2023

Occupational Therapy Practitioners' Perceptions of Their Confidence and Skills When Providing Community and Social Interventions After a Guided Educational Experience

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Presented in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Occupational Therapy

Eastern Kentucky University
College of Health Sciences
Department of Occupational Science and Occupational Therapy

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2023

Executive Summary

Background: As the population is aging, occupational therapy practitioners (OTPs) are well placed to address the community and social needs of older adults to promote healthy aging. However, OTPs seem to be lacking the resources and guidance to implement community and social interventions routinely.

Purpose: This quantitative non-experimental, pre-, and post-survey design aims to determine the impact of a guided education intervention on how OTPs perceive their skills and confidence when providing community and social interventions.

Theoretical Framework: The Model of Health Promotion (Wilcocks, 2006) and Lifestyle Redesign® (Clark et al., 1997) program were used as the guiding theory and program to support the educational intervention and capstone project.

Methods: Prior to the educational intervention, participants completed a presurvey to determine their perceived skills and confidence when providing community and social interventions. Then, OTPs participated in a two-part educational intervention about community and social interventions. Following the completion of the educational intervention, participants completed a post-survey to determine any change in perceived skills and confidence when providing community and social interventions.

Results: After participating in this educational intervention, OTPs demonstrated an increase in their perceived confidence and skills when providing community and social interventions. 90% of the participants reported that they were "likely" or "significantly more likely" to provide community and social interventions after the educational intervention.

Conclusions: This capstone provided a guided educational experience to OTPs who work with older adults in non-acute settings with the goal of improving their perceived confidence and skills to provide community and social interventions. Analysis of the quantitative data indicates that OTPs reported an increase in their perceived confidence and or skills when providing community and social interventions. This is both clinically and educationally relevant to the field of occupational therapy; however, additional research would be beneficial to determine if these results could be generalized to a larger sample size and if the participants implemented what they learned during this educational intervention.

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COLLEGE OF HEALTH SCIENCES

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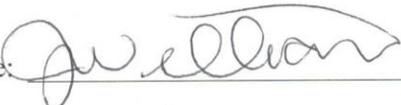
Date of Submission: 5/6/23

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Section 1: Nature of the Project and Problem Identification

Introduction

As the world population is aging, the number of older adults is expected to grow by 30 million in the next 30 years (Alzheimer's Association, 2022). Older adults are more likely to live alone and manage chronic conditions, decreased mobility, physical performance, and cognitive concerns, all of which affect their ability to engage in the community (Administration of Community Living, 2021; Smallfield & Lucas Molitor, 2018). Older adults who are living alone with chronic conditions are at risk of social isolation and loneliness. Loneliness and isolation have been positively linked to an increased risk of falls, cognitive decline, depression, and poor management of chronic disease, leading to an increased rehospitalization risk and alcohol use (Dury et al., 2021; National Academies of Sciences, Engineering, and Medicine, 2020). Moreover, these risk factors further impact the ability of older adults to stay active in community and social activities.

This cycle of chronic condition and social isolation places older adults at increased risk of hospital admissions (National Academies of Sciences, Engineering, and Medicine, 2020). After a hospital admission, injury, or illness, older adults typically go through the continuum of care, starting with a hospital and leading to a rehabilitation stay and home health care (Harvell et al., 2016). Across the continuum of care, occupational therapy practitioners (OTPs) are not fully addressing community and social participation. One reason noted by Turcotte et al. (2019) included a lack of educational support and guidance.

The American Occupational Therapy Association (AOTA) provides guidance on how to address the community and the social needs of clients. The 2020 Occupational Therapy Practice Framework 4 (OTPF- 4) lists social participation, which includes the subcategories of

community participation, and community mobility, as occupations that occupational therapists can address within their own practices. The OTPF-4 also defines participation as "involvement in a life situation" (AOTA, 2020, p. 80) as an outcome of interventions. Both social participation and community mobility include being involved in life situations that are meaningful in a variety of communities, environments, and social contexts. For this project, the phrase "community and social participation" will be used to encompass community mobility and social participation (within the subcategory of community participation).

The Office of Disease Prevention and Health Promotion (Healthy People 2030, n.d., Social and Community Context, pp. 1) recognizes the importance of community and social participation by stating that "people's relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being." Healthy People 2030 describes well-being as overall life satisfaction and states that well-being is reflective of overall health and non-health factors such as satisfaction with social and community participation. AOTA's statement on the Promotion of Health and Well-Being adds to the definition of well-being to include "satisfaction with life, fulfillment, and positive functioning" (AOTA, 2013, p. 1). OTPs have a valuable role in addressing social and community participation to improve the health and well-being of older adults, but OTPs seem to be lacking the training, resources, and administrative support to do so (Turcotte et al., 2019; W. Stav et al., 2011).

Problem Statement

Community and social participation have been positively linked to health outcomes and quality of life (Fu et al., 2021; Mackenzie & Abdulrazaq, 2021). Thus, targeted interventions to address community and social participation can positively impact the health and wellness of community-dwelling older adults. However, OTPs are not routinely incorporating community

and social interventions routinely into practice with older adults (Turcotte et al., 2019). Turcotte et al. (2019) found that one reason for this seems to be a lack of resources and guidance needed by OTPs to initiate and implement community and social interventions.

Purpose

The purpose of this quantitative non-experimental, pre-, and post-survey design with an educational intervention was to determine if participation in a guided educational intervention impacts OTPs' perceived confidence and skills when providing community and social interventions.

Research Objectives

The following objectives were designed to determine if this educational intervention impacted the perceived skills and confidence of OTPs when providing community and social participation interventions to older adults:

1. How do OTPs perceive their confidence when providing community and social interventions after participating in a guided educational intervention?

2. How do OTPs perceive their skills when providing community and social interventions after participating in a guided educational intervention?

Theoretical Framework

This project was guided by Wilcock's Model of Occupational Health (2006), which assumes that people who are engaged in meaningful occupations tend to live a healthy life. This model finds three factors that can lead to ill health and disability: (1) occupational imbalance, (2) occupational deprivation, and (3) occupational alienation (Wilcock, 2006). As the work of Wilcock developed, the role of occupation moved from being a function of health and wellness to a matter of occupational justice, which is an issue that concerns older adults and is related to

community and social participation. As adults age, several factors such as decreased mobility and chronic illness place them at risk of occupational limitations such as occupational imbalance, deprivation, and alienation, which can result in occupational injustice. The Model of Occupational Health (health promotion) is closely aligned with the purpose of this capstone to provide resources to OTPs to "do, be, and become" providers of community and social interventions through occupation-based programs and resources.

Health Promotion

This model is defined by Wilcock (2006) as follows:

> …. The application of medical, behavioral, social, and occupational science to prevent physiological, psychological, social, and occupational illness, accidents, and disability and prolong the quality of life for all people through advocacy and mediation and through occupation-focused programs aimed at enabling people to do, be, and become according to their natural health needs. (p. 217)

The purpose of the educational intervention was to support OTPs in providing community and social interventions when working with older adults. Subsequently, this educational intervention strived to improve the lives of older adults by enabling participation in meaningful community and social activities through occupation-based interventions, self-efficacy, providing resources, and allowing clients to be the driver of their community and social needs.

The model of health promotion also highlights the concept of "doing, being, and becoming" (Wilcock, 2006). The purpose of this project aimed to reach the goals of the educational intervention by providing resources and guidance to OTPs so that they can provide community and social interventions to older adults. The evidence suggests that many OTPs are

not fully addressing the community and social needs of older adults due to a lack of resources and guidance (Turcotte, 2019). This lack of intervention is a form of occupational injustice to the growing population of older adults. Therefore, this project aimed to empower OTPs to "Do, Be, and Become" providers of community and social interventions with the ultimate goal of improving the overall well-being and occupational justice of older adults.

Guiding Program

This project was also guided by the Lifestyle Redesign® program, which was an outcome of the Well Elderly Study (Clark et al., 1997; Jackson et al., 1998). The purpose of having an additional guiding program was to guide the development of the educational intervention to fit the needs of both the OTPs and the older adults who will be the recipients of the strategies and interventions that the OTPs learned throughout this experience. Lifestyle Redesign® has been found to be an effective preventative lifestyle program to address the needs of an aging population (Clark et al., 1997; Jackson et al., 1998). It has also been found to result in positive outcomes for quality of life and various health functions, which supports the vision of the United Nations (UN) and World Health Organization (WHO)'s Decade of Healthy Aging.

The educational intervention includes a Community and Social Participation (CASP) Toolkit created by the primary investigator according to the Lifestyle Redesign® methodology to be a self-paced resource for OTPs that is included in the educational intervention. The educational intervention, including the CASP Toolkit and guided small group experience, was created following the three themes the Well Elderly Study found contributed to the positive outcomes: topics related to health management; high individualization, with opportunities to apply this to daily life; and specific strategies to overcome barriers (Clark et al., 1997). The methodology of the Lifestyle Redesign® program was used throughout the development of the

educational intervention. Please see Table 4 for a detailed outline of how the methodology was used to guide this project.

Clinical Significance

To address the issue of an aging population and related public health concerns, the UN, in partnership with the WHO, declared 2021–2030 the UN Decade of Healthy Aging. The Decade of Healthy Aging (n.d.) states that healthy aging is a possibility for everyone but will require a "shift in focus from considering healthy ageing as the absence of disease to fostering the functional ability that enables older people to be and to do what they value" (p. 3). The initiative acts as a call to action for stakeholders to create programs and partnerships that "prevent disease, promote health, and maintain intrinsic capacity and enable functional ability" (p. 3). Occupational therapy is well-placed to address healthy aging and the wellness of older adults through targeted interventions that address community and social participation. The educational intervention and CASP Toolkit were created to improve the overall health and wellness of older adults by providing the necessary tools and resources to OTPs so that they can address the community and social participation needs of older adults. The literature found that education alone is not sufficient for OTPs to translate knowledge into practice: Higher levels of perceived confidence are associated with the translation of knowledge into practice (Brangan et al., 2015). Thus, this educational intervention was designed with evidence from the literature to provide opportunities for OTPs to improve their confidence and skills related to community and social interventions that promote knowledge translation.

Section 2: Literature Review

The purpose of this literature review is to explore the role of OTPs when they provide community and social interventions and to determine what educational support OTPs need to successfully integrate these interventions into practice. This literature review looked at the benefits and barriers of community and social participation for older adults as well as the role of occupational therapy (OT) in enabling older adults to stay active in these meaningful occupations. Evidence in the literature was found to support current OT practices that address community and social participation such as individual and group treatment to address leisure and disease management as well as reasons why OTPs are not addressing community and social participation. The literature review concludes by considering the necessary skills for OTPs to provide community and social interventions and how to build those skills through training opportunities.

The Impact of Community and Social Participation for Community-Dwelling Older Adults

Social isolation and loneliness are public health issues that are becoming more prevalent as the world population is aging (World Health Organization, 2022). According to the National Academies of Sciences, Engineering, and Medicine (2020), a quarter of adults aged 60 and older are socially isolated. Social isolation and loneliness have a negative impact on older adults, communities, and healthcare systems. For example, older adults who are socially isolated or lonely suffer increased rates of depression, anxiety, dementia, premature death, and hospital admissions/emergency room visits and have increased expenses when in the hospital compared to those who are not socially isolated (National Academies of Sciences, Engineering, and Medicine et al., 2020). Overall, social isolation adds up to approximately 6.7 million dollars in additional Medicare spending each year (Flowers et al., 2017). This public health crisis

highlights the importance of providing opportunities for community and social participation to reduce the impact of social isolation on older adults.

The Impact of Life Space on the Health of Older Adults

Life space refers to the amount of space a person takes up in life (Polku et al., 2014). For example, a person who stays at home takes up less space than a person who is active in the community. Higher levels of life space mobility are associated with fewer depressive symptoms, increased well-being, and increased cognitive function (Polku et al., 2014). Many activities that require higher levels of life space can be difficult for older adults to participate in due to a variety of issues including chronic health conditions, lack of transportation, cognitive and communication barriers, and lack of caregiver support (Barclay et al., 2016; Steppe et al., 2021). On the other hand, older adults who stay active in community and social activities present with increased mobility, improved physical health and strength, reduced fall risk, and reduced risk of cognitive decline (National Academies of Sciences, Engineering, and Medicine, 2020; Stjernborg, 2017). A review of the literature reinforced the finding that the ability to participate in community and social activities can promote life space mobility and overall health and wellness (Dury et al., 2021).

Barriers and Supports to Community and Social Participation for Older Adults

OTPs are well-placed to address the barriers and enablers of community and social participation to support healthy aging and increased life space through targeted interventions and programs (Papageorgiou et al., 2016). Common barriers to community and social participation were found to be acute health issues, communication, cognitive deficits, chronic conditions, lack of confidence, falls and fear of falling, environmental barriers, lack of resources, and transportation (Hoffman et al., 2021; Raymond et al., 2014). In contrast, caregiver or social

support as well as easy access to resources were found to be enablers of community and social participation (Huffman & Amireault, 2021).

Current Evidence-Based Interventions for Community and Social Participation

Social and community participation can be promoted through individual treatments, including leisure education and chronic disease self-management (Smallfield & Molitor, 2018). However, OTPs typically lack the training, resources, and administrative support to implement evidence-based treatments in practice (Turcotte et al., 2019). A review of the literature found evidence to support three specific programs that were successful in addressing community and social participation: Lifestyle Redesign® (Clark et al., 2011), Let's Go (Mulry & Piersol, 2014), and the CRISP program (Kalina et al., 2018), which are group programs that have been found to address community participation effectively. Two of the three programs have inclusion criteria that are not generalized to the population of older community-dwelling adults with a variety of chronic conditions. Furthermore, all three programs used group treatment models that are not always available (location) or are difficult for older adults with chronic conditions or mobility issues to attend. Thus, the current literature highlights the need for a more generalized/customizable program to meet the needs of older adults with chronic health conditions.

Lifestyle Redesign® as an Evidence-Based Guide for Interventions

The Lifestyle Redesign® program is a result of the Well Elderly Study (Clark et al., 1997) that was designed to slow age-related changes among community-dwelling older adults. Lifestyle Redesign® is a preventative wellness program that includes both group and individual activities that have been linked to positive changes in bodily pain, vitality, social function, mental functioning, life satisfaction, and depressive symptoms (Clark et al., 1997; Clark et al.,

2012; Jackson et al., 1998). These positive health changes can support healthy aging by improving overall health and well-being. A follow-up randomized control trial (the Well Elderly 2) was performed by Clark et al. (2012) to look at the effectiveness of lifestyle interventions among ethnically diverse older adults in community-based settings using a combination of group and individual sessions with monthly community outings. The results of the Well Elderly 2 study supported the results found by the Well Elderly 1 study by finding positive changes in mental well-being, vitality, social function, physical function, life satisfaction, and reduced symptoms of depression and bodily pain (Clark et al., 2012).

Although Lifestyle Redesign® has been found to improve health and well-being for well-elderly adults, less is known about this program for individuals with chronic conditions or other health conditions (ill-elderly). Adapted Lifestyle Redesign® programs have had mixed results but show an overall trend toward positive changes in social participation for older adults. Levasseur and colleagues (2019) performed a mixed-methods study on an adapted Lifestyle Redesign® program that included older adults with and without disabilities and focused on life-space mobility and leisure engagement. These two components were not addressed by previous Lifestyle Redesign® studies and provided a positive result for mental health, leisure engagement, mobility, and social participation. However, another study by Levasseur et al. (2022), which looked at an adapted Lifestyle Redesign® program for community-dwelling older adults with and without disabilities, found that those with disabilities missed more sessions due to illness, other appointments, and had additional personal factors that impacted participation in the program. Levasseur et al. (2022) found that additional studies are needed to assess the contextual adaptations of the Lifestyle Redesign® program to allow it to be tailored to the specific profiles of older adults with and without disabilities. The results and effectiveness of the Lifestyle

Redesign® program with older adults inspired the author to create the Community and Social

Participation Toolkit (CASP Toolkit) by incorporating the founding principles of the program

and allowing options for customization to meet the needs of the ill-elderly. In order to investigate

how the CASP Toolkit used available knowledge to impact service implementation, the literature

will now be reviewed.

Lifestyle Redesign® as a Foundational Guide to the CASP Toolkit

Of the three themes that were found in the Well Elderly Study, the first theme was that

activities were chosen based on principles from the OT field that are related to health

management. Because activities related to health management were related to the successful

outcome of the Well Elderly Study, the CASP Toolkit includes evidence-based interventions that

address health management techniques to enable community and social participation for older

adults.

The second theme found in the Well Elderly Study (Clark et al., 1997) was that although

the sessions were performed in a group setting, the interventions were highly individualized, and

the participants were given opportunities to apply learning to their own day-to-day lives. Because

of this, both the CASP Toolkit and related educational opportunities allow OTPs to apply what

they have learned to current or past clients as well as integrate the principles into interventions

applicable to their current practice setting.

The third theme (Clark et al., 1997) found that the Well Elderly Study offered specific

strategies and tools for overcoming barriers. Therefore, the CASP Toolkit provides a variety of

tools and strategies to guide OTPs in various practice settings to initiate and implement

community and social participation interventions. The CASP Toolkit provides recorded training

for OTPs in these tools and in utilizing the Toolkit to reduce obstacles related to implementing community and social participation interventions.

The Lifestyle Redesign®-recommended methodology for guiding interventions was used to develop the Toolkit modules and educational intervention with accommodations to fit the needs of the ill-elderly. Please see Table 4 below for details as to how the methodology was integrated into the Toolkit and educational intervention. Core concepts were used from the original Well Elderly Study and the resulting Lifestyle Redesign® program (Clark et al., 1997; Clark et al., 2012; Jackson et al., 1998) as a foundational guide for the CASP Toolkit and educational intervention with the aim to provide tools and resources to OTPs to improve their confidence in and implementation of community and social interventions.

The Impact of Perceived Confidence and Skills on Service Implementation

Perceived confidence in skills and ability is necessary for OTPs to translate knowledge gained into practice (Brangan et al., 2015). AOTA (2021) defines competency as "an individual's actual performance; that is, observed performance of applied knowledge, skill, or action measured against set criteria." Translating skills and knowledge into practice has been found to enhance OTPs' confidence in their abilities/skills (Brangan et al., 2015). When an OTP has high perceived confidence in a practice area, they are more likely to engage in that practice (Salback & Jaglal, 2010). Experience, years of practice, continuing education, reflective opportunities, goal setting, and small group work have been found to be effective in improving the confidence and skills of OTPs (Bornman & Louw, 2019; Chilton et al., 2022; Finn, 2019; Holmes et al., 2016; Hovick & Provident, 2018; Schoen et al., 2021; Shooman & Fowler, 2020).

Likewise, self-efficacy refers to an individual's belief in their capacity or confidence in their ability (Bandura, 1977). A greater sense of self-efficacy was noted when OTPs were given

opportunities to practice newly learned skills and receive follow-up reinforcement/mentoring to translate newly learned skills into practice (Holmes et al., 2016; Schoen et al., 2021). Therefore, it is important to find ways to provide opportunities for active learning through learning platforms, including remote or web-based learning (which are becoming increasingly common), to improve learning outcomes, confidence, and application of learning to practice (Bryan et al., 2018). For this reason, the educational intervention includes guided small group learning experience through video conferencing software to provide OTPs the opportunity to participate in activities in order to promote confidence and skills development and therefore the translation of learning into practice.

Types of Current Training Methods to Inform the Development of the Educational Intervention

With the explosion of technology, there are a variety of ways for OTPs to obtain additional training: (a) formal/informal, (b) in-person, (c) remote, (d) hybrid, and (e) tutorials. Formal, face-to-face learning experiences are no longer the most common form of continuing education. Furthermore, face-to-face, remote, and hybrid learning platforms were compared and found to be equally effective at impacting satisfaction, confidence, and knowledge; however, a flexible learning platform in any of those settings was found to improve participation and adherence to the learning experience (Perea & Sit, 2020). Likewise, a comparison of formal vs informal learning opportunities found informal learning environments to be as effective as formal ones (Andersen, 2001). Despite the many types of learning environment factors such as self-directed learning, active learning experience, mentorship, and flexible learning opportunities have been found to positively impact the effectiveness of learning opportunities across all learning platforms (Perea & Sit, 2020). Thus, these factors were considered and intentionally

integrated into the CASP Toolkit and educational intervention in order to maximize learning outcomes.

Many OTPs are facing organizational barriers that make it difficult to find the time for formal continuing education opportunities. Nevertheless, self-directed learning and hybrid opportunities have the benefit of being more flexible for learners and can result in increased opportunities/access for OTPs (Kent et al., 2018). Phillips et al. (2022) looked at a self-directed online educational program using a one-group pre- and post-measurement. The self-directed online learning experience was found to be effective at increasing knowledge on the topic but did not determine if the knowledge was translated into increased competency or practical skills (Phillips et al., 2022). This suggests that self-directed or hybrid learning can be further improved by incorporating opportunities for additional support and active learning.

Active learning can further strengthen learning opportunities and result in increased confidence in relation to newly learned content (Fitzgerald et al., 2015). Active learning can include a variety of opportunities including reflection, goal setting, case studies, and collaboration. The Occupational Therapy Clinical Learning Framework (OTCLF) (Fitzgerald et al., 2015) provides a framework to support learning that includes active learning experiences with reflection, review, and collaboration, which aligns well with the Lifestyle Redesign® methodology including (a) peer exchange, (b) active learning, and (c) personal exploration (Clark et al., 1997). These active learning opportunities can be easily incorporated into all learning platforms since technology and social media have expanded the opportunities for collaboration and group work in hybrid or remote settings.

Mentorship is essential for professional growth and building skills/knowledge for anyone from the novice to the experienced OTP (Schoen et al., 2021). Schoen et al. (2021) found that

"mentorship programs instilled confidence, positively affected their professional outlook. … had a specific influence on clinical skills such as clinical observations, clinical reasoning, translating theory to practice, and access to resources" (p. 4). Training materials that include some type of mentoring or small group collaboration can result in the increased application of gained knowledge (Hovick & Provident, 2018; Juckett, 2020). Moreover, advances in technology have made it easier to find mentorship and collaboration with professionals in your practice setting or area of interest. Overall, social media as a medium for collaboration and mentorship is becoming more common (Davis & Voyce, 2015). OTPs find social media sites accessible, and it allows practitioners to collaborate and communicate with other professionals globally with low to no cost and minimal effort (Murray & Ward, 2019). Finally, creative uses of technology and social media provide options to include mentoring/collaboration in self-paced or web-based learning platforms.

Training Methods in Relation to the Educational Intervention and CASP Toolkit

The review of the literature on training methods found that the most effective training methods include opportunities that are flexible, easy to access, and provide active learning experiences and opportunities for collaboration/mentorship (Bornman & Louw, 2019; Holmes et al., 2016; Schoen et al., 2021; Stav & Herman, 2022). This capstone project designed the educational experience to be flexible for OTPs in a variety of ways, including both self-study and group learning opportunities.

The CASP Toolkit was used as a flexible self-study resource and has pre-recorded videos that guide the learner through the content. The Toolkit includes eight modules, allowing the user to pick and choose what topics are relevant to their current client. The content of the Toolkit manual, modules, and pre-recorded videos provide background information and evidence-based

interventions to increase OTPs' knowledge and skills in the topics of community and social participation. The educational intervention included a guided small group learning experience that provided opportunities for active learning, collaborations, and mentorship to improve confidence with community and social interventions. The educational intervention also aimed to promote clinical competency through an evidence-based design that provided opportunities to develop confidence and skills through a flexible learning platform with opportunities for active learning and mentorship.

Summary

In summary, the findings of the literature review support and guide this capstone project in the following ways:

1. OTPs are well placed to address the barriers and enablers of community and social participation to reduce the impact of social isolation for community-dwelling older adults (AOTA, 2020).

2. Current programs are not generalized to meet the needs of older adults with chronic conditions (Levasseur et al., 2022).

3. OTPs are lacking the resources and tools to implement community and social interventions (Turcotte et al., 2019).

4. Confidence and skills are critical components of clinical competency that are necessary for OTPs to translate knowledge into practice and implement community and social interventions (Brangan et al., 2015).

5. Flexible learning experiences that provide opportunities for active learning, collaboration, and mentorship help OTPs develop clinical competency (Perea & Sit, 2020).

6. The educational intervention in this capstone is designed to be a flexible learning tool with opportunities for active learning to empower OTPs to provide community and social interventions for community-dwelling older adults.

Section 3: Methods

Design

This project used a quantitative one group pre-and post-survey design with an educational intervention to examine the impact of a guided educational intervention on the perceived confidence and skills of OTPs when providing community and social participation interventions. The project consisted of a two-part educational intervention (one part self-study and one part small group learning over video conferencing software). The outcomes of the educational intervention were assessed with two surveys.

Setting

This educational intervention took place in two phases, each with different settings. Phase one of the study consisted of a self-study that participants completed in their own time using the CASP Toolkit with pre-recorded videos and a user manual that was emailed to each participant via a Google Drive link. No restrictions were placed on where the participants completed the self-study and the only materials required were access to the Toolkit and pre-recorded videos. Phase 2 consisted of a guided small group learning opportunity that took place over a video conferencing software program. OTPs joined the video conference using their personal accounts on a computer, laptop, or cell phone from their location of choice. Participants were asked to participate in a location where they had access to the CASP Toolkit and manual, could actively participate in the group activities, and no one else had a view of the screen in order to protect the identity of the other participants. No further restrictions were placed on

where the participants completed the synchronous group learning experience. The guided group learning experience was divided into three groups and was facilitated by the primary investigator. The groups were created to keep the group size small, allow for collaboration, and provide more opportunities for participants to find a time that fit into their schedules.

Inclusion and Exclusion Criteria

The inclusion criteria required that participants were occupational therapy practitioners who are English-speaking, have an active OT license, live in the United States, work with adults 65 and older, and who work with clients that experience limitations in community and social participation. Both occupational therapists and occupational therapy assistants were included in the study. This included OTPs who currently work in non-acute settings such as home health, outpatient and inpatient rehab, skilled nursing, or community-based settings. Also, OTPs were included who were convenient for the primary investigator to contact by email through personal acquaintance or direct referral. It was required that the participants had time to complete self-study (1.5 hours) and the small group experience (1 hour). Excluded participants included those who did not have a current OT license, had more than 15 years of experience, worked in acute settings, or did not work with adults 65 or older. OTPs who had more than 15 years of experience were excluded because this project looked at perceived confidence and skills, which are impacted by increased years of experience (Finn, 2018).

Participant Recruitment

An email invitation explaining the project was sent to pre-identified OTPs who worked in home health and community settings and who were familiar with the primary investigator utilizing a convenient sampling method. After email invitations were sent out to OTPs familiar to the primary investigator, a snowball effect occurred, and several OTPs reached out who met the

inclusion criteria and who were interested in the project. Of the several who reached out, eight fit

the inclusion and exclusion criteria and agreed to participate. The invitation included a project

description, which included the inclusion criteria, and a statement that OTPs should inquire if

they:

1. Work with older adults who experience limitations in community and social

   participation in non-acute settings.

2. Have time to complete eight self-study modules (1.5 hours) followed by a

   synchronous 1-hour Zoom meeting to recap and discuss the self-study modules.

Procedures

Please view Table 1 for an outline of the educational intervention in relation to the

procedures.

Table 1: Educational Intervention Timeline and Procedures

Timeline	Materials	Procedure	Time required
Pre-survey	15-question Qualtrics survey	Sent via email. Must be completed before moving on to phase one.	10 min
Phase one: self-study	CASP Toolkit (included 2 pre-recorded videos and a manual)	Materials sent via email. Participants must watch both pre-recorded videos and review at least two modules of the Toolkit before moving on to phase two.	1.5 hr
Phase two: group learning	Video conferencing software, access to the Toolkit and manual	Participate in the guided group learning opportunity.	1 hr
Post-survey	16-question Qualtrics survey	Sent via email after completing phase two.	10 min

Following recruitment, a cover letter was provided to each participant, which outlined the purpose of the project, the voluntary nature of the project, and the procedure for withdrawal. After reviewing the cover letter, a time was scheduled for the synchronous learning activity. Participants demonstrated understanding of the cover letter through email correspondence by responding with a RSVP for the synchronous learning activity. After agreeing to participate, participants were given access to the pre-survey and self-study learning material (CASP Toolkit) through email. Participants completed the asynchronous learning activity before the group learning experience. The asynchronous self-study learning opportunities allowed participants to learn at their own speed and convenience. It included watching two pre-recorded videos and reviewing at least two modules of the CASP Toolkit and manual. See below for a list of the module topics.

Table 2: Modules of CASP Toolkit

Module 1	Introduction to CASP
Module 2	Anxiety and Fear of Falling
Module 3	Energy Conservation
Module 4	Managing Environmental Barriers
Module 5	Personal Safety
Module 6	Using Technology to Stay Connected
Module 7	Transportation
Module 8	Caregiver Training

All participants had access to the same materials, which could be used after the study but were not shareable due to copyright issues. After completing the self-study, participants met in small

groups for phase two over an hour-long video conference hosted by the lead investigator in order

to accomplish the following agenda:

Table 3: Phase 2: Guided Small Group Agenda

Time	Methodology	Task
5 min	Objectives	1. Identify barriers and enablers of community and social participation for older adults. 2. Identify the role of the OTP to provide interventions related to community and social participation. 3. Describe two goals and interventions to address community and social participation. 4. Describe barriers to implementing community and social interventions in your practice setting. 5. Create a personal action plan to provide interventions related to community and social participation.
10 min	Didactic education	Briefly review the content for the self-study (the impact of community and social participation, barriers/enablers, and the role of OT when providing related interventions).
30 min	Active learning	Review two case studies. Create two goals and two interventions for each case study using the CASP Toolkit as a guide.
10 min	Personal exploration	Group discussion on current practice, barriers/enablers of the practice setting, and an opportunity to create personal goals.
5 min	Wrap up (Q&A)	Time for question and answer.

After completion of the guided small group learning experience, the post-survey was sent to

participants via email using Qualtrics. Results of the pre-and post-survey were de-identified

using a pre-determined code system.

Instruments

Community and Social Participation (CASP) Toolkit

The CASP Toolkit is an evidence-based guided educational tool that was created by the

primary investigator to meet the needs of the ill-elderly. The CASP Toolkit is a non-standardized

tool without any reliability or validity norms. The Toolkit consists of eight modules that address components of community and social participation, a user manual, and two pre-recorded videos.

Each module in the Toolkit is supported by the literature as a barrier or enabler to community and social participation. The modules were designed to support the OTP when working with older adults by providing educational PowerPoints to guide OTPs with didactic education, active learning activities, worksheets, and additional resources that could be used in practice.

The associated user manual is a written document that provides a literature review, topic background, theoretical backing, and a topic outline for each module of the CASP Toolkit. The user manual also contains worksheets and additional resources in its appendix and provides support for the OTP when using the Toolkit.

Video one consists of educational content, including the role of community and social participation for older adults; common barriers and enablers to community and social participation for older adults; a literature review; current evidence-based practice; and support for writing goals, creating interventions, and documenting. Video two consists of a brief overview of the Toolkit and how to use it. The Toolkit including the videos and user manual as well as the group learning experience was designed around the recommended method of content delivery from the Lifestyle Redesign® program. The Well Elderly Study (Clark et al., 1997) was used as a program model and the Lifestyle Redesign® methodology was used to design the Toolkit modules and the guided small group learning experience. The University of Southern California Chan Occupational Therapy department permitted the Lifestyle Redesign® methodology to be used in the creation of this Toolkit and educational intervention (personal communication, July 22, 2022).

Table 4: How Lifestyle Redesign® Methodology Was Integrated Throughout the Toolkit and Educational Intervention

Methodology	Toolkit	Pre-recorded videos	Small group learning
Objectives	Each module starts with specific module objectives.	The videos start with objectives.	Group learning objectives are outlined in the Zoom agenda.
Didactic education	Each module provides education for the OTP to use with the client.	After the objectives, the pre-recorded video provides detailed education on the topic background and the role of OTs.	A brief (15 min) overview of the education provided in the pre-recorded video.
Peer exchange	Each module provides an opportunity for discussion between the OTP and the client.	NA	After the brief content overview, there are opportunities for peer exchange.
Direct experience	The Toolkit provides recommendations for direct experiences.	NA	There are several opportunities to practice writing goals and design interventions throughout the Zoom session.
Personal exploration	Each module wraps up with a reflection and provides an opportunity for creating an action plan.	NA	The Zoom session ends with an opportunity to reflect on current practice and practice setting barriers and personal goals.

Guided Group Learning

The guided small group learning experience took place over video conferencing software and consisted of a review of the Toolkit and manual, case studies, discussion, reflections, goal setting, and question and answer. The case studies were completed independently and then each participant discussed their case study and the goals/interventions they designed to meet the needs of the case study with the rest of the group. The small groups were designed to allow time for collaboration and mentorship to improve learning (Beneciuk et al., 2019; Hovick & Provident, 2018; Juckett, 2020; Stav & Herman, 2022).

Outcome Measures

The survey application of Qualtrics was used to create a pre-and post-survey using a five-point Likert scale including questions about perceived confidence and skills. The survey was self-constructed to accommodate the lack of an appropriate existing survey. The self-constructed survey was not standardized and did not have reliability or validity norms. The five-point rating scale related each numeric score to a descriptive value: (a) 1 = no confidence, (b) 2 = some confidence, (c) 3 = neutral, (d) 4 = confident, and (e) 5 = extremely confident. The same Likert scale was also adapted to rate perceived skills. Confidence-based questions included rating perceived confidence with (a) knowledge of the topic, (b) evidence-based practice, and (c) the ability to provide education. Skill-based questions included rating perceived skills with (a) performing assessments, (b) writing goals, (c) implementing interventions, and (d) documenting the skilled nature of services. One additional question was asked in the post-survey to determine if participants how likely they were to initiate community and social interventions.

Table 5: Pre-Survey and Post-Survey Questions

Questions

Confidence: (1 = not confident at all, 5 = extremely confident)

- On a scale of 1 to 5, how would you rate your knowledge of the health benefits of community and social participation for older adults?

- On a scale of 1 to 5, how would you rate your knowledge of evidence-based practice for community and social participation?

- On a scale of 1 to 5, how would you rate your confidence in providing education to clients and families on the role of occupational therapy in enabling community and social participation?

- On a scale of 1 to 5, how would you rate your ability to prioritize community and social participation interventions?

Skills: (1 = no skills at all, 5 = extremely skilled)

- On a scale of 1 to 5, how would you rate your ability to perform assessments related to community and social participation? (Skip if not applicable.)

- On a scale of 1 to 5, how would you rate your ability to provide interventions to enable community and social participation, including:
  a. Educational interventions?
  b. Preparatory interventions?
  c. Simulated interventions?
  d. Interventions in the community/outside the home?
  e. Virtual participation intervention?
  f. Personal safety interventions?
  g. Educating on resources related to transportation?
  h. Caregiver training to enable community and social participation?

- On a scale of 1 to 5, how would you rate your ability to write down goals related to community and social participation? (Skip if not applicable.)

- On a scale of 1 to 5, how would you rate your ability to document the skilled nature of the services provided related to community and social participation?

Additional Post-Survey Question: (1 = no more likely to initiate, 5 = significantly more likely to initiate)

- Do you feel more likely to initiate community and social participation interventions?

Data Analysis

The purpose of the statistical analysis was to determine how the educational intervention impacted the perceived skills and confidence of OTPs in order to provide interventions related to community and social participation. After completing the educational intervention and post-survey, the results of the pre-and post-survey were analyzed using descriptive statistics with a focus on determining the percentage of change. Additional inferential testing was completed using a paired t-test of the scores of each category (confidence and skills). Then, data was exported from Qualtrics to a data analysis software Jamovi version 2.3 (2022) to complete the data analysis. Survey responses contained numerical data in the form of a Likert scale where participants ranked their perceived confidence and skills, which allowed the investigator to determine any differences between pre- and post-educational intervention in terms of perceived confidence and skills.

Data analysis was completed by looking at both each individual participant and each question of the survey (Bonnel & Smith, 2018). Total scores of the confidence and skill-based questions were used for a paired t-test, while descriptive analysis was used to look at the results of each participant individually to determine the percentage of positive changes compared to neutral and negative changes.

Follow-up exit surveys were also completed with two participants to gather more information on possible trends to provide context to the results. Open-ended questions were asked regarding the participants' perceptions of the educational experience, their current practice setting, years of experience, and their comfort with community and social participation prior to this educational experience. Basic demographic data was also collected, including (a) gender, (b) degree, and (c) years of experience.

Ethical Considerations

The risks associated with this project were minimal and an exemption application was approved by the Eastern Kentucky Institutional Review Board (IRB). Please see Appendix A for the IRB approval letter. As per IRB policy for exempted studies, signed consent forms were not required. Furthermore, the purpose of this study and the time commitment associated with this project was explained to each participant before they chose to participate. Each participant was given a cover letter that clearly explained the voluntary nature of this project and outlined the procedures to withdraw at any time if they so choose. Then, the participants gave oral or written consent as per the guidelines for an exempt study. Careful consideration was given to protecting confidentiality and all study materials were stored in a password-protected online software management system, while a list of participants' first names with an associated de-identification code was kept in a locked filing cabinet. Participants also received a certificate of completion to use as continuing education credits for state licensure, which could be seen as an incentive to participate. Survey questions were reviewed by a committee member and chair to reduce biased language.

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Section 4: Results

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Introduction

The proposed outcome of this capstone project was to empower OTPs to provide community and social interventions by using the educational intervention including the CASP Toolkit to promote healthy aging and occupational justice for community-dwelling older adults. Pre-and post-survey results were compared to determine if participants reported a perceived change in confidence and skills to provide community and social interventions after the educational intervention.

Subject Participation Throughout the Educational Intervention

The pre-survey was completed by 11 participants. One dropped out after the pre-survey due to a scheduling conflict. 10 participants completed phase one (self-study) of the educational intervention between the weeks of January 1–16. Phase two (the guided small group learning experience) was divided into three groups that took place on January 16 (3 participants), January 17 (6 participants), and January 20 (1 participant). Groups were uneven as participants were allowed to choose the date and time that best fit their schedules. Altogether, 10 participants completed the post-survey. Results were analyzed by category (confidence and skill) by each individual participant and for total percentage of change. Further qualitative clarification was required give context to the mixed quantitative results. The primary investigator reached out to the three participants with the lowest self-reported scores on the post-survey to schedule follow-up exit interviews. Two exit interviews were completed, while the third participant did not respond to attempts by the primary investigator to schedule one. Results of the exit interviews consisted of anecdotal information to provide further context to the results.

Demographic Makeup of The Participants

The 10 practitioners who participated in this project had the following terminal degrees: (a) one Certified Occupational Therapy Assistant, (b) seven Masters of Occupational Therapy, and (c) three Doctors of Occupational Therapy. Years of experience varied. See Figure 1 below for years of experience and degree relationships. All the participants worked with community-dwelling older adults in non-acute settings.

Figure 1: Pie Chart Showing the Demographics of the Project Participants

Education and Experience

1
11 years

3
1 = 1 year
1 = 5 years
1 = 6 years

6
3 = 4 years
1 = 5 years
1 = 10 years
1 = 14 years

■ OTA ■ MOT ■ OTD
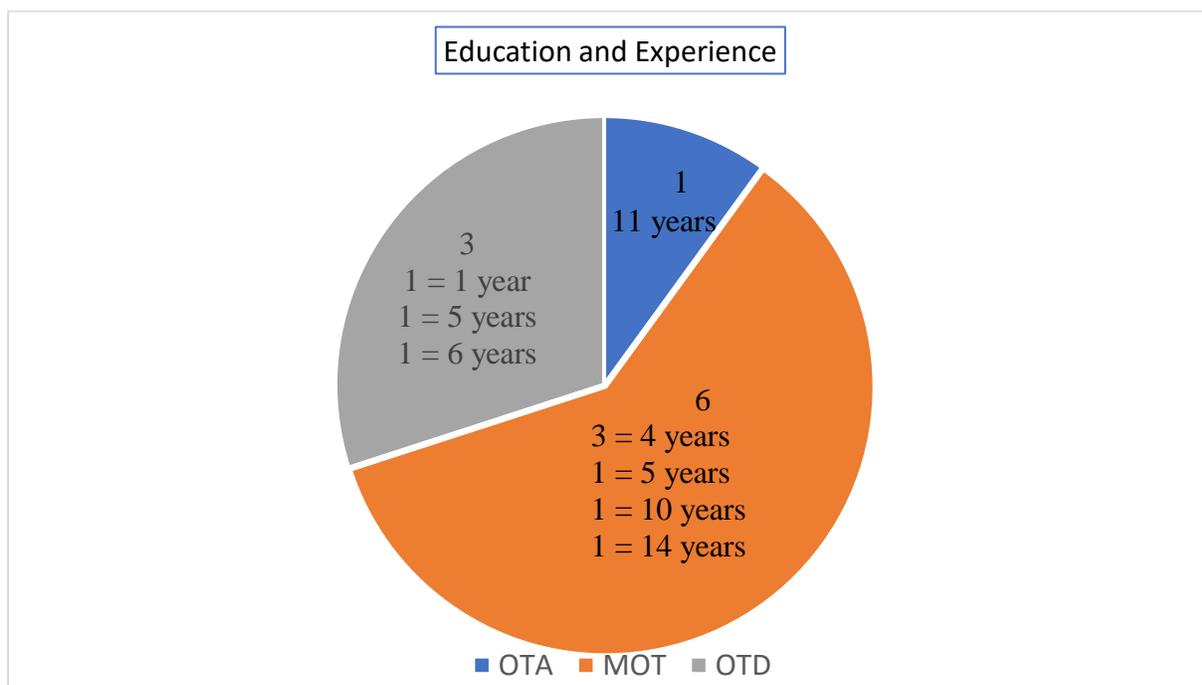
Individual Participant Results

      The individual participant results were analyzed using descriptive statistics including mean, median, and standard deviation for each participant to determine the percentage of change in their perceived confidence and skills after the educational intervention. See Tables 6 and 7 for the individual results of each participant separated by category (confidence and skills). All participants demonstrated some overall improvement in post-survey: 50% of the participants demonstrated more than a 50% positive change for confidence- and skill-based questions, 30% of the participants had a gross score improvement between 25% and 50%, and 20% of participants had a gross score improvement between 12% and 25%. It was noted that two participants had an overall decrease in perceived confidence and two others a decrease in perceived skills after the educational intervention.

Table 6: Percentage of Change for Confidence-Based Questions per Participant

Participant ID	Confidence pre-mean	Confidence post-mean	Confidence percentage of change
1	3.75	4	6.6
2	4	4.5	12.5
3	4	3.75	−6.25
4	2.5	2.25	70
5	2.25	4.5	100
6	2.75	4.25	54
7	4	3.75	−6.25
8	2.5	4.5	88
9	4	4	0
10	3.75	4	6.6
N = 10	**3.35**	**4.147**	**23.8% Total Percentage of Change**

Note. Scale: not confident at all = 1, some confidence = 2, neutral = 3, confident = 4, extremely confident = 5

Table 7: Percentage of Change for Skill-Based Questions per Participant

Participant ID	Skills pre-mean	Skills post-mean	Skills percentage of change
1	3.09	3.81	23.3
2	3	4.27	42.3
3	3	3.63	21
4	2.90	4.27	46.8
5	1.72	4.09	100
6	2.5	3.8	50.8
7	3.3	3.09	18.1
8	2.8	4.18	49.2
9	4.1	3.66	−10.4
10	3.90	3.45	−11.5
N = 10	**3.025**	**3.915**	**28.7% Total Percent of Change**

Note. Scale: not confident at all = 1, some confidence = 2, neutral = 3, confident = 4, extremely confident = 5

Table 8: Percentage of Positive, Neutral, and Negative Responses per Participant

Participant	Percentage of positive responses	Percentage of neutral responses	Percentage of negative responses
1	46%	33%	13%
2	66%	33%	-
3	40%	40%	20%
4	73%	26%	-
5	100%	—	-
6	80%	20%	-
7	40%	46%	13%
8	80%	20%	-
9	13%	26%	46%
10	20%	13%	46%

Confidence-Based Results

The survey included four questions that looked at the perceived confidence of OTPs in providing community and social interventions. Participants rated the questions using a five-point Likert Scale. There was a positive 23.8% change for the confidence-based questions as a group. Meanwhile, the group mean for the confidence-based questions changed from a neutral score of 3.306 for the pre-survey to a confident score of 4.167 for the post-survey.

Table 9: Results of Confidence-Based Scores

Question	Mean	
	Pre	Post
Knowledge of the health benefits of community and social participation	3.8	4.2
Knowledge of current evidence-based practice related to community and social participation	3.1	3.888
Confidence to provide education on community and social participation	3.5	4.3
Ability to prioritize interventions about community and social participation	3	4.2
Total	**3.306**	**4.167**
Percentage of Change		**23%**

Note. Scale: not confident at all = 1, some confidence = 2, neutral = 3, confident = 4, extremely confident = 5

Skill-Based Results

  The survey included 11 questions about the skills required for OTPs to implement community and social interventions. The participants rated their perceived skills using a five-point Likert scale. Pre-and post-means are calculated below for each question in the skills section of the survey. Note that three questions were not answered in the pre-survey and two were not answered in the post-survey. The total percentage of positive change in the perceived skills was 28%. The mean for the skill-based survey questions was 2.883 pre-survey (not skilled) and increased to 3.909 post-survey (neutral in skill level). See Table 10 for more details on the mean scores for each question in the skill-based section of the survey.

Table 10: Mean Scores for Skill-Based Perceptions Pre-and Post-Survey

Question	Mean	
	Pre	Post
Ability to perform assessments	2.77	3.777
Ability to write goals	2.875	4
Ability to provide educational interventions	3.4	4
Ability to provide preparatory interventions	3	4.1
Ability to provide simulated interventions	3	4
Ability to provide interventions in the community	2.8	3.5
Ability to provide interventions related to virtual participation	2.8	3.5
Ability to provide interventions related to personal safety	3.6	4
Ability to provide interventions related to transportation	3.3	3.9
Ability to provide caregiver training	2.8	4.1
Ability to document skilled services	2.9	4.2
Total	**2.883**	**3.909**
Percentage of change		**28%**

Note. Scale: no skills at all = 1, some skills = 2, neutral = 3, skilled = 4, extremely skilled = 5

Results of the Additional Post-Survey Question

The post-survey asked one additional question that was not on the pre-survey, which was to determine if the participants felt that they were likely to change their practice after the educational intervention. 90% reported that they were "significantly more likely" or "more likely" to perform community and social interventions after the educational intervention. In contrast, 10% gave a neutral response when asked if they felt more likely to initiate community and social interventions.

Inferential Analysis of Pre- and Post-Mean Scores

A paired t-test was completed to look at the relationship between pre- and post-survey responses and revealed a statistically significant change in both confidence- and skill-based questions. Since the sample size was low, Cronbach's α was completed for both categories to determine the reliability of the responses before running the t-test. The responses to the confidence-based questions had a Cronbach's α score of .852, indicating that the responses were reliable, while the responses to the skill-based questions had a Cronbach's α score of .787, which also indicates good reliability. The paired t-test for both categories of the survey indicated a statistically significant result, with a p value of less than .005 in both confidence- and skill-based survey questions. (See Table 11 for results of the paired t-test.)

Table 11: Paired t-Test Results

Pre-category	Post-category	p value	Mean difference	SE difference	Effect size
Pre-confidence	Post-confidence	.034	−.0861	.336	−.854
Pre-skills	Post-skills	.002	**−1.026**	**.326**	**−1.190**

Note. p value < .05

Table 12: Pre- and Post-Descriptives by Category

Category	Number of responses	Mean	Median	SD	SE
Pre-confidence	9	3.306	3.750	0.778	0.259
Post-confidence	9	4.167	4.250	0.306	0.102
Pre-skills	7	2.883	3.000	0.655	0.248
Post-skills	7	3.909	3.818	0.315	0.119

Note. Number of responses calculated is less than 10 as some questions were not answered by the participants.

Anecdotal Findings in the Exit Interviews

Exit interviews were scheduled with the two participants that gave negative responses to the post-survey. Participants were asked about their practice settings, clinical experience, years of practice, and overall perspectives on the project. Overall, the anecdotal responses of both participants indicate that their responses to the educational intervention were not negative.

Participant 10 had the greatest number of negative changes in the post-survey (45%). She has a master's degree and four years of clinical experience. She responded that she works in a day institute program where she goes on several community outings with her clients regularly and that she felt comfortable with this topic prior to the intervention. Participant 10 has the most experience with community and social interventions in the cohort and stated, "I did learn some things that I had never thought of before, like personal safety."

An exit interview was completed with participant 3, who had 20% negative responses in the post-survey. Participant 3 works in inpatient rehab, has a master's degree, and 11 years of experience in inpatient rehab. She had an overall positive review of the Toolkit and the small group learning experience. She stated, "I have been telling my co-workers about this training and Toolkit. I like how the Toolkit could be used for one-on-one sessions or in groups! I think the material would be good to use for groups in the rehab department." She also reported, "I helped someone set up Instacart between sets of exercises the other day and that is not something I would have thought of before this class." She reported that the found the small group training to be helpful to her because she had not considered the barriers to community and social interventions that practitioners in other settings encountered: "It helped me understand the continuum of care and how I can't pass these things down the line." She also stated that she had been using some of the techniques in the Toolkit such as mindfulness strategies when working

with clients who are fearful of falling, and she was mindful of how that would translate into community and social interventions as well.

In summary, none of the participants reported having a negative response to the educational experience and were unable to provide insight into why their scores indicated a negative change. In addition, both participants reported positive views of the intervention. Thus, it remains unclear why they scored in the negative range in their post-survey results.

Section 5: Discussion

The Impact of Guided Educational Intervention on OTPs' Perceived Confidence and Skills

The purpose of this capstone project was to determine if a guided educational intervention had an impact on OTPs' perceived confidence and skills to provide community and social interventions. Supporting the findings in the literature, this project found that after participating in this flexible educational intervention with opportunities for collaboration and active learning, participants reported improved perceived confidence and skills ranging between 23.8% and 28.7%. Additionally, 90% of the participants responded that they were "significantly more likely" or "more likely" to provide community and social interventions after completing this educational experience. These findings support the evidence of Brangan et al. (2015) that a higher level of perceived confidence and skills relates to the translation of these skills into practice. Because of these findings, this project concludes that guided educational experiences are a feasible way to develop the skills and confidence needed to reach clinical competency.

The Role of the Guided Educational Experience

The initial intent of this capstone project was to focus on ways to improve the confidence and skills of OTPs when providing community and social interventions. However, as the project progressed, the role of the "guided educational experience" was found to be a critical component

of this project to support the confidence and skills of OTPs. This capstone project supports a body of literature that argues that flexible learning experiences with active learning, collaboration, reflection, and mentorship can improve confidence and support knowledge translation. This outcome was a result of a combination of factors, including the intentional integration of theory and evidence throughout the design of this educational experience. Here, theory and evidence were used together to create a guided learning experience that offered both asynchronous and synchronous learning opportunities to allow the educational intervention to remain both flexible and promote active learning/collaboration.

Guidance by Wilcock's Model of Health Promotion and Lifestyle Redesign® was relevant and supported the OTPs' outcomes. While Lifestyle Redesign® has been successful in the literature as a program for addressing the well-elderly, its methodology also fit nicely with what was found in the literature to support confidence and knowledge translation. The recommended Lifestyle Redesign® format included didactic education, active learning, and personal exploration, and these methods were expanded on by the evidence found in the literature to create an educational experience (Clark et al., 1998). Together, all the methods in this educational experience were created with the desired outcome of Wilcock's theory of health promotion to empower OTPs to Do, Be, and Become providers of community and social interventions (Wilcock, 2006). Although it is not possible to say this with full confidence, this blended educational design appeared to yield good results in terms of increased perception of both confidence and skills.

How the Outcomes Are Reflected in the Group

Looking at the post-survey as a whole, 100% of the participants had some degree of positive change in their perception of their confidence and/or skills after the educational

experience. The results were even across the various terminal degrees of the participants except for participant 9, who was the only participant with the terminal degree of Certified Occupational Therapy Assistant (COTA). Participant 9 had the greatest level of negative perceived change in skills after the educational intervention (although she had a positive perceived change in confidence). Nevertheless, since participant 9 was the only participant who practiced as a COTA, it is not possible to draw any conclusions; still, it is worth reflecting on what the root cause of this negative perception of skills might be. It is also worth noting that three out of the four participants who reported a negative perception of confidence or skills had the most years of experience (10–14 years). Thus, there is evidence to suggest that those with more years of experience naturally had a higher level of perception of their confidence (Finn, 2019). It is therefore unclear how this relates to any negative perception of confidence and skills following the educational intervention.

How the Exit Interviews Connect to the Results

Exit interviews were completed as a follow-up to the educational intervention to gather additional context to support the quantitative data from the surveys with two participants who had a small number of negative responses in the post-survey. Both participants who completed the exit interview reported that they had already changed their practice in some ways and were more aware of the community and social needs of their clients. This supports the finding of the last question on the survey where 90% reported they were more or significantly more likely to provide community and social interventions. It is remarkable that even with some negative responses to the survey, these two participants reported that they were in fact incorporating what they had learned into practice. Furthermore, both participants did not report perceiving negative scoring in their initial grading nor verbally reported positive changes. During the exit interview,

both participants remarked on the benefit of the small group learning experience, which supports the literature regarding active learning experiences and collaboration (Bornman & Louw, 2019; Chilton et al., 2022).

Implications

Implications for OTPs

OTPs are balancing the demands of an ever-changing health profession with demanding productivity standards. Furthermore, continuing educational experiences can be time-consuming and expensive. Nevertheless, flexible opportunities for learning can increase access to educational experiences for a variety of OTPs and reduce barriers to participation (Kent et al., 2018). This learning experience was therefore designed to be flexible by providing self-study learning opportunities (phase one) which the participants could complete according to their own timeline/location (Kent et al., 2018; Phillips et al., 2022). The self-study also provided several modules that allowed the participant to choose the courses that were most interesting to them. Then, the small group learning (phase 2) provided multiple time options to allow the participant to choose what time best fit their schedule. The learning experience also included opportunities for reflection, group discussion, active learning, and collaboration, which was found in the evidence to build confidence and support the translation of knowledge into practice (Hovick & Provident, 2018; Juckett, 2020; Schoen et al., 2021). Subsequently, the results of this project found that after completing the educational experience, the participants reported both an increase in perceived skills and confidence as well as an increased likeliness of providing community and social interventions.

The reported increase in both confidence/skills and likeliness of initiation interventions is consistent with the evidence in the literature that having confidence in their skills and abilities

helps OTPs translate new learning into practice (Brangan et al., 2015). Indeed, after the educational intervention, there was a statistically significant increase in both skills and confidence. The reported increase in skills and confidence is directly related to the last question in the post-survey where 90% of the participants reported that they were more likely or significantly more likely to provide community and social interventions. This seems to suggest that this educational intervention was effective at both increasing skills and confidence as well as the likeliness of knowledge translation. Although further research is necessary to investigate how to carry over learning into practice, the exit interviews which were completed a few weeks after the intervention indicate that at least one of the participants reported carrying over new skills into practice.

Implications for Older Adults

After participating in this guided educational experience, OTPs reported feeling more likely to initiate community and social interventions. As OTPs feel more comfortable with community and social interventions, they are more likely to implement them (Brangan et al., 2015). This is backed up by evidence in the literature where studies found that confidence and experience are related to clinical competency (Bornman & Louw, 2019; Chilton et al., 2022). Thus, increased confidence and experience could result in more older adults having access to OTPs who can provide interventions relating to community and social participation. In short, having greater access to community and social interventions has the potential to improve the overall health and wellness of the older adults being treated by practitioners who provide these interventions.

Implications for the Profession

To keep up with the needs of the growing aging population, it seems that it would be beneficial for OTPs to have opportunities to be trained in current evidence-based practices that are flexible and easy to access. OTPs have a variety of ways to obtain knowledge, and the result of this capstone suggests that guided learning experiences that are flexible for OTPs can result in increased confidence/skills and the translation of learning into practice. OTPs can be leaders in the health care system by providing ongoing training opportunities that are effective at not only increasing knowledge but also enabling OTPs to translate that knowledge into practice so that OTPs can "Do, Be, and Become" providers of evidence-based practice (Wilcock, 2006).

As a healthcare system and as a profession, there is a tendency to separate practice settings. Emphasis has been placed in the literature on the importance of interprofessional collaboration in healthcare, but there is less literature about intra-professional collaboration along the continuum of care. There is an opportunity to break down the barriers between practice settings and encourage OTPs along the continuum of care to work together to help clients meet their goals. This capstone project included guided small group learning experience that consisted of OTPs in various practice settings to provide an opportunity to discuss how each setting can serve older adults and what barriers they run into when proving community and social interventions. Although this was not the direct focus of this capstone project, the anecdotal findings in the exit interviews show that the collaborative environment promoted the participants' understanding that community and social participation ought to be addressed along the continuum of care.

Additionally, this project was created as the primary investigator found that there was a lack of resources in a specific practice setting. This self-identified gap led to the creation of a

Toolkit and educational experience that could support other OTPs. Overall, there is an opportunity for OTPs to find gaps in their practice setting and to develop tools and resources to support other OTPs, which can promote entrepreneurship as well as help advance the profession.

Limitations

The limitations of this study include the fact that the small convenience sample of 10 participants limited the ability of the results to be generalized to the greater population of OTPs. Since there was a sample of participants who were familiar to the primary investigator, there could have been unintentional bias in responses to both the survey and exit interviews. Moreover, there was a small number of participants that had some negative perceptions of their skills and confidence that were not substantiated in their exit interviews. Since these results did not seem to be consistent with the exit interviews, it is possible that variations in the subject's responses indicate a differing response level based on the day, their mood, or other variables. It is not possible to determine the main reason due to the lack of a control group. Since phase one of the educational intervention was self-study, completion was not observed by the primary investigator and the results assume that all self-study was completed according to protocol.

Strengths

This project included participants with variable terminal degrees, years of experience, and practice settings. Because of the varied experiences of the OTPs, the guided group learning experience allowed for intra-professional collaboration among practitioners along the continuum of care. During the exit interview, one of the participants who worked in inpatient rehab reported that she was not aware of the barriers other OTPs encountered when providing community and social interventions. She reported that having a better understanding of what other practitioners

can do or not do help her better understand how to address community and social participation in her setting.

Another strength of this project was the flexible nature of the educational intervention. Phase one of the educational intervention was a self-study that participants were able to complete at their convenience. The CASP Toolkit included in the self-study comprised of eight modules that allowed the participants to pick and choose depending on their interest and needs. The participants were able to choose one of the three time options for the guided small group learning experience, which was completed over video conferencing software. This allowed OTPs of various geographical locations to attend at a time that fit their schedule. This flexible learning method is supported in the literature as it makes learning opportunities accessible to OTPs of various geographical areas and with various time restrictions (Kent et al., 2018).

Although the small convenience sample limits the ability of the results to be generalized, the results of the paired t-test indicate a statistically significant result that is further strengthened by a reliable Cronbach α score. The results of this project and significance found in the t-test are further strengthened by the anecdotal findings of the exit interviews.

Future Research

The findings of this capstone project highlight the need for further research in several areas. While the findings indicate that after the educational intervention, OTPs had improved perceived skills and confidence to provide community and social interventions, additional research is needed to determine if these results will translate into a change in practice. Thus, this project used a guided small group learning experience via video conferencing to provide active learning experiences and suggests that further research is needed to determine what other platforms, such as social media groups, could provide effective active learning and collaboration

in order to best support OTPs where they are. Additionally, further research could be done to establish a normative tool to assess community and social participation for older adults.

Summary

This capstone provided a guided educational intervention to OTPs who work with older adults in non-acute settings with the goal of improving their perceived confidence and skills when providing community and social interventions. Analysis of the quantitative data indicates that the goal of this educational intervention to improve OTPs' perceptions of their skills and confidence was met overall. The mean scores of the pre- and post-surveys reveal an improvement in confidence and skills across the group, which suggests that this guided educational intervention did increase the perceived confidence and/or skills of OTPs when providing community and social interventions.

There is a need to develop educational opportunities that support the growth and development of occupational therapy. As a profession, we can work together as educators, colleagues, and practitioners to "Do, Be, and Become" providers of occupation-based practice and be agents of change for our clients and the greater healthcare system.

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Appendices

Appendix A

Hello Jenny Williams,

Congratulations! Using a limited review process, the Institutional Review Board at Eastern Kentucky University (FWA00003332) has approved your request for an exemption determination for your study entitled, "The CASP Toolkit: Supporting occupational therapy practitioners to provide community and social participation interventions for older adults" This status is effective immediately and is valid for a period of three years as long as no changes are made to the study as outlined in your limited review application. If your study will continue beyond three years, you are required to reapply for exemption and receive approval from the IRB prior to continuing the study.

As the principal investigator for this study, it is your responsibility to ensure that all investigators and staff associated with this study meet the training requirements for conducting research involving human subjects and comply with applicable University policies and state and federal regulations. Please read through the remainder of this notification for specific details on these requirements.

Adverse Events: Any adverse or unexpected events that occur in conjunction with this study should reported to the IRB immediately and must be reported within ten calendar days of the occurrence.

Changes to Approved Research Protocol: If changes to the approved research protocol become necessary, a Protocol Revision Request must be submitted for IRB review, and approval must be granted prior to the implementation of changes. If the proposed changes result in a change in your project's exempt status, you will be required to submit an application for expedited or full review and receive approval from the IRB prior to implementing changes to the study. Changes include, but are not limited to, those involving study personnel, subjects, recruitment materials and procedures, and data collection instruments and procedures.

Registration at ClinicalTrials.gov: If your study is classified as a clinical trial, you may be required by the terms of an externally-sponsored award to register it at ClinicalTrials.gov. In addition, some medical journals require registration as a condition for publication. In the case of journals with membership in the International Committee of Medical Journal Editors, clinical trials must be registered prior to enrolling subjects. It is important that investigators understand the requirements for specific journals in which they intend to publish. In the case of sponsored project awards, timeline requirements will vary for awards that require registration. Approved consent forms must be uploaded in the system for all Federally-funded clinical trials after subject enrollment has closed, but earlier registration is not required for all agencies. If you have questions about whether a sponsored project award requires registration and on what timeline, please send an email to tiffany.hamblin@eku.edu before beginning recruitment so that the specific terms of the award can be reviewed. If you have a need to register your study and do not have an

account in the system, please send an email to lisa.royalty@eku.edu and request to have a user account created.

If you have questions about this approval or reporting requirements, contact the IRB administrator at lisa.royalty@eku.edu or 859-622-3636.

For your reference, comments that were submitted during the review process are included below. Any comments that do not accompany an "I approve" response have been provided to you previously and were addressed prior to the review process being completed.