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Occupational therapists fostering unified expertise and learning (O.T. F.U.E.L.): a virtual community of practice

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OCCUPATIONAL THERAPISTS FOSTERING UNIFIED EXPERTISE AND LEARNING (OT F.U.E.L.): A VIRTUAL COMMUNITY OF PRACTICE

by

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DEDICATION

I would like to dedicate this work to my parents, both of whom emigrated from Mexico as teenagers. Among other things, they instilled in me grit and a love of learning. They have always believed in me and taught me that I can do anything that I set my mind to.

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I could not have done this without the love and help of my family, Ted, Anja, Ben, and my parents, Arturo and Elsa. They supported me working hours on end, yet still provided love, and guidance, and a sounding board when required.

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OCCUPATIONAL THERAPISTS FOSTERING UNIFIED

EXPERTISE AND LEARNING (OT F.U.E.L.):

A VIRTUAL COMMUNITY OF PRACTICE

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ABSTRACT

While holistic care is fundamental to occupational therapy (OT) practice, organizational and systemic factors often push for compartmentalized and specialist practice. Because services in many practice areas are compartmentalized, occupational therapy practitioners' (OTPs) continuing professional development (CPD) efforts typically focus on one clinical specialty, and many often do not learn skills across different clinical areas. It is imperative that OTPs continue to learn and integrate knowledge across specialty areas so as to provide comprehensive and holistic care to all individuals who seek OT services.

In addition to this, there is a known knowledge-to-practice gap that limits the implementation of research into practice. Numerous research studies (Summers et al. 2015; Stewart et al. 2020; Jones et al. 2015; Thomas et al. 2020) support the need for active engagement in CPD, implementing the most recent research into practice, and maintaining a holistic and integrated approach to healthcare. However, many clinicians experience barriers to the implementation of that knowledge, such as time, cost, staffing, and organizational influence. Healthcare organizations, on the other hand, must function

in a competitive healthcare industry, by optimizing client outcomes while maintaining qualified and engaged staff. *Occupational Therapists Fostering Unified Expertise and Learning (OT F.U.E.L.)* was designed with these barriers in mind, and addresses them by creating a cost-effective, timely, and engaging platform for knowledge exchange across the profession of occupational therapy.

OT F.U.E.L. is designed as an online community of practice, focusing on intra-professional social learning and knowledge implementation for OTPs working in the various siloed specialties of OT, including pediatrics, orthopedics/hand therapy, inpatient/outpatient rehabilitation, and mental health. The objective is to reconnect with the common roots and approaches of occupational therapy, and enhance practice skills and expertise — integrating clinical knowledge and skills from various clinical specialties across the profession. Overall group size will be limited to 16 participants, with subspecialty groups of approximately four members to ensure diversity of experience. The groups will be moderated by a "knowledge broker" who can facilitate interconnections between the specialty areas.

There will be three phases to the piloting of this program. In the initial pilot (*Phase 1*), participants will be OTPs who are also fieldwork educators (FWEs), recruited using established affiliations with an entry-level Master of Occupational Therapy program. For the pilot, FWEs will be recruited through their employer in order to get organizational buy-in for their engagement in the program, as well as encouragement from management to participate. A secondary objective for this approach is to demonstrate the value of organizational support of professional development during established work hours. *Phase 2* of piloting will involve running the program through other Universities in a variety of regions within the United States. *Phase 3* will be potential dissemination through the American Occupational Therapy Association (AOTA).

Ultimately, *OT F.U.E.L* is expected to result in several intermediate and long-term outcomes, including OTPs increased the confidence and competence with integrating skills and concepts across specialty areas in their practice. By reducing the barriers and facilitating the implementation of new knowledge, the clients will benefit, and likely demonstrate improved outcomes.

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LIST OF ABBREVIATIONS

KT .... Knowledge Translation

LHS .... Learning Health Systems

MSTeams .... Microsoft Teams

NPT .... Normalization Process Theory

OJOT .... Open Journal of Occupational Therapy

OT FUEL .... Occupational Therapists Fostering Unified Expertise and Learning

OT .... Occupational Therapy

OTJR .... Occupational Therapy Journal of Research

OTP .... Occupational Therapy Practitioner

OTPF-4 .... Occupational Therapy Practice Framework, Fourth Edition

GLOSSARY

Academic Fieldwork Coordinator	Employed through an academic institution, they are "principally responsible for developing, coordinating, organizing, and monitoring the entire occupational therapy fieldwork process including the oversight and preparation of the fieldwork educator and the fieldwork student" (Persons et al., 2021, 7512505152p1)
Community of Practice	A group of people who share common interests or problems and interact regularly in a process that builds and shapes knowledge in dialogue, collectively reflecting, analyzing, investigating, and evaluating their own practices, actions, values, and knowledge (Wenger, 1998).
Continuing Professional Development	"A self-directed, reflective process of lifelong learning aimed at maintaining practitioner competence, ensuring client safety and quality outcomes, enhancing or expanding professional practice, and reaching career goals" (*AOTA,* 2017, 7112410017p1).
Evidence-Based Practice	"The integration of best available evidence from clinical research with clinical expertise and patients' preferences" (Sackett et al., 1996, p. 71).
Fieldwork Clinical Coordinator	Practitioners working at affiliate sites who coordinate available placements with interested fieldwork educators.
Fieldwork Educator	"A currently licensed or otherwise regulated occupational therapist who has a minimum of 1 year full-time (or its equivalent) of practice experience as a licensed or otherwise regulated occupational therapist prior to the onset of the Level II fieldwork" (ACOTE, 2018, p.42).
Knowledge Translation	"The integration of the best available evidence with practice in the hopes of improving patient outcomes" (Gutierrez & Kaplan, 2016, p. 112).
Occupational Therapy	Occupational therapy promotes health, well-being, and participation in the important activities of life through the use of occupations (AOTA, 2023).
Occupational Therapy Practitioners	Occupational therapists and occupational therapy assistants

CHAPTER ONE – Introduction

Specialization in Health Services

The provision of health care services has become increasingly specialized. Emery (2012) reported that specialists cure single diseases and manage routine care with quality and efficiency. While specialty care is necessary for effectively managing particular conditions, it is not always suited to addressing the growing number of people who have multi-morbidities, which increases with age or lower socioeconomic status (Emery, 2012). The specialist model can lead to patient treatment gaps and decreased quality of care when patient needs do not neatly align with the scope of specialist services. The lack of integrated and holistic care in healthcare can result in practitioners with limited mental flexibility due to specialist-focused education, practitioners who are limited to their area of expertise, and hospitals unable to provide inclusive service to patients (Anderlini, 2018).

Specialization in Occupational Therapy

Holistic care, addressing the whole person, is a hallmark of the occupational therapy (OT) profession. The American Occupational Therapy Association (AOTA) asserts that "Occupational therapy practitioners [OTPs] have a holistic perspective, in which the focus is on adapting the environment to fit the person, and the person is an integral part of the therapy team" (AOTA, 2021, para 1). Through adopting a holistic perspective, OTPs consider the bio-psycho-social factors relating to the individual, and how these factors interact and influence occupational performance.

While holistic care is fundamental to OT practice, organizational and systemic factors often push for compartmentalized and specialist practice. Workplaces and health systems often require OTPs to specialize in a clinical area or deliver services focused on particular populations. For example, OTPs may be employed to work solely in a specialist service (e.g., stroke unit), and become specialist clinicians with advanced knowledge in a specific clinical area (e.g., neurological OT). The specialist model can be very beneficial for clients as they receive high quality care from highly skilled clinicians with an intimate knowledge of best practice for their particular condition.

One consequence of compartmentalized practice, however, is that it can negatively impact individuals who have conditions or issues that do not neatly fit into specific clinical areas. This was evident when this author worked with an individual who was diagnosed with autism at the age of 23. He shared that he had searched the entire northern area of Illinois, calling different clinics looking for therapy to address his recently-identified autism, with little success. Elsewhere, he was told that he was too old for pediatric clinics that typically treat clients with autism, and yet outpatient therapists were not confident providing services for adult clients with autism. Subsequent OT service provided by this author involved teaching him to establish daily routines, gain independence with Instrumental Activities of Daily Living (IADLs), increase activity tolerance, and community integration. These are essential elements of OT practice, and appropriate treatment options should have been more easily accessible for him. However, because his circumstances were considered atypical by many therapists, appropriate treatment was unavailable to him.

The focus on specialization in OT can negatively impact all clients with needs that do not fit within rigid eligibility criteria or specialist expertise of individual therapists. These clients often face challenges accessing services and healthcare systems that do not see them beyond a superficial diagnosis. OTPs must be careful to not create populations that are under-served because of the ways in which treatment approaches or services are organized.

Because services are compartmentalized, there can be a reluctance from OTPs to learn skills from different clinical areas. Consequently, therapists can easily become complacent about continued skill development beyond their area of specialty, only treating conditions that they are comfortable with. Cramm and colleagues (2013) state that OTPs are often “entrenched in particular practice patterns” (p. 121) on which they rely and for which they report reliable results. In addition, they are embedded in interdisciplinary and multidisciplinary practice contexts that may be resistant to practice change. It is, therefore, imperative that OTPs continue to learn and integrate knowledge across specialty areas so as to provide comprehensive and holistic care to all individuals who seek OT services.

Through adopting a holistic perspective of clients, OTPs can apply their clinical lens to clients across the lifespan, in various settings, and with varying needs and abilities. For example, sensory principles from pediatrics can supplement the treatment of neurological conditions; and neurological principles like mental imagery can benefit orthopedic injuries. While health services and systems may still drive specialist care, OTPs need to consider ways to integrate knowledge across specialty areas in order to achieve holistic care that is integral to OT practice.

Occupational Therapy Practice Framework

For nearly 20 years, OT practice has been guided by the *Occupational Therapy Practice Framework (OTPF)*. The most current edition, OTPF-4 (4th ed.) (AOTA, 2020), identifies and describes a set of cornerstones which are foundational to the success of OTPs. These OT cornerstones emphasize how OTPs should view clients and clients' occupations to facilitate the OT process. The OT process, as described in the OTPF-4, emphasizes taking a comprehensive view of the client's domain to understand how daily roles, routines, and independence are impacted. Furthermore, the OTPF-4 states that "interwoven throughout the concept of context is that of occupational justice, defined as 'a justice that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social class, or other differences' (Nilsson & Townsend, 2010, p. 58)." And yet, for some clients, this is not their experience of OT. Somewhere in the journey from education to practice, OTPs are seemingly influenced to adopt a narrower scope of practice.

Knowledge-to-Practice Gap

There is a notable disconnect between what OT students learn during their professional training, and the way OTPs are able to practice in existing workforce structures. Students are taught frames of references and models that promote a holistic understanding of clients, however, on-the-job training can have greater impact on practice skills than those theories. Ashby et al. (2016) explored perceptions of professional identity and indicated that this disparity between education and practice "highlights a need for educators to provide university-based curricula activities, which better prepare students for a potential dissonance between explicit occupation-based curricula and observed practice education experiences." (p. 233)

Once in the workforce, it can be challenging for OTPs to maintain their full scope of practice while facing occupational demands of the workplace. Therefore, another part of the issue lies in the demands of a treatment setting, considering the significant influence of management at that setting. Gifford (2018) reported that "the growing body of evidence…indicates that manager-staff dyads are influential in translating research evidence into action. Findings also reveal that leadership for research use involves change and task-oriented behaviors that influence the environmental milieu and the organizational infrastructure that supports clinical care" (p. 127). Without management support, clinical skill development is not prioritized.

One method to address this practice gap within OT was the development of The Scholarship of Practice (Crist and Kielhofner, 2013), a model focusing on the application of classroom theories into clinical practice, utilizing a deliberate application to relevant practice. The Scholarship of Practice nurtures students' independent learning and partnership with community-based settings to promote best practice within the field of OT. The application of this model into practice demonstrates that the integration of knowledge into practice requires an intentional effort for maximal success.

Research in knowledge translation (KT) and knowledge implementation is another area that has focused on the disconnect between book learning, evidence-based practice standards, and actual treatment practices. This research investigates various factors that influence the development and implementation of learning, including but not limited to personal/professional, organizational, financial, and regulatory organizations. KT research has found various reasons for the inconsistent application of learning in professional practice, such as preference for personal clinical experience over research literature, limited access to evidence and a general lack of applicable research, and a belief that research cannot solve for the complexities of the problems (Thomas & Bussières, 2021).

Proposed Project

The proposed project aims to address the challenge of implementing holistic, evidence-based OT practice in specialty-driven, compartmentalized health services and systems. Addressing this issue involves understanding entry-level OT educational curricula, and the practices and perceptions of current clinicians, fieldwork educators (FWEs), and organizational leadership.

As this issue is multi-faceted, this project will primarily focus on addressing the knowledge, skills, and attitudes of FWEs and clinicians. Entry-level OT programs have multiple connections to OTPs and a shared academic investment in the education and application of evidence-based practice and clinical competency of students. Therefore, the author has developed the program *Occupational Therapists Fostering Unified Expertise and Learning (OT F.U.E.L.)* as a virtual community of practice (CoP) to promote intraprofessional collaboration and learning as a university offering for FWEs. The program specifically supports the integration of the various specialty areas of OT.

OT Academic Fieldwork Coordinators (AFWCs) in university settings can thereby collaborate with FWEs and placement sites to promote changes in the field including recent evidence-based practices, enabling current practitioners to be better equipped to integrate knowledge into practice approaches across specialty areas. It is anticipated that demonstrating this evidence-informed and holistic care will improve client outcomes and decrease current service gaps while also supporting current OT fieldwork students to apply learned material. This collaboration could promote the cycle of information and updates to the profession so that both students and OTPs are better educated and supported in the delivery of holistic OT services. Furthermore, the FWEs would have a direct line with the academic setting to share their applied clinical knowledge and observations to drive future research. Organizational leaders benefit from their support of this program by promoting continuing professional development (CPD) for their staff, contributing toward improved client outcomes.

As part of the development of OT F.U.E.L., the author has developed an evaluation and research plan, utilizing qualitative and quantitative measures of the program to support its benefits to participants and clients, while establishing the value of CPD that is supported through the workplace. This research of the piloting of this program aims to contribute to the literature on the value of CoPs for the integrated practice within all areas of OT. Following the initial piloting and assessment of program evaluations, the author will further disseminate the program to other FWEs through other AFWCs at OT programs around the United States, and eventually seeks to be an official CoP of the AOTA.

CHAPTER TWO – Project Theoretical and Evidence Base

Conceptual Framework

OTPs have a professional responsibility to "display unwavering commitment to excellence and lifelong learning, as it is imperative that a professional stays current in their field. This means that the professional is committed to continued training and development" (DeIuliis, 2017, p. 13). While professional responsibility is an expectation for all OTPs, the transition from OT student to experienced OTP is wrought with barriers that limit the ability to apply OT's holistic education into practice. These numerous internal and external barriers make it difficult to consistently apply these professional principles to practice. This is of concern because this may result in OTPs that may not be able to address the needs of their clients in the holistic manner they need. To address this issue, it is imperative to understand and impact those barriers that limit holistic OT practice.

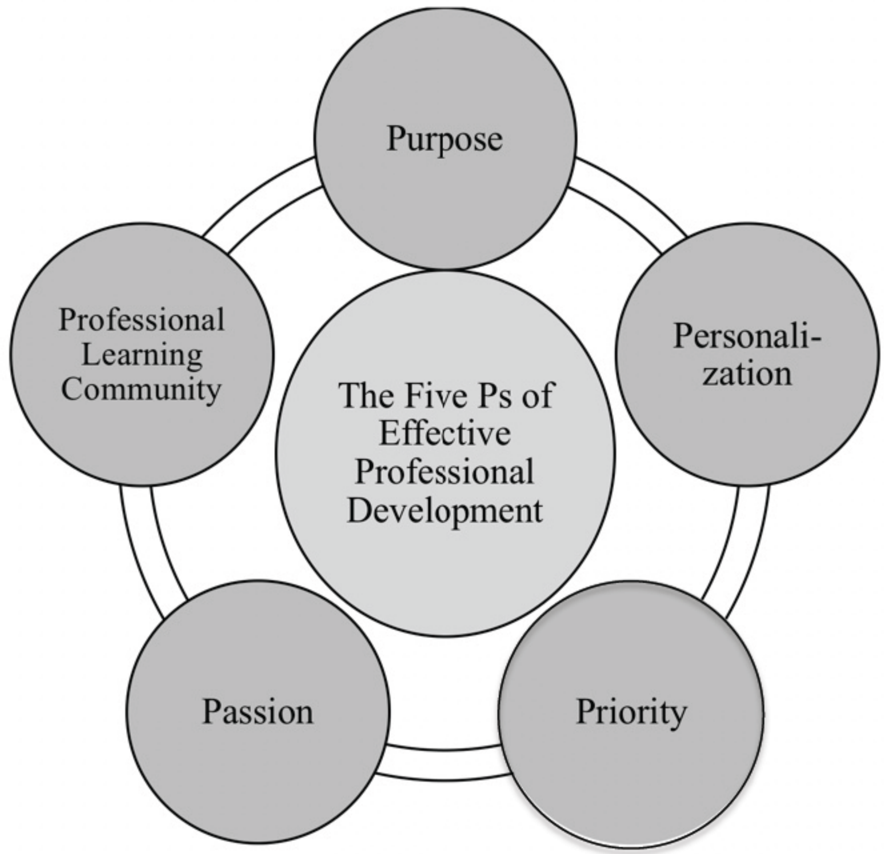
There are many theories, such as learning theory or motivation theory, that can serve to understand what contributes to this problem. For instance, operant conditioning models "view adaptive and maladaptive function as learned behaviors. It explains learning as acquisition or extinction of behaviors in response to the presence or absence of reinforcement" (Sharrott & Cooper-Fraps, 1986, p. 252). This highlights how external influences such as management support or productivity standards can have a strong influence on practice. Nevertheless, this theory does not address how the individual practitioner maintains motivation and passion for continued learning and development. Nor does it address the issue of the change in scope of practice over time, which may be understood better through experiential learning. Specifically, while OT education is focused on a generalist, holistic approach, the practice of OT in traditional settings still primarily follows a specialist model approach, contributing to the disconnect between education and practice. Since this is a multi-faceted issue, a more multi-dimensional theory is required for understanding all its components.

Theoretical Model

In the field of education, in which teachers combat similar issues, a model was created to understand the complex interaction of the practitioner and environment. In 2018, Dr. Neil Anderson developed with the “Five Ps of Effective Professional Development” model (*Figure 2.1*), which was originally intended for teachers but has applicability to other human-centered professions. As it is a newer model, literature is limited in describing its use with other professions, therefore use of this model within the context of OT contributes to the literature and pool of research.

Figure 2.1

Five Ps of Effective Professional Development Model (5 Ps)



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Considering the numerous barriers to occupational therapy holistic practice, the '5 Ps' model is appropriate because of its multi-variable approach to understanding the influences on the practitioner. This model takes an interactive approach to understanding professional development. The '5 Ps' model considers both the top-down influences, such as regulatory standards or institutions determining what the practitioner needs to know, and the bottom-up influence that are directed solely by the individual practitioner.

Research indicates that sustained professional development requires active involvement from the practitioner in concrete ways, and concentrated on specific instructional practices (Anderson, 2018). When this interactional approach is taken, the needs of the individual and institution are best met.

In the ‘5 Ps’ model, professional development is approached with purpose, personalization, priority, passion, and professional learning communities. Each of these components addresses micro to macro-level factors influencing CPD. For instance, “purpose” is the intrinsic sense of meaning gained from contributing to the well-being of others. However, this sense of purpose can also be supported by the employer through mission statements and the organizational culture.

Similarly, “personalization” requires self-reflection and intentionality as it is centered on the perspective of the individual and their perceived needs for development. Through interactions with organizational leadership, employers can facilitate opportunities for CPD. Institutional support of this education can not only lead to more effective and meaningful learning opportunities but also positive employee-employer relationships.

Personalization is closely tied to “priority” in that intentionality is required to prioritize the most important areas of improvement. In human-centered care, it can often become overwhelming to think about additional demands for professional development on top of already busy schedules in a high-demand job. This is why focusing on one area of development at a time allows for progress without becoming overwhelmed.

Another important factor to mitigate feelings of overwhelm, is “passion.”

Connecting to that which excites the individual clinician drives them toward goal achievement. By passionately engaging in the learning process, the clinician is then more likely to passionately engage in the application of that learning. This is why the implementation of the final step of "professional learning" is so important to the learning process. Through the utilization of a professional learning community, participants take an active role in engaging with planning, learning, and problem-solving together. This community of learners is accountable to one another, thereby strengthening professional relationships and outcomes (Anderson, 2018).

As a human-centered profession, the concept of "purpose" is central to the OT profession, as its focus is on contributing to the well-being of others through their engagement in occupation. How that is achieved, however, is up to the individual OTP through the concept of personalization. Personalization is OTP-directed learning for professional enrichment, but is subject to the barriers of limited time for self-study or focus solely on areas of interest, which can restrict therapists to their comfort zone over time. The influence of priority, acknowledging one's limited ability to focus on too much, is significant to understand the impact of productivity standards and limits on payment and practice set by insurance and institutions.

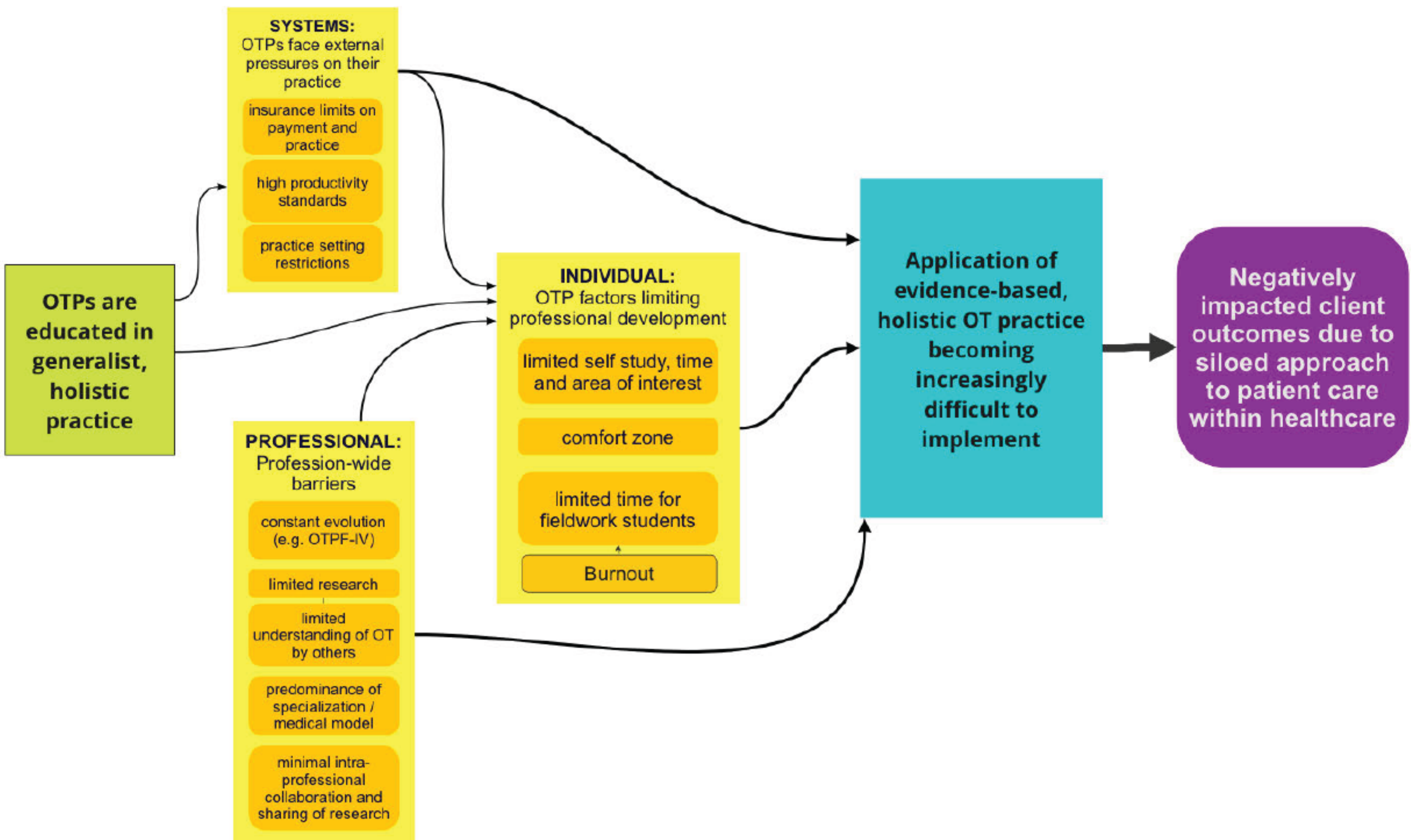
Passion is closely related to Duckworth's concept of grit, which she defines as a "ferocious determination," (Duckworth, 2016, p. 8) that is demonstrated by individuals through resilience, hard work, passion and perseverance. She also emphasizes that a central aspect of grit is the effort that one invests. This concept of grit is central to the creation of the '5 Ps' model. The final component of the '5 Ps' model is professional learning communities. As a younger profession, OT has limitations in applicable research for practice, and this limited evidence-based application of practice negatively impacts the ability for practitioners to clearly define their distinct role and purpose for clients. Additionally, while there may be a recent development in professional practice communities, there is still limited sharing of research across all areas of OT.

Explanatory Model

This doctoral project addresses the multi-variate influences on CPD and knowledge implementation that are negatively impacting the holistic practice of OT in various settings. Those factors are illustrated in the explanatory pathway presented in *Figure 2.2*, with further details described after the illustration.

Figure 2.2

Explanatory Model



Literature Review of Factors Contributing to the Issue

To investigate the relationships between factors presented in the explanatory model, a literature search was conducted. The literature review sought to answer the following research questions:

1. What are the barriers to health professionals engaging in professional development in the clinical setting?
2. What are the barriers to knowledge translation in clinical practice for OTPs?
3. What systems or organizational factors influence OTPs scope of practice?

The following databases were searched to identify relevant articles and research studies: Cumulative Index to Nursing and Allied Health Literature (CINAHL), APA PsycINFO, and PubMed. Search terms utilized included combinations and variations of the following terms: “barriers”, “occupational therapy”, “knowledge translation”, “professional development”, “health professional”, and “scope of practice” and “service or system” in title/abstract, as relevant to the research question. Results were limited to peer-reviewed articles published from the year 2012 onwards. Due to the limited results for Research Question 1, the timeframe was expanded to 2002. The abstracts and full text of the retrieved articles were reviewed, and the most relevant were included in this literature review.

Synthesis of the Evidence and Its Impact on the Problem

Barriers to Professional Development

In the United States, licensure as an OTP within each state requires CPD every few years so that practitioners keep up to date with new advances in the profession. However, it is apparent from the literature that numerous barriers exist that limit health professionals' capacity to engage in professional development, in particular time and cost. For instance, in a qualitative study by Haywood et al. (2013), health professionals identified common issues such as funding and time which make it challenging to engage in CPD. Similarly, Maharaj (2013), in their cross-sectional study investigating rehabilitation therapists' perceptions of CPD, underscored the cost of continuing education, which is often not covered by the employer; as well as scheduling challenges due to limited time off and staff shortages, limiting daytime availability. The experience of time and cost is even higher for practitioners working in rural areas (Penz, et al. 2007; Summers, et al. 2015), especially when considering the additional expense and time off needed for travel since there are often limited professional development opportunities offered in rural areas. Even if a practitioner were to be able to take a course, time continues to negatively impact CPD because of the limited available time "to share learned knowledge among colleagues, frequent staff rotation in hospital services, the lack of refresher training and mentorship, and staff turnover" (Tuyisenge, et al., 2018, p. 1205).

The literature review also revealed other barriers which are less expected. For example, Haywood et al. (2013) discussed the changing needs for professional development as experience and specialization increases, which makes available in-services less beneficial. While studying nurses working in rural and remote areas, Penz et al. (2007) identified that the perception of barriers to professional development also depends on characteristics of the practitioner. The authors found that the perception of barriers occurred with practitioners who demonstrated certain characteristics, such as being middle-aged, unmarried, employed full-time, having higher levels of education, and having dependents. The perception of barriers to participation was also associated with lower job and scheduling satisfaction. This was supported by Summers et al. (2015) who conducted a literature review of the barriers and supports to CPD in Australia. Several considerations were identified, including: unsuitable conference dates, lack of personal commitment or interest in topics, past experience of inadequate CPD, and lack of support or guidance from the manager or employer.

Nevertheless, some studies (Stewart, et al. 2020; Gunn & Goding, 2009) have found that many professionals demonstrate internal motivation toward CPD. However, external factors such as organizational influence have a significant positive or negative impact on motivation for CPD. In their qualitative study involving OTPs and health service administrators, Townsend, et al. (2006) found that the employer policies relating to time and funding of professional development can be additional barriers. When studying the perception of mandatory CPD policies in South Africa, Maharaj (2013) identified that many employers did not offer additional time and funding to attend mandated continued professional education. Additionally, they found that clinicians only attended continuing education because it was required but were not actively engaged if not interested in the content that was not in their specialty area. It is, therefore, apparent that there are both individual and environmental factors influencing the professional development practices of health professionals.

Some of the studies also presented more nuanced challenges to engaging in professional development. For instance, through completing focus groups with clinicians and patients, Haywood et al. (2013) found that many clinicians also wanted “initiatives by clinical specialists to reduce professional isolation” (p. 136) and reported concerns about succession planning. Additionally, feedback from patients receiving services highlighted different insights than what was mentioned by managers and clinicians, such as the importance of communication skills with the patient. It is clear that the challenges for engaging in CPD is multi-faceted and are varied depending on perceptions of the various stakeholders (e.g., the patient, the health professional, and the health service). Insightfully, in their position paper, Ahuja (2011) questions the current structure of CPD, which focuses on learning inputs or processes, when it would benefit more from an emphasis on outcomes such as demonstrated learning by the clinician, or patient outcomes following service.

Barriers to Knowledge Translation in a Clinical Setting

“Knowledge translation (KT) is the integration of the best available evidence with practice in the hopes of improving patient outcomes” (Gutierrez & Kaplan, 2016, p. 112). However, the application of new learning appears to inconsistently make it to clinical practice, resulting in an evidence-practice gap. It is important to understand what works and what does not before establishing further educational opportunities. In their case study, Gutierrez & Kaplan (2016) discussed several factors influencing knowledge translation in an outpatient setting, such as the clinic's culture, administrative support, staff readiness for change, awareness of evidence that affects practice, as well as staff confidence and competence. These various factors indicate that there are both top-down and bottom-up influences at play in knowledge implementation as well.

Some studies, like Munce et al. (2017), validate the previously identified barriers of KT by highlighting “the challenges of overcoming environmental factors including time pressures and insufficient staff in implementation efforts and the need for organizational support to mitigate these challenges” (p. 11). They also found additional factors influencing the implementation of knowledge into practice, such as “facilitation, agreement with the intervention – practical, familiarity with the recommended treatments, and environmental factors, including time and resources” (p. 4). Overall, the environmental factors of the organization must be addressed to make any intervention feasible due to the multivariable impact it has on the clinician’s ability to implement new learning.

The literature review also identified barriers to KT relating to health professionals’ level of research knowledge or skill. For instance, DiRezze et al. (2013) presented research to school-based OTPs who expressed wanting to engage in research, but did not know how. The researchers used Summary of Findings tables, which summarized key findings of Cochrane systematic reviews. They found that participants still had a difficult time interpreting the numbers in the research, such as confidence intervals, and some preferred to have the statistical numbers removed altogether. Overall, most clinicians were looking for a bottom line on how to implement the data into practice. Several studies discussed attempts to support health professionals to implement KT; however, Warner et al. (2013) found that short narrative presentations of guidelines (omitting study characteristics such as design and sample size) did not provide sufficient detail to allied health clinicians to translate knowledge into practice. According to Hitch et al. (2019), the simple provision of information, like databases and shared repositories, even when synthesized in an accessible format, is insufficient to support effective KT. It is, therefore, clear that further work is needed on how to best support health professionals engage with research and implement it in their practice, and may require additional clinician education on how to read the research and interpret the numbers.

Another barrier to implementing knowledge into practice is the differing language and terminologies related to KT. In their study of health professionals who participated in KT professional development workshops, Hitch et al. (2019) found that "the diverse disciplines and vocabularies used in KT has been found to have a negative impact on the search filters of one of the key databases in this field…, leading to suboptimal findings from evidence searches" (p. 413). Meaning that when searching for research from other disciplines, the language of each discipline must be considered to achieve maximum access to the available research. Unfortunately, this is another example of how the siloing of specialization limits the sharing of knowledge.

Jones et al. (2015) completed a systematic review of KT interventions, finding that while educational components are common for KT interventions in many disciplines, there is limited evidence of their effectiveness. They further indicate that "the modest-to-low methodological quality assessed in the studies underscores the gaps in KT strategies used in rehabilitation and highlights the need for rigorously designed studies that are well reported" (p. 663).

For this reason, some studies endeavored to establish research protocols (Cahill et al., 2018) or frameworks (Campione et al., 2021) for the implementation of knowledge into practice. Cahill's study protocol outlined that "a multi-component approach to knowledge translation includ[es] i) tailoring of the implementation intervention to site-specific barriers and enablers, ii) interactive group training workshops, iii) establishing and fostering champion therapists and iv) provision of written educational materials and online resources" (p. 1). In their discussion paper, Campione et al. (2021) outline the Knowledge-to-Action framework, which was developed to guide the process of knowledge translation by "facilitating the use of research knowledge by several stakeholders, such as practitioners, policymakers, patients and the public. The process has two components: Knowledge Creation and Action" (Graham et al., 2006). Campione and colleagues state that although a study was being conducted to evaluate the implementation of the framework, results have yet to be released. Other researchers approached this issue by using already-established frameworks. Cahill et al., (2021) suggested a hybrid version of the Knowledge-to-Action framework and the Consolidated Framework for Implementation Research to establish tools, targeted to the stakeholder needs, to improve the implementation of knowledge into practice. However, this report was a study protocol, and therefore lacks supporting data of its efficacy. Nevertheless, it is notable that there appears to be greater interest in recent years in establishing systematic approaches to addressing the numerous barriers identified to have more effective KT interventions.

Systems or Organizational Factors that Influence the OT Scope of Practice

According to Accreditation Council for Occupational Therapy Education (ACOTE, 2018) standard, *A.5.1 - Preparation to Practice as a Generalist*, the curriculum for occupational therapy practitioners must include, “a broad exposure to practice settings…and practice areas, including new and emerging areas …[and] to work with a variety of populations including…infants, children, adolescents, adults, and older adults in areas of physical and mental health” (p. 19). While accredited OT programs achieve this in their curriculum, once qualified and working, OTPs often specialize in one or more clinical areas. Consequently, generalist practice, where OTPs integrate a breadth of clinical approaches across a variety of population groups, is seemingly uncommon. It is important to understand how the scope of OT practice is shaped in various clinical settings, in particular with respect to specialist and generalist services.

As indicated from the previous literature, the effects of organizational support can be a major support or barrier to the practice of therapy in different settings. Boshoff et al. (2005) examined OT Early Intervention manager perceptions of the barriers to service delivery in southern Australia using questionnaires and an online focus group. The main issues that were brought up were regarding service delivery models used, staffing, wait lists and venues of service delivery as all having an impact on their therapists. Service delivery was primarily direct 1:1 service, groups, consultation and monitoring as the most common. Additionally, the nature of the interventions was personalized and required specialized training, most often in sensory integration and neuro-developmental interventions. The next issue of staffing then makes sense, with most clinics surveyed indicating employing a sole OTP, and having clients on the waitlist an average of 110 days. Understaffing, lack of time, and heavy workloads are all reasons for a negative impact on service delivery. Half of the participants reported a need for change, but over half of those respondents also anticipated difficulties implementing changes due to both staff and upper management seeing the need for change. While this study only looked at Early Intervention services in southern Australia, some of these findings resonate with other research.

Another study that looked at the managerial perspective on service innovation was conducted by Abendstern et al. (2014). Notably, this study took place in the United Kingdom shortly after the implementation of client self-assessment as part of the social care for all citizens. Three issues were looked at, including the culture within the organization and among the staff, staff engagement strategies, and promoting change with the use of staff ‘champions’. Among other barriers, Abendstern et al. (2014) indicated that OTPs play an important role in organizational change, but that change requires self-reflection and self-assessment of current practices and culture. In particular, the literature indicates that the prevailing culture of an organization needs to be open to change and believe it is needed, as well as see the value of innovation over prevailing practice, and believe that they are competent to deliver those skills. The researchers identified various roles of management that are necessary to implement and maintain change, including the identification of needs, communication of a vision for the organization, mobilization of support through the recruitment of service champions, and establishing sustainable practices through reinforcement. The recruitment of service champions was identified as a critical component, as these "near-peers are seen as key in bridging the gap between innovators and adopters" (Abendstern et al., 2014, p. 501). Additionally, considerations for sustainability measures need to be addressed for the ongoing provision and future improvement of services. While this study was based around a new policy in the United Kingdom at the time, this policy appears to be relatively similar to what physical therapists now have with their clients in the United States through direct access of services. Additionally, it is a standard of practice for OTPs to complete patient profiles and establish meaningful occupation-based goals for their clients, therefore the findings may also be relevant in a United States context.

There is increasing acknowledgment of the influence that environmental factors have on knowledge integration. For example, "leadership style, organizational culture, social capital, availability of resources, staffing, time, and space are among the main factors that influence the uptake of [evidence-based practice]" (Thomas et al., 2020, p. 1051). Among other findings, Thomas et al. (2020) found that the work setting is an important variable as well. For instance, when compared to public practice, private practice was more positively associated with using activities that are evidence based. Most interestingly, however, was that practitioner confidence was strongly correlated with the use of evidence-based practice. Despite receiving a foundational education on evidence-based knowledge within their OT curricula, the study showed that OTP knowledge did not correspond with use of evidence in practice or activities. One of the reasons cited was decreased confidence with critically appraising the research. However, as Thomas and associates note, other research indicates that increased confidence occurs with more clinical experience, but is not necessarily done by applying scientific evidence, and instead uses clinical experience as the primary source of evidence. However, other research found that confidence in applying research into practice was low for experienced clinicians as well, calling into question the quality of the evidence behind the services being provided.

In 2022, the American Journal of Occupational Therapy (AJOT) published an issue regarding ‘High-Value Occupational Therapy’ and the various factors that influence its practice. Hand et al. (2022) completed a literature review of these factors and highlighted three main areas: “(1) clients’ access to and use of occupational therapy, (2) the effects of occupational therapy on important quality-of-care indicators and client outcomes, and (3) the value of occupational therapy services through the lens of cost-effectiveness” (p. 1). There was confirmation of disparities across multiple socio-demographic characteristics, including age, race, ethnicity, sex, and urbanicity. Some of these factors impacting patient care are similar in a study by van Biljon et al. (2017) despite taking place in South Africa. For example, urban areas in South Africa may be similar to urban areas in the United States, in that clients speak numerous different languages and have a variety of cultural backgrounds. This, coupled with high workload demands on the few OTPs, creates situations of high productivity demands due to insufficient staffing to meet the diverse care demands. This results in short-term solutions to care emphasizing the quantity of clients seen over the quality of care provided. The study specifically examined convergent interviewing, which allows the client to speak with as few interruptions from the therapist as possible. Reflections from OTPs who undertook this approach found that this approach, standard in OT education, resulted in improved therapeutic use of self and rapport building. Unfortunately, van Biljon and colleagues found that this fundamental component of patient care in OT was getting lost due to the large caseloads. This research also highlighted that because of the current standards of practice, their clients were not aware of needed services that could and should also be provided by the OTPs.

Kinney et al. (2022) focused on how OT can learn to apply high-value care across a variety of practice settings through the application of Learning Health Systems (LHS). They explain that LHS as a system within which "science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience" (p. 2). Their study highlights the need for this as approach, as they found that clients with lower performance on their activities of daily living were "more likely to receive occupational therapy services, but disparities based on race and ethnicity, insurance type, and age were observed even after accounting for ADL performance," which is consistent with the findings of the van Biljon study. Studies such as these give further evidence of the impact that the current state of practice is contributing to the problem of occupational injustice and social inequities.

Impact of Holistic Approaches on Functional Client Outcomes

Upon completion of the above literature review for the identified questions, it became apparent that evidence of the meaningful client impact of these barriers required further investigation. Therefore, a further question was generated asking, "Do holistic approaches to practice improve patient functional outcomes?". The search terms "holistic", "patient outcomes", "function", and "professions" were researched using the same search parameters as indicated above. Due to the limited results generated, additional handpicking of research articles occurred using the AJOT, resulting in seven total articles.

The literature thus far supports that not actively participating in CPD, not implementing the most recent research into practice, and not maintaining a holistic approach to the practice of OT in all settings can have impacts beyond the individual practitioner or field of OT; it impacts the lives and well-being of clients. By shifting the focus to client outcomes, then the nature of the problem becomes even more urgent and hopefully garners the attention of all involved stakeholders.

Numerous studies examined integrated care models, incorporating the impact of OT as part of a holistic approach to patient care, and found that it leads to improved client outcomes (Laver et al., 2014; Escher et al., 2018). For instance, Laver et al. (2014) reported on the benefits of integrated care, including improved functional outcomes and reduced length of stay resulting in a reduction in mortality and morbidity for the stroke patients studied. Similarly, Escher et al. (2018) found that a holistic approach, including physical therapy, speech language pathology, and nutrition significantly improved outcomes on the Canadian Occupational Performance Measure (COPM), goal attainment scaling, and Stroke Impact Scale, in a community-based program for stroke patients. In a study regarding pediatric cancer care, Lenker (2021) reported that early collaborative care during hospitalization can prevent regression and improve functional mobility when both the family and medical team are educated. It is clear that a holistic approach that focuses on relationship building and information sharing is beneficial to both the client and the clinician.

Sleight et al. (2022) completed a systematic review of functional outcomes also within the area of cancer care. They found that many studies use physiological measures (e.g., weight) and/or clinical measures (e.g., range of motion and manual muscle testing) to quantify the efficacy of interventions, without taking into consideration the client's quality of life, mental health, or occupational engagement. These findings are supported by a study by Sagev-Jacubvski et al. (2022) that examined predictors of health for clients who had fallen and had a hip fracture. They found that at a "6-month follow-up, functional ability was correlated more with optimism than with age, gender, or hand grip strength measured at admission" (p. 1). These findings apply to all people across the lifespan. A study by Lenker (2021) specifically links symptoms to occupation by stating that beyond the physical impairment of gross motor difficulties, balance, and difficulty with ambulation, deficits with thinking, memory, concentration, learning, reasoning, handwriting, fine motor activities, and organizing content can negatively impact school-based participation for children receiving cancer treatment. These are all areas that OTPs can address because of their direct impact on occupations.

Including functional goals beyond traditionally thought of treatments, even for mental health conditions, can improve overall client outcomes, independence and overall well-being. Vizzotto et al. (2021) studied occupational goal intervention methods for clients with treatment resistant schizophrenia, and found significant improvement compared to the control group. A study by Wong et al. (2019), looking at predictors of return to work for clients with stroke, brain injury, or spinal cord injury, found that external variables significantly impact client outcomes, such as marriage and education. This highlights the importance of a holistic approach, looking beyond the injury to the context of each client. OT evaluations should address the client's psychological and social factors, and intervention should aim to strengthen these factors as powerful aids in recovery.

Conclusion

This literature review indicates that there are significant gaps between research, occupational therapy practice, and client outcomes for a multitude of reasons. Beyond personal factors of limited time or comfort zone, meso, and macro level influences such as practice setting restrictions and workplace culture significantly impact the application of current research into practice. These implications are significant because of the impact that they have on the overall outcomes of the health and well-being of the clients. Many of these reasons are indicated in the established explanatory model and are supported by the literature. Therefore, no changes are needed to the established explanatory model.

CHAPTER THREE – Overview of Current Approaches and Methods

Literature Review of Interventions Addressing the Issue

Considering the established barriers which impede the application of holistic care within the field of occupational therapy, it is important to determine the current best practice evidence for potential solutions. The literature review sought to answer the following research questions:

1. What motivation or learning theories can be used to support health professionals to change their practice?
2. Which approaches best enable effective knowledge translation in healthcare?
3. How have Communities of Practice been used in OT practice?

The following databases were searched to identify relevant articles and research studies: Cumulative Index to Nursing and Allied Health Literature (CINAHL), APA PsycINFO, and PubMed. Search terms utilized included combinations and variations of the following terms: "knowledge translation", "healthcare", "health professionals", "communities of practice", "occupational therapy", "motivation or learning", theory", "practice change" in title/abstract, as relevant to the research question. Results were limited to peer-reviewed articles published from the year 2012 onwards. The abstracts and full-text of the retrieved articles were reviewed, and the most relevant included in this literature review.

Synthesis of the Evidence and Solution to the Problem

Theories Used to Support Practice Change

As demonstrated, integrating knowledge into clinical practice is a well-established problem. To address this issue, solutions to implementing change have been approached in many ways in the literature. The learning and motivation theories used to support health professionals implement practice change were researched in order to determine which strategies best supported a change in practice. Several studies (Rangachari et al., 2015; Desvaux et al., 2021; Loe et al., 2021) examined a variety of known motivation/ learning theories, such as Complex Systems Theory (Plsek, 2001), Normalization Process Theory (May & Finch, 2006) and Self-Determination Theory (Deci & Ryan, 1985).

As indicated previously, when identifying the barriers to CPD, the organizational impact has a significant effect on the clinician. Rangachari, et al. (2015) addressed this issue by utilizing complex systems theory (Plsek, 2001), which states that collective tacit knowledge, often demonstrated as know-how, is one of the most important organizational forms of knowledge and emphasizes the importance for managers to create this knowledge within complex systems. In their prospective study of practice changes in an intensive care unit (ICU), communication logs were completed by the ICU physicians, managers, and nurses, and outcomes were monitored through weekly chart reviews. Units involved in the study demonstrated significant improvement in outcomes. This is consistent with the underpinnings of complex systems theory indicating that “there can be no organizational change without organizational learning, and the latter, in turn, requires the creation of collective tacit knowledge (Plsek, 2001). The complex systems literature has put forth that "collective tacit knowledge may be the most strategically important kind of organizational knowledge, and mechanisms to create this type of knowledge may be the most crucial task of managers in complex systems" (p. 67).

Normalization Process Theory (NPT) was used by Desveaux et al. (2021) when studying the intention-to-action gap in staff physicians. In this qualitative study, NPT was selected "to understand the implementation, embedding, and integration of new approaches in healthcare settings. It accounts for how people understand and make sense of an approach (coherence), engage and participate with it (cognitive participation), distribute work (collective action), and reflect or appraise its effects (reflexive monitoring)" (p. 2). It is notable to mention that in Canada, where this study took place, there are publicly funded primary care organizations that include an interprofessional team, therefore integration of knowledge is necessary for the established professional expectation of collaborative family health teams.

Through an analysis of their interview questions that focused on audit and feedback, as well as the role and perceptions of data in quality improvement, Desveaux et al. discovered three themes.

"Theme 1: Perceptions of the data were the primary driver of engagement with reflexive monitoring (or lack thereof)" (p. 4). All physicians actively engaged in the data from the audit and feedback completed, but had different responses to it. Most believed that the findings were difficult to apply because it did not take into consideration the inherent complexity of each case nor engagement of the client. However, some still believed that the data was beneficial and could positively contribute toward practice change.

“Theme 2: Physicians struggled to interpret how aggregate practice-level data reflected their individual actions” (p. 5). This is reflective of the dissonance between the relationship focus of clinical practice and the aggregate approach of practice-level information. Through that lens, then the interpretation of the data and application to personal practice is understandably difficult. Nevertheless, some physicians looked at this as an opportunity to collaborate and learn more as to how to incorporate the data into their practice.

“Theme 3: Physicians expressed a need for support to identify modifiable actions that drive performance” (p. 6). Generally, the initial response to the data was for the physicians to use it as a social proof, in that they wanted to compare their performance to that of their peers. However, the processing of the data lacked an understanding of the what and why’s of their performance. Furthermore, most participants established a goal related to practice change but were unable to specify an action to achieve that goal, especially in a manner that was within their control since many outcomes rely on patient opinions.

The interconnection of the individual perspective with the social application of the findings from Desveaux et al. suggest the need to have opportunities to learn from one another to help make sense of information. A learning collaborative was used by Erickson et al. (2022) for primary care healthcare providers in a large system that covers five states. The learning collaborative was able to provide members with feedback related to the importance of new practice recommendations as perceived by their peers.

Collaborative learning maintained member interest and engagement in the group. Even disparate specialties were able to collaborate and learn new treatment recommendations, with improved standardization.

Part of the reason that this approach was successful could be because of a learning theory utilized in a study by Loe et al. (2021). They developed a workshop to address racism as an adverse childhood experience following Kern's six steps to develop a workshop. Strategies were then guided by self-determination theory by addressing the participant's need for autonomy, competence, and relatedness. By utilizing this approach, they seem to have addressed some of the participant concerns identified in the aforementioned studies. The presentation of the information included learning objectives that were divided, with the first four focusing on content knowledge, and the second four focused on skill building. Some studies, such as Vogel et al. (2021), applied this approach by adopting a clinician-focused approach to practice change by implementing a leadership development program for community nurses. Other research (e.g., Welch Bacon et al., 2022; Miller & Catherine, 2016; Phillips, 2019) focused on the meso-level influences on clinical practice such as "unlearning", "perspective taking", and "spaced education".

Lacy et al. (2022) addressed the concept of unlearning as an essential step to the uptake of new learning. Not to be confused with simply forgetting something, unlearning is the intentional process of replacing knowledge. Unlearning follows self-reflection and identification of ineffective practices, and leads to replacement of ineffective practices with new knowledge and skills. This process, however, can be hard to do when faced with “habit and security, fear of the unknown, fixed mental models and mindsets, and lack of awareness of the need to unlearn” (p. 177). Some common manifestations of these are the concept of a comfort zone, sticking to what is already well known, tunnel vision, and not having challenges indicating a need to change practice behaviors. Lacy et al., however, also offer numerous mindset-oriented strategies to address these barriers, including but are not limited to keeping an open mind, working in a high functioning environment, and forming communities of practice. Concrete examples are also given for how to apply these strategies, such as analyzing patient care documentation, establishing a network that communicates about best-practice recommendations, book clubs around leadership and a growth mindset, as well as reflective journaling.

Gupta, Boland, & Aron (2017) used a grounded theory-based qualitative approach to conduct their case study of primary care physicians. Through this process, of listening to the lived experiences of others without judgment, they established that “(1) practice change disturbs the status quo equilibrium. Establishing a new equilibrium that incorporates the change may be a struggle” (p. 4). Respondents to this survey reported that a change that requires an addition is perceived to be easier to implement than a change that requires the cessation of a current practice. This notion relates to the concept of unlearning, which was previously mentioned by Welch Bacon. Gupta et al. also identified that “(2) part of the struggle to establish a new equilibrium incorporating a practice change involves both the “evidence” itself and tensions between evidence and context” (p. 4), which requires further examination.

Miller & Catherine (2016) focused their research on interprofessional learning in primary care. Their process highlights the importance of perspective taking and understanding of the "other." The steps to their process included: 1) Reviewing the evidence; 2) Gaining perspectives through focus groups about knowledge of other professions and experiences of collaboration; 3) Developing resources: developed by a multi-professional team; 4) Sharing impressions: identify the profession from a quote of what they do; 5) Sharing knowledge: single service groups respond to questions about aspects of other services and then meet with the service in question clarifying and correcting their knowledge; 6) Sharing roles, values, and conflicts: three stage case study in mixed groups; 7) Sharing plans: personal and collective action planning. Using this approach systematically works through pre-conceived notions of the "other" and facilitates a shared understanding and appreciation of one another, focusing more on the similarities than the differences.

McGonagle, Jackson, & Kane (2015) studied mental health workers from a variety of professions, including OT. Their value-based training initiative emphasized self-reflection and group discussion surrounding the practical application of values into practice. Much like indicated by the concept of unlearning, prior to being able to change one's practice behaviors, a reflection of current practices was needed to identify a need to change first. McGonagle et al. (2015) also identified another necessary element of community practice, which requires a mutual respect for the different values of others, much like the findings of Miller & Catherine (2016). This approach, in turn, allows personal freedom to challenge one's own beliefs. Furthermore, the application of learning to real clinical experiences enhanced the learning experience.

Some of the other novel approaches in the literature include spaced education, as presented by Phillips et al. (2019). They completed a systematic review to evaluate the effectiveness of spaced education for clinician CPD. Spaced education uses “spacing, repetition and testing learning content to increase topic-specific knowledge” (p. 1). Of the 17 articles that were included in their systematic review, participant knowledge significantly increased in 10 studies, and significant changes to clinician behavior occurred in seven of the studies. Indications of improvement in the confidence of clinicians, clinical skills, and patient outcomes were cited in fewer than four studies. Nevertheless, they concluded that offering spaced education on an online platform would be a scalable format for CPD that can increase clinical knowledge and practice change.

Research has indicated how the use of motivation and learning theories have been used in an attempt to address the knowledge-to-practice gap. A program created to address the needs of the participants must be intentional with not only the selection of the participants, but the timing, setting, and content. The research supports the use of an online platform that facilitates clinician education through application, and communication and collaboration through a variety of interactive activities.

Effective Knowledge Translation in Healthcare

Numerous studies have attempted to research the most effective means of translating knowledge into practice in a healthcare setting, and various approaches were identified through the literature review. For instance, Boehm et al. (2019) aimed to promote implementation science and the need for implementation-trained nurses. Their article provided an analysis of the resources available for nurses, by including a multipage table indexing institutions, websites, and descriptions, then advocating for more nurses to be trained in implementation science as a necessity when working in multidisciplinary teams. While this article does not provide any empirical evidence about the effectiveness of the approaches, it does provide helpful strategies such as sharing of knowledge and resources, and encouraging their readers to take action.

Some of the included articles completed literature reviews on specialty topics related to a specific area of practice (Funabashi et al., 2012; Jahn et al., 2020; Stoney et al., 2022) and use the journal article as the primary means of disseminating knowledge. Funabashi et al. (2012) focused on the knowledge exchange in physical therapy and manual therapy. They found that facilitators to knowledge exchange and translation include enhancing the relationship between researchers and clinicians by using simple language, providing access to evidence-based resources, and promoting collaboration between researchers and clinicians. Additionally, Stoney et al. (2022) presented implementation strategies related to cardiovascular behavioral medicine. The article was organized to facilitate the understanding of the current state of the science, barriers, challenges and opportunities, and readiness for interventions. By not only sharing the knowledge but also identifying the barriers to implementation and readiness for change, the content may become more clearly understood and manageable for the reader.

Jahn et al. (2019) took a different approach by completing a systematic review looking at how knowledge crosses institutional boundaries of the public and private sectors, followed by semi-structured interviews with high-ranking scientists. They found that the academic channels were common means of dissemination, such as publications in journals or presenting at conferences, which were viewed as having academic legitimacy. The most explored form of knowledge exchange involved collaborative research. This perception of legitimacy may also be present in the perception of information when comparing academia to clinical practice, highlighting why collaborative endeavors with healthcare organizations may facilitate the transfer of academic knowledge into practice.

Kläusler-Troxler et al. (2019) completed participatory action research in a collaboration initiated between senior nursing leadership teams and senior clinical nurse specialists. The project took place between 2015–2017 at a women's health hospital in Switzerland, focusing on guiding knowledge translation to develop a family-centered practice culture. Through the use of the action cycle of 'Look-Think-Act', which required self-reflection, critical dialogue, and the development of an action plan for implementation. Despite a shared commitment to the established goal of the participants, inconsistent communication and a lack of continuity resulted in ineffective outcomes. The researchers concluded that "the use of a cyclic, recursive and participatory process that engages various stakeholders is required for a shift [in] practices" (p. 1).

An exemplary approach to this process is described in the case report by Gresh., et al. (2017) profiling the approach of the Global Alliance for Nursing and Midwifery (GANM). This group is a community of practice that is moderated by both students and health professionals within the fields of nursing and midwifery. Students were contributors of the group in order for them to learn to instruct others by sharing the up-to-date information about recent innovations learned in school. GANM maintains a blog site and includes both written and video posts. Additionally, they offer webinars on best practice, current practice or research, led by experts in the topic with time for questions and group discussion incorporated into the allotted time. They also make use of discussion boards, an open-access database of evidence-based practice resources, and social media to promote publications, podcasts, and events. This multi-modal method of knowledge dissemination contributes to the ongoing learning and knowledge integration of the group.

A similar but different approach was studied by Rolls et al. (2020) in which they retrospectively examined the knowledge exchanges that took place in a virtual community of practice from 2003–2017 with the multidisciplinary staff of an ICU in Australia. The group utilized the "know-what, know-how and know-why taxonomy [to] reflect both the evolution of professional competence and how different forms of knowledge come together in action" (p. 1383). A content analysis of the virtual community identified six elements that facilitated participation and knowledge exchange through a safe and collegial environment: "(a) the discussion thread; (b) sharing of artifacts; (c) community; (d) cordiality; (e) maven work; and (f) promotion of the Virtual Community" (p. 1388). They postulated that healthcare organizations could utilize virtual communities of practice to support the CPD of their clinical staff.

Collaborative approaches can also be utilized to create interventions, such as in the development of nutritionDay 2.0 (Moick, et al., 2021), which incorporated a multi-national and multi-professional approach to evidence-based practice. They utilized an audit and feedback approach incorporating economic and quality indicators, feedback, and action strategies to address the knowledge to action gap of nutrition care within the hospital setting. Through the use of repeated audit and feedback over three years, the creation of nutritionDay 2.0 demonstrated a positive outcome resulting from collaboration for a shared goal.

Use of Communities of Practice in Occupational Therapy

Communities of practice (CoP), as proposed by Etienne Wenger (1998), draw upon the diverse experiences of its participants to collaboratively develop novel applications of their knowledge. It is a collaborative learning community of practitioners committed to the shared learning of their professional endeavors. In the literature, CoPs have been implemented with OTPs. For instance, in Brazil, between 2013 and 2017, Marcolino et al. (2020) completed three phases of their study following an evolving format of their CoPs, each focusing on defined purposes for the group to address. The first phase centered on establishing a unified language and role for OTPs within the hospital, the second phase involved self-reflection on practice behaviors and processes, and the third phase focused on collaborating on innovative solutions to practice challenges. The OTPs participating in the CoPs were also preceptors for OT students. Fifteen face-to-face meetings were held every one to two months from 2013–2015, lasting approximately 60–90 minutes. However, due to time limitations, it was decided that meetings would occur less often but for a longer duration from 2016–2017. In order to maintain connection between the meetings, the research team established weekly emails, which included a reflective question. It was noted, however, that a weakness of the group was the variable participation because of its long duration. One solution to mitigate this issue and establish continuity was the creation of a group chronicle using the in-person meeting transcripts, which were read at the start of each subsequent meeting.

Galheigo et al. (2017) completed participatory action research with nine occupational therapists who were working with hospitalized children and adolescents in various units of an urban hospital. The participants attended ten online CoP meetings addressing “assessment and evaluation; therapeutic projects; methodologies of action; case studies; and challenging dimensions of intervention” (p. 453). These meetings also provided activities such as forums, on-line discussions, blogs, exchange of literature or other materials that the therapists had produced. While there were planned activities, the participants were offered the opportunity to reflect on the current session and collaborate on the theme for the upcoming meeting. This semi-structured group process facilitated group member communication and collaboration for improved professional knowledge exchange. This article shows the benefit of when the group decides on how to address a specific topic and works collaboratively to create a solution.

Two years later, Galheigo et al. (2019) established another similarly structured CoP of nine OTPs, all working in acute care, but with a variety of ages. Ten meetings, eight face to face and two virtual, were conducted over the course of seven months. The themes identified from this study indicated that the most important aspects of a CoP for the OTPs were the “ (i) dialogic engagement; (ii) reflective opportunities; (iii) a sense of belonging; (iv) affirming professional identity; and (v) cultivating professional knowledge” (Galheigo et al,. 2019, p. 783). Interestingly, they found that the ability to engage in dialogue with other areas of the hospital allowed for more complex understandings of practice beyond the individual specialty area. This, in turn, contributed to a greater sense of belonging and affirmation of professional identity. This ability to connect with and learn from other specialty areas is promising for intra-professional collaborations between different specialties of OT to foster a unified sense of professional identity.

Each of the above-described communities of practice have findings consistent with a literature review completed by Barry et al. (2016). Of the five articles included in the literature review, four themes emerged as the most important components of the communities of practice. Professional development occurs through the process of sharing knowledge, regardless of the way in which the sharing occurs. KT requires personal interactions, either through verbal discussions or observing others participate. Dedicated time and space are required for reflective practice. Finally, a variety of geographic and professional settings are required for the essential component of boundary crossing.

Wilding et al. (2012) also conducted a study of a CoP involving 20 OTPs in Australia. Participants ranged from new graduates to those with over 30 years' experience; and worked in a variety of practice settings including pediatrics, neurology, hand therapy, mental health, and general medicine, including those in rural settings. Participants met monthly in a teleconference as they were able, and worked on assignments issued from a textbook, *Enabling Occupation II* (Townsend & Polatajko, 2007), designed to promote self-reflection on their use of occupations within their practice. Themes that emerged revolved around promoting scholarship and promoting professional competence, passion, and cohesion, each indicated by the following participant reflection (p. 316).

> I guess overall the emails and the case studies helped because I could see what we all had in common a bit more as OTs [occupational therapists]. To nail down a little bit more what makes us OTs, which we all have in common across all practice areas.
>
> (Teleconference 2)

> To be reminded about the breadth and the scope of our profession and the commonality despite our practice context and what have you. And that people are on a very similar journey. So I guess for me it was a nice outward-looking opportunity at the profession, rather than sometimes navel gazing that we might do within our own context.
>
> (Teleconference 3)

Some of the challenges noted in this study highlighted the lack of non-verbal communication, since the groups were held over teleconference, making it difficult to know when to speak or identify the next speaker. Since this study, however, online platforms for meetings have become commonplace and include the option of video. While communicating over a variety of time zones can still be a challenge, the benefits remain the same, with the cost effectiveness and decreased travel costs increasing access for more participants.

Another study by Keegan et al. (2021) identified similar findings of the benefits of a CoP for acute care OTPs, however identified additional perspectives of the participation in a CoP. The four themes identified were: 1) Time is tight: there has to be an outcome; 2) Our tight-knit group is a safe place; 3) This group helps me feel occupational therapy is worthwhile; and 4) It's not just prescribing over-toilet frames. Goals and structure are important, especially when coming from the fast pace of an acute care environment, and many therapists sought to have the sacrifice of their time spent to be worthwhile with tangible outcomes. The development of a group identity through shared challenges was common and led to a closer connection with the role of OT theory and practice. This was highlighted by the academic-practitioner collaboration that was a component of this study. This collaboration "enabled exposure to different ideas and opinions, assisted the team in learning new theoretical concepts while providing an opportunity for supportive brainstorming" (p. 37). This structure of collaboration also serves to bridge the knowledge-to-practice gap, which can accelerate the application of research in clinical practice.

Finally, Roberts (2015) looked at CoP enablers and barriers within the school setting using a mixed methods approach incorporating a questionnaire and semi-structured interview with their participants. Numerous CoPs were offered throughout the year, and those who attended either more than 12 hours or less than 7 hours were asked to participate in order to describe their views of the enablers and barriers to participation. Through the use of the questionnaire and analysis of the findings, the researchers were able to identify six themes which the participants used to describe their experience: "structure– engagement, learning, growth–becoming, fellowship–belonging, implementation–doing, and contributing–influencing" (p. 298). Roberts found that the inverse of a facilitator often indicated a barrier to participants. For example, comments from participants indicated wanting discipline specific groups, which they found more relevant and comfortable, whereas others sought out multi-disciplinary groups to be exposed to a greater variety of perspectives. Overall, primary enablers were: support offered by management, group sizes of 10–12, relevance, effective group facilitation, discussion and exchange of information from a variety of perspectives, development of skills and professional competence through reflective practice and professional development, ideas supported by research and others, “how-to’s”, staff morale, quality and innovation.

Conclusion

CPD through the use of CoPs has been supported through the literature review. While there have been a variety of iterations of the idea, the research validated that supported social learning is an effective means to promote positive changes in practice, which can then improve overall client outcomes. Commonalities between the groups indicate the need for a safe environment facilitating the open sharing of thoughts and concerns, collaborative social learning through discussion and knowledge exchange, opportunities for self-reflection, and opportunities to expand thinking with other perspectives.

CHAPTER FOUR – Description of the Proposed Program

Program Description

Occupational Therapists Fostering Unified Expertise and Learning (OT F.U.E.L.) is a virtual CoP for OTPs working in the various siloed specialties of OT practice, including pediatrics, orthopedics/hand therapy, inpatient/outpatient rehabilitation, and mental health. While the OT profession embraces holistic, occupation-based approaches to working with clients, OTPs often work in compartmentalized specialty areas. Specialty practice is important, however, there may be missed opportunities for OTPs to learn and integrate concepts and approaches from other clinical areas which may be helpful to the clients that they serve. Additionally, clients with needs that do not neatly fit into specific clinical areas may not receive optimal care through specialty practice unless OTPs are able to integrate a range of approaches from various clinical areas in their practice.

OT F.U.E.L. is designed as an online CoP focusing on intra-professional social learning and knowledge implementation. The objective is to reconnect with the common roots and approaches of OT, and enhance practice skills and expertise - integrating clinical knowledge and skills from various clinical specialties across the profession.

The purpose of *OT F.U.E.L.* is to promote the application of knowledge from various specialty areas of OT, by utilizing social learning theory as applied through a CoP. By integrating the various concepts utilized within disparate areas of OT, it is hoped that the participating OTPs will be better able to adopt a holistic and generalist approach to their practice, and their clients will thereby have improved outcomes. *Figure 4.1* presents a case example of how an OTP might benefit from OT F.U.E.L.

Figure 4.1

Case Scenario for OT F.U.E.L.

Jacquelyn is a hand therapist with over 25 years of experience, who works for a local large hospital group. Jacquelyn has been having fieldwork students on a yearly basis for the last 15 years. However, the organization has gone through a lot of transitions, leading to recent changes in staffing, increased productivity standards, and a decrease in benefits for continuing education. All that has resulted in less time for completing all the continuing education she would like and feeling overwhelmed and burned out at work. Jacquelyn primarily treats clients with orthopedic injuries and occasionally clients post-stroke. Recently, however, she completed an evaluation for a distal radius fracture on an adult client with autism. She created treatment plans similar to the ones she usually does, but the client did not tolerate the auditory and tactile sensations of the modalities and did not tolerate the wearing schedule of the orthosis she fabricated. Jacquelyn did not know what she should be doing differently but did not have the time to spend researching because of the productivity demands. As a result, the client experienced ongoing pain and limitations with the functional use of their hand.

Jacquelyn's clinic manager informed her of an opportunity for free continuing education, OT F.U.E.L., offered through the university of her next fieldwork student. Her manager encouraged Jacquelyn to attend. Through collaboration with other hand therapists, as well as outpatient pediatric therapists, neurological specialists from an outpatient clinic, and mental health therapists, Jacquelyn now feels a paradigm shift in her understanding of the OT scope of practice. She better understands what her autistic client is experiencing, and can better problem solve what she is able to do to address his needs. Jacquelyn has started advocating for more holistic practice for occupational therapy. Jacquelyn's clinic manager reports overall improved client outcomes after Jacquelyn's participation in the course, with many of her clients now reporting feeling treated as a "whole person" rather than just their hand injury.

There are three phases of this project:

Phase 1: Pilot testing OT F.U.E.L with FWEs in Illinois.

Phase 2: Pilot testing OT F.U.E.L with FWEs across the United States through other university AFWCs.

Phase 3: Exploration of broader implementation of OT F.U.E.L across the United States.

For the *Phase 1* pilot, FWEs will be recruited through their employer in order to get managerial buy-in for their engagement in the program, as well as encouragement from management to participate. In order to incentivize organizational buy-in for the program, grant funding will be obtained and used to reimburse the participating organizations for contract staff to cover the lost treatment times of the participating OTP.

Overall group size will be limited to 16 participants, with subspecialty groups of approximately 4 members to ensure diversity of experience. *OT F.U.E.L.* will take place on Microsoft (MS) Teams for six, 60-minute sessions, offered every three weeks. The groups will be moderated by a "knowledge broker" who can facilitate interconnections between the specialty areas.

Basis of the Proposed Program

Despite the broad education that OT students receive that promotes holistic practice, health care services and systems often push for specialist or compartmentalized practice. This may present challenges for clients whose needs do not neatly align in one clinical area. Specialist practice likely also influences OTPs to engage solely with CPD in their clinical area, and be less adept at integrating knowledge from across specialty areas to meet clients' needs and provide holistic care.

CoPs, as proposed by Etienne Wenger (1998), draw upon diverse experiences of its participants to collaboratively develop novel applications of their knowledge. Through regular meetings, the CoP enables participants to engage in "a process that builds and shapes knowledge in dialogue with themselves and with others, collectively reflecting, analyzing, investigating, and evaluating their own practices, actions, values, and knowledge (Wenger, 1998; Wilding et al., 2012)" (Marcolino, et al., 2020, p. 4). Additionally, a CoP enables its members to problem-solve current challenges and create new knowledge through the provision of resources, such as member knowledge or shared content.

Program Participants

In the initial pilot (*Phase 1*), the intended program participants will be OTPs who are also FWEs, and therefore have at least one year of professional practice experience. Each group will include 12–16 occupational therapists representing approximately four specialty areas of OT, including pediatrics, orthopedics/hand therapy, inpatient/outpatient rehabilitation, and mental health.

To recruit participants for the program, a convenience sample of employers/ organizational representatives (managers, OT supervisors, etc.) will be sent a personalized email describing the *OT F.U.E.L* CoP. This email will include a fact sheet (*Appendix C*) that includes the potential benefits of participation in the program, combatting common issues in practice now, such as burnout, attrition, and the research to practice gap. By highlighting how these all negatively impact client outcomes, and explaining the personal and professional benefits of participating in a CoP, especially one that is supported by an employer, the employer has the opportunity to meaningfully support their staff as well as offer a free continuing education credit opportunity.

Program Resources

Since *Phase 1* focuses on FWEs, the knowledge broker is designed to be an AFWC from a university sending students to the participating OT FWE. Therefore, university resources will be utilized to facilitate the running of *OT F.U.E.L.*. An MS Teams site through the university will serve as a central repository for program participants to meet and share information, through virtual meetings, discussion posts, and a shared resource library. The meetings will take place virtually on MS Teams. The meetings will be video recorded, and audio will be transcribed to facilitate the establishment of themes, and through that documentation will then promote continuity between sessions. Each week of the CoP will have an established focus for which to make interconnections. While the experience and knowledge shared among the group members is a valuable resource, there will also be expert guest presenters who currently work integrating different areas of practice who will be invited to participate. The knowledge broker will need to establish appropriate resources to share for each meeting and share them on the MS Teams site. Finally, in order to incentivize participation in the CoP, the University will complete the process to become a certified AOTA provider of continuing education. This way, the university can offer continuing education credits to the participants upon their completion of the program.

Interventions and Activities

Since the foundational basis for a successful CoP requires a safe environment for honest communication, as well as connections with the group members, the majority of the first session will be spent getting to know each of the participants through icebreakers and small breakouts, which include identifying and correcting preconceived notions about other specialty areas. Then, general education about evidence-informed data regarding OTP barriers to engaging with and implementing new knowledge will be provided. Considering the studies that report practitioner discomfort with understanding research evidence, the initial sessions will also include an introduction on how to engage with research, including how to read the studies and find the key take-aways. The end of the first session will include collaborative goal setting for identifying the primary objectives of the participants.

OT F.U.E.L. will specifically address knowledge translation and implementation, as well as self-care to foster a positive learning environment for the OTPs. Therefore, each subsequent meeting will follow the same general structure: 1) whole-group activity to engage in self-care (e.g. yoga, mindfulness), 2) MS Teams breakout rooms for each specialty area to collaborate on and discuss a designated case study and/or research article, 3) large group will meet again for sharing, with each member offered the opportunity to share their insights and feelings about the topic. 4) As needed, the group facilitator will act as a knowledge broker to encourage connections among the different groups by making general connections to the findings of each group, 5) group members will then be given the opportunity for reflection and challenged to share one way they can apply something learned during the session to their daily practice. One way of achieving this would be to start each session with a reflection on how the concepts and skills learned were applied to existing clients since the last session.

Two example session plans for sessions one and three are presented in *Appendix A*. These lesson plans illustrate how the sessions integrate community learning into the exchange of knowledge among the participants.

Evidence Informing Program Development

As described in *Chapter 3*, the literature identified several approaches that have been utilized for knowledge translation and implementation with health professionals. Professional collaboration (Moick. et al., 2021; Kläusler-Troxler et al., 2019), and even virtual communities of practice (Gresh. et al., 2017; Rolls et al., 2020) have all demonstrated benefits to CPD and integration of knowledge into practice. Many studies (Wenger, 1998; Gresh et al., 2017; Galheigo et al, 2019; Kläusler-Troxler et al., 2019) indicated that the essential components of the collaboration required the establishment of a safe environment for open sharing of thoughts and concerns, social learning through discussion and knowledge exchange, opportunities for self-reflection, and the presence of those with different backgrounds to expand other perspectives. Some approaches to creating an inclusive environment is to establish group rules at the start of the program, seek feedback from group members throughout their participation, and incorporate group member ideas into the content of the program.

Program Outputs and Outcomes

Anticipated program outputs include the number of participants involved in the program, the number of sessions of the CoP, educational materials created for the OTPs, as well as the number of cross-specialty collaborations that are established.

The short-term outcomes are intended to benefit the OTPs by increasing their confidence in knowledge of evidence-based practice from all areas of OT, increasing their utilization of self-care strategies to promote learning and mitigate burnout, and to increase feelings of organizational support by their encouragement of the OTPs participation in this program.

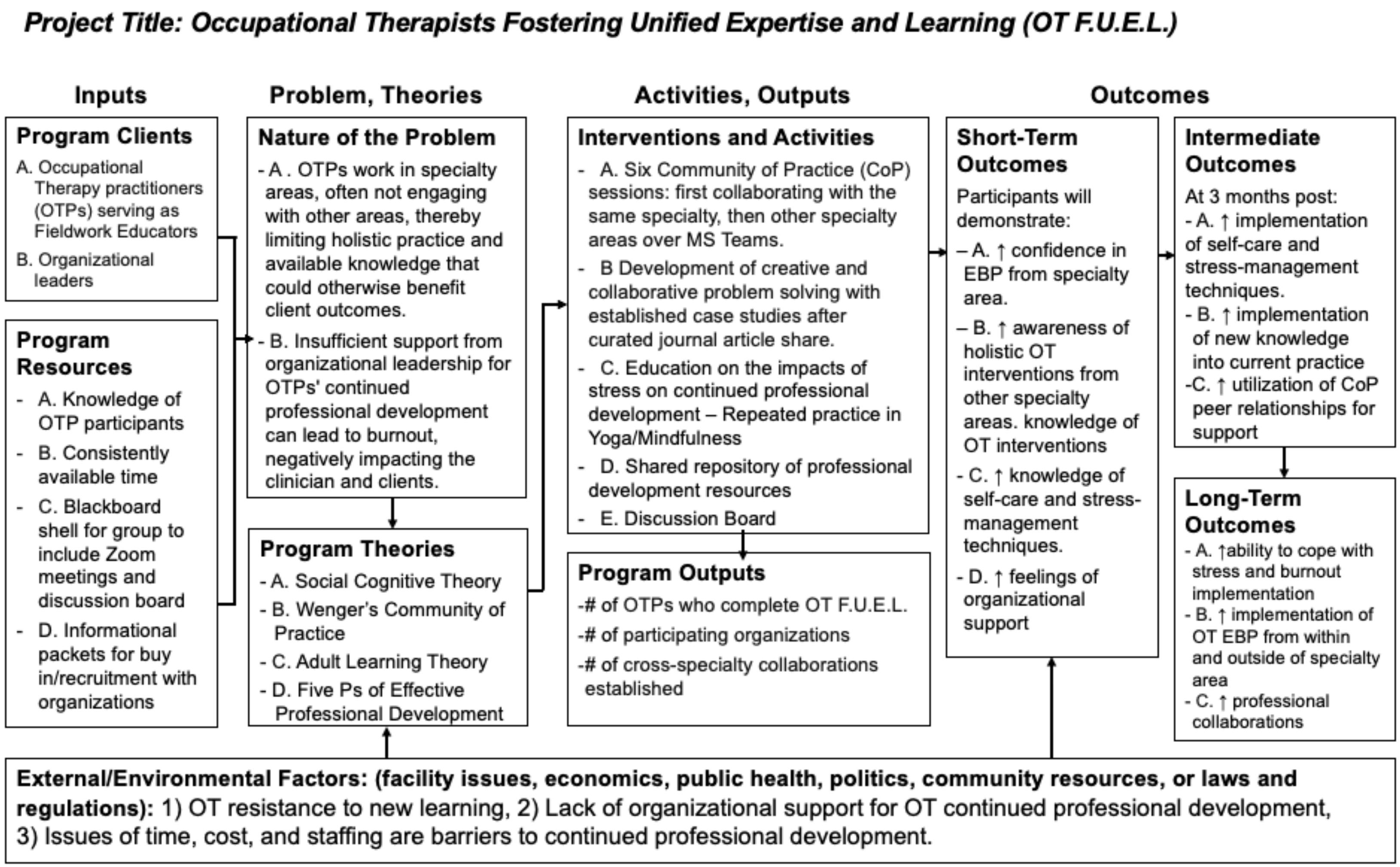
As previously mentioned, employee burnout and lack of organizational support are major barriers to actively engaging in CPD. Therefore, by addressing these issues as part of the CoP structure then the OTPs may be more ready to learn, teach, and connect.

Ultimately, the intermediate and long-term outcomes are expected to result in the implementation of the learning that took place in *OT F.U.E.L.*. By reducing those barriers and facilitating the implementation of new knowledge, the clients will benefit, and likely demonstrate improved outcomes.

The logic model presented in *Figure 4.2*, provides an overview of the inputs, problems, theories, activities, outputs, and outcomes associated with *OT F.U.E.L.*.

Figure 4.2

Logic Model



Launching the Program

The primary stakeholders for this CoP will be the participating OTPs. The participants will be selected by an OT program academic fieldwork coordinator (AFWC) from a convenience sample of OTPs who are also FWEs. Additionally, since the research has indicated that allied health professionals see a lack of support (e.g., cost, time, engagement) from employers as a barrier to CPD (Townsend et al., 2006; Gunn & Goding, 2009; Summers et al., 2015; Stewart et al., 2020), an additional stakeholder will be organizational leadership. These could be managers, lead therapists, or other staff who supervise occupational therapists. Another stakeholder would be the AFWC and university, that will be established as an accredited provided of continuing education units, as to provide this CoP as free continuing education benefit for their FWEs.

Given that research indicates that decreased organizational engagement contributes to an increase in burnout among allied health professionals, the first step to running *OT F.U.E.L.* necessitates engagement with and the endorsement of organizational leadership (managers, lead therapists, or other staff who supervise OTPs, which can also include fieldwork clinical coordinators). The OT FWEs will receive encouragement from their clinic managers, with the intention to also increase the OT FWEs engagement within the program. Ideally, the OT FWEs will be allowed to participate in the program during work hours, as to further incentivize participation and nurture feelings of organizational support.

Anticipated Barriers and Challenges

There are several barriers that can impact the launch of this program, including but not limited to organizational support, time, insight for a need to change, and inconsistent participation from those in the group.

Organizational collaboration is a fundamental step in increasing stakeholder support from organizational leadership of their OTPs. Managers may not be interested in participating in this program, may be reluctant to allow staff to participate during work time, or may not even respond to the request for participation, which would therefore limit the number of OTPs who could participate.

Even if organizational support is obtained, the OTPs themselves may not see the need to participate in a CoP, especially with other specialty areas. Some may be resistant to new learning, or lack the insight for the need for new learning of current best practices.

In all cases, however, there is the significant barrier of time available to participate. This is intended to be supported by the organizations, but if that is not possible, then the group would need to run in the evenings or weekends, which may be less appealing to some participants.

To mitigate the resistance, AOTA approved continuing education credits will be awarded for their participation in the program. This will be offered free of charge to FWEs who take students from the host university program.

Summary

The professional collaborations among the currently disparate specialty areas of OT will not only reinforce the application of CPD for the individual OTP, but within the profession itself. The social learning that takes place within a CoP also affirms increased professional identity and unity (Galheigo et al., 2019). Furthermore, there is urgency needed for this intervention because of the impact that the various barriers to CPD and holistic care have on client outcomes (Laver et al., 2014; Escher et al., 2018). Therefore, the anticipated outcome of *OT F.U.E.L.* is to increase the holistic approach to professional development of occupational therapists, thereby improving overall client outcomes.

CHAPTER FIVE – Program Evaluation Research Plan

Program Scenario and Identified Stakeholders

OT F.U.E.L. is a virtual CoP for OTPs of various specialties, including pediatrics, orthopedics/hand therapy, inpatient/outpatient rehabilitation, and mental health. This CoP is designed to promote intraprofessional social learning and knowledge translation in order to decrease to research to practice gap and improve client outcomes through the sharing of knowledge. The purpose of *OT F.U.E.L.* is to promote learning from those from other specialty areas of OT, by utilizing social learning theory as applied through a virtual community of practice. There are three phases of this project:

Phase 1: Pilot testing OT F.U.E.L with FWEs in Illinois.

Phase 2: Pilot testing OT F.U.E.L with FWEs across the United States through other AFWCs.

Phase 3: Exploration of broader implementation of OT F.U.E.L across the United States.

The initial pilot (*Phase 1*) will take place through a Master of Occupational Therapy (MOT) program in Illinois, but then be disseminated to other OT programs throughout the United States. In each cohort, there will be a total of 12–16 OTPs, with smaller groups made up of three to four members. The CoP will take place on MS Teams over six sessions, which will run every three weeks. The first session will be spent getting to know each of the participants through icebreakers and small breakouts, as well as providing general education about evidence-informed data regarding OTP barriers to engaging with and implementing new knowledge. *OT F.U.E.L.* will specifically address knowledge translation and implementation, as well as self-care to manage burnout among occupational therapists. Each subsequent meeting will follow the same general structure: 1) whole-group activity to engage in self-care (e.g., yoga, mindfulness); 2) MS Teams breakout rooms for each specialty area to collaborate on and discuss a designated case study and/or research article; 3) large group will meet again for sharing, with each member offered the opportunity to share their insights and feelings about the topic; 4) as needed, the group facilitator will act as a knowledge broker to encourage connections among the different groups by making general connections to the findings of each group; 5) group members will then be given the opportunity for reflection and challenged to share one way they can apply something learned during the session to their daily practice.

The primary stakeholders for this CoP will be the participating OTPs. The pilot participants will be selected by an OT program AFWC from a convenience sample of OTPs who are also FWEs. Since the research has indicated that allied health professionals see a lack of support (e.g., cost, time, engagement) from employers as a barrier to CPD, an important secondary stakeholder will be organizational leadership. These could be managers, lead therapists, or other staff who supervise OTPs. Another stakeholder would be the AFWC and university, which is providing this CoP as free continuing education for their FWEs.

Vision for the Program Evaluation Research

Completing research on the program evaluation from *OT F.U.E.L.* will have both short-term and long-term implications for occupational therapy practitioners and the profession. In the short term, information collected on specific program elements (integration of management support, stress management, education, collaboration with similar peers, or collaboration with peers from other specialty areas) can be evaluated for their usefulness in promoting new knowledge and opportunities for application into daily practice. Feedback from participants can also inform the topics or group activities that need continued development. By engaging the support of organizational leadership for FWE participation in *OT F.U.E.L.*, this program gives leadership the opportunity to promote CPD in a timely and cost-effective manner, while the research data can also be used to make the case for completing CPD during work hours. This may improve staff perception of a lack of organizational support, which is a reported barrier to CPD and contributes to burnout (Stewart et al., 2020).

The long-term implications for a program evaluation on *OT F.U.E.L.* can be far-reaching. For the stakeholders, the FWEs and organizational leadership have additional ways to increase the application of evidence-informed practice into their clients' treatments, which has the possibility to contribute to improved outcomes. Lessons learned can also be shared with other staff in a cost-effective manner through in-services or lunch-and-learns. Additionally, completion of free continuing education with *OT F.U.E.L.* through the university may contribute to FWE preference for university placements, which is a significant benefit at a time of a shortage in fieldwork placements and educators (Ozelie et al., 2014). This, in turn, may help recruit new, potential FWEs for future cohorts of *OT F.U.E.L.*.

On a larger scale, the application of recent suggestions from previous research for future CoP elements will contribute to the body of research on effective means of knowledge translation and implementation. This should be completed within – occupational therapy journals as well as at the AOTA conference. The creation of *OT F.U.E.L.,* and the dissemination of its outcomes, lays the foundation for the profession of OT to become more integrated and holistic in its approach within each specialty area.

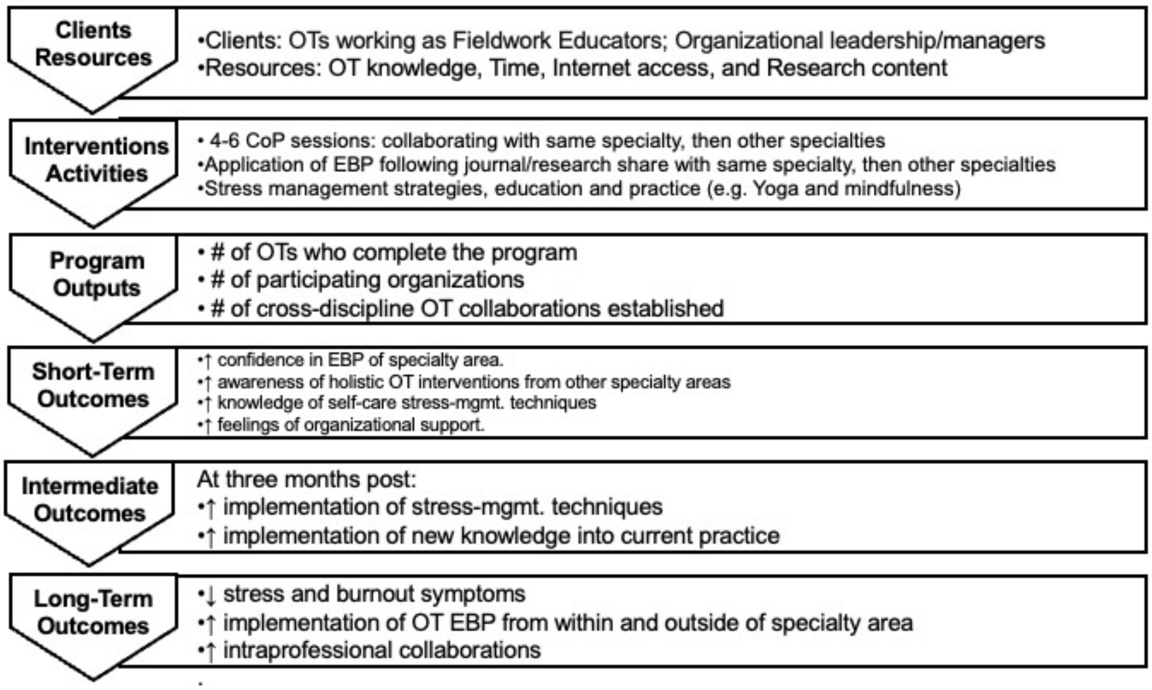
Simplified Logic Model of the Program and Evaluation Plan

The organizational leadership, who are secondary stakeholders, will receive a simplified logic model during the recruitment phase for program participation. The simplified logic model (*Figure 5.1*) clearly demonstrates the potential impact on their OTPs, while also serving as a tool to highlight their important role in that process.

The primary stakeholders, the FWEs, will also receive a simplified logic model of *OT F.U.E.L.* upon registration, prior to starting the CoP, in order to help them make connections between the program inputs and outputs to the short-term and long-term objectives of their participation.

Figure 5.1

Simplified Logic Model for OT F.U.E.L.



Engagement of Stakeholders in the Program and Evaluation Research

The role, interest, and need of each stakeholder will influence their level of engagement. The initial stakeholder is the AFWC, who will be acting as the recruiter, group facilitator, and researcher. They will be responsible for all the logistics of the group and subsequent data collection.

Because research indicates that decreased organizational engagement contributes to an increase in burnout among allied health professionals, the first step to running *OT F.U.E.L.* necessitates engagement with and the endorsement of organizational leadership (managers, lead therapists, or other staff who supervise OTPs, which can also include fieldwork clinical coordinators) to allow for participants to complete the program during scheduled work hours. Organizational leadership will be encouraged to demonstrate buy-in with the incentivization of grant-funded reimbursement for employee time. The OT FWEs will receive encouragement from their clinic managers, with the intention to also increase the OT FWEs engagement within the program. Ideally, the OT FWEs will be allowed to participate in the program during work hours, as to further incentivize participation and nurture feelings of organizational support. However, understanding the current state of therapy and the high productivity standards that most therapists have, the program will likely have to be offered in the evenings or on weekends as to elicit the most engagement. Organizational leadership/managers will participate in the initial stages and 6 months after the program for feedback on their OTP and client outcomes. Due to the busy schedules of these stakeholders and the geographic distance of the clinics, meetings with organizational leadership will be completed virtually based on their availability.

The primary stakeholders, however, are the participants of *OT F.U.E.L.* who are the occupational therapy FWEs. Their active engagement in the group will start with the sharing of the simplified logic model before the first meeting of the group, then with their engagement in establishing group rules and goals. This is done for the program to be relevant to their needs and interests, which will increase engagement in group activities. Ensuring this aspect contributes to the program's availability and sustainability.

Table 5.1

Basic Matrix for Organizing Stakeholder Information

Stakeholder or Stakeholder Group	Type of Involvement	Possible Role(s)	Specific Interests
Researcher/AFWC/ Knowledge Broker	Planning Implementing Reflecting	Overseeing recruitment, group participation, and administering the program activities, and coordinating logistics for program evaluation.	Enrolling a sufficient number of CoP participants from a variety of specialties, successful CoP implementation, usable data to answer evaluation questions
Primary intended users: OT FWEs	Planning Implementing Reflecting	Engagement in establishing group rules and goals. Participation in all group activities, including feedback	Sharing experiences of success and where continued growth is needed
Organizational leadership (managers, lead therapists, or other staff who supervise OTP, which can also include fieldwork clinical coordinators)	Planning Reflecting	Recruiting staff for program participation. Feedback on OT and client outcomes	Increasing employee engagement/decreasing staff attrition, improved client outcomes, and utilizing cost-effective option for continuing education
OT AFWCs and program directors	Reflecting Feedback	Consultation on methodology, analysis, logistics, and eventual dissemination	Design rigor and valid outcomes that meet quality research standards.

Eliciting Stakeholder Involvement and Use of Evaluation Results

The first stakeholder meetings that need to occur will be with organizational leadership to collaborate on participant recruitment. The initial meeting with the supervisors/managers will be collaborative, allowing them to express their needs and any observed problems with staff, therefore facilitating their engagement in the program goals. Data will be gathered from organizational leadership to establish their identified "problem areas" through semi-structured interviews or open-ended questions on a questionnaire (to complete at their convenience).

At that initial meeting, they will also be offered a presentation or a handout like the fact sheet, with a summary of the research regarding the benefits of holistic and integrated care, the negative trends in OT burnout and attrition, the research-practice gap, and evidence of the positive impacts on these through organizational support. Some examples of supporting research include:

- Numerous studies examined integrated care models, incorporating the impact of occupational therapy as part of a holistic approach to patient care, and found that it leads to improved client outcomes (Laver et al., 2014; Escher et al., 2018).
- Samuelsson & Wressle (2015) studied OTP perceptions of barriers to CPD. "The occupational therapists identified three main barriers to the use of research: insufficient facilities (82%); lack of time to read research (77%); difficulty understanding statistical analyses (75%)" (p. 175).
- A recent report by Shin et al. (2022) indicated that OT burnout, that may reduce patient safety, contribute to attrition, demonstrate lower empathy for patients, and have decreased creativity.
- Gunn & Goding (2009) reported that "there is evidence that shared responsibility between staff and employers, and adequate support to enable skills development

are critical factors in facilitating ongoing engagement in continuing professional development" (p. 210).

They will then receive research on the benefits of participation in OT F.U.E.L., focused on the benefits of a CoP.

- Anaby et al. (2016) studied the guided knowledge translation process. "Clinicians discussed the benefits of learning and knowledge acquisition. Gaining new knowledge was perceived as empowering; it strengthened professional identity and reassured clinical work" (p. 444).

Additionally, organizational leadership will be presented with the cost-saving opportunity for continuing education offerings for their staff, by offering the program as a free continuing education benefit received from the university for being a fieldwork educator. The participating organizations will also be reimbursed for lost staff time through grant funding, in order for staff to be able to participate during work hours. Organizational leadership will then be invited to participate six months after the program for their feedback on observed changes to practice since the program, contributing to the assessment of the implementation of education. Therefore, they will not only have input into program evaluation development and analysis of implementation but also have data on outcomes for clients and staff after the program.

Based on the programs that enlist with the CoP, emails to the primary stakeholders, the OT FWEs, will be sent with background information about *OT F.U.E.L.*. Included in this email will be the simplified logic model as well as a summary of research similar to what was presented to the organizational leadership, in order for them to understand the targeted outcomes of the program. They will then be asked to consider what they would like to get out of the program, and to then come prepared to share those ideas with the group at their first meeting. Additionally, participants will have the opportunity to meet with the program leader, either virtually or in person, prior to the start of the program if they request to further understand the program and the research opportunities.

The OT FWEs will also be informed that their feedback and opinions are very important to the continued development and value gained from OT F.U.E.L., and as such, they will be asked at the end of each session to reflect and provide feedback within the group as well as anonymously through a questionnaire on Qualtrics® with specific questions about their experience. Summative data will also be collected six months after the end of the program. They will participate in a brief semi-structured interview led by the AFWC, having them identify ways in which the program has been implemented into their daily practice.

If possible, organizational leadership will also be asked to provide corroborating data by sharing appropriate data on patient outcomes, or just observed changes in clinical practice. Through this process, the participants have a clear understanding of the expectations for their active engagement and honest feedback prior to starting the program.

Finally, based on enrollment in the program, the AFWC will complete additional outreach to clinics to enroll the specialty areas not yet represented in the group, and then complete the above-specified process.

Program Evaluation Research Questions by Stakeholder Group

Research questions need to be relevant to the varied interests of the different stakeholders for increased engagement with the program. *Table 5.2* outlines potential research questions for each of the various stakeholders that could be answered through the research findings.

Table 5.2

Stakeholder Program Evaluation Research Questions

Stakeholder or Stakeholder Group	**Formative Evaluation Research Questions**	**Summative Evaluation Research Questions**
Researcher/AFWC/ Knowledge Broker	Does participation in each session of *OT F.U.E.L.*: • Result in an increased awareness of knowledge within other areas of OT? • Facilitate establishment and nurturing of group relationships? • Result in the desired outcomes of increased applicable knowledge and improved self-care skills? • Encourage participant feedback for session highlights and growth areas? Was the information presented: • At an appropriate level of skill and knowledge for participants? • Delivered with sufficient time to process and engage with other participants?	Does completion of *OT F.U.E.L.*: • Result in the knowledge implementation of learned skills and knowledge into daily practice at least 6 months later? • Demonstrate the successful application of a CoP for integrated OT collaboration, based on recent research and suggestions?
Primary intended users: OT FWEs	Will participants:	Can a CoP that includes various specialties of OT:

	• Report a better understanding of knowledge within their specialty area? • Report a better understanding of knowledge within other specialty areas? • Identify applicability of knowledge from other specialty areas to practice within their own specialty? • Complete learned self-care activities, such as mindfulness or yoga, outside of the CoP for improved coping to combat burnout?	• Facilitate intra-professional learning? • Increase the practice of a more holistic application of OT across settings? • Increase confidence and competence with application of new skills to daily practice? • Increase problem solving and creativity with clients' treatments? • Create a larger sense of community within the field of OT?
Organizational leadership (managers, lead therapists, or other staff who supervise OTPs, which can also include fieldwork clinical coordinators)	n/a	Does FWE participation in *OT F.U.E.L.* result in: • improved quality of clinical care and application of EBP? • improved client outcomes? • decreased burnout? • decreased attrition?
OT AFWCs and program directors	n/a	Does FWE participation in *OT F.U.E.L.* result in: • increased ease with finding fieldwork placements with FWEs who completed the program? • improved learning experience with students, reflecting a more holistic and generalist approach as is taught in school?
State and National OT associations	• Do participants report an increased understanding of the holistic role of occupational therapy in provision of services?	• Will findings demonstrate that the course content integrates different specialties of OT, developing skills and closing the knowledge gap within the field?

Research Design

Formative Design

Semi-structured interviews with organizational leadership will be conducted before the start of the program to understand their current pain points with their staff and client outcomes, to better elicit engagement and promote collaboration with the program.

OT FWEs will engage in a similar process, with initial individual contact over email, providing basic information about the program, and preparing them for the first session. At the first CoP meeting, the participants will engage in a focus group with all participants to establish group rules and objectives that are meaningful to the participants.

Summative Design

Because this CoP is not only focusing on knowledge translation between various specialties of OT, but also knowledge implementation in terms of how much of that knowledge gets applied to daily practice, the data will be collected once the formal program activities have completed. The program participants will participate in a focus group at the last session, responding to prompts about their overall experience with the program, perceptions on strengths and areas for improvement of the program, and general feedback on specific aspects of the program, such as self-care, learning activities, and research. An anonymous survey will also be available to every participant, should they not feel comfortable with sharing their honest thoughts within the group. Themes will be compared to the previous week's reflections.

Six months after the completion of the program, participants will complete a survey having them reflect on their current knowledge, compared to knowledge prior to starting the program, indicating a numerical value to highlight the rate of change for measures of knowledge, within their specialty and with other specialties, as well as confidence and competence with the new knowledge.

Additionally, six months after the completion of *OT F.U.E.L.*, organizational leadership with be sent an online survey to provide their perceptions on the change of the FWEs practice, client outcomes, and overall job satisfaction.

Methods

Confidentiality

An application for Institutional Review Board (IRB) review will be submitted to the IRB at the author's workplace outlining the program evaluation of the CoP. In the application, details will be presented about how the participants' confidentiality will be maintained. Additionally, at the first group meeting, the moderator will establish rules of confidentiality within the group, having members only share first names and the type of setting they work at rather than the specific place of employment. The group member guidelines for the sessions are to include that this group is a safe place to share. As such, it will be the expectation that all discussions are confidential to the group.

Furthermore, participants need to provide consent prior to audio and video recording on MS Teams. Participants will be instructed to edit their MS Teams name to not include their full name for it to not show up in video recordings or transcripts. Only the researcher will have access to any identifiable data. The dataset will be de-identified prior to data analysis. No individuals will be identifiable in any dissemination of the findings as only group data will be presented. In addition to clicking on "I Agree" when recording on MS Teams, the participants will also complete and electronically sign a consent form for their participation in the program along with other necessary audio and visual recordings. This form will be securely electronically stored on Etrieve™, which has a two-factor authentication of identity. Participants will be informed that the author will not be sharing the group recordings with anyone, and they will only be used for research purposes. The recordings and audio transcripts will be kept on a secure online drive that only the author can access with two-factor authentication.

Formative Data Collection

Formative data collection will occur prior to the start of *OT F.U.E.L.*. These formative data will be collected from the stakeholders of the OT FWEs and their employers. Additionally, the OT FWEs will participate in formative assessments after each session via within-group conversations as well as an anonymous questionnaire on Qualtrics®.

Methods for Formative Data Management and Analysis

Since the groups will be run over MS Teams, the audio transcripts of the participant engagement and feedback will be generated automatically. These transcripts will likely need to be edited for accuracy, as confirmed by the video recording also available. Since the group will utilize Cole's seven steps for group leadership (Cole, 2017), specifically using the steps of "Sharing" and "Processing" immediate feedback will be obtained from all participants about the group and activities, at the end of each group. Miro will be used for content analysis to map out themes from written transcripts, as the post-its are easy to use and move as themes begin to emerge. This more laborintensive way of data analysis is preferred, as it facilitates a better sense of the data through repeatedly reading and analyzing it. Once this process has been completed, other AFWCs or university faculty will be recruited to review the theme analysis and provide reflections. Miro is password protected, therefore only the researcher will be able to access the data to share with fellow staff.

Summative Data Collection

Summative data will be collected from the FWEs six months after the completion of *OT F.U.E.L.*to assess which aspects of the group had successful, sustained implementation.

Independent Variable. The independent variable is the self-perceived knowledge acquisition of the OTPs after participating in a virtual community of practice, *OT F.U.E.L.* The sessions will be hosted over MS Teams, and the AFWC will serve as the knowledge broker between the groups., then participate in break-out groups to discuss curated research or case studies to promote collaborative learning and creative problem-solving. A member of each group will be made a co-host to enable the recording of the break-out rooms as well.

Dependent Variables. 1) *Self-care education and practice*. Participants will have received self-care education and engaged in a weekly designated activity to reduce symptoms of burnout. Participants will rate the ease of completing the activity and the likelihood of continuing to engage in the activity since the completion of the group.

2) *Self-perceived knowledge acquisition.* Participants will rate their perception of the value and applicability of knowledge learned, for both within-specialty and external-

to-specialty areas. This will be completed on a Likert scale, where: 5 = Very applicable to my practice; 4 = Applicable to my practice; 3 = Somewhat applicable to my practice; 2 = Minimally applicable to my practice; 1 = Not applicable to my practice.

3) *Social Learning.* Participants will rate their perception of the overall value of the interpersonal, and professional relationships within the group, for both within-specialty and external-to-specialty groups. Ratings will be completed on a Likert scale, where 5 = Very valuable for my practice; 4 = Valuable for my practice; 3 = Somewhat valuable for my practice; 2 = Minimally valuable for my practice; 1 =Not valuable for my practice.

Another summative component of the study involves administering surveys to organizational leadership to assess their perceived changes in their staff and practice outcomes. They will be sent a link to a Qualtrics® survey with Likert scales asking their perception on improved quality of clinical care and application of evidence in practice. They will be asked to specifically reflect on client outcomes, burnout symptoms, staff changeover. Additionally, they will be asked if they found the program to be overall beneficial for their staff, and if so, whether they would like to participate again with other OT staff members.

Methods for Summative Data Management and Analysis

Since this program will run as part of a university offering for FWEs, data can therefore be collected through available university programs/applications, like Qualtrics®. Qualtrics® offers customizability of question format and integrated data analysis, making the data collected easy to manage. Each participant will need a computer, iPad, or phone to complete the questions.

Disseminating the Findings of Program Evaluation Research

Because of the multiple stakeholders of this program, dissemination of the findings of the program evaluation research will occur in a variety of ways for the easiest comprehension. For instance, an infographic is generally visually appealing and communicates sometimes complex information in an understandable way. This might be used for future recruitment of organizations and participants so they can quickly and easily see the benefits of the program from their unique perspective. Additionally, this infographic could also be included in the annual newsletter published by the author's university OT department, which goes out to alumni and community partners, further sharing the value of not only participation in the CoP, but also affiliation with the university program.

For dissemination to occupational therapists, the author will submit an application for a research poster presentation at the AOTA annual conference to be able to share the findings with other OTPs in attendance, but also have the abstract published for others to be able to locate. Additional opportunities to publish in peer-reviewed journals will also be pursued, such as the *Open Journal of Occupational Therapy,* to further share the program evaluation research with those OTPs who may not be members of AOTA. Another powerful tool for sharing the impact of the program is storytelling, which would likely take the form of short videos from past participants, sharing the impact of the program on their daily practice and overall mindset. These videos could also be used when first meeting with organizational leadership, highlighting the impact to facilitate buy-in. These stories could also be shared through one of AOTAs "Conversations that matter" discussions that take place during the annual conference. In addition to spreading the idea of a more unified, holistic approach to OT, this could be an opportunity to also learn from others who have organically had similar paradigm shifts to their practice.

CHAPTER SIX – Dissemination Plan

Program Overview

Occupational Therapists Fostering Unified Expertise and Learning (OT F.U.E.L.) is a virtual CoP for OTPs working in the various siloed specialties of OT, including pediatrics, orthopedics/hand therapy, inpatient/outpatient rehabilitation, and mental health. While the OT profession embraces holistic, occupation-based approaches to working with clients, the practice of OT remains fragmented into specialty areas. *OT F.U.E.L.* is designed as an online educational program focusing on intraprofessional social learning and knowledge implementation. The objective is to reconnect with the common roots and approaches of OT and enhance practice skills and expertise with the vast knowledge available within different areas of the profession. There are three phases of this project:

Phase 1: Pilot testing of OT F.U.E.L. with FWEs in Illinois.

Phase 2: Pilot testing of OT F.U.E.L. with FWEs across the United States through other AFWCs.

Phase 3: Exploration of broader implementation of OT F.U.E.L. across the United States.

Goals

The overall goal of disseminating this project is to increase awareness of *OT F.U.E.L.*, highlighting not only the intraprofessional knowledge and resources shared, but also how it unifies the unique aspects of the OT approach through all settings. Furthermore, through analysis of program evaluation data collected during *Phases 1* and

2, an additional goal is to demonstrate to health services and OT managers the value of continuing professional education offered during work hours. Therefore, the dissemination goals of this project include three short-term goals and two long-term goals.

Short-Term Goals (6–12 months)

1. Through the dissemination of *Phase 1* program evaluation data, FWEs will be made aware of the impact of the OT F.U.E.L. program.
2. Through the dissemination of *Phase 1* program evaluation data, OT managers will be made aware of the impact of the OT F.U.E.L. program.
3. Through the dissemination of *Phase 1* data, OT managers will be made aware of the value of supporting in work time for professional development.

Long-Term Goals (2–5 years)

1. Through the dissemination of *Phase 1* and *2* data of OT F.U.E.L., there will be increased awareness in the OT community of the need for holistic practice across specialty areas.
2. Dissemination of *Phase 1* and *2* data of OT F.U.E.L. supports efforts to implement the program more widely across the USA.

Target Audiences

OT F.U.E.L. will be disseminated in three phases, with the target audience varying per phase.

Phase 1 (Pilot Testing with FWEs):

The primary target audience for *OT F.U.E.L.* dissemination during *Phase 1* pilot testing are OTPs who are also FWEs in the state of Illinois. The program is specifically designed for the collaboration of various specialty areas of OT. Therefore, the initial target specialty practice areas of the participants will be pediatrics, mental health, inpatient and outpatient rehabilitation, and hand therapy.

The secondary audience targeted during the dissemination of *OT F.U.E.L.* is organizational leadership (e.g., program directors, department managers, lead therapists) who manage OTPs within their organizations. Those in these roles were chosen as the secondary audience for *Phase 1* because they are the decision-makers within the organizations who have governance over staff supervision and time off requests. As such, their active engagement and support of their employee's participation in *OT F.U.E.L.*, can have a direct impact on the employee perception of organizational support for CPD.

Phase 2 (Pilot Testing Through AFWCs in OT Programs Across the USA):

The key target audience of dissemination during *Phase 2* pilot testing are additional FWEs to be reached through AFWCs from OT programs in the various regions of the United States. Therefore, recruitment is needed during this phase to solicit their active involvement for pilot testing within their region. Their involvement is needed to not only continue pilot testing *OT F.U.E.L.* to other regions of the country, but also to generate additional data from the program evaluations for research indicating the value of CPD offered during work hours.

The secondary audience is the OT professional community. Dissemination of *Phase 1* findings in *Phase 2* is targeted to those who attend professional conferences at the state and national level, through poster presentations and short courses, as well as reporting on the findings of *Phase 1* of the program in a scholarly journal such as the Open Journal of Occupational Therapy (OJOT).

Phase 3 (Implementation Across the USA through AOTA):

Dissemination during *Phase 3* has the goal of reporting the findings of the *Phase 2* pilot testing to the OT professional community. Like *Phase 2*, this will be targeted to those who attend professional conferences at the state and national level, through poster presentations and short courses, as well as reporting on the findings of *Phase 2* of the program in professional, scholarly journals.

The secondary audience for *Phase 3* would be CoP organizers of the American Occupational Therapy Association (AOTA), to further disseminate the group content to the greater AOTA community. Because of its scope of access to OT practitioners throughout the United States, AOTA is a natural choice for large-scale dissemination of this program.

Key Messages for Target Audience

Table 6.1 lists the key messages for each target audience, primary and secondary, for each phase of dissemination. While some of the messaging may be similar between the groups, there are also distinct differences in the messages because of the audience member and the phase within which it is being reported.

Table 6.1

Key Messages for Target Audiences

Phase 1
Primary Audience - Occupational Therapy Fieldwork Educators
1. CPD can be derived from other specialty areas of OT, which can then be applied to your specialty area. The transformational learning that occurs in CoPs is because of the participation of those representing a variety of perspectives and experiences. 2. A holistic approach, within the entire scope of OT, can improve overall client outcomes. 3. The social learning that takes place in a community of practice can benefit you both professionally and personally, thereby improving client outcomes.
Secondary Audience - Organizational Leadership
1. Research indicates that healthcare workers often feel unsupported by organizational leadership, leading to increased burnout and job attrition. 2. Barriers to continued professional development, such as time and cost, staffing, and work demands, often lead to decreases in client outcomes. 3. *OT F.U.E.L.* is offered in partnership with organizations to not only track outcomes, but address the barriers, by being offered as free continuing education during work hours. This, in turn, can lead to improved employee satisfaction and outcomes. 4. Grant funding will be used to compensate organizations for the loss in billable time of the participating OTP.
Phase 2
Primary Audience - Academic Fieldwork Coordinators
1. *OT F.U.E.L.* is an evidence-based intervention program that addresses systemic barriers to the holistic practice of OT across all specialty areas. 2. Offering *OT F.U.E.L.* to fieldwork educators ensures their confidence and competence with delivering holistic OT in their workplace, especially important to demonstrate when teaching OT students. 3. Offering *OT F.U.E.L.* as free continuing education to FWEs incentivizes their participation with your academic institution in taking future OT fieldwork students.

Secondary Audience - OT Professional Community
1. There is a need for increased intraprofessional collaboration within the various specialty areas of OT. 2. The benefits of a CoP that unifies the specialty areas, not only improved outcomes of the individual practitioners, but unites the profession of OT. 3. Data from *Phase 1* pilot testing indicates the value of completing continuing professional education in collaboration with organizational leadership.
Phase 3
Primary Audience - OT Professional Community
1. There is a clear benefit of increased intraprofessional collaboration within the various specialty areas of OT. 2. *OT F.U.E.L.* unifies the specialty areas, not only improving outcomes of the individual practitioners, but uniting the profession of OT. 3. Data from *Phase 2* pilot testing indicates the value of completing continuing professional education in collaboration with organizational leadership.
Secondary Audience - AOTA Members
1. Communities of practice benefit most from a variety of experiences and perspectives, however AOTA CoPs lack that diversity. 2. There is a need for increased intraprofessional collaboration within the various specialty areas of occupational therapy, as supported by the evidence of *OT F.U.E.L.,* which should be endorsed by the American Occupational Therapy Association as an official CoP of the AOTA. 3. All occupational therapy practitioners would benefit from this collaborative learning, not just fieldwork educators.

Sources or Messenger

Phase 1 Primary Audience

For the initial participants, the primary messages will be delivered over email and phone calls by the author. Research indicating the personal and professional benefits of participating in a community of practice will be shared. Furthermore, the OTPs will be informed of the incentive to participate by the award of free continuing education credits at the end of the program, awarded by the host university from which they accept Level II Fieldwork students. As needed, additional communication will be made over the phone. An announcement will also be placed in the annual MOT program newsletter, which the author publishes yearly and shares electronically with all current and previous affiliates, including AFWC and FWE. Additionally, the Illinois Occupational Therapy Association (ILOTA) can share an electronic announcement with all state members.

Phase 1 Secondary Audience

The dissemination during *Phase 1* of *OT F.U.E.L.* hinges on engagement from organizations. These organizations will be sourced from existing affiliations already established through fieldwork collaborations. Initial communication will be initiated by the author over email, but then follow up with in-person or Zoom meetings. Communication with the organizations will include research evidence to demonstrate the impact that employee burnout and stress have on client outcomes, as well as overall employee attrition. This will then be contrasted with evidence of the value of communities of practice on personal and professional growth and competence. Finally, organizational leadership will be informed of the incentive to participate with the benefits of being able to offer their participating employees free continuing education credits, while being compensated $100 per hour of their employee's participation.

Phase 2 Primary Audience

The dissemination of *OT F.U.E.L.* to additional AFWC throughout the United States will benefit from personal accounts of those OTPs who participated in the initial pilot testing. These personal accounts can be in the form of quotes or overall outcomes reported from program participants. Reporting this qualitative and quantitative data will be valuable in demonstrating the potential impact the program can have on individual participants, as well as the field of occupational therapy. This information can be shared on the state and national Academic Fieldwork Coordinator Collaborative (AFWCC) List-AOTA for the education of the program and potential recruitment.

Phase 2 Secondary Audience

The dissemination of *OT F.U.E.L.* to the overall OT professional community at state and national conferences would benefit from this qualitative and quantitative reporting of personal accounts of those who participated in the program. This would not only promote the benefit of the *OT F.U.E.L.*, but also disseminate research regarding the benefits of integrated OT practice and organization-supported continuing professional education.

Dissemination Activities and Tools

Written Information

Email to Fieldwork Affiliates. Communication with *Phase 1* primary and secondary audiences will initiate over email. A brief email will be sent to established community partners of the university. The email will describe the program and its benefits, and request a follow-up meeting (in-person or virtual) to further discuss participation. Attached to the email will be an informational fact sheet. Should there be no response after one week of sending the initial email, a follow-up email will be sent.

Informational Fact Sheet. An informational fact sheet will be created to provide an overview of the *OT F.U.E.L. CoP* to potential participants using Adobe InDesign, which is an available faculty resource. Initial versions of this document will include a summary of the research-supported benefits of CoPs. Subsequent versions will also include personal accounts from previous participants, as well as outcome measures derived from the program evaluation surveys. In all versions of the fact sheet, there will be a program description outlining specifics, such as the time requirements for participation, and expectations for the participants and program, as well as contact information to request participation in the program. The fact sheet will be shared digitally in the initial recruitment email, as well as printed for in-person meetings and events.

Executive Summary. An executive summary will be created as a more in-depth version of the fact sheet, but targeted toward program administrators. The executive summary will specifically focus on the impact of organizational support for CPD, which impacts overall client outcomes. Therefore, outcome measures will be highlighted throughout the document, of both staff and clients.

Informational Handbook. After the initial *Phase 1* pilot testing, the author will develop an in-depth instructional guide for *Phase 2* of the program for other academic fieldwork coordinators to use to run their own program. This handbook will include an overview of the program, including specific information of the program design, sample session plans, and outcomes. While this handbook will be available for free as a PDF, printed copies will also be made available as needed, to include the cost of printing and shipping.

Journal Publication. The author intends to submit a journal article proposal regarding the *OT F.U.E.L.* program and outcomes to peer-reviewed journals, such as the OJOT, published through Western Michigan University's Department of OT, or the Occupational Therapy Journal of Research (OTJR), published quarterly by the American Occupational Therapy Foundation, Inc. Publication of this article will increase awareness of the program, and the need for further dissemination. The article will include relevant contact information for the program and its author.

Electronic Media

Facebook. Program information, updates, and outcomes will be shared on the Facebook group *OT Fieldwork Educators*. This group has approximately 1300 members, which include FWEs and AFWCs.

Instagram. An Instagram account will be created for *OT F.U.E.L.* that will include contact information where interested parties can direct message the author for additional information or to register for the course. Contact information for this Instagram account will be shared in the *OT Fieldwork Educators* Facebook group.

Person-to-Person Contact

Meetings. Formal meetings with organizational leadership or potential participants will be scheduled either in-person or on Zoom. The author will have printouts of both the fact sheet and executive summary. A formal PowerPoint presentation will also be created to facilitate the flow of information during the meeting. This information will include the program structure, budget and expenses, expected outcomes including the short-term and long-term impact of program participation on both the occupational therapy practitioners and their clients. This PowerPoint presentation will also be made available to phase two pilot testers to facilitate engagement with their local program.

Conferences. The author intends to present the findings at state and national occupational therapy conferences following the first and second rounds of pilot testing. These poster presentations will be for both dissemination to the professional community as well as recruitment of additional AFWCs to run the program in different regions. Therefore, the posters will need to include current supporting evidence from applicable research, as well as program outcomes for both the participants and their clients. The poster will include QR codes to the program fact sheet and Instagram account.

Budget

Dissemination costs for primary and secondary dissemination are negligible because the majority of the communications are completed electronically or in-person. This includes emails, social media, and electronic presentation materials. The expense for dissemination comes in during later phases with conference registration and poster printing expenses, and possible submission or publication fees for journals. Other expenses include printing costs of resources for primary and secondary audiences. *Table 6.2* details the costs for dissemination.

Table 6.2

Anticipated Budget for Dissemination Activities

Dissemination Activity	**Resource**	**Cost**
Written Communication		
Handouts: Fact Sheet, Executive Summary	Adobe InDesign Campus Print Shop	$0 $.25 per page of color printing. Fact sheet: 2 pages Executive Summary: 4 pages Year 1: 12 sites per CoP 2 CoP per year=$36
Informational Handbook	Adobe InDesign Campus Print Shop	$125 Printing of 10 copies, 50-page document in color
Peer-Reviewed Journal	OJOT OTJR	$300 $0
Electronic Media		
Social Media	Instagram Facebook	$0 $0
Person-to-Person Contact		
National OT Conference	AOTA Conference Registration AOTA Conference Travel AOTA Conference Lodging	$425 $470 $600
IL State OT Conference	ILOTA Conference Registration	$189
Poster	Blueprint Shop	$60
	Total	**$2205.00**

Evaluation

Evaluation of the dissemination efforts for *OT F.U.E.L.* will seek to determine the impact and effectiveness of those efforts. *Table 6.3* details how the impact and effectiveness will be evaluated for each activity or tool.

Table 6.3

Evaluation of Dissemination Activities

Dissemination Activity or Tool	***Measurement of Dissemination Effort***
Written Communication	
Email to affiliates	Number of responses to either initial or follow-up email, asking for further information
Fact Sheet	Number of OTPs expressing interest in program
Executive Summary	Number or organizational leaders expressing interest in the program, or seeking additional information
Informational Handbook	Number of requests for handbook
Journal Publication	Acceptance of article Number of contacts resulting from publication
Electronic Media	
Facebook	Number of followers and likes to posts
Instagram	Number of followers and likes to posts Number of contacts requesting additional information
Person-to-Person Contact	
Meetings	Agreement to participate in program
Conferences	Number of attendees, OTP contacts made Number of times poster was looked up Number of requests for additional information

Conclusion

Dissemination of *OT F.U.E.L.* has increased complexity due to its numerous phases of dissemination, including two rounds pilot testing. Therefore, a clear plan and understanding of the unique needs of each phase is necessary for successful dissemination. Despite the different audiences at each phase, a consistent focus of dissemination is education about the program and its benefits. This message will be delivered using a variety of communication methods, including written, electronic, and in-person contact to reach the widest possible audience. Budget considerations for this range of activities was considered, with the primary expenses coming from conference registration and travel expenses, yet most other resources at little to no cost due to already-available resources. Finally, the success of dissemination was considered by establishing outcome measures for each method of communication discussed. Through this variety of efforts, the author intends to increase awareness of the need for this program by highlighting its benefits, which have been tailored to the lens of each unique audience member.

CHAPTER SEVEN – Funding Plan

Program Overview

The *Occupational Therapists Fostering Unified Expertise and Learning (OT F.U.E.L.)* is virtual Community of Practice focusing on intraprofessional social learning and knowledge implementation. As such, it requires important consideration for funding sources, based on the different phases of implementation and dissemination.

Grant funding is required for *Phase 1* of the pilot program, as well as for running the program two additional phases. This funding is needed to provide financial reimbursement to participating organizations to allow OT staff to participate in the CoP during work hours. The additional objective of *Phases 1* and *2* is to establish the value of employers providing continuing education during work hours. Once the group processes are refined after *Phase 1*, *Phase 2* will expand dissemination to OT programs in other areas of the country and will also focus on funding for dissemination at state and national conferences through poster and short-course presentations.

Phase 2 also encompasses recruitment of additional AFWC CoP leaders for additional pilot testing of this program throughout various regions of the United States. *Phase 2* requires grant funding for additional institutions in the six different regions of the United States to provide the CoP, offering financial reimbursement to participating organizations to allow OT staff to participate in the CoP during work hours. This will be followed by *Phase 3*, a collaboration with AOTA for further dissemination as one of their official CoPs. AOTA requires 750 signatures from AOTA members in support of the CoP, which will require funds for marketing and recruitment, in addition to eventual implementation. Data collection for both these phases will occur to not only gather data on the value of participation in the program, but also in the value of completing CPD as part of an employer-supported program.

Available Local Resources

Since *OT F.U.E.L.* is a virtual CoP designed for FWEs, the author intends to use the assets offered within her current role as AFWC within an MOT program. Assets available include access to a computer, which includes Outlook email and Microsoft Teams. Outlook is necessary for communication with all stakeholders. Teams will be utilized because it is available for free to all users and has features that facilitate the sharing of resources and knowledge, such as video conferencing, file sharing, and chat. Data collection will be completed through Qualtrics®, which is available through the author's employer, at no additional charge. University resources also include the Center for Scholarship and Teaching, whose staff offers support and guidance for the design and implementation of online offerings. As faculty, the author has online access to the university library, which will be utilized for the allocation of recent evidence-based resources to be used during the program. Additionally, the relationships and connections established through the role of AFWC will aid in initial recruitment for the pilot testing of *OT F.U.E.L.*. The participation of professionals from various settings within OT is an asset, as their knowledge will be utilized and shared within the collaborative group activities. Finally, as faculty, the author is entitled to $1500 annually for expenses associated with conference presentations.

The University Central Printing is also available for production of *OT F.U.E.L.*

resources and materials. Printed materials include fact sheets for stakeholder recruitment in *Phase 1*, as well as recruitment materials during *Phase 2* for *Phase 3* implementation. *Table 7.1* represents the list of how local resources available to the author will be utilized.

Table 7.1

List of Available Local Resources

Local Resources	**Purpose**
Computer, including Microsoft software such as Outlook and Teams. Qualtrics®	Utilized for communication through email, video conferencing the *OT F.U.E.L. CoP*, and sharing of resources with stakeholders Resource for data collection and analysis
Office Supplies, including folders	Folders issued during recruitment meetings with organizations, to include fact sheet (for OTP) and executive summary (for management)
University Library	Resource for seeking current, evidence-based resources to use during the *OT F.U.E.L. CoP meetings*
University Print Shop	Resource to produce printed materials for *Phases 1* and *2* of *OT F.U.E.L.*
Professional knowledge of participants	Collaborative learning experiences benefit from the shared knowledge of all within the group
Conference presentation funds for faculty	Facilitates the dissemination of research

Needed Resources: Budget

A thorough understanding of all necessary costs and resources needed to execute the various phases of *OT F.U.E.L.* requires the establishment of a funding plan. The costs of *OT F.U.E.L.* primarily fall into the categories of time, marketing, and dissemination. *Table 7.2* presents the breakdown of costs and a projected two-year budget needed for each phase of the program. The cost for the first year of implementation is anticipated to total $8425.50. The second-year estimate for the AFWC dissemination is $35,616.00, as a result of the additional funds needed for organizational reimbursement throughout various regions of the United States. *Phase 3* estimate for the AOTA dissemination totals $2819.75, taking into account the increased costs of marketing and dissemination, but decreased cost of organizational reimbursement.

Time

The cost of time is a significant consideration from the perspective of various stakeholders. From the organizational management perspective, the time that their staff are anticipating to be at work completing non-billable activities, such as the *OT F.U.E.L. CoP*, is a barrier that needs to be addressed in order to establish organizational buy-in for staff participation. Therefore, the initial pilot will include a group that participates during work-hours, but offers organizations compensation for the time the staff is not working with clients in order to offset the cost of back-filling other therapists to cover their time. Based on personal experience, the current average registry rate for OTPs in various settings within the Chicagoland area is $50 per hour; however, incentivize participation, organizations will be offered $100 per hour for each OTP.

Participating OTPs also have a significant consideration of time to participate in the program, considering their likely already-busy schedules. Therefore, the University will be offering compensation in the form of continuing education units (CEUs) for their participation. These CEUs will be at no cost to them, as a benefit of their participation, but will be at an expense to the University offering the program, requiring them to become certified AOTA providers of CEUs.

Finally, while the author will initially be taking the time to run the program, it falls within current job responsibilities as an AFWC, and therefore does not incur additional cost. However, the time involved will include, creating and organizing the online space of MS Teams to include easy access to shared resources, locating the appropriate research for each group, and creating digital resources such as a program manual for future program leaders.

Marketing

During *Phase 1*, the plan is to make initial contact with potential organizations using email and phone calls, however, it will likely also be necessary to make onsite visits to further discuss the program benefits. This will require travel expenses and marketing materials for each site. However, once a relationship and agreement has been established, additional OTPs from established organizations are expected to participate, requiring less recruitment in the subsequent year. During *Phase 2*, additional recruitment materials will be needed to obtain the necessary 750 signatures to establish an official CoP through AOTA.

Dissemination

Following pilot testing of *OT F.U.E.L.*, and once initial results have been analyzed, this author intends to report the findings to the OT community. This will be done through submission to OJOT as well as via professional state and national conference poster and short course presentations.

Table 7.2

Two-Year Budget

Resource	Cost	Year 1 total	Year 2 total -AFWCs	Year 2 total -AOTA
Time				
Staffing cost to reimburse organizations to back-fill time at work of participants	Year 1: $100/hour 6-week program 12 participants/CoP Year 2-AFWCs: $100/hour 6-week program 12 participants/CoP 4 different regions	$7200	$28,800	$0
Continuing Education Units	Tier 1 AOTA approved provider program (APP) application= $575 annually	$875	$3500 For 4 other institutions	$575
	Tier 1 AOTA APP fee per program =$300 (5-year approval)		$1200 For 4 other institutions	$0
Marketing				
University Central Printing	$.25 per page of color printing. Fact sheet: 2 pages Executive Summary: 4 pages Year 1: 12 sites per CoP 2 CoP per year=$36 Year 2-AOTA: 6 sites per CoP 2 CoP per year=$18 Year 2-AFWCs: 12 sites per CoP 4 different regions	$36	$72	$18
	~100 of above-listed documents for marketing at conferences =$150			$150

Travel expenses	Mileage reimbursement= $.655/mile	$65.50 Anticipating 100 miles	$0	$32.75 Anticipating 50 miles
Dissemination				
Printing of poster	Blueprint Shop $60	$60	$60	$60
ILOTA	Conference registration fee	$189	$189	$189
AOTA	Conference registration fee	$0	$425	$425
	Airfare	$0	$470	$470
	Hotel ($200/night)	$0	$600	$600
Open Journal of Occupational Therapy	Processing fee, if accepted	$0	$300	$300
	TOTAL	$8425.50	$35,616.00	$2819.75

Potential Funding Sources

As full-time University faculty, the author is eligible to apply for an annual Summer Faculty Research Grant of $3000. This grant is for “high-quality research proposals that require substantial time (usually during the summer) and demonstrate the potential for having a significant impact on the scholarship of the applicant” (Elmhurst University Center for Scholarship and Teaching, 2023).

Alternatively, a larger-scale option for grant funding would be the American Occupational Therapy Foundation (AOTF) Implementation Research (IR) Grant. This grant specifically funds approaches supporting OTPs with knowledge implementation for improved client outcomes within OT. “This research grant develops and evaluates the processes used to implement, sustain, and or scale-up evidence-based practice into routine care with an end goal to improve the quality and effectiveness of care" (AOTF, 2023). The IR Grant is awarded either for one year for $50,000, or for two years for $100,000. Utilization of this grant would facilitate the direct dissemination of *OT F.U.E.L.* to other academic fieldwork coordinators to run within their local region, allowing for additional funding support to enable completion of the program during work hours, ideally strengthening the evidence of its benefits with additional sample groups.

A final option would be the Boston University Student Research Grant, valued at up to $5000 (*College of Health & Rehabilitation Sciences: Sargent College*, 2023). These grants support the research efforts of Sargent College students and prioritize grants that are otherwise unable to receive funding.

Conclusion

Identifying funding considerations is an essential component of program development. *OT F.U.E.L.*, for instance, has distinct needs for time, marketing, and dissemination. The author's employer and job role offer supports toward the dissemination of this program. Nevertheless, having a clear understanding of the expenses at each of the identified stages can enable the successful implementation of this program, and facilitate the grant application process for additional needed funding.

CHAPTER EIGHT – Conclusion

As presented in *Chapter 2*, in addition to organizational support and research knowledge and confidence, “leadership style, organizational culture, social capital, availability of resources, staffing, time, and space are among the main factors that influence the uptake of [evidence-based practice]” (Thomas et al., 2020, p. 1051). These implications are significant because of the impact that they have on the overall outcomes of the health and well-being of the clients.

Chapter 3 discussed the evidence to support the approaches to address these barriers. Many of the strategies used focus on community, especially understanding and collaborating with a perceived “other.” These collaborations with those from a variety of backgrounds serve to improve the understanding of the commonalities and strengthen the relationship, which can be beneficial for the OT profession. Consistent participation, reflective practices, knowledge sharing, and active engagement in goal setting are essential components of successful CoPs. The structure of collaboration found within communities of practice also serves to bridge the knowledge-to-practice gap, which can accelerate the application of research to clinical practice.

This project is significant because it works to address the research to practice gap through collaboration within the profession. As described in *Chapter 3*, the literature identified several approaches that have been utilized for knowledge translation and implementation with health professionals. Professional collaboration (Moick. et al., 2021; Kläusler-Troxler et al., 2019), and even virtual CoPs (Gresh. et al., 2017; Rolls et al., 2020) have all demonstrated benefits to CPD and integration of knowledge into practice.

Many studies indicated that the essential components of the collaboration required the establishment of a safe environment for open sharing of thoughts and concerns, social learning through discussion and knowledge exchange, opportunities for self-reflection, and the presence of those with different backgrounds to expand other perspectives.

OT F.U.E.L. is designed as an online CoP focusing on intra-professional social learning and knowledge implementation. The objective is to reconnect with the common roots and approaches of OT, and enhance practice skills and expertise — integrating clinical knowledge and skills from various clinical specialties across the profession. *OT F.U.E.L.* was developed to promote the application of knowledge from various specialty areas of occupational therapy, by utilizing social learning theory as applied through a CoP. By integrating the various concepts utilized within disparate areas of OT, it is hoped that the participating OTPs will be better able to adopt a holistic and generalist approach to their practice, and their clients will thereby have improved outcomes. Ultimately, the intermediate and long-term outcomes are expected to result in the implementation of the learning that took place in *OT F.U.E.L.*. By reducing those barriers and facilitating the implementation of new knowledge, the clients will benefit, and likely demonstrate improved outcomes.

Professional collaborations among the currently disparate specialty areas of OT, will not only benefit the OTP but also the profession as a whole. The social learning that takes place within a community of practice also affirms increased professional identity and unity (Galheigo et al., 2019). Furthermore, there is urgency needed for this intervention because of the impact that the various barriers to CPD and holistic care have on client outcomes (Laver et al., 2014; Escher et al., 2018).

APPENDIX A –Sample Lesson Plans

OT F.U.E.L. #1	Date:
CoP Focus	Establishing a community, through relationship building and defining the safe environment
Pre-Work ~10 minutes	Upon signing up for the group, participants complete the pre-test. Before starting the group, participants will answer the following: List what you think an OTP that works in the following setting mostly addresses: 1. Outpatient pediatrics 2. Ortho/Hand therapy 3. Neuro/Outpatient 4. Acute/Inpatient 5. Mental Health
Orientation to group ~15 minutes	1. Background about Communities of Practice and purpose of this group 2. Collaborative establishment of rules for the group (e.g. respectful, confidential, etc.) 3. Brief mindfulness activity
Introductions ~15 minutes	Participants will answer the following questions: 1. Personal: Name, favorite hobby or something interesting about yourself 2. Professional: Where I work, how long I've been an OT, what I love about being an OT 3. Share your assumptions of the different specialties and discuss
Small Groups 20 minutes	1. Each specialty will break out into small groups with those of a similar setting, continuing to get to know one another. 2. Collaboratively come up with a case study of a challenging client
Large Groups ~10 minutes	1. Debrief about experience of group and connecting with peers from similar settings 2. Establish goals for next meeting: an assigned reading

OT F.U.E.L. #3	Date:
CoP Focus	Learning from the pediatric practice area
Pre-Work ~20 minutes	Read the following research article before group: Tanner, K., Schmidt, E., Martin, K., & Bassi, M. (2020). Interventions within the scope of occupational therapy practice to improve motor performance for children ages 0–5 years: A systematic review. *American Journal of Occupational Therapy*, *74*(2), 7402180060p1. https://doi.org/10.5014/ajot.2020.039644
Reorientation to group ~10 minutes	1. Brief mindfulness activity 2. Review of the previous session transcript and main take-aways 3. Group share from anyone that wants to share
Instruction ~20 minutes	1. Discussion of research article 2. Encourage pediatrics experts to share their experiences and knowledge working with this population, possibly using the interventions highlighted in the article. Sample questions to discuss: • How might the strong evidence for motor development be applicable to orthopedic care, or neurological rehabilitation? What findings might be applicable in acute care or mental health treatment? • What mental health implications do expect these interventions have on a client for each specialty area? On the families or caregivers?
Small Groups 30 minutes	1. Each group will meet in small groups with one representative from each specialty area of practice. 2. Collaboratively address the pediatrics and neuro case studies of challenging clients created earlier by the group
Large Groups ~10 minutes	1. Debrief about solutions brought up by the small groups. 2. Self-reflect on different perspectives taken 3. Establish goals for next meeting: an assigned reading

APPENDIX B – Executive Summary

Introduction

The occupational therapy (OT) profession embraces holistic, occupation-based approaches to working with clients, however, health services and systems often require occupational therapy practitioners (OTPs) to work in compartmentalized specialty areas. Specialty practice is critical for delivering high quality care and best practice for particular conditions, however, a solely specialist model may present missed opportunities for OTPs to learn and integrate concepts and approaches from other clinical areas which may be helpful to the patients or clients that they serve. Additionally, patients or clients with needs that do not neatly fit into specific clinical areas may not receive optimal care through specialty practice unless OTPs are able to integrate a range of approaches from various clinical areas in their practice. There is, therefore, a need for OTPs to integrate knowledge to effectively work with clients who have needs that span across multiple clinical areas, in order to deliver holistic care.

It is important for OTPs to engage in continuing professional development (CPD) to maintain knowledge currency required for safe and effective practice. CPD is one avenue which also may be helpful in enhancing OTPs attitudes and abilities relating to integration of knowledge across specialty areas in delivering holistic care. Evidence-based practice is fundamental to this kind of knowledge integration, drawing on high quality research to inform OT practice. Numerous studies (Summers et al. 2015; Stewart et al. 2020; Jones et al. 2015; Thomas et al. 2020) support the need for OTPs to actively engage in CPD in order to implement robust research findings into practice. The OT literature also purports the importance of a holistic approach, looking beyond the injury to the context of each client, which is what OTPs are uniquely trained to do.

While CPD and knowledge integration are important, many clinicians experience numerous barriers to their implementation, such as time, cost, staffing, and organizational influence. Healthcare organizations, on the other hand, must function in a competitive healthcare industry, by optimizing client outcomes while maintaining qualified and engaged staff. This can be a challenge but is a priority considering that those outcomes are tied to reimbursement (Vaughn et al. 2018, p. 74).

To address the challenge of implementing holistic OT practice in specialty-driven, compartmentalized health services and systems, the author developed *Occupational Therapists Fostering Unified Expertise and Learning (OT F.U.E.L.)*: A virtual Community of Practice (CoP) to promote intraprofessional social learning, facilitate knowledge exchange across OT specialty areas, and enhance OTPs skills with EBP and knowledge translation.

Conceptual Framework

The conceptual framework guiding the development of this program is based on Dr. Neil Anderson's "Five P's of Effective Professional Development." In the Five P's model, professional development is approached with purpose, personalization, priority, passion, and professional learning communities. As a human-centered profession, the concept of purpose is central to the OT profession, as our focus is on contributing to well-being through engagement in occupation. How that is achieved, however, is up to the individual OTP through the concept of personalization. Personalization is self-directed learning for professional enrichment. However, barriers of limited time for self-study or focus solely on areas of interest, can restrict therapists to their comfort zone over time. The influence of priority, acknowledging one's limited ability to focus on too much, is significant when considering the impact of productivity standards and limits on payment and practice set by insurance and institutions. Passion is closely related to Duckworth's concept of grit, which she defines as a "ferocious determination," (Duckworth, 2016, p. 8) that is demonstrated by individuals through resilience, hard work, and perseverance. The final component of the 5 Ps model is professional learning communities, such as a CoP. Based on the literature review for this project, OT is lacking sufficient applicable research for practice, and this limited evidence-based application of practice negatively impacts the ability for practitioners to clearly define their distinct role and purpose for clients.

Considering the numerous barriers to holistic OT practice, the 5 Ps model is appropriate because of its multi-faceted approach to understanding the influences on the practitioner. The 5 Ps model considers both the top-down influences, such as regulatory standards or institutions determining what the practitioner needs to know, and the bottom-up influence which is directed solely by the individual practitioner. Research indicates that sustained professional development requires active involvement from the practitioner in concrete ways, and concentrated on specific instructional practices. (Anderson, 2018). When this interactional approach is taken, the needs of the individual and institution are best met.

Project Overview

OT F.U.E.L. is a virtual CoP for OTPs working in the various siloed specialties of occupational therapy, including pediatrics, orthopedic/hand therapy, inpatient/outpatient rehabilitation, and mental health. It is designed as an online educational program focusing on intra-professional social learning and knowledge implementation. The objective is to reconnect with the common roots and approaches of occupational therapy, and enhance practice skills and expertise — integrating clinical knowledge and skills from various clinical specialties across the profession.

OT F.U.E.L. will take place on Microsoft Teams for six, 60-minute sessions, offered every three weeks. *OT F.U.E.L.* will specifically address knowledge translation and implementation, as well as self-care to manage burnout among OTPs. Therefore, each meeting will follow the same general structure: 1) whole-group activity to engage in self-care (e.g., yoga, mindfulness), 2) MS Teams breakout rooms for each specialty area to collaborate on and discuss a designated case study and/or research article, 3) large group will meet again for sharing, with each member offered the opportunity to share their insights and feelings about the topic. 4) As needed, the group facilitator will act as a knowledge broker by making general connections to the findings of each group, 5) group members will then be given the opportunity for reflection and challenged to share one way they can apply something learned during the session to their daily practice.

Overall group size will be limited to 16 participants, with subspecialty groups of approximately four members to ensure diversity of experience. The groups will be moderated by a “knowledge broker” who can facilitate interconnections between the specialty areas.

There will be three phases to the piloting of this program:

Phase 1: Pilot testing OT F.U.E.L with FWEs in Illinois.

Phase 2: Pilot testing OT F.U.E.L with interested FWEs across the United States through other university AFWCs.

Phase 3: Exploration of broader implementation of OT F.U.E.L across the United States.

In the initial pilot (*Phase 1*), participants will be OTPs who are also FWEs, recruited using established affiliations with a university Master of Occupational Therapy (MOT) program. FWEs were selected based on demonstrated engagement in the profession by mentoring fieldwork students. By offering this program through the university, academic fieldwork coordinators (AFWCs) can ensure that the FWEs have the most updated professional knowledge to best support their students.

For the pilot, FWEs will be recruited through their employer in order to get organizational buy-in for their engagement in the program, as well as encouragement from management to participate. A secondary objective for this approach is to demonstrate the value of organizational support of professional development during established work hours. *Phase 2* piloting will involve running the program through other universities in a variety of regions within the United States. *Phase 3* will be dissemination through the American Occupational Therapy Association (AOTA).

Anticipated Outcomes

Anticipated program outputs include the number of participants involved in the program, number of sessions of the CoP, educational materials created for the OTPs, as well as the number of cross-specialty collaborations that are established.

The short-term outcomes are intended to benefit the OTPs by increasing their confidence in utilization evidence-based knowledge from all areas of OT, increasing their knowledge of self-care strategies to mitigate burnout, and to increase feelings of organizational support by their encouragement of the OTPs' participation in this program. Therefore, by addressing these issues as part of the CoP structure then the OTPs may be more ready to learn, teach, and connect.

Ultimately, the intermediate and long-term outcomes are expected to result in the implementation of the learning that takes place in *OT F.U.E.L.*. By reducing those barriers and facilitating the implementation of new knowledge, the clients will benefit, and likely demonstrate improved outcomes.

Recommendations

Participation in collaborative professional learning is beneficial to the OTPs and organizations, but requires the active engagement from all parties involved. As a community of learning driven by relationships and the sharing of professional knowledge and experiences, it is important for participants to consistently attend all sessions. From the organizational perspective, they need to be able to justify the cost of repeatedly allowing their staff to participate during work hours when they could be billing for client care. Therefore, grant funding is recommended to reimburse the participating organizations at a standardized hourly rate for the time when their staff is engaging with this program. From the clinician perspective, *OT F.U.E.L.* should be offered as a free benefit to FWEs who are already supporting the professional development of the next generation of OTPs, awarding them continuing education units at the completion of the program.

Future use of the program should include dissemination to other entry-level OT programs across the country as well as the general OT population through AOTA. This could promote standardization of knowledge and practice standards and facilitate a shared identity of the profession.

Conclusion

Integration of knowledge across specialty areas is often critical in OT practice, to meet the wide-ranging needs of clients, and deliver holistic care. CPD within the profession of OT will benefit from professional collaborations among the currently disparate specialty areas of the profession. The social learning that takes place within a community of practice also affirms increased professional identity and unity (Galheigo et al., 2019). Furthermore, there is urgency needed for this intervention because of the impact that the various barriers to CPD and holistic care have on client outcomes (Laver et al, 2014; Escher et al., 2018). The anticipated outcome of *OT F.U.E.L.* is to increase the holistic approach to professional development of OTPs, thereby improving overall client outcomes.

APPENDIX C – Fact Sheet

BOSTON UNIVERSITY

OCCUPATIONAL THERAPISTS FOSTERING UNIFIED EXPERTISE AND LEARNING (OT F.U.E.L.): A VIRTUAL COMMUNITY OF PRACTICE

by

ELSIE HURTADO POLLARI

The Problem:

Specialty practice areas are common in occupational therapy (OT) and are often a result of the health system and workplace structures. While specialization is important for high-quality care, many clients have conditions that span multiple specialty areas or have circumstances that do not neatly align with only one area. In these cases, clients may not receive the holistic care that they need, or they may fall through the gaps in health systems and structures. There is, therefore, a need for holistic generalist practice which integrates knowledge across specialty areas.

The Implications:

The application of evidence-based holistic OT practice is becoming increasingly difficult to implement because of personal, professional, and organizational barriers. This leads to:

- limitations in practice knowledge and applications
- professional isolation
- overall decreased holistic care

Unhappy with how these influences impact your professional practice?
Unsure of how to best implement change amidst all the demands on your time?

Refill your OT tank …with your peers…during work hours!

The Solution:

Occupational Therapists Fostering Unified Expertise and Learning (OT F.U.E.L.), a virtual community of practice to promote intraprofessional occupational therapy practitioner (OTP) collaboration and learning.

What is a Community of Practice (CoP)?

A CoP is a group of people who share common interests or problems and interact regularly in a process that builds and shapes knowledge in dialogue, collectively reflecting, analyzing, investigating, and evaluating their own practices, actions, values, and knowledge (Wenger, 1998; Wilding et al., 2012).

Doesn't AOTA already have CoPs?

The American Occupational Therapy Association (AOTA) has created CoPs that are housed under individual special interest sections (SIS), such as school-based, early childhood, hospital-based, and fieldwork educators (2022). However, there is not yet one CoP that focuses on integrating specialist knowledge across clinical practice area.

How is OT F.U.E.L. different?

Group participation is limited to no more than four OTPs from each specialty area of pediatrics, orthopedics/hand therapy, inpatient/outpatient rehabilitation, and mental health, capped at 16 total participants.

Group members will first meet with those from their specialty area to establish social and professional connections. Together, they will create a case study of a challenging client, that will be used in subsequent weeks during mixed-group collaborations.

Each week will include:

- Mindfulness activity to foster mindset for learning
- Introduction of a recent research article from each specialty for cross-application
- Mixed group collaboration to analyze and problem solve solutions to case study
- Whole-group collaboration and sharing of ideas

Individual > Like-group > Mixed-group > Whole-group = OTP Holistic Practice

OT F.U.E.L. meets:

- during work hours
- every 3 weeks
- 1 hour each meeting
- a total of 6 sessions

Offered through a university for fieldwork educators of OT students as free CEUs.

Theoretical Basis:

In the Five P's model, professional development is approached with purpose, personalization, priority, passion, and professional learning communities. Each of these components addresses micro to macro-level factors influencing continued professional development.

The Five Ps model considers both the top-down influences, such as regulatory standards or institutions determining what the practitioner needs to know, and the bottom-up influence which is directed solely by the individual practitioner (Anderson, 2018).

References:

REFERENCES

2018 Accreditation Council for Occupational Therapy Education (ACOTE ®) Standards and Interpretive Guide (effective July 31, 2020) August 2020 Interpretive Guide Version (n.d.). https://acoteonline.org/wp-content/uploads/2020/10/2018-ACOTE-Standards.pdf

Abendstern, M., Hughes, J., Tucker, S., Clarkson, P., & Challis, D. (2014). Self-assessment and personalization in occupational therapy services: A managerial perspective on the challenges and opportunities of a service innovation. *British Journal of Occupational Therapy*, *77*(10), 499–506. https://doi.org/10.4276/030802214x14122630932395

Ahuja, D. (2011). Continuing professional development within physiotherapy - A special perspective. *Journal of Physical Therapy*, *3*, 4–8.

American Occupational Therapy Association. (2017). Continuing professional development in occupational therapy. *American Journal of Occupational Therapy*, *71*(2), 7112410017p.1–5. https://doi.org/10.5014/ajot.2017.716s13

American Occupational Therapy Association. (2020). Occupational Therapy Practice Framework: Domain and Process (4th ed.). *American Journal of Occupational Therapy, 74*(Supplement_2), 7412410010p1–7412410010p87. https://doi.org/10.5014/ajot.2020.74S2001

American Occupational Therapy Association. (2023). *What is Occupational Therapy?* https://www.aota.org/about/what-is-ot

American Occupational Therapy Foundation (2023). *Implementation Research Grant.* https://www.aotf.org/Grants/Implementation-Research-Grant

Anderlini, D. (2018). The United States health care system is sick: From Adam Smith to overspecialization. *Cureus, 10*(5). https://doi.org/10.7759/cureus.2720

Anderson, N. (2018) *The Five Ps of Effective Professional Development for Language Teachers*. MEXTESOLJournal. https://www.mextesol.net/journal/index.php?page=journal&id_article=3416

Ashby, S. E., Adler, J., & Herbert, L. (2016). An exploratory international study into occupational therapy students' perceptions of professional identity. *Australian Occupational Therapy Journal*, *63*(4), 233–243. https://doi.org/10.1111/1440-1630.12271

Barry, M., Kuijer-Siebelink, W., Nieuwenhuis, L., & Scherpbier-de Haan, N. (2016). Communities of practice: A means to support occupational therapists' continuing professional development. A literature review. *Australian Occupational Therapy Journal, 64*(2), 185–193. https://doi.org/10.1111/1440-1630.12334

Boehm, L. M., Stolldorf, D. P., & Jeffery, A. D. (2019). Implementation science training and resources for nurses and nurse scientists. *Journal of Nursing Scholarship, 52*(1), 47–54. https://doi.org/10.1111/jnu.12510

Bolt, M., Ikking, T., Baaijen, R., & Saenger, S. (2019). Occupational therapy and primary care. *Primary Health Care Research & Development*, *20*(27). 1–6. https://doi.org/10.1017/s1463423618000452

Boston University (2023). *Student Research Grant.* College of Health and Rehabilitation Sciences: Sargent College. https://www.bu.edu/sargent/%20research/research-funding-administration/funding-opportunities-for-sargent-faculty-and-students/student-research-grant/

Cahill, L. S., Lannin, N. A., Mak-Yuen, Y. Y. K., Turville, M. L., & Carey, L. M. (2018). Changing practice in the assessment and treatment of somatosensory loss in stroke survivors: Protocol for a knowledge translation study. *BMC Health Services Research*, *18*(1), 34. https://doi.org/10.1186/s12913-018-2829-z

Crist, P., & Kielhofner, G. (2013). *Scholarship of practice: Academic-practice collaborations for promoting occupational therapy*. Routledge.

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York, NY: Plenum.

DeIuliis, E. (2017). *Professionalism across occupational therapy practice*. Slack.

Desveaux, L., Ivers, N. M., Devotta, K., Ramji, N., Weyman, K., & Kiran, T. (2021). Unpacking the intention to action gap: A qualitative study understanding how physicians engage with audit and feedback. *Implementation Science, 16*(1). https://doi.org/10.1186/s13012-021-01088-1

Di Rezze, B., Santesso, N., & Law, M. (2013). Exploring the utility of a novel knowledge translation tool for school-based occupational therapists. *British Journal of Occupational Therapy*, *76*(4), 194–199. https://doi.org/10.4276/030802213x13651610908498

Dickerson, A.E, Reistettere, T., Schold Davis, E, Monahan, M. (2011) Evaluating driving as a valued instrumental activity of daily living. *American Journal of Occupational Therapy, 65*(1), 64–75. https://doi.org/10.5014/ajot.2011.09052

Duckworth, A. (2016). *Grit: The power of passion and perseverance*. New York, NY: Scribner.

Elmhurst University (2023). *Center for Scholarship and Teaching Grants.* https://www.elmhurst.edu/academics/academic-centers/center-scholarship-teaching/grants/

Emery, N. (2012, July 31). Our unsustainable culture of medical specialization. *The Atlantic*. https://www.theatlantic.com/health/archive/2012/07/our-unsustainable-culture-of-medical-specialization/260504/

Erickson, R., Abu Dabrh, A. M., Chavez, A., Cristiani, V., DeJesus, R., Laabs, S., Presutti, R., Rosas, S., Westfall, E., Witt, T., & Thacher, T. (2022). Development and early experience of a primary care learning collaborative in a large health care system. *Journal of Primary Care & Community Health,* 13. https://doi.org/10.1177/21501319221089775

Escher, A. A., Amlani, A. M., Viani, A. M., & Berger, S. (2018). Occupational therapy in an intensive comprehensive aphasia program: Performance and satisfaction outcomes. *American Journal of Occupational Therapy, 72*(3), 7203205110p1. https://doi.org/10.5014/ajot.2018.026187

Funabashi, M., Warren, S., & Kawchuk, G. N. (2012). Knowledge exchange and knowledge translation in physical therapy and manual therapy fields: Barriers, facilitators and issues. *Physical Therapy Reviews, 17*(4), 227–233. https://doi.org/10.1179/1743288x12y.0000000016

Galheigo, S. M., Braga, C. P., Mieto, F. S. R., Parreira, F. V., Sarmento, G. Q., Motta, M., Silva, M. C. A., Santos, M. F., Spinola, P. F., Serpa, R. B. L., Mitre, R. M. de A., Lagôa, T. dos R. O., Oliveira, T. A., Santos, W. de A., Magalhães, L., & Kinsella, E. A. (2017). Exchanging knowledge within a community of practice: Toward an epistemology of practice in occupational therapy paediatric hospital care. *Cadernos Brasileiros de Terapia Ocupacional, 25*(3), 449–459. https://doi.org/10.4322/2526-8910.ctoao1119

Galheigo, S. M., Braga, C. P., Magalhães, L., & Kinsella, E. A. (2019). An occupational therapy community of practice within pediatric acute care: Fostering professional, social and cultural capital in resource challenged settings. *Cadernos Brasileiros de Terapia Ocupacional, 27*, 776–791. https://doi.org/10.4322/2526-8910.ctoAO1825

Gifford, W. A., Squires, J. E., Angus, D. E., Ashley, L. A., Brosseau, L., Craik, J. M., Domecq, M.-C., Egan, M., Holyoke, P., Juergensen, L., Wallin, L., Wazni, L., & Graham, I. D. (2018). Managerial leadership for research use in nursing and allied health care professions: A systematic review. *Implementation Science: IS*, *13*(1), 127. https://doi.org/10.1186/s13012-018-0817-7

Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: Time for a map? *The Journal of Continuing Education in the Health Professions*, *26*(1), 13–24. https://doi.org/10.1002/chp.47

Gresh, A., Mena-Carrasco, F., Rauh, A., & Pfaff, T. (2017). Utilization of communities of practice for ongoing learning and knowledge dissemination: Making the case for the Global Alliance for Nursing and Midwifery (GANM). *Nurse Education in Practice, 26*, 64–67. https://doi.org/10.1016/j.nepr.2017.07.001

Gunn, H., & Goding, L. (2009). Continuing professional development of physiotherapists based in community primary care trusts: A qualitative study investigating perceptions, experiences and outcomes. *Physiotherapy*, *95*(3), 209–214. https://doi.org/10.1016/j.physio.2007.09.003

Gupta, D. M., Boland, R. J., & Aron, D. C. (2017). The physician's experience of changing clinical practice: A struggle to unlearn. *Implementation Science, 12*(1). https://doi.org/10.1186/s13012-017-0555-2

Gutierrez, D., & Kaplan, S. L. (2016). Aligning documentation with congenital muscular torticollis clinical practice guidelines: Administrative case report. *Physical Therapy, 96*(1), 111–120. https://doi.org/10.2522/ptj.20150012

Hand, B. N., Li, C.-Y., & Mroz, T. M. (2022). Health services research and occupational therapy: Ensuring quality and cost-effectiveness. *The American Journal of Occupational Therapy*, *76*(1). https://doi.org/10.5014/ajot.2022.761001

Haywood, H., Pain, H., Ryan, S., & Adams, J. (2012). Continuing professional development: Issues raised by nurses and allied health professionals working in musculoskeletal settings. *Musculoskeletal Care*, *11*(3), 136–144. https://doi.org/10.1002/msc.1033

Hines Senia, R. (2015, February). *Current capacity building needs of occupational therapists related to older driver screening, Assessment, and Intervention* [PhD Thesis, Walden University]. Walden University ScholarWorks. https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1379&context=dissertations

Hitch, D., Pepin, G., Lhuede, K., Rowan, S., & Giles, S. (2019). Development of the Translating Allied Health Knowledge (TAHK) framework. *International Journal of Health Policy and Management*, *8*(7), 412–423. https://doi.org/10.15171/ijhpm.2019.23

Jahn, R., Müller, O., Nöst, S., & Bozorgmehr, K. (2020). Public-private knowledge transfer and access to medicines: A systematic review and qualitative study of perceptions and roles of scientists involved in HPV vaccine research. *Globalization and Health, 16*(1), 22. https://doi.org/10.1186/s12992-020-00552-9

Jones, C. A., Roop, S. C., Pohar, S. L., Albrecht, L., & Scott, S. D. (2015). Translating knowledge in rehabilitation: Systematic review. *Physical Therapy*, *95*(4), 663–677. https://doi.org/10.2522/ptj.20130512

Keegan, E. M. (2021). Acute hospital occupational therapists' experiences of a short-term community of practice. *New Zealand Journal of Occupational Therapy*. *(68)*2, 34–40.

Kinney, A. R., Fields, B., Juckett, L., Read, H., Martino, M. N., & Weaver, J. A. (2021). Learning health systems can promote and sustain high-value occupational therapy. *The American Journal of Occupational Therapy*, *76*(1), 7601347020. https://doi.org/10.5014/ajot.2022.049071

Kläusler-Troxler, M., Petry, H., Lanter, R., & Naef, R. (2019). Implementing family systems nursing through a participatory, circular knowledge-to-action research approach in women's health. *International Practice Development Journal, 9*(2), 1–15. https://doi.org/10.19043/ipdj.92.005

Korner-Bitensky, N., Menon, A., von Zweck, C., & Van Benthem, K. (2010). Occupational therapists' capacity-building needs related to older driver screening, assessment, and intervention: A Canada-wide survey. *The American Journal of Occupational Therapy*, *64*(2), 316–324. https://doi.org/10.5014/ajot.64.2.316

Lacy, A. M. P., Lam, K. C., & Welch Bacon, C. E. (2022). Addressing the habitual practice issue: The role of unlearning in promoting evidence-based practice and lifelong learning. *Athletic Training Education Journal, 17*(2), 174–181.

Laver, K., Lannin, N. A., Bragge, P., Hunter, P., Holland, A. E., Tavender, E., O'Connor, D., Khan, F., Teasell, R., & Gruen, R. (2014). Organising health care services for people with an acquired brain injury: An overview of systematic reviews and randomised controlled trials. *BMC Health Services Research, 14*(1), 397. https://doi.org/10.1186/1472-6963-14-397

Laverdure, P. (2019). Knowledge translation: Embracing the shift from professional to practice development. *SIS Quarterly Practice Connections, 4*(3), 8–10.

Lenker, H. (2021). Multidisciplinary rehabilitation within pediatric cancer care: A holistic approach. *Rehabilitation Oncology*, *39*(2), E12–E14. https://doi.org/10.1097/01.reo.0000000000000263

Loe, I. M., Froehlich, T. E., Edrees, H. H., & Spinks-Franklin, A. (2021). Racism as an adverse childhood experience: An interactive workshop to train pediatricians to address racism in clinical care. *Journal of Developmental & Behavioral Pediatrics, 42*(6), 502–511. https://doi.org/10.1097/dbp.0000000000000984

Marcolino, T. Q., Kinsella, E. A., Araujo, A. da S., Fantinatti, E. N., Takayama, G. M., Vieira, N. M. U., Pereira, A. J. A. T., Gomes, L. D., Galheigo, S. M., & Ferigato, S. H. (2020). A community of practice of primary health care occupational therapists: Advancing practice-based knowledge. *Australian Occupational Therapy Journal, 68*(1), 3–11. https://doi.org/10.1111/1440-1630.12692

May, C., & Finch, T. (2009). Implementing, embedding, and integrating practices: An outline of normalization process theory. *Sociology*, *43*(3), 535–554. https://doi.org/10.1177/0038038509103208

McGonagle, I., Jackson, C. S., & Kane, R. (2015). The ten essential shared capabilities: Reflections on education in values-based practice: A qualitative study. *Nurse Education Today, 35*(2), e24–e28. https://doi.org/10.1016/j.nedt.2014.12.001

Miller, R., & Catherine, M. (2016). Crossing the tracks: Continuing interprofessional development in social and primary care. *International Journal of Integrated Care, 16*(6), 188. https://doi.org/10.5334/ijic.2736

Moick, S., Hiesmayr, M., Mouhieddine, M., Kiss, N., Bauer, P., Sulz, I., Singer, P., & Simon, J. (2021). Reducing the knowledge to action gap in hospital nutrition care – Developing and implementing nutritionDay 2.0. *Clinical Nutrition, 40*(3), 936–945. https://doi.org/10.1016/j.clnu.2020.06.021

Munce, S. E. P., Graham, I. D., Salbach, N. M., Jaglal, S. B., Richards, C. L., Eng, J. J., Desrosiers, J., MacKay-Lyons, M., Wood-Dauphinee, S., Korner-Bitensky, N., Mayo, N. E., Teasell, R. W., Zwarenstein, M., Mokry, J., Black, S., & Bayley, M. T. (2017). Perspectives of health care professionals on the facilitators and barriers to the implementation of a stroke rehabilitation guidelines cluster randomized controlled trial. *BMC Health Services Research, 17*(1), 440. https://doi.org/10.1186/s12913-017-2389-7

Pendleton, H. M., & Schultz-Krohn, W. (2017). *Pedretti's occupational therapy* (8th ed.). Mosby.

Persons, K., Dwyer DeIuliis, E., LeQuieu, E., Laverdure, P. A., & Dolin, E. (2021). Understanding roles, expectations, and supports of Academic Fieldwork

Coordinators in OT programs. *The American Journal of Occupational Therapy*, *75*(2), 7512505152p1-7512505152p1. https://doi.org/10.5014/ajot.2021.75s2-rp152

Phillips, J. L., Heneka, N., Bhattarai, P., Fraser, C., & Shaw, T. (2019). Effectiveness of the spaced education pedagogy for clinicians' continuing professional development: A systematic review. *Medical Education, 53*(9), 886–902. https://doi.org/10.1111/medu.13895

Plsek, P. (2001). Redesigning health care with insights from the science of complex adaptive systems (Appendix B, 309–322). In Institute of Medicine, *Crossing the quality chasm*. Washington, DC: National Academies Press.

Rangachari, P., Madaio, M., Rethemeyer, R. K., Wagner, P., Hall, L., Roy, S., & Rissing, P. (2015). The evolution of knowledge exchanges enabling successful practice change in two intensive care units. *Health Care Management Review, 40*(1), 65–78. https://doi.org/10.1097/HMR.0000000000000001

Roberts, G. I. (2015). Communities of practice: Exploring enablers and barriers with school health clinicians. *Canadian Journal of Occupational Therapy, 82*(5), 294–306. https://doi.org/10.1177/0008417415576776

Rolls, K. D., Hansen, M. M., Jackson, D., & Elliott, D. (2020). Intensive care nurses on social media: An exploration of knowledge exchange on an intensive care virtual community of practice. *Journal of Clinical Nursing, 29*(7–8), 1381–1397. https://doi.org/10.1111/jocn.15143

Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal*, *312*(7023), 71–72. https://doi.org/10.1136/bmj.312.7023.71

Scott, S. D., Albrecht, L., O'Leary, K., Ball, G. D. C., Hartling, L., Hofmeyer, A., Jones, C. A., Klassen, T. P., Kovacs Burns, K., Newton, A. S., Thompson, D., & Dryden, D. M. (2012). Systematic review of knowledge translation strategies in the allied health professions. *Implementation Science*, *7*(1), 70. https://doi.org/10.1186/1748-5908-7-70

Segev-Jacubovski, O., Magen, H., & Maeir, A. (2022). Psychological factors predicting functional ability and participation after hip fracture. *The American Journal of Occupational Therapy*, *76*(3). https://doi.org/10.5014/ajot.2022.047365

Sharrott, G.W. & Cooper-Fraps, C. (1986) Theories of motivation in occupational therapy: An overview. *American Journal of Occupational Therapy*, *40*(4), 249–257. https://doi.org/10.5014/ajot.40.4.249

Stewart, H., Wisby, D., & Roddam, H. (2020). Physiotherapists' reported attitudes to and perceived influences on their continuing professional development: Results of an online questionnaire. *International Journal of Therapy and Rehabilitation*, *27*(4), 1–13. https://doi.org/10.12968/ijtr.2018.0114

Stoney, C. M., Brown, M. K., Campo, R. A., & Mensah, G. A. (2022). Integration of implementation science in cardiovascular behavioral medicine. *Health Psychology, 41*(10), 755–764. https://doi.org/10.1037/hea0001208

Summers, A., Dickerson, P. S., & Lubejko, B. G. (2015). Continuing professional development in Australia: Barriers and support. *Journal of Continuing Education in Nursing, 46*(8), 337–339. https://doi.org/10.3928/00220124-20150721-11

Thomas, A. & Bussières, A. (2016). Knowledge translation and implementation science in health professions education: Time for clarity? *Academic Medicine, 91*(12), e20. https://doi.org/10.1097/acm.0000000000001396

Thomas, A., Al Zoubi, F., Mayo, N. E., Ahmed, S., Amari, F., Bussières, A., Letts, L., MacDermid, J. C., Polatajko, H. J., Rappolt, S., Salbach, N. M., Valois, M., & Rochette, A. (2020). Individual and organizational factors associated with evidence-based practice among physical and occupational therapy recent graduates: A cross-sectional national study. *Journal of Evaluation in Clinical Practice*, *27*(5), 1044–1055. https://doi.org/10.1111/jep.13518

Thomas, A., & Bussières, A. (2021). Leveraging knowledge translation and implementation science in the pursuit of evidence informed health professions education. *Advances in Health Sciences Education: Theory and Practice, 26*, 1157–1171. https://doi.org/10.1007/s10459-020-10021-y

Townsend, E., & Polatajko, H. (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation*. Ottawa: CAOT Publishers.

Tuyisenge, G., Luginaah, I., Hategeka, C., Babenko-Mould, Y., Cechetto, D., & Rulisa, S. (2018). Continuing professional development in maternal health care: Barriers to applying new knowledge and skills in the hospitals of Rwanda. *Maternal & Child Health Journal, 22*(8), 1200–1207. https://doi.org/10.1007/s10995-018-2505-2

van Biljon, H., du Toit, S. H. J., Masango, J., & Casteleijn, D. (2017). Exploring service delivery in occupational therapy: The use of convergent interviewing. *Work*, *57*(2), 221–232. https://doi.org/10.3233/wor-172557

Vaughn, V. M., Saint, S., Krein, S. L., Forman, J. H., Meddings, J., Ameling, J., Winter, S., Townsend, W., & Chopra, V. (2018). Characteristics of healthcare organisations struggling to improve quality: Results from a systematic review of qualitative studies. *BMJ Quality & Safety*, *28*(1), 74–84. https://doi.org/10.1136/bmjqs-2017-007573

Welch Bacon, C. E., Pike Lacy, A. M., & Lam, K. C. (2021). Knowledge translation in athletic training: Considerations for bridging the knowledge-to-practice gap. *Journal of Athletic Training, 56*(11), 1165–1172. https://doi.org/10.4085/0470-20

Wenger, E. (1998). *Communities of practice: Learning, meaning, and identity*. Cambridge: Cambridge University Press. http://dx.doi.org/10.1017/CBO9780511803932

Wilding, C., Curtin, M., & Whiteford, G. (2012). Enhancing occupational therapists' confidence and professional development through a community of practice scholars. *Australian Occupational Therapy Journal, 59*(4), 312–318. https://doi.org/10.1111/j.1440-1630.2012.01031.x

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