Strategies used to host allied health students in private practice placements: The perspective of private practices and clinical education coordinators

ROMA FORBES[1],
ALANA DINSDALE
ANNE HILL
JODIE BOOTH
DANIELLA CAIN
MEAGAN CRABB
RUTH DUNWOODIE
LUCY HUNTER
AURIEL SHER
JODIE COPLEY
The University of Queensland, Brisbane, Australia

Allied health new graduates are entering private practice in increasing numbers despite limited opportunity to experience this setting during training. Exploring strategies used to host students may provide insight into how students can be integrated into practice whilst minimizing disruption to staff, clients, and service delivery. This study aimed to explore actual and potential strategies to integrate students into private practice organizations from the perspective of practices who currently, have previously, and who have never hosted allied health students (n=26) and university clinical education coordinators (n=13). Four themes were generated that encompassed key strategies in hosting allied health students. Allied health private practices and clinical placement coordinators use a range of strategies to integrate students, centering on supporting involvement in client care and steps to minimize disruption to service delivery. Consideration of such strategies may provide avenues for future practice-university partnerships, thereby increasing placement capacity in this sector.

Keywords: clinical education, higher education, private practice, allied health, clinical placements

Clinical placements for allied health professional students are essential for the development of a safe and effective workforce as they allow transformation of theory into practice (Koontz et al., 2010), while promoting professional identity and socialization (Hecimovich & Votel, 2011; Rodger et al., 2011; Shields et al., 2013). Developing and sustaining clinical placement opportunities, however, is challenging and not all students are able to experience placements across relevant workplace settings, particularly within the private practice sector (Peiris et al., 2019; Queensland Government, 2007). An historical and ongoing reliance on the public sector for allied health placements (Australian Institute of Health & Welfare, 2020) may be increasingly unsustainable due to rising numbers of university programs and student enrolments (Lincoln, 2012; Sokkar et al., 2019).

Over half of all Australian physiotherapists, audiologists, speech pathologists and exercise physiologists and approximately 20% of occupational therapists are employed within private practice settings (Department of Health and Human Services, 2018; Exercise & Sports Science Australia, 2019; Health Workforce Australia, 2014; Speech Pathology Australia, 2014). Further growth in the allied health private practice sector is anticipated, with increased community demand, the introduction of private and government healthcare funding schemes, and increasing privatization of healthcare (Hazelwood et al., 2019; Rodger et al., 2008; Sokkar et al., 2019). Despite an increasing proportion of

[1] Corresponding author: Roma Forbes, r.forbes2@uq.edu.au

allied health practitioners in private practice, previous reports have suggested that few placements occur in these settings, with less than 10% of speech pathology (Sokkar et al., 2019) and less than 50% of physiotherapy students (Peiris et al., 2019; Wells et al., 2017) experiencing full-time placements in private practice. The current lack of private practice placement opportunities may have significant implications for sustainability and contemporary clinical education and the workforce readiness of new graduate allied health professionals. Research indicates that new graduates are challenged with entering private practice settings, especially meeting expectations of employers (Jones et al., 2010; Wells et al., 2017), with reports suggesting that they are underprepared for both clinical and non-clinical aspects of private practice work, including clinical reasoning, time management, and knowledge of funding providers (Jones et al., 2010; Wells et al., 2017). These issues are reportedly compounded where students have not had placement experiences within a private practice organization during their training (Atkinson & McElroy, 2016; Wells et al., 2017).

Research to date has focused on the motivations and challenges of hosting students from the perspective of allied health private practices and the staff members within them who act as clinical educators (Forbes et al., 2020b; Hall et al., 2015; Kent et al., 2015; Sloggett et al., 2003; Sokkar et al., 2019). Major benefits reported by the practices who have hosted students include recruitment of graduates who have completed placements within the practice, increased flexibility in staff workloads and exposure to the contemporary clinical knowledge and research that students bring to the placement (Bowles et al., 2014; Forbes et al., 2020b; Hall et al., 2015; Rodger et al., 2007). Some practices have also acknowledged the benefit of additional or longer duration clinical services for clients that students can provide (Forbes et al., 2020b; Hall et al., 2015). Importantly, staff have reported enjoying teaching and identified it as not only an important part of their professional role (Forbes et al., 2020b; Sokkar et al., 2019), but also a way of improving their own knowledge and clinical reasoning (Bowles et al., 2014; Davies et al., 2011; Forbes et al., 2020b). Private practice managers and their staff, however, have raised concerns over managing time, space and workload commitments when hosting students and the educational and administrative demands that result (Hall et al., 2015; Recker-Hughes et al., 2014; Rodger et al., 2007). Private practices have also carefully considered the impact on clients and associated service delivery when students are hosted, with challenges relating to identifying appropriate clients, maintaining client satisfaction, and ensuring that students can participate in services that are not restricted by funding provider limitations (Forbes et al., 2020b; Hall et al., 2015; Recker-Hughes et al., 2014; Rodger et al., 2007).

The term 'strategy' is used to describe specific planned activities that aim to achieve a goal or solution (Moore, 1959). Planned strategies for hosting students are often advocated within educational settings to maintain relationships between education providers, such as universities, and the external community, including clinical placement hosts (Gordon et al., 2000; McCune, 1986). There has been some research to date that has explored strategies used by private practice student hosts. Research has indicated that physiotherapy private practices rely on support from the education provider to aid the process of integrating students into service delivery whilst mitigating disruption to existing services and staff (Forbes et al., 2020a; Recker-Hughes et al., 2014). Practices also cited developing and utilizing additional learning activities for students when client care opportunities were not available. Flexible approaches for students to be involved in client care, such as providing additional or longer services, are considered valued by both clients and students (Forbes et al., 2020b).

Although this research has been an important step in understanding how physiotherapy private practices navigate student placements, the research to date has not included the perspective of the university education provider, who is often responsible for initiating and supporting such initiatives.

Furthermore, the perspective of private practices across allied health professions who have chosen to discontinue hosting students or who have not yet chosen to host students has not been included. Understanding the needs of these practices, as well as the perspective of education providers, is an important step in understanding how new and existing allied health private practices can successfully integrate students into their settings. Such research may aid the development of strategies aimed to promote student placements to the wider private practice sector and, for existing hosts, may minimize the challenges associated with student placements. Therefore, the aim of this study was to explore actual and potential strategies to integrate students into private practice organizations from the perspective of Australian university education providers and private practices who currently, have previously, and who have never hosted allied health students.

METHODS

A thematic analytical approach (Braun & Clarke, 2006) with a thematic network tool (Attride-Stirling, 2001) was used to guide the methodology. This approach was selected to allow for a detailed yet pragmatic approach to the analysis of a large amount of data across several participant groups (Nowell et al., 2017) and to establish commonalities across these groups (Attride-Stirling, 2001). The authors took an inductive interpretive stance (Smith & Sparkes, 2016). Interpretivism assumes that the social world and its participants are constructed through social interactions and thus, realities are acknowledged and described from the perspectives of social beings enmeshed in meaning-making activities (Smith & Sparkes, 2016).

Participants

Three allied health private practice participant groups were selected for participation: those who currently host students from a single institution; those who have previously hosted students from a single institution but no longer host; and those who have never hosted student placements from any educational institution. A range of allied health professions that typically had a large proportion of services delivered in private practice settings were sought. These were audiology, exercise physiology, occupational therapy, physiotherapy and speech pathology.

Although few inclusion criteria for practices to participate were identified, selection of participating practices considered the following factors: 1) practices that had hosted at least one student within the previous 24 months (current hosts) from (blinded), 2) practices that had hosted at least one student within the previous five years but had discontinued hosting students from (blinded) (previous hosts), and 3) practices that had never hosted a full-time clinical placement from any institution (non-hosts). Interview participants were required to be representatives of the practice who were owners or managers, involved in clinical education and able to provide insight into how students were hosted within the organization (Rubin & Rubin, 2011). University clinical placement coordinators were purposively sought, specifying those that had been employed by an education provider and directly involved in clinical education support for allied health private practice hosts for a minimum of at least 6 months, within the previous 24 months, to allow for sufficient experience and recall For the purposes of the study and manuscript, these participants are referred to herein as 'clinical placement coordinators' Ethical clearance for this study was obtained from The University of Queensland Human Research Ethics Committee (approval number 2020002067).

Email contacts for potential participating practices were accessed from the (blinded) educator database and invitations to participate were sent from the lead researcher via email in rounds of 20. This email outlined the study and inclusion criteria and asked the participant to respond with an appropriate time

for an interview Further email rounds were sent after seven days for a total of five weeks. A total of 93 emails were sent to current (n=43) and previous (n=33) hosts, and to known practices who had never hosted full-time student placements (n=17). Thirty-two private practitioners (response rate 34%) responded to the initial email and indicated interest. Of these, 31 met inclusion criteria. Twenty-nine respondents were then purposively selected to reflect a range of professions and host types. Twenty-eight respondents provided written consent to an interview. All remaining potential participants were informed via email that participation was no longer required. A total of 48 emails were sent to clinical placement coordinator contacts of the research team who represented each of the allied health professions, inviting them to reply to the lead researcher. These participants were invited from universities across Australia, to ensure that a wide range of perspectives could be sought outside of the research team. A total of 16 clinical placement coordinators responded via email (response rate 29%). A web-based poll was used to select four potential times for focus groups over a two-week period (March-April, 2021). Thirteen participants indicated availability and provided written consent to participate.

Procedure

The research team developed draft interview (private practices) and focus group (clinical placement coordinators) frameworks following a review of the literature and consultation with stakeholders including a private practice provider, two clinical educators and one clinical placement coordinator. Interview guides were piloted with two private practice representatives before data collection commenced. Example questions from interviews and focus groups are outlined in Figure 1 and in Figure 2.

FIGURE 1: Example interview questions.

- Can you think of any actions from your practice or staff that are undertaken that help improve or mitigate challenges associated with hosting students? (current and previous hosts)
- How did you find this out/where did you learn this? (current and previous hosts)
- How has this impacted your practice/staff/clients? (current and previous hosts)
- Are there strategies that have been used to maximize some of the benefits to hosting students? (current and previous hosts)
- What advice would you give to new private practice hosts to help integrate the student into their setting or into service delivery? (current and previous hosts)
- What do you think would be the most substantial challenges to hosting students in your practice? (non-hosts)
- How do you see the role of the university in assisting with student placements in your setting? (all)
- How do you or your staff view the role of the university in providing strategies? Is this something that you think would benefit new or existing practices? What would this look like? (all)
- What supports and measures do you think are needed for more private practices to be actively involved in clinical education? (all)
- How do you see the role of the University in training and supporting clinical educators in the private sector? (all)
- What do you think would benefit clinical educators and other practices in your setting? (all)

FIGURE 2: Example focus group questions.

- What is unique about private practice? What makes their needs different to other hosts?
- Can you tell me about experiences that you have had where private practice sites have more successfully integrated students into their service delivery?
- Can you tell me about experiences that you have had where private practice sites have integrated students effectively for excellent student learning experiences?
- What do you think would help future, current or previous private practice placement sites to integrate students more successfully in a way that benefits the practice and its staff?
- What are the main concerns from providers (or potential providers) around student preparedness for this setting?
- Additional probes
  - Could you explain that a little bit more?
  - Could you give an example?
  - Do you think others would feel the same way?
- How could this be better achieved?
  - Why do you feel that is the case?
  - Would you add anything else?

All interviews and focus groups were conducted by the lead researcher, experienced in qualitative interviewing and focus group facilitation, and with a professional background of private practice clinical education. Interviews were conducted via telephone and audio recorded. Focus groups were conducted using Zoom Video Conferencing (Version 5.12) which is identified as a viable method for qualitative data collection, as it provides an easy to use, cost-effective and secure method of engagement (Archibald et al., 2019). All data were transcribed through a professional transcription service and de-identified by the lead researcher prior to analysis. Data collection and analysis occurred concurrently from November 2020 until March 2021. Interviews were a mean of 38 minutes (18-59 minutes) in duration. Focus groups were a mean of 44 minutes (29–52 minutes) in duration.

Data analysis

Thematic analysis, also described as reflective thematic analysis (Braun & Clarke, 2019), was selected to allow for the development of similar and contrasting patterns, codes and themes across more than one participant group. This process began with the lead researcher (RF) who undertook field notes and journaling during interviews and focus groups, and then highlighted key insights to track key thoughts and perspectives, as well as similarities and differences, across groups. Formal data analysis was then undertaken with familiarization of data, categorization into initial coding, and searching for, assigning, reviewing and defining codes, and then themes, by the lead researcher. A thematic network tool was used by the lead researcher (RF) to identify and establish consensus on commonality of themes across participant groups (Attride-Stirling, 2001). A thematic network assists the thematic analysis process through organizing qualitative data and facilitating "structuring and depicting of these themes" (Attride-Stirling, 2001, p. 387). This included grouping of themes, with concurrent and relevant subthemes reflecting ideas from individual, multiple, or all participant groups. These were further organized into overarching themes that were able to summarize the overall data (Attride-Stirling, 2001).

As consistent with a thematic network, separate coding was maintained for interviews and focus groups to allow similarities and differences across participant groups to be considered and acknowledged. These were then compared to identify tensions and similarities, which aimed to enhance reflexivity. This process was then completed independently by a second researcher (AD), with several meetings held to discuss and assign coding and themes across and between participant groups. These steps were then shared with the research team.

Steps to enhance rigor and reflexivity were considered with acknowledgement of the authors' interpretivist orientation that relied on the inductive lens through which the data is considered. To maintain credibility, all processes of transcriptions into coding, subcategories and themes were undertaken independently by two researchers (RF, AD) and these steps were then reviewed by further members of the research team (AH, JC) including debriefing and reviewing of coding. Member checking of interview data was performed by returning transcriptions to all interview participants with no changes to data. Dependability was enhanced through ensuring procedures for data analysis were performed independently by more than one researcher (RF, AD) and emergent themes were discussed amongst the research team who included those with experience in clinical education. Utilizing two participant groups and ensuring that participants reflected a range of professions and perspectives enhanced transferability of the findings. Rigorous qualitative research also requires researcher reflexivity in order to consider how data interpretation may be influenced by worldviews or perspectives (Mays & Pope, 2000). The primary researcher conducting interviews and analysis had over fifteen years' experience as a private practice clinician and clinical educator and had been teaching physiotherapy students in a university setting for over five years. This may have contributed to a deep understanding of the impact and challenges of hosting students on private practice providers, staff, and service delivery in addition to holding the perspective of an education provider. The second researcher who conducted all steps independently had over ten years' experience in private practice and experience in clinical education within these settings. The research team employed several strategies to enhance trustworthiness of the findings. The interviewers had no relationship with the practice providers and were not involved in providing or managing student placements. The two lead researchers engaged in regular review meetings throughout data collection to identify and discuss potential biases and assumptions.

RESULTS

Current host practices who were interviewed had been hosting allied health students for between one and 19 years (mean = 6.5 years). Six practices had experience of hosting multiple physiotherapy students within the same placement period. Further demographic data are outlined in Table 1.

TABLE 1: Private practice demographic information.

Participant	Host status	Profession	Number of clinic sites	Location	Years host	Multiple students	Students / year	Supervision ratio (Staff: student)
1	Current	A	2	M	6	N	7	1:1
2	Current	A	6	M	14	N	8	1:1
3	Current	EP	1	M	10	Y	12	7:3
4	Current	EP	2	M & R	4	N	2	2:1
5	Current	EP	1	M	2	Y	1-2	2:1
6	Current	EP/OT/PT	1	M	5/3/12	Y	6/6/10	1:1
7	Current	OT	2	M	8	Y	8	3-4:2
8	Current	OT	13	M	2.5	N	1	2:1
9	Current	OT	1	R	12	N	3	1:1
10	Current	OT	1	M	3	N	4	2:1
11	Current	PT	1	M	5	Y	8	2:2
12	Current	PT	1	M	2	N	3	4:1
13	Current	PT	1	M	10	Y	4	2:1
14	Current	PT	1	R	2	N	4	1:1
15	Current	PT	1	M	1	N	4	2:1
16	Current	PT	1	R	4	N	6	1:1
17	Current	PT	1	M	19	N	3	3:1
18	Current	SP	1	R	4	N	1	2:1
19	Current	SP	2	M	1	N	2	1:1
20	Previous	EP/PT	1	M	11/4	N	NA	NA
21	Previous	PT	1	M	5	N	NA	NA
22	Previous	PT	1	M	5	N	NA	NA
23	Non	OT	1	M	NA	NA	NA	NA
24	Non	OT	1	M	NA	NA	NA	NA
25	Non	PT	1	M	NA	NA	NA	NA
26	Non	PT	1	M	NA	NA	NA	NA

Note. A – Audiology, EP – Clinical exercise physiology, OT – Occupational Therapy, PT – Physiotherapy, M – Metropolitan, R – Regional or Rural

Clinical placement coordinators ranged in experience from 6 months to 10 years (mean = 5.1 years). Further demographic data is outlined in Table 2.

A total of four themes were generated that encompassed the range of strategies considered useful for hosting students. Each theme is accompanied by illustrative quotes with further quotes supporting each theme located in Table 3.

TABLE 2: University clinical education coordinator demographic information.

	Focus group 1	**Focus group 2**	**Focus group 3**	**Focus group 4**
Participant #	Participant 1 (FG1P1)	Participant 1 (FG2P1)	Participant 1 (FG3P1)	Participant 1 (FG4P1)
Profession	Physiotherapy	Physiotherapy	Physiotherapy	Speech Pathology
Location (state)	Victoria	Queensland	South Australia	Queensland
Experience	1 year	5 years	8 years	2 years
Participant #	Participant 2 (FG1P2)	Participant 2 (FG2P2)	Participant 2 (FG3P2)	Participant 2 (FG4P2)
Profession	Exercise Physiology	Occupational Therapy	Occupational Therapy ACT	Speech Pathology
Location (state)	Queensland	Queensland		Queensland
Experience	6 months	6 years	7 years	10 years
Participant #	Participant 3 (FG1P3)	Participant 3 (FG2P3)	Participant 3 (FG3P3)	
Profession	Occupational Therapy	Exercise Physiology	Physiotherapy	
Location (state)	South Australia	Queensland	New South Wales	
Experience	6 years	7 years	2.5 years	
Participant #		Participant 4 (FG2P4)	Participant 4 (FG3P4)	
Profession		Exercise Physiology	Physiotherapy	
Location (state)		Queensland	Queensland	
Experience		2 years	9.5 years	

Theme 1: Seeking opportunities to add value

Practices actively sought strategies to ensure that the involvement of students within their teams and services could add value to staff, clients, and the practice. These strategies included involvement in direct client care such as providing additional or longer therapy services, and planning and leading group therapy classes which was viewed by some as having an 'extra set of hands' (P8). Strategies also extended to opportunities where students could contribute to non-service-related activities that aimed to benefit staff and the wider practice.

> Some have clearly established a student role, where they can offer some extra sessions that are billed especially for students, or some group programs where they get an extra person with a therapist to run groups, and it helps with their ratios (FG2P1).

> At the end of the placement, we have the students run a presentation about what they have learnt on placement or some condition that they may have come across… and they provide us with an educational presentation and they do a flyer up as well that we provide as part of our reading material for clients (P3).

> In other ways they utilize students, for example with writing reports, like reviewing case notes, writing reports, that can then be quickly double checked by the practitioner, and then that's the way they're able to utilize a billable service – and then be a bit more productive themselves and integrate the students that way (FG2P2).

TABLE 3: Examples of supporting quotes.

Theme	Examples of Supporting Quotes
Theme 1 Seeking opportunities to add value	I certainly had some of our students giving clients more frequent intervention. So for example, I would only be able to see them once a fortnight. While the students are (here), they have been able to have weekly therapy (P9)
	We have holiday groups for the kids (clients). Students put the materials together so that we can open a document, there it is, and the session should be able to be completely planned and run, so that if the therapist hasn't had a lot of preparation time, they can just pick it up and work with it (P9)
	Even when they aren't seeing patients, they have things to do… they can be working on health promotion tasks to benefit themselves and the practice (P11)
	You can offer your clients…a 20-minute appointment, but you're going to get an extra 10 minutes after, the student is going to continue with these techniques that we've been doing, or they're going to take you out into the gym and they can continue with your exercise. So they're getting more than they would normally get (FG1P3)
	Reviewing case notes, writing reports, that can then be quickly double checked by the practitioner, and then that's the way they're able to utilise a billable service and then be a bit more productive themselves and integrate the students that way. That happens quite a bit in occupational rehab (FG2P2)
Theme 2 Managing client expectations and care	All of our clients and families, we seek permission well before we even get to that process, so that we know who's going to be appropriate, and then can schedule accordingly (P10)
	Usually it's the first week or so, to observe and meet all the clients and observe and then that gives them a week to process, okay, what's happening with each client. By the second week, I think I also tell them very early on, okay week two, I'm expecting this, this, this (P18)
	Very early on I get them to fill out clinical reasoning forms for a client, and give them a day to think that through, and we sit down about that and go, "What would you have done differently?" This gives me an opportunity to see their thought process is and see what we need to be helping them work on, and also identify what their strengths are (P23)
Theme 3 Student preparation and learning	Simple things - we have a laminated piece of paper that has a timetable on it and the students fill that out independently each day so that they know exactly who they're going with and so practitioners know who is going with them (P3)
	If the student is struggling in the first couple of weeks, we get them using patient planning forms from the university. We sit them down to think through the processes where we can send them away to reflect on what they are doing (P11)
	We see quite a lot of palliative clients in the community. And you may have client that passes away while you're on placement, and to have someone there who can share the highs and the lows of that and understand some of the trickier situations, it's (peer learning) good from a debriefing point of view (P8)
	Having a well-planned orientation makes a really big difference about what the expectations are within a practice, because that then can help the student differentiate that from perhaps what they've experienced previously (FG4P2)
	With (placements) taking two students, the students can practice on each other after with the hands-on skills and work out whatever assessment procedure it is (FG3P3)
Theme 4 Teamwork and seeking support	We'll go through each week as a team with the student and say, look, this is how your week's going to look. You're going to be in this room, you're going to be at this location, and that way they're getting as much as they can and seeing as much different clientele as they can (P20)
	We give the clinical educator some time to get themselves organised. And we also do give them some block out admin time so they've got time during the placements as well to catch up on any of that sort of stuff as well so they're not falling behind (P11)
	But for me the biggest thing is the time and can I provide support for them? And can my other staff do that, and can we share the load so that that way it's not just one person doing all the supervision? (P23)
	If there's any difficulties that we're coming across, then we contact (the education provider) and the support for the interim assessment at the four-week mark is really great because we can really freely talk and get the (student) feedback done (P3)
	I could potentially share with another clinician. So that would definitely help if you had some days where you could just come in and do business as usual (P23)
	We've certainly offered that personalised placement set up. Where we'll meet with them, we say we'll come to you and we'll do some individual training for your setting (FG2P1)
	I think our placement requirements allow for a lot more flexibility so we can do project-based placements, group placements or student facilitated services with a lot more remote supervision and support (FG3P2)

Participants reflected that utilizing such strategies required planning in advance to ensure that hosting students could add value to clients, staff and the wider practice. Planning ensured that the time used for supervision was efficient and that client care or other outcomes achieved were of value to the practice.

> If they're already predeveloped and planned what services students can offer, it just makes it really easy for them to brand it and then launch it, whether that's videos, social media posts, blogs, those sort of things (FG2P2).

Theme 2: Managing client expectations and care

Practices strongly considered the impact of hosting students on clients and undertook several actions to manage client expectations relating to student-delivered care. Most practices prioritized early and open client communication about the opportunities, and often relayed benefits, of student involvement. This often had a team focus where client communication and expectations were managed by administrative staff, through to the supervising clinician.

> They'll (admin staff) let (clients) know that the student is nearly qualified, therefore they are more likely to be happy (P17).

> (Some) practices advertise (to clients) that they specifically have student services available... so then they can charge a discounted rate and give the students the opportunity of providing their service within whatever capacity they can (FG2P2).

When considering and managing the involvement of students within client care, participants undertook several steps, or processes, to manage client expectations and the involvement of students within their care. Some systems related to scaffolding or 'building' student involvement in client services to aid the transition into the practice and to get to know the student and their 'abilities' and ensure clients were more amenable to student involvement.

> We start off just by observing the student doing basic services like adult testing. What this does is gives us an idea about where the student is at in terms of their abilities to know what might be right for them and our clients (P2).

> Over the six-week block, we have three different phases - the first (phase) is primarily the students getting to know the practice... as we progress into their third and fourth week… they might run group classes, run small groups.. exercise plans. And then in that last phase, either week 5 or week 6, we're more autonomous. So they might be running full sessions (P3).

> We've coached a lot of our private providers to look at how they might design and develop up a particular service that will address a particular client need that the students can more independently run depending on what level they are in their studies (FG3P2).

Some strategies were developed to aid communication amongst a wider team within the practice to minimize the burden associated with organizing student activities or learning.

> We have a process on our booking system that allows the (team) to know whether a client is student friendly. So, a lot of processes have been put in place over the years …to not impact our client experience (P3).

Theme 3: Student preparation and learning

Participants placed a strong emphasis on strategies that minimized disruption to service delivery before, or at the commencement of, a student placement. Introducing and orienting the student to the wider team and practice was historically considered a burden on time, and planned strategies tended to focus on minimizing this.

> We've already got modules recorded on our learning management system, it's really easy to set them up when they start with the same orientation, because it's been already to go. There's no additional work to orientate them (P8).

The role of the practice in providing education was an important consideration and strategies needed to be developed to support students' development of knowledge and skills throughout the placement. As student involvement in client care was not always possible, practices utilized several strategies to ensure that students were able to continue learning. These strategies were also seen as opportunities to prepare students for client care within the placement whilst minimizing time and personnel cost and stress.

> We get them to practice on the other staff and have them go through an assessment, we might get them to do a full knee assessment and run them through the whole thing with someone who's maybe just a pretend patient so that they're not as intimidated and they can build their confidence (before seeing the client) (P11).

Some participants utilized and 'preferred' (P8) peer learning (where more than one student was hosted) to aid with student learning and minimize time costs and service disruption. This was viewed as a way of students being able to 'support' each other and to 'spread the load' (FGP2).

Theme 4: Teamwork and seeking support

There was overarching value placed on strategies that focused on teamwork between practice staff, and these often included the student as part of the team. Team collaboration was seen as critical to allow the student to integrate effectively into the practice in a way that minimized negative impacts on staff and service delivery. These strategies included ensuring adequate time was provided for staff within their workday to support clinical education and administrative requirements of the placement and taking a 'whole of practice' approach to ensure students had access to client care and supervision.

> Having multiple clinics, we can look across our clinics and see where it's not too busy but not too quiet, so the clinicians are not too pushed. So, for example if it is quiet (at one clinic), we can send the student over to the other so that they are getting more practical experience and it's not too hard on our staff (P2).

These collaborative strategies were often initiated by clinical placement coordinators.

> I look at where their gaps in services are, I look at their pressure points and then try and help them and guide them on how a student model of placement could potentially help lead them to address some of their strategic goals and develop their services more (FG2P2).

Some participants described seeking support from the education provider to arrange clinical services that could be used flexibly to accommodate students. Participants also sought assistance from the education provider in managing the time commitments in hosting students.

> We've coached a lot of our private providers to look at how they might design and develop up a particular service that will address a particular client need that the students can more independently run depending on what level they are in their studies (FG3P2).

> If there's any way that the universities could help with reducing time. Sometimes the (student) meetings are really important … but meetings are time consuming. Like having them mid-way, half an hour where a client could be and those sorts of things…, I can see a limitation (P3).

> Something we implemented is reducing the (time) burden of assessment…we've transferred that all on to an online process that (is) very straightforward to use. So there's none of the – not as much, I guess written work that they have to do and then, it's an opt-in for their feedback (FG1PG2).

Participating practices that had not hosted students recognized that flexibility from the education provider in the way students could be hosted would be an integral strategy that may enable them to host students.

> If I could navigate pairing with another private practice, then we can share the load of the one student between two practices, but I think logistically unless the University facilitates that, it gets a bit hard for the part time practitioner (P24).

> If I had a student that could come say, one afternoon a week for four weeks, or for eight weeks or whatever, I would be really happy with that to work around my schedule. Or if I had a student that could come and have five days on the Saturday, like five consecutive weekends or something that would work for me (P26).

DISCUSSION

The purpose of this study was to investigate the strategies, both proposed and already in use, that assist private practices to host allied health professional students on placement, with a focus on those aimed to minimize service disruption whilst supporting student learning. The study explored strategies from the perspective of a range of allied health private practices, including current hosts, those who have discontinued hosting students and those who have never hosted students before. We also included the unique perspective of clinical placement coordinators who often share responsibility in supporting practices to host students and who have insight into strategies that have successfully integrated students into private practice organizations. Participants reflected on the value of student involvement in client care and that this value was able to be maximized by providing flexibility in clinical services and integrating students into additional aspects of service delivery. Teamwork and collaboration amongst practice staff, and support from the university, often enabled enhanced practice and student outcomes. Practices had developed specific processes and systems, employed before and during student placements, to minimize service disruption and ensure that students were integrated into the practice in a way that was seen to benefit staff, clients, and students. Lastly, this study has showcased the role of strategies that are aimed to minimize time associated costs and other burdens when hosting students, from the perspective of practices and clinical placement coordinators. These findings provide insight into how education providers and allied health professional bodies may support private practices to initiate and sustain successful student placements that support both private practice hosts and student outcomes.

Strategies described by allied health private practices and clinical placement coordinators primarily centered on how optimal client care could be maintained or, in many cases, enhanced, with the involvement of students. These included opportunities for increased frequency of services or additional consultation time that could be offered by supervised students (Boucaut, 2009; Forbes et al., 2020a; Kent et al., 2015; Sloggett et al., 2003). Active involvement of students in client care in some cases enabled staff to increase their own client care activities or associated tasks (Forbes et al., 2020a). This is an important consideration given the reported challenges in allied health to provide the required dosage of therapy to maximize clinical outcomes (Ruggero et al., 2012; Sokkar et al., 2019). The involvement of students in client care, however, was carefully weighed up by private practices, and several strategies were employed to enable this to occur. Of note, practices and clinical placement coordinators used strategies to ensure appropriate clients were amenable and consenting to the involvement of students and when they were, steps were taken to ensure that clients expectations were met through early and open communication and teamwork between staff. This is an important consideration where medico-legal requirements stipulate that students must be closely supervised (Gordon et al., 2000), and where patient satisfaction is largely dependent on close and active supervision within and across the continuum of care (Forbes & Nolan, 2018), potentially impacting the reputation of the practice (Kauffman et al., 2010). This confirms previous research highlighting that client care is the main consideration and concern for private practice hosts (Forbes et al., 2020b; Sokkar et al., 2019), and enabling student contribution to service delivery, or having an 'extra pair of hands' is continuously weighed up against perceived and actual costs (Reeders et al., 1999, p. 10; Forbes et al., 2020b).

Although the findings of the current study support the perceived benefits of exploring and adopting flexible, additional or extended services with the presence of students, practices and clinical placement coordinators strongly reflected on the requirement of adequate time, space and supervision to ensure success and sustainability (Forbes et al., 2020b). Not surprisingly, strategies utilized often focused on minimizing time and supervisory resource costs, often with a goal of reducing education or administrative related burden and potential financial costs to the practice and staff, as consistent with previous reports (Forbes et al., 2020a). These strategies were often formal processes that practices had developed, including communication across clinic sites, phasing student activities over the course of the placement as they progress in knowledge and independence (Stoikov et al., 2018), and utilizing formal induction and orientation procedures (Forbes et al., 2020a). Strategies that sought to minimize disruption to client care and time stressors tended to relate to managing student activity, often through providing flexible or additional learning opportunities for students. Interestingly, these strategies, both proposed and used by practices and clinical placement coordinators, were planned in a way that was considered to benefit not only student learning, but also client care, and the wider practice (Forbes et al., 2020b; Kent et al., 2015). Strategies included involving students in activities outside direct client care such as planning, case preparation, assisting with reports and providing opportunities for students to practice clinical skills. Some practices adopted strategies where students were able to actively contribute to quality improvement within the practice through projects such as developing learning resources for staff. Such approaches may provide the opportunity and flexibility to allow smaller, part-time or emerging organizations to begin, or continue to, host students where pragmatic barriers such as availability of clientele, levels of staffing and physical space available may have otherwise precluded their involvement (Forbes & Martin, 2020). Further research should aim to investigate the potential for existing or new private practice hosts to initiate or maintain hosting students where client loss, staff attrition or service restrictions have occurred, especially as a result of COVID-19 (Forbes & Martin, 2020).

Despite only six of the 19 current practices hosting more than one student at a time, the use of peer learning emerged as a key strategic approach from the perspective of practices and clinical placement coordinators. Where previous reports have suggested that hosting multiple students is often a 'pragmatic' response to requests from university providers (Hall et al., 2015), the current findings provide a new perspective. Hosting multiple students may be considered a strategic approach by practices to enhance student learning and maximize benefits for the practice while potentially minimizing challenges and costs. These findings also support previous research from hospital settings where hosting multiple students is viewed as a practical solution to student learning requirements and issues regarding clinical placement capacity (Stoikov et al., 2018). Opportunities for peer learning should be considered and promoted to private practice settings, given the benefits to student learning (Dawes & Lambert, 2010), and the opportunity for increasing clinical placement capacity in this sector. It must be recognized, however, that the time and physical space constraints already recognized within this setting may be a barrier to hosting more than one student (Forbes et al., 2020b; Sokkar et al., 2019), and that significant planning, support and skill in enabling peer learning are required for its success in clinical education (Lekkas et al., 2007).

Clinical placements rely heavily on the development and sustainability of partnerships between education providers and clinical organizations (Fleming et al., 2018). Overall, the results highlight the dynamic practice-university partnership needed for successful and sustainable placements (Bowles et al, 2014), especially within private practice settings where there are typically fewer staff to share supervisory and educational loads (Bowles et al., 2014). These findings support previous research where private practices have emphasized the integral role of the university in actively supporting the hosting of allied health students (Forbes et al., 2020a; Kent et al., 2015; Rodger et al., 2007; Sokkar et al., 2019). These findings have, however, also provided the unique perspective of the university provider through the clinical placement coordinator, where examples and experiences of partnership with new and existing practices, and those considering hosting students, have occurred, especially where it relates to integrating students into service delivery and minimizing resource costs. Given that time is identified as a major challenge of hosting students (Davies et al., 2011; Hall et al., 2015; Kent et al., 2015), universities must openly communicate with private practices to establish realistic time commitments and collaboratively develop solutions to minimize the burden on the host organization. Additionally, incentives such as honorary academic appointments and access to university resources such as libraries could foster private practitioners' motivation to enter partnerships. Such partnerships not only provide access to clinical education, but they can contribute to shaping curriculum (Van Rooijen, 2011). The input of private practitioners to curriculum could ensure students are better prepared for private practice placements, thereby encouraging placement offers in that sector. Specific strategies, initiatives and partnerships should be evaluated to explore their impact and sustainability for students, private practices and education providers.

Limitations

There are several limitations to this study that should be considered. Recruitment of practices and clinical placement coordinators with subsequent self-selection may have excluded some perspectives, particularly those with negative experiences of hosting students. The recruitment strategy sought practices affiliated with the university, thus there is likely bias towards more positive experiences with hosting students. The research team included those involved in clinical placement coordination which may have influenced participant perspectives and results, particularly with perspectives that may be considered favorable by the researcher. Researchers attempted to minimize these risks by ensuring that researchers who contacted potential participants and conducted interviews and focus groups were

not involved in clinical placements, and data was deidentified. Lastly, private practice participants were limited to one geographic area, therefore results may not be generalizable to other populations especially clinical education settings outside of Australia.

CONCLUSION

Allied health private practices and clinical placement coordinators use a range of strategies to integrate students into practice settings, often centering on supporting student involvement in client care and taking steps to minimize disruption to service delivery. Opportunities for students to contribute to client services in a flexible way and benefits of peer learning where multiple students are hosted have been highlighted as key strategies that benefit both the host practice and student learning. Consideration of such strategies may provide avenues for future practice-university partnerships, thereby increasing placement capacity in this sector.

ACKNOWLEDGEMENTS

This study was supported by an early career research grant from the Australian Collaborative Education Network (ACEN).

REFERENCES

Archibald, M., Ambagtsheer, R., Casey, M., & Lawless, M. (2019). Using zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods, 18*, 1-8.

Atkinson. R., & McElroy, T. (2016). Preparedness for physiotherapy in private practice; Novices identify key factors in an interpretive description study. *Manual Therapy, 1*(22), 116-21.

Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research*, *1*(3), 385-405.

Australian Institute of Health and Welfare. (2020). *Health workforce reports.* https://www.aihw.gov.au/reports-data/health-welfare-services/workforce/reports.

Boucaut, R. (2008). OHS students: Reaching a decision about hosting placements. *Physiotherapy Theory and Practice*, *24*(1), 43-53.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3(2), 77-101.

Bowles, K. A., Haines, T., Molloy, E., Maloney, S., Kent, F., Sevenhuysen, S., & Tai, J. (2014). *The costs and benefits of providing undergraduate student clinical placements for a health service organisation: A rapid review*. Health Education and Training Institute, Australian Government.

Davies, R., Hanna, E., & Cott, C. (2011). They put you on your toes: Physical therapists perceived benefits from and barriers to supervising students in the clinical setting. *Physiotherapy Canada 63,* 224–233.

Dawes, J., & Lambert, P. (2010). Practice educators' experiences of supervising two students on allied health practice-based placements. *Journal of Allied Health, 39*, 20-27.

Exercise & Sports Science Australia. (2019). *Future workforce report.* https://tinyurl.com/kb4m7dk2

Department of Health and Human Services. (2018). *Audiology workforce report*. Victoria State Government. https://www2.health.vic.gov.au/Api/downloadmedia/%7BFF4C4F3E-14BE-4452-A644-9586C3DD2137%7D.

Fleming, J., McLachlan, K., & Pretti, J. (2018). Successful work-integrated learning relationships: A framework for sustainability. *International Journal of Work-Integrated Learning*, *19*(4), 321-335

Forbes, R., Dinsdale, A., Dunwoodie, R., Birch, S., & Brauer, S. (2020a). Exploring strategies used by physiotherapy private practices in hosting student clinical placements. *Australian Journal of Clinical Education, 7* (1). https://doi.org/10.53300/001c.17206

Forbes, R., Dinsdale, A., Dunwoodie, R., Birch, S., & Brauer, S. (2020b). Weighing up the benefits and challenges of hosting physiotherapy student placements in private practice; a qualitative exploration. *Physiotherapy Theory and Practice*, 1-11. https://doi.org/10.1080/09593985.2020.1799461

Forbes, R., & Martin, R. (2020). Project-based learning for physiotherapy clinical education quality and capacity. *OpenPhysio Journal.*

Forbes, R., & Nolan, D. (2018). Factors associated with patient-satisfaction in student-led physiotherapy clinics: A qualitative study. *Physiotherapy Theory and Practice, 34* (9), 705-713.

Gordon, J., Hazlett, C., Ten Cate, O., Mann, K., Kilminster, S., Prince, K., O'Driscoll, E., Snell, L., & Newble, D. (2000). Strategic planning in medical education: enhancing the learning environment for students in clinical settings. *Medical Education*, *34*(10), 841-850.

Hall, M., Poth, C., Manns, P., & Beaupre, L. (2015). To supervise or not to supervise a physical therapist student: A national survey of Canadian physical therapists. *Journal of Physical Therapy Education*, *29*(3), 58-67.

Hazelwood, T., Baker, A., Murray, C. M., & Stanley, M. (2019). New graduate occupational therapists' narratives of ethical tensions encountered in practice. *Australian Occupational Therapy Journal*, *66*(3), 283-291.

Hecimovich, M., & Volet, S. (2011). Development of professional confidence in health education: Research evidence of the impact of guided practice into the profession. *Health Education*, *111*(3), 177-197.

Health Workforce Australia. (2014). Australia's health workforce series: Physiotherapists in focus.. https://www.myhealthcareer.com.au/wp-content/uploads/2019/03/2014-Physiotherapists-in-Focus.pdf.

Jones, M., McIntyre, J., & Naylor, S. (2010). Are physiotherapy students adequately prepared to successfully gain employment? *Physiotherapy*, *96*(2), 169-175.

Kauffman, T., Maloney, P., & Schoo, A. (2010). Working in private practice. In K. Stagnitti, A. Schoo, & D. Welch (Eds.), *Clinical and fieldwork placement in the health professions* (pp. 100-107). Oxford University Press.

Kent, F., Richards, K., Haines, T., Morgan, P., Maloney, S., & Keating, J. (2015). Patient and practitioner perceptions of student participation in private practice consultations: A mixed-methods study. *Focus on Health Professional Education: A Multi-disciplinary Journal*, *16*(2), 42-54.

Koontz, A. M., Mallory, J. L., Burns, J. A., & Chapman, S. (2010). Staff nurses and students: The good, the bad, and the ugly. *Medical Surgical Nursing*, *19*(4), 240-244.

Lekkas, P., Larsen, T., Kumar, S., Grimmer, K., Nyland, L., Chipchase, L., Jull, G., Buttrum, P., Carr, L., & Finch, J. (2007). No model of clinical education for physiotherapy students is superior to another: A systematic review. *Australian Journal of Physiotherapy, 53,* 19–28.

Lincoln, M. 2012. The diversity challenge for universities and clinical educators. *Journal of Clinical Practice in Speech-Language Pathology, 14*(1), 2–6.

Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal, 320* (7226), 50-2.

McCune, S. D. (1986). *Guide to strategic planning for educators*. Association for Supervision and Curriculum Development.

Moore, D. G. (1959). Managerial strategies. In W. L. Warner & N. H. Martin (Eds.), *Industrial man: Businessmen and business organizations* (pp. 219-227). Harper & Row.

Nowell, L., Norris, J., White, D., & Moules, N. (2017). Thematic analysis; striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1).

Peiris, C., Wells, C., Reubenson, A., Lawton, V., Francis-Cracknell, A., & Dunwoodie, R. (2019, October 17-19). "*Moving forward*": *Private practice placement capacity and quality* [Paper presentation]. Australian Physiotherapy Association National Conference: Transform 2019, Adelaide, Australia.

Queensland Government. (2007). *Ministerial taskforce on clinical education and training*. (Final report). https://www.health.qld.gov.au/__data/assets/pdf_file/0033/147399/mt-clinedtrain.pdf

Recker-Hughes, C., Wetherbee, E., Buccieri, K. M., Fitzpatrick Timmerberg, J., & Stolfi, A.M. (2014). Essential characteristics of quality clinical education experiences: standards to facilitate student learning. *Journal of Physical Therapy Education, 28*, 48–55.

Reeders, E., Atchison, M., Pollock, S., & Rizzetti, J. (1999). *Structured work experience: Habit, cargo cult or Cinderella*? [Unpublished. Revised version of a paper presented at the Practicum Project Colloquium Program]. Flinders University.

Rodger, S., Fitzgerald, C., Davila, W., Millar, F., & Allison, H. (2011). What makes a quality occupational therapy practice placement? Students' and practice educators' perspectives. *Australian Occupational Therapy Journal, 58*, 195–202. https://doi.org/10.1111/j.1440-1630.2010.00903.x

Rodger, S., Thomas, Y., Dickson, D., McBryde, C., Broadbridge, J., Hawkins, R., & Edwards, A. (2007). Putting students to work: Valuing fieldwork placements as a mechanism for recruitment and shaping the future occupational therapy workforce. *Australian Occupational Therapy Journal, 54*, S94-S97.

Rodger, S., Webb, G., Devitt, L., Gilbert, J., Wrightson, P., & McMeeken, J. (2008). Clinical education and practice placements in the allied health professions: An international perspective. *Journal of Allied Health*, *37*(1), 53-62.

Rubin, H., & Rubin, I. (2011). Qualitative interviewing: The art of hearing data. Sage.

Ruggero, L., McCabe, P., Ballard, K., & Munro, N. (2012). Paediatric speech-language pathology service delivery: An exploratory survey of Australian parents. *International Journal of Speech Language Pathology, 14*(4), 338-50.

Shields, N., Bruder, A., Taylor, N., & Angelo, T. (2013). Getting fit for practice: An innovative paediatric clinical placement provided physiotherapy students opportunities for skill development. *Physiotherapy*, *99*(2), 159-164.

Sloggett, K., Kim, N., & Cameron, D. (2003). Private practice: Benefits, barriers and strategies of providing fieldwork placements. *Canadian Journal of Occupational Therapy*, *70*(1), 42-50.

Smith, B., & Sparkes, A. (2016). Introduction; an invitation to qualitative research. In: B. Smith & A. Sparkes (Eds.), *Routledge handbook of qualitative research in sport and exercise* (pp. 1-7). Routledge.

Sokkar, C., McAllister, L., Raymond, J., & Penman, M. (2019). Supervisors' perceptions of student placements in speech-language pathology private practice: Benefits, challenges and strategies. *Speech, Language and Hearing, 22*(2), 122-133.

Speech Pathology Australia. (2014). *Submission to the inquiry into the prevalence of different types of speech, language and communication disorders and speech pathology services in Australia.*: *Senate Community Affairs Reference Committee*. Speech Pathology Australia. https://tinyurl.com/2k5wjsvs

Stoikov, S., Shardlow, K., Gooding, M., & Kuys, S. (2018). Clinical activity profile of preregistration physiotherapy students during clinical placements. *Australian Health Review*, *42*(6), 661-666.

Van Rooijen, M. (2011). Transforming 21st century corporate-university engagement: From work-integrated learning (WIL) to learning integrated work (LIW). *Journal of Cooperative Education and Internships, 45*(1), 5–10.

Wells, C., Olson, R., Kent, F., Bialocerkowski, A., Chipchase, L., Scarvell, J., Carroll, S., & Reubenson, A. (2017, October 19-21). *Are new graduate physiotherapists ready for private practice?* [Paper presentation]. Australian Physiotherapy Association National Conference: Momentum 2017, Sydney, Australia.