**2019 Online KT Conference:**

**Innovative KT Strategies That Work**

*KT Strategies to Increase Use of the Canadian Occupational Performance Measure in Stroke Rehabilitation*

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>>ANN OUTLAW: Let's go ahead and get started. Our first presentation is titled: KT Spinal Tap Spinal Tap strategies to Increase Use of the Canadian Occupational Performance Measure in Stroke Rehabilitation. Dr. Piper Hansen is an academic field work coordinator and clinical assistant professor at the University of Chicago. She held the role of occupational therapist at the research lab. Includes knowledge translation, assessment and interventions in neurorehabilitation. If you have any questions during the presentation, please ask them in the chat box and we will address them as we can. Using the chat questions, I'll also be moderating Q&A following Piper's presentation. Are you ready?

>> PIPER HANSEN: I am. First just a little bit more about me. I've been an occupational therapist for the past 15 years. My general background has been clinically focused. Much of this time has been spent providing therapy services in patient neurorehabilitation.

I held the role of clinical practice leader for about the past six years. There I was overseeing knowledge translation projects to promote the increased use of evidence-based practice and also to create new clinical practice guidelines and standards for within the organization.

Myself and the organization have held a particular focus on the integration of standardized assessments as a standard of practice throughout the full continuum care within rehabilitation. What I'll be sharing with you this afternoon is just one piece of a multi-year and multi-layered project that was more globally related to assessment use and patient rehabilitation. Just for a little bit of more context about the environment this project took place, it is housed within a free-standing rehabilitation hospital and the hospital itself has 242 beds. Specifically for this project, we target two of the 7 total adult rehabilitation floors and these floors particularly specialize in stroke rehabilitation. So just to give you a little bit of an idea of how we will start, I will start providing background related to occupational therapy. The occupational therapy evaluation process as it relates specifically to this project. The use of rehabilitation assessments and the assessment battery, particularly in relation to the ability lab practice guidelines that were established about five years ago. And then I will also provide a brief overview of the Canadian occupational performance measure which I will refer to as the COPM, which is the primary focus of this presentation.

I will highlight some high-level details of the project itself as well as kind of next steps within the studies exploration. I will end with some lessons learned and things specific to clinical practice for the group to discuss at the end of the presentation. At the core of occupational therapy is the concept of occupational performance. So an occupation is any activity you might engage in. It can be something more common and basic that we do every day like brushing our teeth every morning to the collective task that make up all of our workdays.

The definition of occupational performance -- more specifically -- is a person's ability to perform these activities, tasks or roles for a living. Again, it's the day-to-day things we all do. Each person's occupational performance is inherent to the person or client themselves but demands a specific activity or occupation has that they're engaging in as well as the where, the how and the why otherwise known as the context and environment of that particular activity. So you can kind of see this triad here on the slide.

So two people may be engaging the same occupation, but their experience and occupational performance can vastly vary. This can be because of individual factors between the two people themselves like different heights or their motivation to complete the activity. But more importantly -- also to not be forgotten -- is the environment of the activity is taken into. If you're try to go cook breakfast in the morning, do you have all of the necessary materials and space that is needed or are you in more of a cluttered kitchen? That is going to impact your performance.

In order to adequately address performance, it is imperative to obtain all of the information about someone and also the context they're engaging in as I mentioned. Many of these categories are listed here and are included in someone's occupational profile as it's referred to within occupational therapy. It is my responsibility to conduct a fact-finding mission to develop this occupational profile -- or generally a holistic view of the person.

I obtain information on the person seeking my services so I can see how to best provide intervention. That might be improving strength, environmental assessment, compensatory training and so on.

Well, the occupational profile is a vital component of the occupational therapy evaluation process, and it really provides much of the necessary information to direct a therapy treatment plan that doesn't directly contribute to rehabilitation outcomes which are becoming increasingly more important in today's healthcare and climate within the United States. Despite the necessity of obtaining a comprehensive occupational profile, this process is also wrought with many barriers. For example, it can take a significant amount of time to complete and in an environment where time is at a premium, this information can get lost within the electronic medical record and not necessarily utilize its full potential.

Also, this type of more narrative personal information is not necessarily valued by third-party payers and this can sometimes be too much information and doesn't necessarily provide a narrow focus to create prioritized goals and to best direct therapy services. So globally in rehabilitation at the post-acute care level, use of assessments has become an increasingly common part of the therapy process. It is used to measure muscle strength, walking speed, someone's memory and so on.

For example, in the photo on the slide, the person is attempting the test item of the action research arm test assessing someone's ability to grasp, hit, pinch, and their general arm mobility in a clinical environment. While these provide assessment and objective data, they do not speak to personal concerns related to their occupational performance. Because occupational performance is a theme to occupational therapy, while also engaging a client in the goal-setting process and setting their own therapy priorities, there really can be a dramatic disconnect between someone's personal therapy goals and common assessments that are being used in rehabilitation.

For me, if you're going to be addressing occupational performance as a central theme to the therapy treatment plan this should also be measured and documented whenever possible. A clinical battery benefits from the use of standardized assessment to promote comprehensive assessment, not just from the client level, or client factor level but also to include participatory levels as well. So the COPM is an available standardized assessment published in 1991 and has been used in a wide variety of settings. COPM expands within a traditional occupational profile using a semi-structured interview style. In addition to gaining information about meaningful occupations, it includes a scoring process to track change during rehabilitation. It is important to know what one's occupational profile is while still ensuring there is objective data or those specific to occupational therapy. While still striving to provide the meaningfulness that is provided. This month, Chicago hosted their annual marathon. As an occupational therapists, if one of the individuals was coming in for therapy, it would be important to know if they were a marathon runner or the person enjoying their breakfast watching the marathon runners. Both can be similar. The occupation was different. The last part of the triad we didn't discuss was the client factors. If one of the individuals was one of those marathon runners, it would also be important to know if they were the professional marathon runners that broke the recent time record. If they're more of a weekend warrior or if they're someone who tried out the marathon but was wishing they had trained more. So through the use of the COPM, the OT cannot only gain information about what the person needs and wants to do, but further explores an individual's satisfaction and their own perceived performance within their occupational profile and will quantify information for tracking.

For those of you who are unfamiliar with this particular assessment, I want to take a few moments to briefly review the process with you to provide a little bit more context about what some of the challenges associated with clinical uses really are. The next two slides are going to depict the general process of COPM administration. Self-care, productivity, and leisure are the three categories. Then they rate the level of importance for themselves on a scale of 1-10.

As for the process, during this brainstorming session, the occupational therapy would ask probing questions about the activities of the person mentioned. If someone was in the hospital and they mentioned their role as a father as something that was important, myself as the OT would then ask additional questions about their roles of father. What kinds of activities do they engage in when they're interacting with their children? If they mention that one of the things they do is cook their kids breakfast in the morning, I would ask questions about is it a hot breakfast? Cold breakfast? Get details. Until I have a tangible therapy goal that we can work on.

So after this initial brainstorming session to discuss activities, up to 5 of the most important occupations from all of those potential categories, are then further scored on a 1-10 scale. But now the areas of someone's performance. If they were to complete that activity today, how would they anticipate they would be able to perform and complete that activity? Then they rate their satisfaction about what today's performance would be potentially be also on a scale of 1-10. These scores are subdivided into an average score that can be used for reporting.

So these identified occupations can assist with goal setting and the integration of meaningful occupations and activities into the treatment plan. So just in briefly describing this process, you can probably see some of the challenges integrating the Canadian occupational performance measure with consumers after stroke. These individuals may have cognitive challenges. They may be experiencing deficits within their communication styles and they may not have tried these activities yet so they may not be able to report on what the performance might actually be. Another limitation is external to the person but can also influence the COPM's impact and rehabilitation. Not all these activities can be completed within a hospital or institutional setting.

Globally, this project led to the knowledge frameworks. Create clinical practice change that were -- excuse me -- that could change a -- that change that could occur using established knowledge translation tools and strategies.

Patient stroke rehabilitation was the targeted group because it was the lowest-performing group throughout the whole organization. It was significantly lower than any of the other teams. So the primary question of the project was how do occupational therapists practice patterns, impact the knowledge action process when introducing the Canadian occupational performance measure in a rehabilitation stroke setting. We also want to look at systematically reviewing the experience and perceived barrier of using the COPM a bit further.

I wanted to learn more about the educational experiences and how that influences practice and how this education needs to be structured to maximize successful utilization of new knowledge and practice. I wanted to explore if there were any inherent characteristics of individual participating in this project that may influence the use of COPM. In this instance, we utilized practice patterns associated with global evidence-based practice use. So this slide provides a high-level overview of the project itself. Again like I mentioned, we recruited therapists from different rehab units. These engaged in facilitated services with some time before and after to apply some of the concepts that the discussion and these facilitated in services were viewed. One of our primary outcomes was a pre and post survey which was administered about a week after the completion of the final pilot. So I think that we all know the traditional strategy and clinical education does not necessarily work. I've also heard this strategy referred to as the train-and-frame model of education. So for the purposes of this presentation, I want to focus last on the evaluation I am framework and process that was utilized. That is not necessarily depicted on this slide right here, but I wanted to focus on some of the intervention strategies used as well as the global process.

You can see a few of these samples listed on this slide and I will highlight a few as well.

A large component of this project was focused primarily on training and education. We will talk a little bit more about what this training looked like. I wanted to be a dynamic, ongoing training in supports that were being provided to the occupational therapist. It was also very targeted in its focus.

In addition to those facilitated inservices that the therapists participated in, we also created additional educational materials we thought would be helpful. This was done in conjunction of the therapists themselves. This was creating supportive communication cards for clients that had aphasia and provided consistency in terms of communication and administration process across the teams.

I also want to highlight that we really focus on developing interrelationships with the participants and the stakeholders. We really identified champions of the assessments within the teams. Who are the bright stars? And we helped them to present for cases to their peers, share their experiences and successes and we really wanted to focus on the most difficult scenarios, the most challenging experiences the clinicians were having. Having them think outside where they were in terms of their assessment use.

A lot of the services surrounded curtailing the assessment itself to our new context. In this case, it was the stroke population. So then we used a lot of facilitated discussions -- a lot of examples and cases to help kind of guide and tailer the education and come up with discussions and to modify the administration process. Make it easier and streamlined to meet the barriers people were experiencing.

Some other strategies that were integrated that were not necessarily included here on the slide were modifications to the electronic medical record. As well as other logistics that were addressed such as making sure people had the assessment forms and that everyone knew what the assessment form $were. We had discussions around how to schedule the assessment, how to plan ahead to make sure you are being more successful. So in order to better understand why the COPM isn't being used, one must first understand barriers within the COPM practice. Some of those were related to some of the logistics that I just mentioned.

There's an occupational therapist and traits and patterns used to their belief and evidence-base the practice. So the four practice patterns we refer to are listed here on this slide. I will briefly review them. The first is traditionalist. This is someone who relies on clinical reasoning and the opinion of other experts. So they really value clinical experience over evidence or new literature research. A pragmatist focuses on a client's needs in the moment and not necessarily on that of evidence-based practice guidelines. They highly value experience over the evidence but they will potentially choose assessments or interventions that are evidence based -- and solely driven on their practicality. Someone in the receptive category tends to also follow the opinions of experts and they tend to lead -- they tend to lean towards valuing the evidence over experience but they also don't want to be the one who is looking different in the clinic. They don't want to necessarily be the one that is standing outta round their peers. The fourth practice pattern that we utilized specifically for this product was a seeker. Seeker utilizes evidence-based practice rather than relying on their own experience. So they're always looking to create change and what is new. This can be a little bit to their detriment at times in that they were kind of -- regardless of how practical the evidence might be, regardless of what other people are doing, they are finding ways to create change in their practice. It is great to find seekers on your team. We hypothesize seekers would integrate the performance measure into their clinical practice and that the seeker's documentation would reflect more diverse goal categories and would also integrate what we defined as more participation-based goals into their goal setting, not necessarily just fall into the categories of self-care activities or exercises. But their goals would also better reflect each individual's characteristics. So we had a small but dedicated group, but in general, was a fair representation of the total occupational therapists in-patient stroke rehabilitation teams at the time. There was other wise 10 total therapists to participate. One was myself. One was on maternity leave. The third who did not participate had increased administration responsibilities so the clients who participate specifically in this project you can see there's a vast number of years in experience. Generally they were newer clinicians.

Then here's a breakdown of the therapist's self-reported practice patterns of style. We had also compared this to a 2007 study that explored about 100 occupational therapist's practice styles. In that study, they were -- 65% of that group was classified as a pragmatist. And only 2% of the group within this study were represented as seekers. So you can see there's a little bit of a difference between this group. It could be potentially because of the small number but also because this study took place in an academic research hospital, we also think this might account for differences within this group in terms of there's a few more seekers you might other wise think there also is no traditionalist in the group.

A little bit about the methods we use. We utilize a pre and post-session survey. We will show you some of those questions a moment. For review of the participation-based goal setting in client-centered care, we also completed a pre and post chart review. The patient records that were selected had been individuals that were admitted in another a 3-month time period before we had started this intervention and a three-month post the intervention. The other components of the charts that we pulled was that the identified primary therapist was one of the participating occupational therapists in the study as well. From a randomized list of charts, we selected 10 charts from the participating OTs. This is 5 charts from the pre-intervention timeframe and 5 from the post. Just to kind of get a sense of what the occupational therapists were documenting. Then we further analyze the chart review to determine if there were any initial trends in their own practice related to their practice patterns. I just want to take a brief step back. The COPM was an assessment to the group. Like I mentioned before, it was established 1991, so it's commonplace in education that all the occupational therapists went to as well as other continuing education they had been exposed to. Instead of repeating basic information about the assessment, we are really focused more on building upon their previous knowledge to increase application of knowledge through practice-based learning.

This method was specifically used to facilitate critical-thinking skills and self-directed learning as well as facilitation of social learning and we really wanted to target and really challenge currently held belief around this assessment itself and how that could impact their practice.

So we utilize cases of current consumers that were currently receiving in-patient rehabilitation so most of the participating OTs knew who they were. These cases were used to demonstrate the impact of the COPM in clinical practice. It led to fairly impactful discussions.

We wanted to broaden perspective who -- who they were could COPM appropriate and who would be a challenging patient to administer this assessment with. Really wanted to change the definition that the therapist really had in their minds around this specific assessment. So for example, one of the occupational therapists who was participating in the pilot reported back in the second facilitated in service that they had thought about utilizing the COPM with one of their newly admitted consumers. She was a young mother who had a stroke during childbirth but decided against it because she thought the person was too emotional. It would have been too challenging about the conversations we had. We utilize the time as a group to really provide her some guidance and some coaching, collectively again as a group. Not necessarily from the facilitator and she actually did go back and administer the assessment with good results. We talked her into it to begin with, but it really was a promising experience and changed what she was doing moving forward.

So, the primary survey results are here. Because it was such a small end, the initial effect was determined and trends were noted. So, there's limited. These were the questions were a bit more conceptually focused. They were rated fairly high on our scale of 1-5 initially. A couple of these questions related to confidence and the concept of participation knowing the purpose of measuring participation with this assessment and how measuring participation enhances the focus of occupation and then treatment plan.

Thankfully though, those questions demonstrated the greatest change were those were the most clinically relevant. That is probably to be expected. A couple examples were that the participants felt adequately trained to administer the COPM, even though we didn't talk about basic administration. We talked about how to address those basic barriers stead. They felt they knew how to interpret the COPM related to goal setting. That was a big focus of this project. And also how to use COPM statistics to improve goal setting and being more objective in the use of the assessment itself. They're moving beyond utilizing occupations with the additional information and interpretation. Let's now share a little bit more about the chart review.

These charts were randomly selected from a database and pulled until 5 charts from each of the two time points -- the pre and the post-timeframes were viewed. We noticed if the COPM was administered. With these different groups of patients -- also again, the review -- the goals that were written by each occupational therapist. Each goal was then categorized one of the 11 categories listed on this slide. So the most common category across the board was considered an ADL. These are those self-care activities like brushing your teeth, eating, dressing, that sort of thing. It is common that these goals are going to rank the highest with patient rehabilitation. The use of the functional independence measure and now the quality indicators in code items are required by Medicare. The other category that we really highly focused in on was the leisure and community-focused goal category. This is what we felt best represented what we were looking for in terms of participatory goal levels that were being set.

In total, 632 goals were written by the 7 OTs in the charts that we looked at. Again, the additional layer of this analysis was exploring was if there were any trends related to reported self-practice style or pattern. Their application of the educational objectives and goals. So again, our hypothesis was that seekers would be likely to modify their practice. We did see that. So the seekers had more diverse goal categories across the different charts that we reviewed. And also seekers -- much more significantly incorporated that those participatory goals into their treatment plan. So beyond those basic self-cares, exercise, balance, there's a lot more focus included in the goals.

Three of the charts utilized the Canadian occupational performance measure a minimum of two times during the person's stay. So at least admission and discharge. It is one from each different category. So one seeker, one pragmatist and one person seeking -- it was an improvement from our pre-survey in which all of the participating OTs said they had not administered this assessment for at least 6 months or more and obviously, the majority of this team also said they had never administered the COPM on one of their clients after stroke and in-patient rehabilitation. So to give you a general sense, in-patient rehabilitation, about 50% of the individuals had the COPM administrated -- administered at least two times during someone's length of stay. In the stroke population, it is half that. It is 25%. It has been utilizing COPM to show change. There's room for continued attention and improvement. So I just wanted to open with a few implications for clinical practice.

I don't think this is necessarily new news -- or new information by any means. I wanted to highlight a few things I found to be important to a hectic possible environment. So the first thing I want to highlight is focused -- they haven't let this influence them to date. Instead of providing education that would be the kitchen sink in sharing a lot of information, we really took a step back to make sure we were taking into account adult learning styles so that they could take this information and apply it and analyze it in new and complex ways. It is helpful to make sure it is a topic the therapist can engage in.

We weren't asking for a lot of time. These were services -- we provide them with food to come to. But I think that -- you know, clinicians who are kind of -- busy throughout the day have different barriers to these kinds of studies -- really want to know they can have something tangible they can take back to their clients the next day. I'm making sure you are discussing people that are currently being seen so they can try things we had discussed right that same day if not the next day. Again, I think this idea of collective learning and support can be effective even more so than just an expert's opinion. I think by facilitating discussions, having people share stories and create an open dialogue help to propel the conversation forward even more so then any education might. The other thing I want to highlight is having organizational support is key.

This is a small grass roots project. I think it is always important to make sure organizational support is on board. I find it can be -- finding management buy-in can be easier when it's explicit about what the potential impact and organizational standards and patient satisfaction can be. When we were discussing this project with stroke rehabilitation management team, a few questions on their post-rehabilitation survey -- had questions related 0 how the consumers felt they were engaged in their own goal setting which has always been rated very low. We've been able to target the priority of the management team while still kind of improving OT practice at the same time. I really think it is important to reflect the changes that are wanted in practice within whatever the documentation system is between utilized within rehabilitation.

In a lot of ways, if it wasn't written down, didn't happen. Documentation not only provides a record of the plan of care, the goals and the interventions, it is really also a communication tool. So, kind of a second area of focus on this project was to have documentation that not only supported communication between healthcare providers but also allowed for additional opportunities in the future for research. So that we could pull that information later on and look at trends and how that was impacting outcomes.

Lastly, want to focus again on feedback. Not a new concept for anyone, I'm sure listening in today. It is really critical for successful knowledge translation to maintain sustainability. By having that, being able to pull specific trends for each of the therapists was helpful information to share with each individual team member as well as the teams collectively because they can't really change their practice if they're not sure what needs to change specifically about them. As a clinician myself, I think I'm checking all the boxes and getting everything done assuming everyone else is the person why group [Indiscernible] are lower in terms of organizational reports. Individual feedback can go a long way by improving the sustainability of this project and others that are similar to it

Finally, I included a slide for potential future reasons for supporting projects related to COPM and other similar assessments and areas of improvement for the future. This was a nice step and how this impacts use of COPM. I feel like I've mentioned before, there is some contained room for improvement. What was nice about the occupational therapists driving our conversations is that as they got more engaged in the process, they also had more things to explore. Determining what the appropriate timing of the administration of the assessment could be and exploring different strategies to make that the most successful. I want to thank you all for joining me for my presentation. I want to acknowledge the therapists who participated and the time and energy they gave to a specific project.

I had students that assisted particularly with the chart reviews. I wanted to make sure they were acknowledged as well as the other contributors as well as related to my project and subsequent related projects as well. I'll stop there and open up for questions and discussion.

>>ANN OUTLAW: Thank you. I see the photo credits are on the slide now. At this time, I would like to invite our reactors to turn on their webcams as they introduce you and for Piper to turn on your webcam as well, please. Great. Thank you so much. First allow me to introduce our esteemed reactors. We have Kate Dunn who is a knowledge translation specialist at SKPR. She works to achieve students' knowledge translation goals and she has a Bachelor of Arts at McMaster and Masters of Public Health from the University of Saskatchewan. Also joining us is Janet Panoch. She has been helping her daughter due to osteosarcoma transformations. Families making surgical decisions for the treatment of osteosarcoma in the lower extremity. We also have with us Dr. Jean Winsor who is a research associate for the Community of Inclusion. With an emphasis on bridging research to practice to employment systems stakeholders. She has been the long-time coordinator of state intellectual and developmental disabilities agencies employment and day services. She is also a policy specialist for the state employment leadership network and rehabilitation research and training center on advancing employment for individuals with intellectual and developmental disabilities. She wasn't busy enough, she is also the project director for the Florida Employ Me First project. Thank you for joining us today. We had a few questions coming in from the audience. If you had questions for Piper or any of the reactors, go ahead and chat them in the chat box now. This one is for you, Piper. We had one comment that said it was interesting that there were no traditionalists in the group. Do you have ideas about why that might be and why there are so many seekers, too?

>> PIPER HANSEN: I also was surprised by that because I used the same survey for students, for occupational therapists and physical therapists. Usually it very much matches the study that I referenced from 2007, I think. Specifically, for this, there were newer clinicians, and they were excited about being in a research hospital. They were taking every opportunity they could and this was reflected in some of their answers. It was an academic hospital setting which might be different to some other kind of rehabilitation setting. It might draw clinicians and engage them more in this practice in general.

>> ANN OUTLAW: This is a very personal question. Where do you think you lie in the continuum?

>> PIPER HANSEN: I take this all the time to see if it changes. I tend to fall into the seeker category myself.

>> ANN OUTLAW: Interesting. It seems like a diverse group would be ideal.

>> PIPER HANSEN: I think like I mentioned the seekers can really be the drivers of change and bring the information to the group, but also can do it without kind of thinking through some of those specific steps that might be needed to really be successful and to actually translate change into practice.

>> ANN OUTLAW: Definitely. We have another question coming in before I get to the reactor discussion area. Sue Lynn is a member of our KTDRRs community of practice and is an occupational therapist and she says they had sum results. They surveyed 151 OTs and PTs who treat stroke survivors. One indicated they use movement-related standardized assessment more than 75% of the time. 71% were PTs, 29% were OTs. Do you know if there's an association between the level of education and the use of standardized assessments?

>> PIPER HANSEN: I don't know if there's necessarily an association between level of education. I think the occupational therapists tend to march to their own drum a little bit sometimes in that you focus on the occupations are individualized to the person and individualizing that practice. I don't think we always necessarily incorporate that to our practice because it can feel a little bit more restrictive at times than some of my PT colleagues.

>> ANN OUTLAW: Thank you so much. Jean, I'm going to switch gears a little bit. Have you adopted practice guidelines and tailored KT strategies in any of your projects?

>> JEAN WINSOR: Absolutely. Having the opportunity to really take some time and look at Piper's implications for clinical practice, some much resonated with me. I saw so much crossover between the ICIs particularly with employment support professionals and job developers. I'm going to talk a little bit about some of the work my colleague has led for more than 5 years now. Trying to really understand not only what is the disconnect between employment service provider's knowledge about best practice but trying to understand how to in house support and coaching within their daily practice to improve performance. The work that they had done and again, led by my colleague Alberto has focused on the development of a daily survey that is delivered through a smart phone application and through that survey not only are they collecting data on a daily basis, point in time -- where the implement support professional is and whether or not they're engaging in the best practices we know that that help people with disabilities get jobs in the community. Are we able to use that data and Taylor intervention and coaching information and small bits of information back to those support professionals and again on your communities of practice and also through the application and other opportunities that they have to interact with those. And they have found that has been a valuable tool because so many professionals are not sitting in their office. They are out there on their own having to navigate challenging situations on a daily basis. So having that daily survey was a fantastic opportunity for them to get some support as well as for us to continue to understand what are the interactions between best practice and what is happening in the field. So thank you, Ann.

>> ANN OUTLAW: Thank you, Jean. Kate, I’ll turn this over to you. Piper mentioned briefly about peer mentorship, have you found this similar to your experience or have you found other strategies to be effective in implementing an innovation among practitioners?

>> KATE DUNN: Thanks, Piper for this excellent presentation. I kept thinking to myself, as I sit here in Saskatoon, Saskatchewan, that unfortunately, we are not really lucky in the sense of having a big group of occupational therapists. You can't get trained here. So a lot of people go away to other provinces and end up staying there. So I was a little jealous during your presentation hearing about all that beautiful OT work that was happening. But yeah. Very effective knowledge translation strategy creating some mentoring and peer learning environments. One study that we're supporting right now is really coming to light is physiotherapist who is doing research with individuals with MS, and she is introducing some different techniques and exercises to an MS population through using physios. Sure enough, the up take in her project would be two months, up to 300 people recruited which is absolutely outstanding. The buy-in from the physio point of view has just been unreal and tons of support from the team. So I think when you're discussing peer mentorship and peer engagement, you're hitting the nail on the head. I really like what you said about maintaining and beginning with communication and buy in. That is so key and so critical from the very beginning, explaining to health care providers and decision makers, what you're trying to accomplish and bringing them along on the journey and bringing them up to date. Whether that is a success story or some of the challenges in implementing the different strategies that your research is trying to unfold. Excellent presentation. I like those points. Thank you.

>> ANN OUTLAW: Thank you so much, Kate. Piper, would you like to respond to that?

>> PIPER HANSEN: Yeah, I think that I agree. It is about people feel like they own the topic and the change. It is not something that is being brought to them. So even in our -- I didn't mention this, but we also had a focus group previous to beginning this from that really focus on what were some of their barriers and providing the kind of care they wanted to provide. It led us to the pathway of wanted to be more occupation focused, more client focused. You were able to channel that into utilizing the COPM to help direct some of that and obtain that information in a more objective way.

>> ANN OUTLAW: Definitely, thank you. Janet, I will turn the mic over to you. During Piper's presentation, she discussed a few methods of maintaining communication and buy-in among practitioners. What recommendations do you have for supporting communication and buy in?

>> JANET PANOCH: That is a really good question. When it comes to the time suck, we always get a lot of push back from practitioners and clinicians. That is an ongoing problem. I think -- we talk a lot about training and all these things we can do to prepare clinicians to more effectively communicate with patients but we don't really talk very much about what we can do for the patients or the consumer on that side. So because we don't do very much patient advocacy training or communication skills training with the patients, often times you know, we as the patients default to sort of more of the passive role expecting the clinician to be the expert. So as far as -- I think it would make the clinician's position easier in the sense that if we were to offer some training for the patients, letting them know what the expectations are to be active and to communicate some of those things you showed in the occupational profile, things about their environment and themselves that give a more global picture so the practitioner doesn't have to spend time-piecing it out, you know? If everybody is coming to the table wanting to be parties in this, it takes time away from everybody and also contributes to patient satisfaction, better health outcomes and so on. So if everybody sort of has an understanding of that he think that would help. But I really think we overlook patient communication skills training. Letting them know that they are expected to advocate for themselves and share these kinds of information to have better health outcomes.

>> ANN OUTLAW: That is a really great point, Janet. Thank you for sharing that. I know from a patient perspective, sometimes you're a little nervous to talk to the doctors. They know the situation best. They are the experts, but really you are the experts of your own health, too.

>> JANET PANOCH: That is exactly right.

>> ANN OUTLAW: We had a couple questions coming into the chat box. Shanpin? Forgive me if I'm mispronouncing that. Walking or ambulation is the occupation that is usually not in the scope of OT practice. What is the proportion of the goals that is about to quote -- be able to walk -- and how do you manage this goal specified by patients? Piper, do you have an idea about that?

>> PIPER HANSEN: That is the number 1 kind of most common scenario. When you initially meet someone and you ask them what their goal is for one of the first things for just about everyone I see is they want to be able to walk good. What we've been working on is to ask additional questions outside of that. I think we also can't -- because -- walking isn't necessarily part of occupational therapy, I can also ask questions surrounding where do they want to walk to? Spin the question a little bit to learn more about holistically about what is it about wanting to walk again that isn't more meaningful. They go on a walk with their dog. We want to acknowledge that we acknowledge that as a primary goal but use that as a way to get to other things as well.

>> ANN OUTLAW: Thank you so much for that clarification. Another question is coming in from Ashley from the UVN Medical Center? Can you speak to the overall duration of your project from beginning to end? Did you measure the change in percentage of administration of the COPM pre-implementation and post? If so, what was the delta?

>> PIPER HANSEN: Specifically, for this project, from beginning to end, it was an 8-week project, so we had people come in for the pre-focus group, complete their surveys. They came to a 1-hour service and they had two weeks to come practice. We came back as a group one additional time and we had a couple weeks to test out again some of the things that we discussed until the end of the 6th week pilot. So it was pretty quick in terms of the time we took specifically at this juncture. I don't necessarily have a comprehensive idea of the change in percentage administrations totally specifically within that floor. We do track that now. Right now, the COPM administration is kind of right in the first half of frequently used assessments within the team. We are also working right now to define what assessments create change in people coming in for rehabilitation.

>> ANN OUTLAW: Thank you so much, another question has come in from Elizabeth. She is in a university setting. There are researchers who have evidence-based research, we are trying to think about how we can facilitate the flow or accessibility of this work into the hands of clinicians. First Piper, do you have any thoughts? I'll turn it to the reactors after you chime in.

>> PIPER HANSEN: I think some of it kind of depends on the difference -- evaluation or assessment. Off the top of my head, a couple things that come to mind is finding a community collaborator. Someone who might have some kind of connection to the University. I also think that utilizing students can be helpful in occupational therapy -- students go out to different internships in different clinics or clinical sites. And they usually have to do a project. One of those projects can be taking this new assessment and educating the team about that. It is relevant to where they are.

>> ANN OUTLAW: Great. Thank you. Kate or Jean or Janet. Have you thought about this topic?

>> JEAN WINSOR: I think about the fact that I'm also in a University setting. One of the things that we at the institute have access to is our rehabilitation studies program. A strong connection has been built over many years with that department and organization. That is one place we very intentionally formed relationships so that information can cross over directly and be implemented by students as they're learning so it becomes part of their natural practice and not necessarily an add on. I also think about our role as a university of excellence in mental disabilities and the connection that provides to our program. Again, that opportunity to develop those intentional connections and to ensure that individuals are participating and have access to all of the information. It is such an important piece and that gatekeeper, finding the right person to establish long-term relationships is so crucial.

>> ANN OUTLAW: Thank you, Jean. I realized I missed a question in the chat box, so let me go back up to that one. Let's see. Cheryl Mosher asked was one of the aims of this study was to whether OT practice style, for example seeker -- influence or predicted whether the COPM form could be used in practice and secondary is your opinion based on your data in this study outcome? What might be another stronger predictor for whether the COPM form will be used in practice? Piper?

>> PIPER HANSEN: We were curious to see what someone self-rated, their influence of new knowledge and jumping on and utilizing the knowledge translation, techniques and strategies that were adjusted. So I think that was an interesting addition while trying to increase the utilization itself. Thinking about stronger predictors, I think things around emotional intelligence potentially can be related to how comfortable someone might feel utilizing this assessment. Those kind of soft skills, being able to be in an uncomfortable space while having a conversation with people is really important. I find as a more senior clinician within the organization and interacting with students, that is something that is really hard to learn. So, I think that is an opportunity in rehabilitation across the board to best facilitate those kinds of conversations and utilize tools like COPM.

>> ANN OUTLAW: Definitely and it relates back to what Janet was saying. Being able to be in the moment and listen to patients at the table. So paper, thank you so much. Thank you to our reactors. I will ask you all to turn off your webcams and we are going to move along to your next presentation.