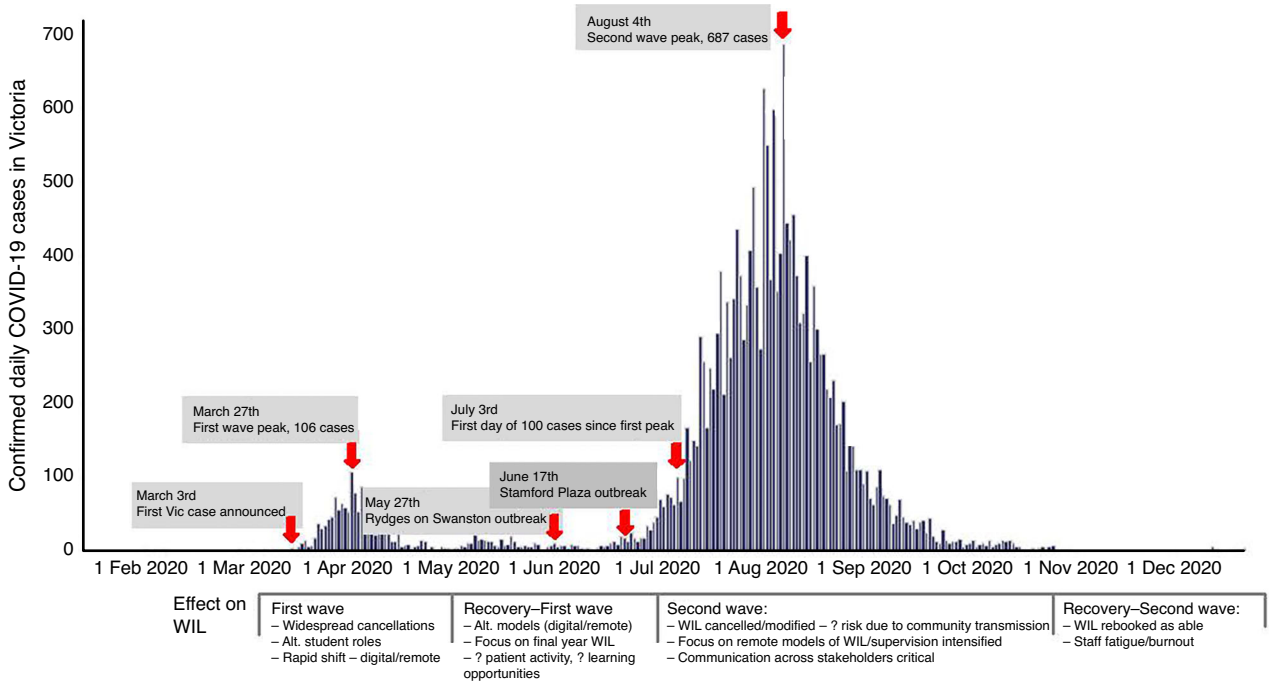

Fig. 1. Timeline of Victorian COVID-19 infections in 2020, key dates and effect on WIL. Alt., alternative.

created concerns regarding capacity to meet placement requirements. In addition, staff fatigue, an expectation of a 'second wave', and information technology (IT) and physical space challenges hampered efforts to maintain placement capacity. To optimise resource allocation, strategies to prioritise placements essential to the progress of students in their final years of study were implemented.

During the first wave response, the state-wide AHCEN CoP adapted from face-to-face to virtual meetings. The CoP also increased its meeting frequency from every 2 months to fortnightly to enable rapid sharing of approaches and collaborative problem solving to facilitate student learning across public health services.

Second wave response: July–October 2020

In early July, a state-wide lockdown (Stage 3) was implemented and, by August, a State of Disaster had been declared, including restrictions that differed between metropolitan and regional Victoria. Out-of-home travel was limited to essential workers for work and childcare access.[4] Guidance from DH clarifying the application of these directives to WIL was released in mid-August, with subsequent monthly updates. Table 1 outlines key public health restrictions and their effects on AH service provision during the second wave of transmission.

Community transmission was driven by the 20- to 29-years age group, with multiple simultaneous outbreaks among healthcare workers across different health services.[5] This posed new challenges for health services, shifting the 'direction of transmission' and increasing transmission risk via asymptomatic staff or students. Combined with escalating numbers of COVID-19 cases requiring care, 'on-site' placements were modified or cancelled as a 'circuit breaker'. The need to focus on remote supervision models for placements further intensified.

As COVID-19 cases dropped in September, placements recommenced with a focus on hybrid models combining on-site and remote learning. AH clinicians, working in a 'COVID-dominated' environment and in lockdown for most of 2020, had limited capacity to reschedule placements. Placement planning for 2021 commenced with uncertainty around the ongoing impact of COVID-19 associated with social distancing, IT capability for remote placements and widespread redundancies in the tertiary sector. By November 2020, relief from lockdown came as restrictions were eased.

Effect of COVID-19 on student placement activity

Changes in WIL activity for selected disciplines between 2019 and 2020 are presented in Table 2. AH recorded a 15% reduction in public health service placement activity for all of 2020. In contrast, WIL activity across all professions (including nursing and medicine) decreased by 35%. Changes in AH placement activity were most notable for smaller disciplines, with a reduction of 91% for optometry, contrasting with a 15% increase for prosthetics/orthotics. There were substantial reductions in placement activity for audiology (73%), social work (51%) and psychology (43%). AH assistance was an anomaly, recording a 21% increase, possibly as a result of the Victorian Government's Free TAFE (technical and further education) initiative.[6]

Effects on WIL varied for metropolitan and regional/rural public health services due to different COVID-19 restrictions. For example, students were not able to move between Melbourne and regional Victoria during the second wave, and restrictions on health service delivery were eased earlier in

Table 1. Timeline of Victorian COVID-19 public health restrictions and effect on AH services and WIL
ED, emergency department; PPE, personal protective equipment

Date (2020)	Public health restrictions	Effect on AH service provision
23 March	Business closures	Restrictions on entering aged care
	Limit on outdoor (500) and indoor (100) gatherings	Density restriction impacts
	Social distancing (1.5 m distance)	Social distancing adherence
	Physical distancing (1 person per 4 m^2)	Increase in fail to attend rates
25 March	Additional business closures	Elective surgeries cancelled
	Limit on attendees for weddings (5) and funerals (10)	Community centres and hydrotherapy pools closed
	'Gatherings' in homes discouraged	
30 March	Four reasons to leave home: shopping for essentials, medical care, exercise, work/education	Reorganisation of hospitals
		Significant disruption to health services
	Work from home	Alternative models of care
	Limit to household visitors (2)	Increased fail to attend rates
	Quarantine for returned travellers	Reduced ED presentations
		Surge workforce preparations
		Focus on PPE/infection-prevention procedures
2 August		
Metropolitan	Four reasons to leave home (1 h)	Closure of many private and community AH services
	Mandatory mask use	Criteria for essential 'in-person' AH services – telehealth preferred
	Travel within 5-km radius	Major effect on health services (particularly in north-west Melbourne)
	Night-time curfew	Face-to-face therapy and exercise classes cancelled
	No visitors to home	Permitted worker permits
	Barrier between metropolitan and regional travel	
	Permitted worker scheme introduced: required to access childcare	
Regional	Four reasons to leave home (2 h)	Closure of many private and community AH services
	Can meet one other person outdoors	Staff should work from home if possible
	One nominated visitor to home if isolated	COVID-safe density quotients, cleaning audits, attestations, limit staff movement
	Retail open (masks required)	
	Hospitality restricted to take-away delivery	
13 September		
Metropolitan	Increased to 2 h limit outside	Focus on services via telehealth (where practical)
	Curfew removed	Face-to-face AH care only in specific circumstances
	Can meet one other person outdoors	Focus on high priority and preventing functional decline
	One nominated visitor to home if isolated	
Regional	Curfew and travel limit removed	Restrictions to some AH services (e.g. groups)
	Five people can meet outdoors	Criteria for 'in-person' AH services – telehealth preferred
	Schools return to on-site	Face-to-face therapy and exercise groups cancelled
28 September		
Metropolitan	Travel radius increased to 25 km	Restart of many face-to-face AH services
	No time limit outdoors, up to 10 people can gather	Focus on preventing functional decline, backlog of assessment and diagnostics and surgical patients
	Childcare reopens for all	
26 October	Removal of four reasons to leave home	Industry restart guidelines released
	Two visitors to households	Telehealth still preferred
	Schools return to on-site learning	Outdoor (1:2) and hydrotherapy (1:1)
	Removal of metropolitan–regional barrier (November 8)	Indoor groups with density quotient
23 November	Up to 20 visitors to homes	Indoor groups (up to 50)
	Up to 50 in outdoor gatherings	Outdoor (up to 50)
		Hydrotherapy (no cap)

regional Victoria. Placements in aged care and private practice settings were particularly affected due to restrictions on staff movement in and across services and limits on non-essential personnel entering aged care facilities, with placements completely suspended within aged care facilities. Aged care and disability sectors took a cautious approach to recommencing placements, prompting concerns about the effect on vocational training and critical workforce shortages in these settings and beyond.

Problems, conflicts and constraints

The COVID-19 pandemic significantly changed health service delivery, including a rapid pivot to telehealth.[7] Health services balanced the provision of clinical care with WIL while managing the risks of COVID-19 transmission and complying with directives from DH for placements to continue wherever possible to mitigate risks to future workforce supply.[8,9] Reduced placement capacity had the potential to adversely affect

Table 2. Change in WIL between 2019 and 2020 for selected disciplines by year of course

GEM, graduate-entry Masters

Discipline	Year of course						Overall change	Comments
	1st	2nd	3rd	4th	5th	6th		
AH assistants	↑21%, +527 days	↑300%, +15 days					↑21%, +532 days	Free TAFE initiatives may have increased demand for placements
Audiology	↓60%, –62 days	↓81%, –147 days					↓73%, –209 days	Space issues in treatment areas due to social distancing
Dietetics and nutrition[A]	↑191%, +124 days	↓10%, –465 days	↓79%, –377 days	↓67%, –943 days			↓26%, –1660 days	Affected by higher exposure to international students (travel ban)
Occupational therapy[A]	↓31%, –573 days	↑274%, +732 days	↓28%, –1836 days	↑9%, +744 days			↓5%, –933 days	Significant increases in final year of GEM (2nd) and Bachelor degree (4th)
Prosthetics and orthotics			↑47%, +37 days	↑9%, +31 days			↑15%, +68 days	Impact potential proportional to small size of discipline
Physiotherapy[A]	↓25%, –253 days	↓20%, –374 days	↓26%, –3982 days	↑24%, +2074 days			↓9%, –2535 days	GEM WIL relatively stable, increase in final year Bachelor degree (4th)
Podiatry			↓60%, –395 days	↑9%, +188 days			↓8%, –206 days	Closure of university student-led clinic increased placement demand
Psychology	↓82%, –1572 days	↓30%, –2022 days	↓42%, –398 days	↓100%, –57 days	↓100%, –105 days	↓48%, –608 days	↓43%, –4761 days	Multiple pathways: higher degree, 5+1 or 4+2 internship pathway
Social work[A]	↓83%, –4799 days	↓23%, –1426 days	↓51%, –1729 days	↓49%, –1847 days			↓51%, –9801 days	Potential lack of flexibility in accommodating long WIL blocks
Speech pathology[A]	↓87%, –247 days	↓57%, –553 days	↓33%, –396 days	↑3%, +107 days			↓18%, –1089 days	Focus on maintaining final year in Bachelor degree (4th) evident
Pharmacy	↓93%, –187 days	↓7%, –60 days	↓28%, –514 days	↓80%, –1760 days			↓27%, –1373 days	Reported reduction in community placements

[A]1st and 2nd year inclusive of Bachelor degree (4-year course) and GEM (2-year course): majority of represented WIL related to GEM; 3rd and 4th year inclusive of Bachelor degree only.

graduate training pipelines, particularly for those disciplines and sectors with substantial decreases in placements.

Constraints included patient casemix changes, with decreased demand in some disciplines (physiotherapy and AH assistants) and increased demand in others (dietetics and social work). Additional tensions included changed service delivery models and a lack of clinical and office spaces to comply with physical distancing rules. Widespread community and workplace transmission resulted in staff furlough, which affected the availability of clinical supervisors. Metropolitan and regional travel restrictions affected student access to placements across geographical areas. Students required explicit guidance on maintaining professionalism and patient confidentiality when working and learning from home.

The pandemic resulted in additional challenges to the usual processes for managing WIL. Contractual education obligations were surpassed by public health requirements, resulting in relationships between education and clinical placement providers that were strained at times. Rapid contract tracing capability to alert students potentially exposed to COVID-19 was hampered by prepandemic privacy policies preventing student contact details being shared with health services.

Student assessment expectations shifted due to modified student learning experiences. The use of extensive personal protective equipment affected communication between students, clinicians and patients.[9] Technology and electronic medical records supported the remote delivery of care, allowing clinical services to continue; however, IT systems struggled with increased demand.[10] Although most clinicians and students adapted well to change, the steep learning curve associated with delivering care and supervising students in dramatically altered environments cannot be underestimated.[11] Rapid changes in education and curriculum design were required to overcome gaps in clinical education caused by the suspension of observational placements, home visits and residential aged care placements. Proven education pedagogies, such as clinical simulation and peer-assisted and interprofessional learning opportunities, were heavily compromised with a reduction or cessation of social contact.[12–15]

Discussion and lessons learnt

Through the COVID-19 pandemic, Victorian health stakeholders learnt that being responsive in a complex devolved-governance system demands a high level of collaboration, communication and connectivity that transcends individual health services. Cross-sector communication was needed at the macro, meso and micro levels to achieve the objective of effective student education. In crisis, people feel safe with order and clear directives, but during the pandemic communication was often compromised in rapidly evolving situations. Clinical education stakeholders built flexible and collaborative relationships and sought to clarify information in a timely and non-blaming manner. At the individual level, the concerns of clinicians and students required regular, transparent and succinct communications.[16]

Students are integral to the healthcare system, and this future workforce requires protection and nurturing. The importance of healthcare worker well-being and psychological safety was acknowledged during the pandemic and the increased focus on well-being from state health leadership will need to continue after the pandemic. Clinicians modelling self-care became an additional focus of student learning. As social distancing requirements persisted after the second wave, there was a greater need to create deliberate opportunities to check in with students and clinical educators regarding their well-being. There is a renewed commitment to discuss reasonable adjustments to placements and to be open, honest and clear about learning opportunities as situations evolve.[17]

Strong risk management related to COVID-19 was required. When stakeholders felt empowered to identify and collaborate on risk management strategies, effective problem solving was demonstrated.[18] An environment that allowed students and clinicians to voice concerns in a safe space and work in partnership helped health services to adapt to unfamiliar and evolving situations to ensure student learning continued, albeit often in different ways. As education leaders, we have learnt that support for AH educators is enhanced through virtual peer-support networks, such as CoP.[19]

The pandemic has provided opportunities for innovation, rapid evaluation and shared learning. AH educators proved to be agile and resourceful in creating alternative learning opportunities. Technology enabled new and different placement models, including virtual placements embracing telehealth, remote supervision and e-learning, to be explored. These examples moved beyond the constraints of traditional apprentice models and time-defined placements. Some of these models are potentially scalable and may assist other Australian and international jurisdictions facing similar challenges. There remains a need for accrediting bodies and education providers to support and guide the assessment of competency for altered placements. Future improvements to operational components of placement management are required to increase flexibility, and this must occur in partnership with government, health and education sectors.

The degree to which the pandemic has affected student learning outcomes remains unknown. We predict the COVID-19 student cohort who are now transitioning to practice as graduate health professionals is more agile, adaptable and resilient than its predecessors. There are likely deficits in interprofessional learning and some clinical skills due to altered learning opportunities during the pandemic, and targeted support will be required for students and graduates. Although some clinical learning experiences cannot be simulated, we should continue to harness technology and think differently. Skills developed in communication, partnership, collaboration and problem solving should be leveraged to improve and expand clinical education practice now and into the future.

Competing interests

The authors declare that they have no competing interests.

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