

The Phenomenon of Communities of Practice as Professional Development for Occupational
Therapy Practitioners in the Atlanta, Georgia Metropolitan Area

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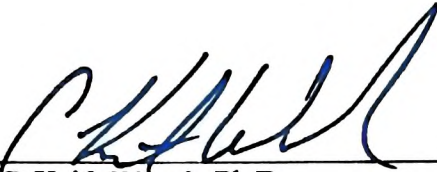
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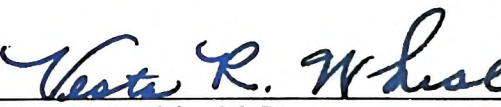

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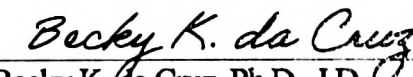

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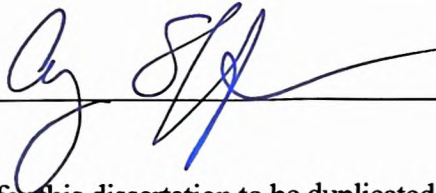
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ABSTRACT

Occupational Therapy practitioners in the state of Georgia are required to participate in formal professional development activities for licensure renewal biennially. Formal professional development activity participation, such as continuing education, is regulated by state licensure law. A variety of research can be located indicating such formal professional development activities are not meeting the immediate needs required to maintain professional currency. The informal professional development activities in which Occupational Therapy practitioners in Georgia participate are not regulated, nor tracked. Limited research has been located related to engagement in informal professional development activities by allied health professionals such as Occupational Therapy practitioners. This study investigated the phenomenon of communities of practice as a form of informal professional development employed by the Occupational Therapy practitioner in the state of Georgia.

A review of the literature was conducted using the proficiency theory of adult learning as the catalyst for informal professional development participation. The literature surveyed further indicated deficits in expected versus reported learning during participation in formal continuing education activities. As a result of this review, a qualitative study using focus groups was conducted to determine how the informal learning in a community of practice influenced the professional development of Occupational Therapy practitioners in the state of Georgia. Analysis of the data indicated that Occupational Therapy practitioners support the proficiency theory of adult learning by consulting communities of practice frequently to impact patient outcomes, support peers, and translate knowledge to practice quickly.

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Chapter I
INTRODUCTION

Background

Occupational therapy is a rehabilitative science that uses evidence-based practice to assist its recipients in increasing their independence and function through the performance of every-day activities known as occupations (American Occupational Therapy Association, 2018a). According to the Occupational Therapy Practice Framework: Domain and Process (2014), Occupational Therapy is the only profession that helps people across the lifespan to do the things they want and need to do through the therapeutic use of daily activities (occupations). Occupational Therapy practitioners enable people of all ages to live life to its fullest by helping them promote health and prevent—or live better with—injury, illness, or disability.

There are currently two practitioner levels and three entry points into the field of occupational therapy (American Occupational Therapy Association, 2018b). One can either become a Registered Occupational Therapist (OTR) or a Certified Occupational Therapy Assistant (COTA). To become a COTA, one must successfully complete an associate of science or an associate of applied science degree in the field of occupational therapy assistant from an accredited program. Graduation is then followed by the successful completion of the National Board for Certification in Occupational Therapy (NBCOT) certification exam (National Board for Certification in Occupational Therapy, 2017b). It is the completion of this exam that provides the “C” in COTA.

To become an OTR, one must complete an accredited program of occupational therapy at either the master's degree or clinical doctorate degree level. As with the assistant, graduates from an Occupational Therapy program must then successfully complete the NBCOT certification exam to practice in the field of occupational therapy. Occupational Therapists who successfully complete their NBCOT exam are awarded an "R" and use the credential, OTR, or Occupational Therapist, Registered (National Board for Certification in Occupational Therapy, 2017b).

The term Occupational Therapy practitioner (OTP) is used to designate either a Registered Occupational Therapist or a Certified Occupational Therapy Assistant. The scope of work carried out by the OTP is guided by the Occupational Therapy Practice Framework: Domain and Process (3rd Ed). (American Occupational Therapy Association, 2014a). Additionally, each state in the United States has designed its own practice act governing the provision of occupational therapy for OTRs and COTAs (American Occupational Therapy Association, 2018c; American Occupational Therapy Association, 2018d). These guiding documents include the scope of practice allowed for OTRs and COTAs, as well as any continuing competence that may be required for OTPs (American Occupational Therapy Association, 2018e).

Continuing competence is an ethical duty for an OTP under the American Occupational Therapy Association (AOTA) Code of Ethics (American Occupational Therapy Association, 2017a). AOTA develops and offers continuing education courses for Occupational Therapy practitioners; however, it is not involved in the management of this ethical duty. NBCOT requires that occupational therapy practitioners pass a certification exam to demonstrate that he or she has the initial education required to perform as an entry-level OTP. This initial certification period is three-years. At that point, OTPs may decide to renew their NBCOT certification or let their certification lapse. If a practitioner decides to renew his or her NBCOT certification, the

practitioner must be able to demonstrate participation in thirty-six hours of “competency assessment units” in the prior three-year period (National Board for Certification in Occupational Therapy, 2018, p. 14). NBCOT maintains a list of acceptable professional development activities for certification renewal. The 2018 NBCOT *Certificant Renewal Handbook* lists thirty-two activities that can be used to earn competency assessment units. These activities range from participation in formal continuing education events, professional service, fieldwork student supervision, conducting presentations, being published, volunteering at events, or serving in a mentoring relationship. The *Certificant Renewal Handbook* also contains the formulas for determining the competency assessment units earned for each activity.

The state of Georgia requires OTPs to participate in continuing education activities as part of its regulation of occupational therapy services (American Occupational Therapy Association, 2018e; State of Georgia, 2017). In the State of Georgia, the provision of Occupational Therapy is governed by rules and regulations known as the *practice act*. State licensure as an OTP in Georgia is required and is also contingent upon regular participation in continuing education activities (State of Georgia, 1976). The practice act currently requires OTPs to document participation in twenty-four hours of continuing education per license renewal period. OTPs must renew their licenses in even years (State of Georgia, 2017).

The practice act defines a continuing education hour as “. . . actual time spent in instruction or organized learning experiences excluding meals, breaks, welcome/introductions, and business meetings” (O.C.G.A. §§ 43-1-4, 43-1-19, 43-1-25, 43-28-7, 43-28-8, 43-28-13, 43-28-14 Ga. Comp. R. & Regs. R. 671-3-.08, 1977 (rev. 2013), para 3). The practice act was last updated in June 2017, and requires Occupational Therapy practitioners to meet the following rules with continuing education:

- (a) At least fourteen (14) hours of the required twenty-four (24) continuing education hours must be related to direct patient care. This includes occupational therapy assessment, treatment planning, occupational therapy implementation and diagnostic related information.
- (b) A maximum of six (6) hours of the required twenty-four (24) continuing education hours can be in "General" continuing education. This includes areas related to administration, supervision, documentation, quality assurance and research.
- (c) A maximum of four (4) hours of the required twenty-four (24) continuing education hours may be used for Level II fieldwork supervision, published professional writing and instructional presentations.
- (d) Each licensee must complete a minimum of two (2) hours of the required twenty-four (24) continuing education hours in the ethics of occupational therapy practice.
- (e) At least twelve (12) of the required twenty-four (24) continuing education hours must be obtained by attendance at live presentations such as workshops, seminars, conferences or formal academic coursework.
- (f) A maximum of twelve (12) of the required twenty-four (24) continuing education hours may be obtained by electronic or web-based courses, formal self-study courses, satellite broadcasts, computer learning activities, webinars, or viewing videotapes in a professional setting.

State of Georgia, 2017 para 3.

OTPs are responsible for locating and participating in continuing education activities that meet the requirements of the practice act. As such, each OTP must locate and attend continuing education courses and events. These events may be provided by continuing education companies, product representatives, medical centers, academic institutions, or internal employee events. The Georgia Board of Occupational Therapy does not approve or certify continuing education providers (State of Georgia, 2017). Each practitioner is expected to participate in and be able to provide documentation of events that meet the above requirements.

Despite having been a recommended practice since 1967, little research has been found ensuring that the methodologies in place for continuing education participation are meeting the needs of the constituents who are regulated to participate. It is unknown if the recommendations by the National Advisory Commission on Health Manpower is even meeting the needs of its prescribed purpose. The Institute of Medicine of the National Academies (2010) stated that research must be conducted related to continuing professional education to determine what works, and what must be strengthened because healthcare professionals in the United States are “not consistently prepared to provide high-quality health care and assure patient safety” (p. 1).

Continuing professional development includes formal, nonformal, and informal professional development experiences; however, the state of Georgia only tracks formal continuing education that meets the licensure renewal requirements (State of Georgia, 2017). This study proposes to fill one of the noteworthy gaps in the literature regarding continuing professional development for the Occupational Therapy practitioner. Through participation in formal continuing education is being tracked, the extent of the use of informal professional development activities is unknown. A review of the current

literature revealed limited information regarding the use of informal continuing professional development in the healthcare arena.

Informal and nonformal professional development have a variety of formats. Communities of Practice (CoP) are one such form of informal professional development. CoP are considered to be a social learning processes by which groups of people who share a common interest collaborate in an effort to increase the professional practice of the group members (Jeffs, McShane, Flintoft, White, Indar, et al., 2016; Johnson, Stribling, Almburg, & Vitale, 2015; Li, Grimshaw, Nielson, Judd, Coyte, & Graham 2009; Wenger, 1998; Wenger & Lave, 1991; Wenger & Snyder, 2000). This work is an attempt to understand better how CoP support the professional development and knowledge translation of OTPs in the state of Georgia by providing the lucrative knowledge, skills, and abilities needed to continue to provide high-quality healthcare in an outcome-driven medical system.

I have been working in the field of Occupational Therapy (OT) since 2004. Being an Occupational Therapy practitioner for this length of time has created a sense of ownership and pride in the profession. I value its role and appreciate its unofficial tag line, *skills for the job of living*. As a veteran Occupational Therapy practitioner, I have developed an interest in changes in the profession that stem from legislative changes, reduced access to services, healthcare payment regulators, other rehabilitation fields, and even poorly trained or unethical practitioners within Occupational Therapy. Holding the position of therapy practitioner educator, I feel the need to cultivate great future practitioners. In addition, I also possess a high personal value for life-long learning, which has only intensified with my matriculation into the Adult and Career Education

doctoral program. I aspire to pass along that desire never to stop learning to the practitioners developed in the Occupational Therapy Assistant (OTA) program in which I work.

As a Certified Occupational Therapy Assistant (COTA) licensed by the state of Georgia and certified by the National Board for the Certification of Occupational Therapy (NBCOT), I have participated in seven state licensure and five national certification renewal cycles. Each of these cycles required participation in continuing education as part of the renewal process. Some of the continuing education events in which I participated were exceptional. These events provided me with current, evidence-based treatment methods I could implement with my patients upon my return to work. They often included hands-on demonstrations or case studies to work through in small groups. Other courses were full-day lectures that contained information not pertinent to the clients or setting in which I was working at the time. Some were selected due to topic or interest, but many others were selected due to cost, location, or looming renewal deadline. In short, I believe that my continuing professional development participation was negatively influenced by not only the continuing education regulations of my state, but also attendance costs, scheduling conflicts, and content availability in my geographic area. My need to learn new skills was not being addressed through formal continuing education; however, my necessity to meet specific criteria related to procuring continuing education hours was being addressed.

When I lacked the knowledge or skill needed to address a specific patient need, that need was often immediate. Scheduling attendance at a face-to-face continuing education event weeks to months in the future did not meet this immediate need. Instead,

new information and skills were often gained on demand by consulting peers via social media groups, consulting listserv members, or viewing web-based resources such as AOTA websites and YouTube videos. This on-demand learning-filled my emergent knowledge gaps with specific patients. I also learned many skills and updated evidence-based practice methods from collaborating with colleagues in my field. This learning was always informal either through asking questions, interdisciplinary treatments, informal in-services, observations, or even social gatherings. These types of learning opportunities were not captured under the definition of continuing education utilized in the practice act (State of Georgia, 2017).

Believing my personal experiences with professional development were not unique to only me, I began asking peers around me if they had similar experiences. These social conversations lead to an informal inquiry of my Occupational Therapy peers. If formal continuing education does not come at the time that it is needed, what do other OTPs in Georgia do? How do other OTPs attempt to provide interventions in situations in which they are under-skilled? Over twenty Occupational Therapy practitioners were asked this question. The answers to this query were a variety of informal learning activities. All practitioners queried suggested that seeking a knowledgeable peer was their first choice to gain new knowledge.

Informal professional development has garnered the attention of the Georgia Occupational Therapy Association (GOTA) as well. Information gathered at the 2018 GOTA state conference resulted in the creation of a task force to further investigate the use of traditionally informal methods of professional development related to the dissemination of new research and evidence-based practice techniques. Ideas presented

at the conference for future development included journal clubs, podcasts, newsletters, and research related listservs to disseminate information gathered from newly published research. A key theme from this conference session was that informal educational opportunities were desired, but participants also wanted to earn continuing education units from their use (Georgia Occupational Therapy Association, 2018). This idea for rewarding participants in knowledge exchanges is supported by research related to the concept of knowledge transfer conducted by Swap, Leonard, Shields, and Abrams in 2001.

Statement of Problem

Occupational Therapy Practitioners in the state of Georgia are mandated to participate in formal continuing education activities to maintain their Occupational Therapy license. Research in other healthcare areas indicates that the most common formal continuing professional development methods being implemented are not effective strategies for maintaining professional currency. Further, formal continuing education activities are not available for the immediate learning needs Occupational Therapy practitioners experience when treating patients currently on their caseloads. Occupational Therapy practitioners in the state of Georgia have reported engaging in informal learning activities within their CoP to fill the knowledge, skills, and ability gaps encountered while providing occupational therapy.

Purpose

The purpose of this qualitative phenomenological study is to understand and describe how Occupational Therapy practitioners in the state of Georgia utilize communities of practice as a form of informal continuing professional development. These informal learning activities have not

been studied and are not being recognized as professional development by the state of Georgia. For this study, a sample of Occupational Therapy practitioners licensed to practice in the state of Georgia will be interviewed in a series of focus groups held in three metropolitan-Atlanta communities. The focus groups are designed to reveal the selected practitioner's experiences with Communities of Practice as a professional development tool in their practice of Occupational Therapy.

To better understand the experiences of OTPs in Georgia, and how the proficiency theory of adult learning leads to the use of informal learning to develop professional currency, I intend to study the role of CoP as an informal educational technique used by Occupational Therapy practitioners in the state of Georgia for professional development.

Research Questions

Current research indicates that formal professional development activities are not meeting the immediate learning needs of health care providers. Healthcare providers have to wait months or longer to attend formal professional development events that increase their skill proficiency (Fisher, 2000; Lysaght, Altschuld, Grant, & Henderson, 2001). No literature has been located which studies informal methods of professional development implemented by Occupational Therapy practitioners in the state of Georgia. Due to the lack of literature present capturing the use of CoP as a method for professional development of the Occupational Therapy practitioner in Georgia, I propose the completion of a qualitative study addressing these experiences. Petterson, Laksov, and Fjellstrom (2015) found that continuing professional development research is narrowly focused on formal methods of continuing education delivery, not on the end user's experiences. Further, a large quantity of professional knowledge is transferred via the

informal process of socialization and internalization (Swap, Leonard, Shields, & Abrams, 2001). This informal knowledge transfer is theorized to be driven by the learner's need to gain skill and become more proficient in the delivery of skilled occupational therapy intervention. As a result, the general research question I seek to answer in this qualitative study is:

Research Question: How does the informal learning in a Community of Practice influence the professional development of Occupational Therapy practitioners in the state of Georgia?

To understand the experience, sub-questions have also been created. This proposed study will further seek to answer the sub-questions posed below.

Sub-Question A: How do informal learning opportunities influence the knowledge translation of Occupational Therapy Practitioners in the state of Georgia?

Sub-Question B: What are the prevailing attitudes and values of Occupational Therapy Practitioners in Georgia toward learning from a community of practice?

Sub-Question C: With what frequency do Occupational Therapy Practitioners in the state of Georgia participate in formal and informal professional development activities?

Significance of Problem

Continuing professional education for health care providers was introduced in 1967, as best practice by the National Advisory Committee on Health Manpower to ensure health care professionals were continuing to build upon the skills learned in post-secondary education and remain up to date on current information (National Advisory Commission on Health Manpower, 1967). This committee further suggested that professional organizations and state agencies should be responsible for the development

of processes and procedures to ensure that health professionals were updating their knowledge and skills regularly. For the field of Occupational Therapy, this mandate is carried out by its professional body, the American Occupational Therapy Association (AOTA), and its credentialing body, the National Board for Certification of Occupational Therapy (NBCOT). Each state in the United States has its own continuing education and regulatory requirements for state licensure of OTPs (American Occupational Therapy Association, 2015a; Hall, Crifasi, Marinelli, & Yuen, 2016).

Despite this mandate being in place for over 50 years, little research regarding the experiences Occupational Therapy practitioners have with continuing professional development has been conducted to determine if the intended purpose of this directive is being met. Research in other healthcare areas has been conducted and indicates that the most common formal continuing professional development methods in use may not be the best methods for ensuring that health care practitioners are maintaining their professional currency. Further, the impact of participation in informal professional development is missing from the literature reviewed.

Informal education has been in existence for centuries (Chunngam, Chanchalor, & Murphy, 2014), however, a paltry amount of information related to its influence exists in the literature (Pollard, 2008). Occupational Therapy practitioners in the state of Georgia have reported using CoP as an informal professional development tool. To better understand the experiences of OTPs in Georgia, and how the proficiency theory of adult learning leads to the use of informal learning to develop professional currency, I intend to study the role of CoP as an informal educational technique used by Occupational Therapy practitioners in the state of Georgia for professional development. This study has been

developed using a phenomenological research approach to uncover “the essence of the experiences of [communities of practice of Georgia Occupational Therapy practitioners] (de Chesnay, 2015, p. III). Gaining this information from other OTPs in my area is important for understanding how OTPs utilize CoP as continuing professional development in Georgia. This information can be used in the future to improve the state-mandated continuing education requirements to better meet the needs of Georgia licensed Occupational Therapy practitioners. Understanding the experiences Occupational Therapy practitioners have with CoP requires that the researcher obtain a deep understanding of “the theories and perspectives of the [Occupational Therapy practitioners] studied rather than relying entirely on established theoretical views or the researcher’s perspective” (Maxwell, 2013, p. 53). This understanding is best gleaned by utilizing a qualitative research design.

My anecdotal experience with continuing professional development has taught me that there is a difference in attending continuing education courses and learning in continuing professional development. Research by Lysaght et al. (2001) determined that common practice indicated that participants in live continuing education seminars related to healthcare topics receive a certificate of participation at the end of the session (if they stay the entire day). The end of course evaluation completed at the end of courses were predominantly questions focused on the comfort of the facilities, the cost to value, and the likelihood to take another continuing education course in the future from the sponsoring provider. In other words, if your body is in the room, you get credit. There is no formal measurement of knowledge gained (Fisher, 2000; Lysaght et al., 2001). Research conducted by Lysaght et al. (2001) further determined that online continuing

education courses required the participant review the material presented, followed by either a quiz, post-test, or evaluation of content learned. This follow-up activity must be completed by the participant before being awarded that participation certificate (Lysaght, et al., 2001). This format requires participants to demonstrate learning gleaned during the session. Neither of these methodologies confirms that the information presented is translated into improved delivery of skilled occupational therapy services. Additionally, these types of learning are not available for the “on-demand” learning often required by Occupational Therapy practitioners when they need new information before treating a patient on their current caseload, for example.

This limitation was a source of concern for me as I felt this compromised my ability to maintain my ethical duty as an OTP to maintain a knowledge of current evidence-based practice and to remain a life-long learner (American Occupational Therapy Association, 2017a). I found myself asking a peer for advice regarding new treatment techniques or ideas. This idea is supported by research conducted by Swap, et al. (2001), who documented that workers ask for information to assist with increasing job performance from others in the workplace (p. 99). As my peer network grew, those interactions began to take place via text or Facebook messaging services. With the technology available today, educational material is shifting to virtual platforms and away from other formats (Nguyen, 2015). Nguyen (2015) further inferred that there was no significant difference in learning effectiveness of online versus face-to-face learning environments.

Armed with this information, I believe that informal learning in the live and virtual environment is being utilized more frequently for Occupational Therapy practitioners

continuing professional development; however, it is not being recognized. Occupational Therapy practitioners in the state of Georgia are limited by statute in how much formal online learning they can participate in for credit toward license renewal. There are no current provisions to award credit for informal learning opportunities (State of Georgia, 2017). The high cost of continuing professional education requires that I be a good steward of my financial resources. Taking courses that both meet the continuing education requirements for license/certification renewal, yet also increase my knowledge, skills, and abilities in evidence-based practice and current trends to ensure I have the professional currency required to perform my occupation as an OTP. Often, this professional currency is developed outside the parameters of the formal continuing education activity.

One hundred percent of the Georgia Occupational Therapy practitioners asked in an informal survey, listed peer discussions and internet resources as their go-to resources to develop clinical competence in an on-demand situation. I am interested in studying the experience OTPs have with informal continuing professional development via CoP. I desire to study the influence CoP have on the professional development of Occupational Therapy practitioners in the state of Georgia. The culture of learning has changed since the rules regulated continuing education for the OTP in Georgia were developed (Amerih, 2013; Anderson, 2001; Bennington & Laffoley, 2012; Coffelt & Gabriel, 2017). Continuing education requirements, however, have not. I wish to focus specifically on OTPs licensed in the state of Georgia. This is for a few reasons. Firstly, I have a personal interest and knowledge in this content as an OTP who is required to participate in regular continuing education to maintain state licensure and continuing professional development to maintain national certification.

Secondly, because each state is responsible for dictating continuing professional development requirements for OTPs working inside that state, I believe this difference alone can have a profound influence on the data collected. Third, there is no identified research specific to this group and topic that has been found.

Anderson (2001) conducted an exploratory study with Florida based Occupational Therapy practitioners to measure “the perceived impact of mandatory and voluntary continuing education activities” (p. 451). Her results found that “the voluntary activities of on-the-job training (in the domain of application) and being mentored had a significantly greater perceived impact compared with the mandatory activity of attending formal programs less than 3 hr long” (p. 452). Her overall results indicated that there was a trend, as far back as the turn of the 21st century that informal educational opportunities common to CoP (mentorship, observing other practitioners, and professional socialization) were perceived as “being as effective, and in some cases more effective, than formal educational activities of 8 hr or less” (p. 452). This research supports the concept of proficiency theory impacting the adult learning environment of the OTP in Georgia. Practitioners recognize a gap in their knowledge and use informal learning opportunities rooted in the knowledge tanks of other practitioners to fill the gaps identified in their personal ability to deliver skilled occupational therapy services.

Anderson (2001) concluded her research with recommending that “consideration needs to be given to including a variety of activities when developing mandatory continuing competency programs” (p. 453) and that more research needs to be conducted related to Occupational Therapy practitioners’ use of informal learning activities as an impactful means of professional development. Further, Norman and Huerta (2006) added that their research regarding the concept of knowledge transfer and exchange theory uncovered that “substantial gaps remain in our understanding of the

way innovations transfer into changes in research and practice” (p. 2). They suggested that CoP could be used to “study [knowledge transfer and exchange] in realistic settings, reflecting everyday practice, in order to promote change and foster system improvements (p. 2). le May (2009) suggested that “CoP are useful structures through which learning, knowledge transfer, knowledge generation, problem-solving, meaning and identity develop” (p. 7), but research conducted by Anderson (2001), Clarke (2005), Janssens, Smet, Onghena, and Kyndt (2016), and Skule (2004) all indicated that research focusing on informal learning and its impact is scarce. This work is attempting to begin filling that void.

Theoretical Framework

Qualitative research design focuses on the participant’s point of view related to a topic rather than the theories of the researcher (Patton, 2015). de Chenay (2015) further elaborated that qualitative research embraces the outliers and actively seeks to enrich understanding by seeking diverse points of view from research participants. The research questions posed in this study focus on determining the participant’s points of view with their personal experiences; therefore, this study is based on qualitative research design. The field of OT dovetails very well with qualitative research study design.

Occupational Therapy is a healthcare field that guides its practitioners to the treatment of the whole person rather than his or her diagnoses or labels (American Occupational Therapy Association, 2017c). The context of one’s environment, the culture of one’s personal background, current location, as well as social norms and group dynamics influence the experiences of the OTP (Thomas, 2015). Because of this viewpoint, OTPs are taught that there is not one specific experience. Instead, each personal experience is rooted in the realities of those factors influencing it (Cronin &

Mandich, 2015). As an OTP, I am seeking out the specific components of a person's experience that are impacting their occupational performance. I have applied this training to my studying of the OTP's experiences with CoP. I desire to understand the specific experiences that OTPs are experiencing with Communities of Practice that are influencing their professional development.

Phenomenological qualitative research was introduced by Husserl to uncover and explain what he coined the "conscious experience" (Farber, 1943, p. 516).

Phenomenology is the study of how one understands and makes meaning of an experience or phenomenon (de Chesnay, 2015). According to Mastin (2009), "experience, in a phenomenological sense, includes not only the relatively passive experiences of sensory perception but also imagination, thought, emotion, desire, volition, and action. In short, it includes everything that we live through or perform" (para, 4). de Chesnay's 2015 work related to nursing research using phenomenology, stated that "a phenomenological approach in the health sciences will ask what is the essence of the experience of ____" (p. III). She further taught that by using phenomenology, the researcher could understand the participant's experience.

Interpretive phenomenology, introduced by Martin Heidegger, aims to "explore in detail how participants are making sense of their personal and social world . . ." (Smith & Osborn, 2007, p. 53). His principles "allow[ed] the text to speak until the turn (understanding) came to the researcher" (Wright, 2012, p. 3) A phenomenological approach allows the researcher to make meaning of the participant's experience (de Chesnay, 2015). Each OTP continues to develop and hone new skills as they progress through their careers using continuing professional development. Wright (2012) indicated that OTPs must develop a "consciousness of craft" (p. 13). This consciousness of craft is specific to each practitioner and "requires a student/practitioner to

understand what it means to be a member of one's profession" (p. 13). A phenomenological study will uncover the meanings behind these experiences or factors that contributed to the individual OTP's consciousness of craft who are included in the study.

The theoretical basis for this research further utilizes the proficiency theory of adult learning as the foundation for participation in continuing professional development. Alan Knox introduced proficiency theory in 1980 by hypothesizing that adults were motivated to participate in learning activities after identifying a need or interest in enhancing their proficiency. Proficiency is described by Merriam-Webster as the "advancement in knowledge or skill" (2019). Occupational Therapy Practitioners are expected to remain current in their skills (professional currency) and, therefore, must self-identify when they are not proficient in the skills or knowledge needed to treat their clients. This realization is then expected to motivate the OTP to develop service competency or proficiency in the identified area. This study is designed to use proficiency theory as the lens in which the phenomenon of OTP's use of CoP as professional development will be viewed.

Limitations/Delimitations

Limitations revolved around focus group participants. Participants were lost between when they volunteered and were screened for participation and the actual participation date. Another limitation was the number of participants at each focus group location. Since each focus group was held in a specific geographical location, it became challenging to recruit the desired number of participants. Thirdly, focus group participants self-reported their experiences and attitudes related to the topic. A final limitation was also the geographical differences intended to be used. It is possible that participants from each location, as a sub-group, may have similar experiences and thoughts that are in part due to the culture of the area.

Through the course of researching the development of this qualitative study, several delimitations were elected. First, all participants were expected to be OTPs licensed to practice in the state of Georgia. Though national certification, state licensure, and the responsibility of life-long learning are common themes to OTPs across the nation, OTPs in each state have unique regulations governing their practice and continuing professional development behaviors (American Occupational Therapy Association, 2017a; American Occupational Therapy Association, 2018c; American Occupational Therapy Association, 2018d; National Board for Certification in Occupational Therapy, 2017). This makes OTPs in each state an inherently unique group compared to those in other states following different regulations (Hall, et al. 2016). The state of Georgia's Occupational Therapy Practice Act regulates continuing education for license renewal of both COTAs and OTRs identically, and under the same rule (State of Georgia, 1976). Since the practice act for Occupational Therapy in Georgia related to continuing education treats all levels of OTPs as a homogenous group, it has been determined it best to continue that premise for this research.

An additional delimitation created was the requirement that all OTPs have a minimum of ten years of practice in the field. This number was selected by the researcher because it created a distance from each participant's formal post-secondary education, and subsequent knowledge translation (Canadian Institutes of Health Research, 2017; Grant, 1994; Pettersson et al., 2015). It also created a participant group who had been through the state license renewal sequence and required continuing education a minimum of five times. Pettersson et al. (2015) also implemented this age of employment in their research regarding physical therapy practitioner's participation in continuing professional development.

A final delimitation for this study is its qualitative nature. A variety of quantitative studies have been conducted with OTPs around the globe related to the types of continuing professional development and barriers to continuing professional development that are common to the groups studied. Very little information has been located that relates to the qualitative data essential to the continuing professional development of Occupational Therapy practitioners. To improve healthcare-related professional development as suggested by the National Academies Institute of Medicine (2010), research must be conducted that explains what is happening as well as why it is happening (Patton, 2015).

Definition of Terms

- Andragogy** Term coined by Malcolm Knowles relating to his principles of adult learning theory (Knowles M. S., 1970)
- AOTA** American Occupational Therapy Association, the professional organization for the field of occupational therapy in the United States (American Occupational Therapy Association, 2018a)
- CCCPD** Commission on Continuing Competence and Professional Development, a committee and part of AOTA that assists with the oversight of continuing professional development for occupational therapy practitioners (American Occupational Therapy Association, 1999)
- COTA** Certified Occupational Therapy Assistant, an occupational therapy practitioner who has completed an associate degree program in occupational therapy and has also been certified by NBCOT (National Board for Certification in Occupational Therapy, 2017b)
- Communities of Practice** Term used to define a group of people who share a craft or profession also known as CoP (Wenger E. , Communities of Practice, 1998)
- Continuing Professional Development/CPD** Term used to define the cycle of development of professional skills and knowledge required to optimally perform one's position. It included formal and informal education opportunities, personal evaluation, and goal setting to increase one's professional body of knowledge (professional currency) (Doney, 1998; Institute of Medicine of the National Academies, 2010; Wheeler & Chisholm-Burns, 2018)
- Continuing** A term used to define formal educational opportunities that relate to

Professional Education	increasing one's professional body of knowledge (professional currency) Also known as CPE or CE (Coffelt & Gabriel, 2017; Fisher, 2000)
Evidence-Based Practice	A term used to describe health care interventions that are rooted in recent peer-reviewed research and also account for specific client factors. It is revered in OT as best practice (American Occupational Therapy Association, 2017a)
Formal Learning	A type of learning characterized by the learner taking on the role of a student with an instructor leading participant through structured learning objectives and course materials (Chunngam, et al., 2014)
GOTA	Georgia Occupational Therapy Association, the professional organization for occupational therapy practitioners in the state of Georgia (Georgia Occupational Therapy Association, 2018)
Informal Learning	A type of learning characterized by its organic nature which happens without planning, intent, or organization (Chunngam et al., 2014)
Institute of Medicine	National Academies Institute of Medicine is part of the National Academy of Sciences, Engineering, and Medicine and is a non-profit, non-governmental organization that serves as an advisor to the nation to improve health through evidence-based practice (Institute of Medicine of the National Academies, 2010)
Knowledge	A spectrum of activities in which a learner engages that moves knowledge

Translation from an education/research product to implementation by users (Canadian Institutes of Health Research, 2017; World Health Organization, 2006).

NBCOT National Board for the Certification of Occupational Therapy, the national credentialing board for the field of occupational therapy. They administer initial certification exams and oversee certification renewals (National Board for Certification in Occupational Therapy, 2017b)

Non-formal Learning Characterized by learning initiation. It may have learning objectives but also may, in actuality, be a byproduct of the experience rather than the intent. (Wright, 2012)

OT Occupational Therapy, the field of rehabilitative medicine that focuses on increasing one's ability to perform their needed and desired daily occupations at the most independent and safe level possible (American Occupational Therapy Association, 2017c)

Occupational Therapy Practitioner Also known as OTP. This term refers to either an Occupational Therapy Assistant or Occupational Therapist. It does not delineate between degree levels or scopes of practice (American Occupational Therapy Association, 2017c)

OTR Registered Occupational Therapist, an Occupational Therapist who has completed either a bachelors, masters or doctorate level of education in occupational therapy and has also been certified by NBCOT (National Board for Certification in Occupational Therapy, 2017b)

Professional Currency A term used to define the act of remaining current and increasing one's professional knowledge, skills, and abilities (Murray & Lawry, 2011)

Proficiency Theory A theory of adult learning that believes that internal motivation escalates when a gap is noted between one's current aptitude and the desired level of proficiency (Knox, 1980).

Chapter II

REVIEW OF LITERATURE

This research study intends to answer the research question, *How does the informal learning in a Community of Practice influence the professional development of Occupational Therapy Practitioners in the state of Georgia?* This question will be answered through the conduction of qualitative focus-group based research focusing on the informal professional development experienced by Occupational Therapy practitioners in Georgia in their Communities of Practice. To study this phenomenon, the proficiency theory of adult learning will be applied as the theoretical frame of reference for interpreting the data.

This review of literature is organized around topics related to the conduction of this study. These topics include background information such as focus group research, the proficiency theory of adult learning, types of learning, professional development, and communities of practice. It also reviews topics related to the research study itself, such as patient outcomes, professional currency, the commitment to lifelong learning, knowledge translation, intrinsic motivation, and best practices in continuing professional development. A brief summary of each topic is included in the subsequent pages.

Focus Group Research

Focus groups are a qualitative research technique in which a small group of participants is lead through a discussion surrounding a specific topic, or focus (Quain, 2019). The purpose of focus groups is to use open-ended questions to facilitate discussion related to the focus topic.

Krueger and Casey (2000) believe focus groups are important to qualitative research because small groups of participants disclose sensitive information when grouped with other participants who share a collective identity.

Focus groups are considered to be a type of qualitative research because the purpose of the method is to use a series of open-ended questions to elicit responses from participants regarding their personal feelings, beliefs, and engagement with the selected topic (Krueger & Casey, 2000; Quain, 2019). Kruger and Casey further caution that questions used in focus groups should be carefully crafted to ensure there are not embedded biases in the questions. Removing embedded biases is also a recommendation for all types of qualitative research, as instructed by Seidman, in his 2013 book related to qualitative interviewing.

Focus Group research is thought to be beneficial to the research field due to its format. Unlike quantitative research, qualitative research focuses on gaining open feedback from participants in a free-flowing format (Quain, 2019). An added benefit of focus group research is costs associated with holding a focus group are typically lower than the costs of creating and distributing a quantitative study (Marshall & Rossman, 1999). Kruger and Casey (2000) also find focus group data beneficial due to the ability of participants to build upon each other's comments for a deeper and richer discussion than those gained in one on one interviews.

The most commonly reported potential drawback to implementing focus groups in qualitative research is the potential for groupthink (Krueger & Casey, 2000; Marshall & Rossman, 1999; Quain, 2019). Groupthink is when the opinions of an influential member of a group becomes the prevailing opinions of the entire group. A second potential drawback of focus groups is its possible effect on adverse information reporting. Quain (2019) reported that consumers in

focus groups are less likely to express negative emotions related to the focus group topic due to the face-to-face setting.

Proficiency Theory of Adult Learning

Moon (2004) found that the attitudes that health professionals held when participating in professional development activities predisposed the effectiveness of the development activity. Research conducted by Ross, Barr, and Stevens (2013) indicated that when professional development was mandated for health care providers, it resulted in a focus on obtaining the requisite number of hours rather than on improving patient outcomes. This hours mandate is what Moon (2004) considered an external source of motivation. External motivation is derived from external influences such as hours mandates, employment regulations, or reinforcement of employer expectations (Erdem & Cicekdemir, 2016; Fox & Miner, 1999). Internal or intrinsic motivation, conversely, is “developed by one’s own needs” (Erdem & Cicekdemir, 2016, p. 159). Internal motivation develops from one’s personal inspiration, interest, or desire (Erdem & Cicekdemir, 2016). Internal motivation is reported to have a much more substantial impact on the motivatee than external motivation (Fox & Miner, 1999). Intrinsic motivation is also one of the cornerstones of adult learning theory (Knowles, Elwood, & Swanson, 2015; Merriam, Caffarella, & Baumgartner, 2007).

Malcolm Knowles (1970) introduced intrinsic motivation as one of his principles of andragogy. He believed that the adult learner would be prepared for new learning when he or she was inspired to learn, or when to learn new information was presented. Extrinsic factors such as regulations for continuing education attendance did not internally motivate the adult learner. Adult learners, however, did attend continuing education seminars. Nevertheless, it has been documented that attendance at a continuing education event does not equate to new learning (Anderson, 2001;

Coffelt & Gabriel, 2017; Erdem & Cicekdemir, 2016; Fisher, 2000; Landers, McWhorter, Krum, & Glovinsky, 2005; Ross et al., 2013).

Health professionals, who are themselves, adult learners, often find internal motivation to seek out new learning when they recognize a skill gap. Informal professional development for the health care provider is rooted in *Proficiency Theory* which states that internal motivation escalates when a gap is noted between one's current aptitude and the desired level of proficiency (Institute of Medicine of the National Academies, 2010; Knox, 1980; Merriam et al., 2007). When applying this theoretical concept to the Georgia based OTP, a knowledge or skills gap is the impetus for seeking additional professional learning. This professional learning is identified, often with the introduction of a newly referred patient, thus increasing the practitioner's haste in obtaining the information.

Continuing Education

The Merriam-Webster Dictionary defines continuing education as a “formal course of study for adult part-time students” (Merriam-Webster.com, 2018a). The American Psychological Association (2018) or APA defines continuing education as “an ongoing process consisting of formal learning activities” (line 1). The Institute of Medicine of the National Academies (2010) states that health professional's “continuing education encompasses the period of learning from post-licensure to career's end” (p. 3). The overarching theme across many industries is that continuing education provides additional formal knowledge and skills training related to one's chosen profession after initial academic training has been completed. Some industries, such as healthcare, mandate continuing education participation in some manner (Agyepong & Okyere, 2018; Fisher, 2000; Institute of Medicine of the National Academies, 2010; Wheeler & Chisholm-Burns, 2018). The field of Occupational Therapy has both national and state-level regulations

(Georgia State Board of Occupational Therapy, 2013; National Board for Certification in Occupational Therapy, 2017).

The Institute of Medicine of the National Academies (2010) further affirmed that the continuing education expectation was designed “to enable health professionals to keep their knowledge and skills up to date, with the ultimate goal of helping health professionals provide the best possible care, improve patient outcomes, and protect patient safety” (p. 3). The APA (2018) indicated that continuing education assists practitioners with maintaining professional currency and keeps them up to date with evidence-based practices that have been developed since their post-secondary training. The APA closed their list of continuing education statements by asserting that continuing education should not be “the primary vehicle for career changes from one APA recognized specialty area to another” (lines 9-10). Research by Agyepong and Okyere (2018) further supported the idea that health-related continuing education is “designed to help an individual develop his or her potential in a specific area” (p. 96).

The Institute of Medicine of the National Academies (2010) cautioned that continuing education has developed over time to include several shortcomings that limit its scope and inhibit its effectiveness. First and foremost, continuing education has morphed into a mechanism for meeting regulatory requirements “rather than identifying personal knowledge gaps and finding programs to address them” (p. 3). Occupational Therapy practitioners in Georgia are one of many health professions that require participation in continuing education activities as the main prerequisite of mandated licensure renewal (State of Georgia, 2017).

A second flaw with the use of continuing education to demonstrate professional currency, according to the Institute of Medicine of the National Academies (2010), lies in the approach to continuing education expected by many health professions. The most utilized continuing education

approach invokes didactic, instructor driven teaching in traditional classroom-like settings. The concepts introduced “may or may not be relevant to the clinical setting” (p. 4). Agyepong and Okyere (2018) deduced in their research that continuing education, as described by the Institute of Medicine of the National Academies, does not include in-services and training conducted by facility employees or other health care professionals. These types of educational opportunities do not meet the definition due to lack of provision by organized education providers.

The Institute of Medicine of the National Academies (2010) similarly expressed concern with measuring knowledge translation and the effectiveness of continuing education programming. They stated that continuing education “providers cannot determine the effectiveness of their instructional methods” (p. 4). As cited by Fisher (2000), Landers et al., (2005), and Grant (1994), the transfer of knowledge to application is not an outcome measure of formal continuing education offerings. Instead, attendance records and satisfaction surveys are the evaluation of choice of continuing education providers. Despite a disparity in formal knowledge translation research, Agyepong and Okyere found their 2018 research supported Aiga and Kuroiowa’s 2006 study of continuing education and rural nursing practice. Their findings indicated that in addition to a knowledge decline, nurses working without the opportunity to participate in continuing education exhibited “professional dissatisfaction, low morale, disillusion, lack of commitment, and reduced interest in their work” (Agyepong & Okyere, 2018, p. 97).

The shortcoming of greatest concern to the Institute of Medicine of the National Academies (2010) with the current climate of continuing education in healthcare was its ineffectiveness to improve patient outcomes. Wheeler and Chisholm-Burns (2018) found that participation in continuing education did increase practitioner knowledge on a subject. They further uncovered that the same knowledge increase did not translate to changes in techniques or increased patient

outcomes. Haywood, Pain, Ryan, and Adams (2013) reported that despite new learning, it is not uncommon for seasoned nurses to continue to utilize previously learned patient care techniques due to a variety of reasons including lack of time for implementation, lack of supplies, or lack of work colleague buy-in. Agyepong and Okyere (2018) concurred and added that antecedents or “events or attributes that [arose] prior to the occurrence of the concept” (p. 102) influenced the nurses studied to both pursue continuing education on a specific subject as well as implement new training into their practice.

Continuing Professional Development

The term continuing education and continuing professional development are often used interchangeably. Professional development researchers, however, share a different opinion. Doney (1998) defined continuing professional development as “an ongoing process aimed at monitoring and upgrading skills and competence of individual workers in the profession” (p. 487). Wheeler, and Chisholm-Burns (2018) and the Accreditation Council for Pharmacy Education (2015) defined continuing professional development as an ongoing cycle of structured, self-directed, outcome-focused learning that concentrates on maintaining and improving performance of one’s professional practice. The Institute of Food Science and Technology (n.d.) defines continuing professional development as “the means by which professionals maintain, improve and broaden their knowledge and skills and develop the personal qualities and competencies required in their working lives” (line 1). It further stated that continuing professional development “should reflect both your current needs and your future aspirations” (line 8). In 2010, the Institute of Medicine of the National Academies defined continuing professional development as having a broader more “holistic view” of professional learning that stretched “from the classroom to the point of care” and “allow[ed] health professionals to tailor the learning process, setting, and curriculum to their needs” (p. 5).

Continuing education generally has a pedagogical style of lecture-based didactic learning with credits earned for seat time (Coffelt & Gabriel, 2017; Fisher, 2000; Grant, 1994; Institute of Medicine of the National Academies, 2010; McKinstry, Allen, Courtney, & Oke, 2009). Wheeler and Chisholm-Burns (2018) and the Institute of Medicine of the National Academies (2010) opined that continuing education was instead a type of continuing professional development. Landers et al., (2005) defined continuing education within the physical therapy field as the formal element of continuing professional development.

The central theme with continuing professional development piggybacks on Malcolm Knowles' adult learning theory principle of intrinsic learner motivation (Institute of Medicine of the National Academies, 2010; Knowles, 1970; Knowles et al., 2015; Moonasar & Underwood, 2018; Wheeler & Chisholm-Burns, 2018). The intrinsically motivated learner will seek out opportunities and activities that develop personally meaningful scholarship (Wheeler & Chisholm-Burns, 2018). These meaningful scholarship activities are not limited to formal didactic courses and seminars (Coffelt & Gabriel, 2017; Institute of Medicine of the National Academies, 2010; McKinstry et al., 2009; Wheeler & Chisholm-Burns, 2018). The Society for Human Resource Management (2014) included seminar attendance, education courses, degree programs, meetings, memberships in professional organizations, scholarly journal subscriptions, books, and computer programs as fodder for continuing professional development. These professional development opportunities offer a broader range of learning opportunities than attendance in formal education seminars.

Unlike the Georgia Board of Occupational Therapy, which has labeled licensure renewal tasks continuing education (State of Georgia, 1976), NBCOT refers to the activities required for Occupational Therapy practitioners to renew certification as professional development (National Board for Certification in Occupational Therapy, 2017a). In addition to the activities supported by

the Society for Human Resource Management, certificants can opt to complete a variety of professional development activities to earn the professional development units needed for re-certification (National Board for Certification in Occupational Therapy, 2017a). Additions to the list include volunteerism, participating in or conducting field related research, professional development plan formation, colleague mentee/mentorships, guest lectures or conference presentations, and supervising students completing their experiential clinical learning (Hall et al., 2016; National Board for Certification in Occupational Therapy, 2016).

The Accreditation Council for Pharmacy Education (ACPE) has developed a classification system for continuing professional development (Accreditation Council for Pharmacy Education, 2017). The system includes three types of professional development, knowledge-based, application-based, and practice-based. Wheeler and Chisholm-Burns (2018) found that in 2015, ninety percent of the continuing professional development offerings for pharmacists were classified as knowledge-based and took the form of continuing education seminars. That left ten percent of pharmacy training to be application or practice-based. Wheeler and Chisholm-Burns (2018) further stated that the majority of continuing education did not meet practitioner needs due to being “knowledge-based programs designed to improve a learner’s knowledge of facts when growing expectations from employers, regulators, and payers call for documented improvement in outcomes” (p. 199). They further advised that ACPE has suggested moving away from a system of continuing education to a system of continuing professional development. ACPE defined continuing professional development as “a cyclical learning process where the learner reflects, plans, learns, evaluates, and applies. The determination of learning experience is based on assessment of needs and goals” (Accreditation Council for Pharmacy Education, 2015, pp. 1-2). Wheeler and Chisholm-Burns (2018) argue that “incorporating the evidence approach into practice

can improve the existing composition of continuing education (p. 199). This idea acknowledged that continuing education is an essential piece of continuing professional development, but the two terms are not synonyms. In fact, according to research conducted by Hall et al., (2016) and Wheeler and Chisholm-Burns (2018), continuing professional development requires more effort than continuing education due to its cyclical and reflective nature.

In 1999, Weingand stated that “the shelf life of a degree is approximately three years and declining. Maintaining competence and learning new skills must be at the top of every professional’s ‘to-do’ list” (p. 201). Maharaj (2013) found that the education of health professionals had a five-year half-life, that was also found to be decreasing as medical knowledge and technology increased. Eggers, Hagel, and Sanderson’s 2012 Harvard Business Review article *Mind The (Skills) Gap* indicated that workers of today are at risk of experiencing “rapid skills obsolescence” (line 7). They mention that fields such as Occupational Therapy and other “positions that cater to America’s aging population” (line 29) to be both high growth and high skills jobs. “People across industries and job segments need hyper-specialized skills to thrive in this environment, and both white and blue-collar jobs will need to innovate to remain relevant” (lines 30-31) Eggers et al., (2012) stated. They further indicated that employers were looking at ways to upskill their employees to remain competitive in the market. Learning opportunities such as peer to peer mentoring, CoP, internal certifications, and the construction of internal talent ecosystems were discussed as continuing professional development methods being implemented. Research by Moonasar and Underwood (2018) further supported these ideas finding that research participants were self-motivated to participate in continuing professional development activities in order to “remain proactive and to keep abreast of changing technologies” (p. 53). Their research found that peer socialization that kept participants in contact with others in their field, as well as “various forms

of mentoring and coaching...allowed for the transfer of knowledge and skills and this allow[ed] further growth” (p. 53).

Types of Learning

Not all types of learning are created equally. Further, not all types of learning fit all learning situations. As a result of this, multiple types of learning delivery methods have been developed. “All learning contributes to an individual’s growth, not only cognitively, but emotionally, socially, and in other ways, too” (Eaton, 2010, p. 7). To facilitate this, four types of learning have been formally recognized.

Research conducted by Neimeyer, Taylor, and Cox (2012) indicated that there is a consensus regarding the core intent of continuing professional development; however, the “mechanisms utilized for accomplishing these objectives” (p. 477) are more divergent. “Scholars and researchers have forged some conceptual distinctions; however, that brings order to this otherwise chaotic cluster of activities” (p. 477). They further theorized that professional development stems from three main types of learning. The first type, formal learning, is most familiar. This type of learning is characterized by the learner taking on the role of a student with an instructor leading participants through structured learning objectives and course materials such as continuing education seminars (Chunngam et al., 2014; Janssens et al., 2016; Johnson et al., 2015; Marsick & Watkins, 2001; Neimeyer et al., 2012; Swap et al., 2001).

Non-formal learning

The World Bank (1987), OECD (2018), and UNESCO-UNEVOC (2010) all defined non-formal education as those education events that happen outside of formal educational offerings and that are educational in nature but do not result in the awarding of a credential. Non-formal learning activities may have learning objectives. Non-formal learning is initiated by the learner; however,

some learning that takes place in non-formal activities are in actuality, a byproduct of the experience rather than the intent. Smith (2001) added that non-formal learning focuses on the idea that learning is an important, life-long activity that does not stop when one exits formal training. Non-formal learning can include professional development activities such as participating in professional organizations, listservs, or colleague led in-services following their participation in formal continuing education. This issue has created difficulty in defining this type of learning. OECD relents that there is not a consensus as to the definitive definition of non-formal learning. In fact, other authors use the terms non-formal and informal interchangeably.

Informal Learning

Informal learning, or tacit learning, by definition from OECD (2018), is a type of learning that happens organically without planning, intent, or organization. UNESCO-UNEVOC (2010) added that informal learning includes exchanges with work colleagues and professionals. Smith (2001) stated informal education is a ‘truly lifelong process whereby every individual acquires attitudes, values, skills, and knowledge from daily experience and the educative influences and resources in his or her environment—from family and neighbours, from work and play . . .’ (para 7). Research conducted by Jannssens et al., (2016) found that informal learning had “become a prominent reality in the knowledge society of today” (p. 92) and that the formal action of “gaining access to information can be considered important for informal learning” (p. 95). Informal learning includes the mentor/protégé relationship, CoP, and professional socialization. Both UNESCO-UNEVOC (2010) and Smith (2001) indicated that there is some overlap and confusion regarding the differentiation between informal and non-formal learning. For the purposes of this work, *informal learning* will be used to indicate the learning that OTPs engage in that cannot be related to the formal practice of continuing education.

Incidental Learning

Incidental learning is defined as “learning that occurs as an indirect product of engaging in some professional activity” (Neimeyer et al., 2012, p. 477). Incidental learning happens as a secondary outcome of an activity. As a result of its incidental nature, unlike formal, non-formal, and informal learning, incidental learning does not allow reflection on the learned information. Incidental learning can include increasing one’s ability to generalize a skill to the future by participating in a specific activity using that same skill in the present. The learner does not immediately recognize he or she has increased his or her learning as a result of that activity. Marsick and Watkins (2001) stated that incidental learning was relevant to the practice of healthcare, including the cultural, family, organizational, and community contexts (p. 26).

Communities of Practice

The concept of a community of practice has been around as long as humans have been in existence to learn (le May, 2009; Wenger, 1998; Wenger & Snyder, 2000). Wenger (1998), an educational theorist, repackaged this ancient notion and reintroduced it as a new organizational concept right before the turn of the twenty-first century to be a catalyst for a new model to reinvent companies in a knowledge economy (Wenger & Snyder, 2000). Communities of Practice (CoP) can be defined as “groups of people informally bound together by shared expertise and passion for a joint enterprise” (Wenger & Snyder, 2000, p. 139). Ranmuthugala, Plumb, Cunningham, Georgiou, Westbrook, et al. (2011a) added that CoPs are “a group of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise on this area by interacting on an ongoing basis” (p. 1). CoPs can take many forms. They can be live, regularly scheduled meetings with a preselected group of participants or occur in the virtual realm with asynchronous participation from a membership that evolves and changes regularly (Li, et al.,

2009; McKellar, Pitzul, Yi, & Cole, 2014; Wenger & Snyder, 2000). le May (2009) even writes that CoPs are at the core of health care (p. vii).

Healthcare and thereby OT, at its core, was forged by the development of a personal relationship between the provider and patient (Cronin & Mandich, 2015; le May, 2009; Thomas, 2015). These personal relationships are also emulated in the experiential educational components of medical education that take place outside the classroom (le May, 2009). Healthcare and ostensibly OT also continue to be rooted in evidence-based practice, which requires its practitioners to remain current in their knowledge and skill delivery to promote the best possible patient outcomes (Institute of Medicine of the National Academies, 2010). Etienne Wenger wrote in the forward of le May's (2009) work that "communities of practice make it possible to give voice to new perspectives, to bridge boundaries between research and practice, to connect practitioners in new ways and to involve a broader range of stakeholders in addressing complex issues" (p. ix). Hence saying the knowledge power of the entire community is higher than the knowledge power of individual members.

CoP can be within an organization but have also developed organically outside of specific organizations (McKellar et al., 2014). CoPs can inhibit the creation of barriers placed inside the profession or within organizations themselves (Ranmuthugala et al., 2011a). Further, they can support the learning needs of entry-level practitioners or practitioners who have recently changed practice areas (Wenger & Lave, 1991). CoPs provide a way for the community members to share tacit professional knowledge as well as an opportunity for knowledge translation of evidence-based practice from one practitioner to another (Barwick, Peters, & Boydell, 2009). Norman and Huerta (2006) added to this paradigm that CoP "develop professional skills and promote rapid

dissemination of knowledge within teams and groups with a common purpose” and are well placed in a “knowledge environment that is both complex and rapidly changing . . .” (p. 3).

Wenger and Lave (1991) initially held that a primary construct of a CoP was that the relationship between expert and novice practitioners developed to include participation and development of a professional identity within the practice community over time. In 1998, Wenger extended his definition of CoP to embrace the importance of the interactions between all member practice levels of the community as learners. Swap et al., (2001) found in their research that expert-level professionals who are defined as having ten or more years in the profession may lack the skills necessary to adequately mentor novice professionals. As a result, practitioners with some experience, but not expert level experience, “may be a better teacher than an expert because the knowledge gap [between practitioners] is not as great” (p. 101). This concept allows CoPs to include members at all levels of practice rather than the traditional mentor/protégé relationship forged between an expert and novice. Swap et al. (2001) cautioned however that one develops expertise via a pattern of learning and then doing, and that “even the most gifted must practice, practice, practice, almost always under the guidance of a more knowledgeable teacher” (p. 97).

Wenger (1998) proposed that three constructs were required to define a CoP. Firstly, a *joint enterprise* is required. Joint enterprise can be taken from the legal field to mean an informal relationship or association or sharing a common purpose (Merriam-Webster, 2018). Secondly, *mutual engagement* takes place. Mutual engagement includes all of the interactions that take place, leading to a common purpose. Third, a CoP must have a *shared repertoire* or shared resources. Resources may include intangibles such as prior knowledge, past experiences, shared processes, professional comraderies, emotional support, or tangibles such as research articles, hands-on instruction, improved techniques, or verbal/written instructions (Ranmuthugala et al., 2011b). le

May (2009) indicated that healthcare-related CoP is an excellent way to have a shared repertoire through mutual engagement. Specifically, she believed CoPs to be the “ideal mechanisms through which people can discuss the best way to implement knowledge to suit the needs and context of their area of practice or particular patients and therefore improve the quality of care they give” (p. 3) and “bridge the ‘know-do’ gap to improve clinical care . . .” (Jeffs, et al., 2016) .

CoPs are advantageous for all stakeholders in the healthcare continuum. le May (2009) stated that CoP “can be very powerful ways for sharing and applying knowledge whilst motivating participants to improve care” (p. 4). They provide the social infrastructure required to cultivate lifelong learning (Janssens et al., 2016; le May, 2009). Improving care and patient outcomes are primary concerns of the IOM in its recommendations for continuing professional development (Institute of Medicine of the National Academies, 2010). le May (2009) further stated that CoP positively impact the standard of care provided to healthcare consumers as well as the “speed with which knowledge and innovation move into practice (p. 4), also known as knowledge translation.

Despite having been in existence for quite some time, limited empirical evidence exists supporting the use of CoPs (Li et al., 2009; Ranmuthugala et al., 2011a). Systematic reviews (Li et al., 2009; McKellar et al., 2014) of CoP found that the majority of research surrounding CoP focused on understanding how they were created rather than their role in knowledge formation and translation. Ranmuthugala et al. (2011b) indicated in their research that “there is a need to understand better the role of CoPs in improving healthcare practice” (p.1). There is not, however, a formal evaluation method with which to measure or define CoP (McKellar et al., 2014; Ranmuthugala et al., 2011b).

Patient Outcomes

The term *patient outcomes* is used throughout this manuscript, and therefore requires definition. The term *patient outcomes* is extolled in the healthcare area as both a quantitative and qualitative term measuring healthcare quality (New England Journal of Medicine, 2018). Liu, Avant, Aunguroch, Zhang, and Jiang, (2014) reported patient outcomes to be defined a variety of ways. First, patient outcomes were defined as measured in terms of patient functional status” (p. 69). This included measurable data such as standardized assessment measures set forth by various agencies such as the Joint Commission. The Functional Independence Measure (FIM), or other benchmarks of patient progress. In the practice of OT, quantitative patient outcomes are often reported by comparing an initial functional assessment of the patient performing needed or desired occupations to functional performance of those same tasks prior to discontinuation of OT services (American Occupational Therapy Association, 2017d).

Second, patient outcomes can be defined as patient safety measures, or keeping a patient safe and unharmed (Liu et al., 2014). This does not include any changes to their functional status. Patient safety goals are specific to the medical institution in which a patient is engaged. In fact, the Agency for Healthcare Research and Quality (2019) reports on five different methods in its 2019 reports as best practices.

The third type of patient outcomes defined by Liu et al., (2014) includes patient satisfaction with their treatment or progress in terms of “comfort and contentment” (p. 69). This third type is the most qualitative in nature, and not only drives the patient’s perception of the care received, but also drives patient satisfaction surveys. These surveys are then used as a metric of patient care. Patient satisfaction is not measurable, and therefore relies on the patient to report subjective data in a meaningful way (New England Journal of Medicine, 2018). In the field of OT, this satisfaction will

also come in the form of reported participation in the occupations the client needs or desires to participate in, at the highest functional level (American Occupational Therapy Association, 2017d).

Professional Currency

Murray and Lawry (2011) defined professional currency in their research with Australian occupational therapists as “participation in activities for professional development and practice competency [that] incorporates engagement with contemporary ideas, interests in the profession’s future direction, and critical reflection about personal and organizational practices” (p. 261). They further stated that their research indicated that a health care professional was professionally current if they engaged in lifelong learning activities that included the use of evidence-based practice (EBP) as well as participated in continuing professional development events to “update skills and knowledge (p. 261). Cross, Liles, Conduit, and Price (2004) added the need to participate in a reflective performance evaluation process to the professional currency definition. These researchers did not quantify the type of learning (formal/informal/nonformal) required for increasing one’s professional currency.

Research conducted by Joyce and Cowman (2007) indicated the importance of continuing professional development by highlighting the increase in accountability placed on healthcare professionals by society and the health care profession itself. Their research further indicated that the overarching goal of continuing professional development in healthcare is to improve and enhance its delivery. Little research has been located; however, to support the idea that commonly implemented continuing professional development methods are meeting this goal. Patricia Nemec (2018) recently conducted research related to the return on investment of continuing professional

development in the field of behavioral health. She found that “in spite of expert opinion and some evidence that the most common training approaches are ineffective, yielding no return on investment, or a negative return (money wasted), agencies continue to provide primarily single session, lecture based training . . .” (Nemec, 2018, p. 1). She further cautioned that a common misunderstanding with continuing professional development related outcomes is that “if staff learn what is being taught, that learning will necessarily improve service outcomes” (p. 2). Vanspronsen and McDonough (2015) and Viljoen, Coetzee, and Heyns (2017) add to this research that increased demand on productivity and patient outcomes has limited the implementation and translation of new learning and/or patient care techniques as care providers indicate they do not have time to slow down to learn how to apply their new learning to the current workload.

Viljoen et al., (2017) determined that implementing compulsory continuing professional development programming in a critical care hospital setting in South Africa “did not have the desired outcome” (p. 71) with the professional development of the critical care nurses targeted by the program. The program was modeled after lecture-style continuing education events frequent in nursing education in the United States. Nurses who attended reported a variety of themes impacting participation including lack of time, varied learning needs among participants, high productivity limiting implementation, and financial concerns. These concerns were echoed by OTPs and other health care practitioners as well (Amerih, 2013; Coffelt & Gabriel, 2017; Garrahy, Thibodaux, Hickman, & Caldwell, 1992; Grant, 1994; Joyce & Cowman, 2007; Landers et al., 2005; Maharaj, 2013; Pettersson et al., 2015; Vanspronsen & McDonough, 2015).

The Lewin Group (2008) indicated that often in health care, regulatory requirements indicate a certain number of hours of training must be obtained. These requirements are measured by “seat time” (The Lewin Group, 2008, p. 16). Bennington and Laffoley (2012) further contributed that seat time and satisfaction are easy to measure but are not valid indicators of learning. Nemec (2018) addressed these concerns in her research and stated that “using a training approach that is known to be ineffective represents a waste of scarce resources (p. 2). Faculty provided professional development resources including time off for attendance, in-house offerings, and funding for off-site opportunities are also on a downward trend according to research in the field of nursing (Viljoen et al., 2017), behavioral health (Nemec, 2018), lab technology (Vanspronsen & McDonough, 2015), Occupational Therapy (Coffelt & Gabriel, 2017) Physical Therapy (Landers et al., 2005), and oncology (Robinson, Ruggiero, Abdolrasulnia, & Burton, 2015). Further, research conducted out of Tufts University School of Medicine by Leyenaar, Capra, O’Brien, Leslie, and Mackie in 2014, indicated a rising concern about continuing medical education (CME) among physicians studied to be provided with “more protected time for CME, and not for fluff CME . . .but for the real thing . . .(p. 366). The researchers went on to indicate those studied wanted “educational opportunities tailored to their professional responsibilities” (p. 366) that went beyond the requisite mandatory annual training common to all employees (e.g., HIPAA and infection control).

Lifelong Learning Commitment

Lori Anderson (2001) stated that “society grants professionals certain privileges, with the tacit agreement that professionals take responsibility to remain competent in

view of the continual changes in the health care system and the rapid advances in technology” (p. 449). Anderson (2001), Haywood et al., (2013), Landers et al., (2005), Maharaj (2013), and Pettersson et al., (2015) further reported that there are advocates of mandatory continuing professional development due to the belief that not all professionals accept their responsibility to maintain professional currency. Anderson (2001) and Collins (1996) both reported debates between NBCOT and AOTA regarding the need for lifelong learning to be a mandated versus volitional process (American Occupational Therapy Association, 1999; Anderson, 2001). Today, NBCOT recertification is volitional, and is not required to maintain licensure in any state (American Occupational Therapy Association, 2018c; American Occupational Therapy Association, 2018d); however NBCOT requires OTPs participate in thirty-six hours of continuing professional development activities for recertification (National Board for Certification in Occupational Therapy, 2017b).

Occupational Therapy practitioners in the state of Georgia are required to obtain and maintain a state license to work in the field of Occupational Therapy (State of Georgia, 2017). The Secretary of State’s Office houses the professional licensing board for Occupational Therapy in Georgia. Licenses expire every other year on March 31. To renew Occupational Therapy related licenses in the state of Georgia, the OTP must complete 24 hours of continuing education that meet specified requirements outlined in the practice act (State of Georgia, 2017). The requirement to obtain continuing education for each license renewal creates a need for OTPs to participate in learning activities for the length of time in which they are licensed.

In addition to state licensure, OTPs must obtain initial certification in the field of Occupational Therapy through NBCOT by successfully completing a board examination. NBCOT certifications expire every three years on March 31 (National Board for Certification in Occupational Therapy, 2017c). NBCOT has also developed a continuing professional development requirement for OTPs to utilize in order to renew their NBCOT certification. Thirty-six hours of competency assessment units (CAUs) are required to be obtained by each Occupational Therapy practitioners before renewing their NBCOT certification (National Board for Certification in Occupational Therapy, 2017c) . NBCOT outlines its definitions of CAU activities in its NBCOT Certification Renewal Handbook (National Board for Certification in Occupational Therapy, 2017c). The options for CAUs are a more extensive range of activities than what the State of Georgia will accept for continuing education units (CEUs); however, the expectation of lifelong learning is implied with this certification renewal requirement. Currently, NBCOT offers thirty-two distinct and different CAU activities that a practitioner can use for professional development (National Board for Certification in Occupational Therapy, 2017a). The Georgia Board of Occupational Therapy offers less than half of these options to fulfill continuing education requirements under their regulations (State of Georgia, 2017).

The American Occupational Therapy Association, or AOTA, is the professional organization for Occupational Therapy practitioners in the United States. It was developed in 1917 to create a standard body for Occupational Therapy practice and support the needs and concerns of practitioners. It further strives to improve the quality of Occupational Therapy services provided (American Occupational Therapy Association, 2017b). “AOTA’s major programs and activities are directed toward assuring the quality

of occupational therapy services; improving consumer access to health care services and promoting the professional development of members” (American Occupational Therapy Association, 2017a). “The AOTA unanimously endorsed licensure for occupational therapists at a special session of the Delegate Assembly in 1974” (Garrahy et al., 1992, p. 939). As with many other fields of practice, AOTA expects that OTPs will be life-long learners.

A part of the mission of the AOTA relates to ethics in the practice of Occupational Therapy, AOTA has created a *Code of Ethics* to guide Occupational Therapy practitioners in the delivery of Occupational Therapy services. The AOTA Code of Ethics (American Occupational Therapy Association, 2017a) was designed to provide guiding principles and values to assist Occupational Therapy practitioners in practice. Its other purpose was to provide an enforceable standard of conduct for Occupational Therapy practitioners (American Occupational Therapy Association, 2017a). Principle One of the AOTA Code of Ethics, Beneficence, obligates OTPs to “take steps (e.g., continuing education, research, supervision, training) to ensure proficiency, use careful judgment, and weigh potential for harm when generally recognized standards do not exist in emerging technology or areas of practice (p. 3). To meet this ethical obligation as an OTP, one must commit to participation in learning events, to develop professional currency, and refine skills that may have changed since the practitioner completed formal training.

AOTA introduced the Commission on Continuing Competence and Professional Development (CCCPD) in 2002 (Coffelt & Gabriel, 2017). This committee was founded by AOTA to assist with meeting the needs of its membership and developing the

standards for continuing competence. The CCCPD completed work on a new position paper on continuing professional development in 2017. This position paper reflected the diversity of learning needs present amongst the body of OTPs. It further encouraged OTPs to be more intentional with their selection of learning opportunities. Finally, the position paper identified a need for OTPs to have the backing that supports maximum competence and achievement of client outcomes (Schultz-Krohn, 2017). This addition of improving patient outcomes follows a 2010 report by the Institute of Medicine of the National Academies, indicating that continuing professional development should include the focus of improving patient outcomes.

Coffelt and Gabriel (2017) addressed standards for clinical competence related to life-long learning needs and commitment to possessing clinical competence as OTPs. Their research supports the idea that OTPs should have developed the skills to identify and perform evidence-based treatment interventions. This ability to incorporate evidence-based practice relies heavily on each therapy practitioner's own ability to research materials, read and interpret the information, and apply new learning in a self-directed manner. (Coffelt & Gabriel, 2017, p. 2-3). Amerih (2013) further found that OTPs participated in continuing professional development for a variety of reasons. Those reasons included ethical duties to increase skills, life-long learning pursuits, skill acquisition, skill-building, additional credentialing/certifications, or to fulfill employment or licensing requirements. Occupational Therapy practitioners must remain up to date on treatment interventions and medical trends. This information often changes from what the practitioner learned in school training. Also, school is not all-encompassing, and often skills are introduced but not fully developed in the post-secondary training environment

(Dublin, 1972). Maharaj (2013) pointed out that the field of health care is changing at a faster rate than ever before seen. Practitioners need to be abreast of the latest products, disease treatment parameters, equipment, surgical techniques, and even ever-changing legal and ethical considerations. Dublin (1972) introduced the concept of a 5-year half-life for medical knowledge. This concept stated that medical knowledge learned in school becomes out of date within five years of graduation. Maharaj (2013) posited this half-life has decreased even more in the current day, further supporting the need for life-long learning.

A variety of research has been found to support the idea that OTPs are life-long learners. Not only is it included in the Code of Ethics governing the field (American Occupational Therapy Association, 2017a), it is required to maintain the right to practice Occupational Therapy in the state of Georgia. No research related to how OTPs make decisions about participation choices with life-long learning activity selection, however, has been located. Research by Coffelt and Gabriel (2017), determined that more research is needed regarding the continuing professional development practices of Occupational Therapy practitioners.

Knowledge Translation

Knowledge translation is a spectrum of activities in which a learner engages that moves knowledge from an education/research product to implementation by users (Canadian Institutes of Health Research, 2017). Knowledge translation (KT) was noted initially in 1914 with the creation of Agricultural Extension offices by the Smith-Lever Act (Research Into Action-A Knowledge Translation Initiative, 2005) Extension office agents introduced published farming and animal handling techniques to local area

farmers, who then implemented these evidence-based techniques in their own businesses. Evaluation of knowledge use in the health care arena has been studied since the 1960s (Donabedian, 1966). The formal study of knowledge transfer or translation has been developing over the past thirty years with the United States Department of Health and Human Services launch of the Agency for Healthcare Research and Quality, and the Canadian equivalent of the Canadian Health Services Research Foundation (Canadian Institutes of Health Research, 2017).

The Canadian Institute of Health Research (2017) first published the term KT and its definition in 2000. In 2005, the National Center for the Dissemination of Disability Research followed with its definition: “KT is a relatively new term that is used to describe a relatively old problem—the underutilization of evidence-based research in systems of care. Underutilization of evidence-based research is often described as a gap between 'what is known' and 'what is currently done' in practice settings.” (Center on Knowledge Translation for Disability & Rehabilitation Research, 2013). According to research conducted by Holmes, Schellenberg, Schell, & Scarrow (2014), health research funding entities are increasing the KT focus by backing studies related to how evidence is being moved to practice or reducing the time between research and implementation.

Continuing professional education courses are the most widely sought-after methods for skill development and continuing professional development (Coffelt & Gabriel, 2017). Coffelt and Gabriel (2017) further noted these formal learning environments typically are either in the form of a multi-day, multi-session conference or a day or two long specific, focused training courses. These types of continuing education are generally conducted by instructors who are rehab professionals and deemed experts

on a particular topic. Continuing education seminars characteristically have an interdisciplinary focus meaning one seminar might address skills and topics of interest to various rehabilitation professionals, not just OTPs. Seminars are concluded with a certificate of attendance or CE certificate. There is often not a formal assessment of learning that takes place (Fisher, 2000).

Current research on the topic of continuing medical education garnered the highest level of learning carryover stemmed from online learning seminars in which case-study type application exercises were included (Salinas, 2015). Salinas (2015) further found that to be effective for knowledge translation, live seminars needed to have a hands-on component to reinforce the skills exhibited in the seminar. Salinas reported that KT happens quickest in online seminars with case studies and knowledge-based assessments. Many face-to-face seminars present information and then rely on OTPs having the right patient with whom to utilize the new skills back at their place of employ. In reality, it may be months or weeks before the “right” patient is available to apply new learning from a face-to-face seminar, considerably reducing the KT rate of the participant.

Some face-to-face courses offer the therapy practitioner the opportunity to perform the newly introduced skills in the class itself. Participation in these types of events does not automatically equate to mastery of the skills, or KT, however. McKinstry et al., (2009) cautioned that participation in continuing education does not automatically equate to increased safety or even competence with a skill or technique. One must continue to practice those skills to maintain new learning after the class has ended. Research conducted by Carpenito (1991) and Marks (1996) further concluded

that mandatory face-to-face continuing professional development seldom established the learning needs of individual participants involved. Moreover, mandatory continuing education courses did not “help the learners apply new skills to the work situation despite the fact that application of skills to improve quality of care [was] the ultimate purpose of continuing competency” (Anderson, 2001, p. 450).

Professional development must be completed by OTPs; however, Coffelt and Gabriel (2017) believe real continuing professional development does not happen unless the practitioner chooses activities that increase his or her own learning, skills, or understanding of the topic. For example, when a practitioner has a challenging patient and needs to seek additional learning to assist with the treatment of the patient.

Pettersson et al., (2015) wrote about the outcome of continuing professional development when it was sought out versus imposed upon the practitioner. These researchers, in the physiotherapy field, found practitioners who sought-out opportunities were regarded as having better knowledge translation outcomes by the practitioners themselves. Evidence of research about knowledge translation after continuing professional development participation in the profession of OT is negligible. Understanding OTPs KT, however, is essential. An investigation by Grant (1994) suggested that there is a lack of evidence that participation in mandatory continuing professional development leads to an increase in skill or change in treatment techniques. Additionally, no research regarding KT after participation in informal occupational therapy-related education has been found.

Intrinsic Motivation

Intrinsic motivation is a component of Malcolm Knowles' theory of adult learning (Knowles et al., 2015). Adult learning theory states that learning in adulthood is driven

by internal factors and a need to know (Merriam et al., 2007). Anderson (2001) referred to Knowles' principles of andragogy in her Occupational Therapy practitioners related research as well. She found that "the andragogical model of learning views learners as self-directed in determining learning needs and objectives, identifying and using learning resources, and evaluating the effectiveness of learning (p. 450). Further, Anderson (2001) and Warmuth (1987) deemed continuing professional development to be intrinsically motivated as the OTPs have the unique ability to evaluate the effectiveness of his or her learning and subsequently modify new knowledge as (s) he believes fit.

Research conducted by Coffelt and Gabriel (2017) and Wheeler and Chisholm-Burns, (2018) found that continuing professional development contains these adult learning principles in that continuing professional development must be self-directed and self-reflective and meet the needs of the practitioner rather than requirements or mandates. Landers et al., (2005) conducted a quantitative study across the nation comparing physical therapy practitioners' responses in states with mandatory continuing professional education versus non-mandatory continuing professional education. It was determined that Physical Therapy practitioners in states with mandated continuing professional education participation had a higher level of participation in continuing professional education than the same group in states that did not have mandatory continuing professional education requirements. The overall finding was that Physical Therapy practitioners reported clinical competence as the number one reason for participation in continuing education. In states with mandatory continuing education however, the number one reason for continuing education participation was linked to

meeting the continuing education requirement, followed by increasing clinical competence.

The findings of Landers et al. (2005) stipulated that health care providers must participate in continuing professional development to prevent the loss of skills as new information and methods enter the market post-graduation. “The concept of obsolescence assumes that Physical Therapy practitioners who fail to keep up with new knowledge, skills, and scientific information become obsolete in their professional knowledge and skill set at the same rate at which scientific knowledge increases” (p. 862). They further inferred that intrinsically motivated learners learned more than learners who were mandated to participate (Landers et al., 2005). Additionally, it is important to note that attendance in a continuing education event does not automatically equate to new learning from the event. Also, the motivation for continuing education participation linkage to its mandatory nature, correlated to a low number of continuing professional development hours taken. Maharaj (2013) revealed that there was little evidence that supported knowledge learning at formal continuing education activities as they seem to be more concerned about evaluating the participant’s comfort than the content provided. Another interesting fact presented in this study was that nurses who were the least educationally prepared for their work in patient care were also the least likely to attend or desire to attend continuing education.

Conversely, those with the highest levels of education were most likely to support continuing professional development mandates and continuing professional development participation (Puetz, 1983). Maharaj (2013) found that “professional requirements are most successful when the needs and desires of those who are affected are considered.

Therefore, there is a need for participants experiences and the nature of formal and informal CPD activities to be reviewed to ensure the desired outcome of life-long and relevant learning” (p. 344). This topic has not been researched as it relates to OTPs in the state of Georgia.

Nonformal CPE Opportunities

Continuing education (CE) is often interchanged with a variety of similar, yet different terms. Those can include professional development (PD), continuing professional development (CPD), healthcare-related professional development, continuing clinical competence, or continuing professional education (CPE). These terms have the same purpose, to continue the development of knowledge, skills, and abilities of the OTP (Amerih, 2013). Most commonly, CE means formal learning opportunities such as participation in courses, seminars, or lectures (Agyepong & Okyere, 2018). There are many non-formal CPD opportunities that benefit OTPs; however, research regarding these opportunities is limited. The Majority of mandatory CPD programs only recognize formal CPD as the resource for meriting professional competency (Anderson, 2001). The CCCPD recognizes that CPD is influenced by the therapist paradigm, professional roles, and contexts, but has not yet formally explored nonformal continuing professional development opportunities as competency builders (National Commission on Continued Competency in Occupational Therapy, 1999).

Wright (2012) detailed the concept of “consciousness of craft” (p. 13) concerning nonformal CPD participation. The consciousness of craft is specific to one’s own occupation. This consciousness means the OTP possesses an awareness of what is required to participate in one’s own career of choice. This includes having a knowledge

of the need for continued skill-building and recognition of activities that build those skills (Wright, 2012). Wright determined that consciousness of craft most frequently occurs with nonformal learning opportunities. Anderson (2001) noted that self-directed and self-identified learning opportunities “are not easily measured and is, therefore, frequently overlooked as a valid method to maintain competence” (p. 450).

The field of Occupational Therapy is so broad that it is quite challenging to be an expert in all practice areas. An OTP with more experience in an area can serve as a tool to increase the knowledge of fellow OTPs in the form of peer-support or mentorship (Fisher, 2000). Falzarano and Zipp (2012) conducted a small-scale study (n = 107) of mentorship in OTR academia. They found that over half of the respondents were engaged in the mentoring process as either the mentor or the mentee. Their research supported earlier studies that indicated that mentoring relationships had positive impacts on both parties of the process. Falzarano and Zipp reported that mentorship lead to higher retention rates, increased professional development, and an improved ability of the mentee to “navigate the [therapy] organizational culture by understanding these expectations” (Falzarano & Zipp, 2012, p. 118).

Mentorship as a type of CPD often occurs automatically, and without the knowledge of the OTPs involved (Coffelt & Gabriel, 2017). This type of CPD is challenging to recognize and track for mandatory reporting purposes. NBCOT does have a formal mentor/mentee process and forms that can be used. Additionally, NBCOT allows both the mentor and the mentee to use up to 18 hours of competency assessment units per three-year renewal period toward the mandatory continuing professional

development requirement. The Georgia Board of Occupational Therapy does not recognize this form of continuing professional development.

Another essential type of CPD is research and lectures. It is vital that the field of Occupational Therapy grows its body of research to support its stance on the use of evidence-based practice (Fisher, 2000). It is also crucial that those in the OT profession share their personal knowledge with others in the field. Research and lectures take up a significant amount of planning and development time and require skills beyond those of the entry-level OTP (Hall et al., 2016). The Georgia Board of Occupational Therapy does not recognize these activities as a source for continuing education hours (State of Georgia, 2017). GOTA, however, has created a committee to study the interest and impact of developing informal opportunities to share information from recently published relevant research (Georgia Occupational Therapy Association, 2018). NBCOT has specific criteria to use to determine the number of competency assessment units awarded for these activities (Hall et al., 2016; (National Board for Certification in Occupational Therapy, 2017a).

A variety of literature supports the idea of peer-to-peer interactions such as mentoring, student supervision, peer support, research, and guest lecturing as continuing professional development techniques, and places high value in their benefit (Agyepong & Okyere, 2018; Falzarano & Zipp, 2012; Fisher, 2000; Garrahy et al., 1992; Lysaght et al., 2001; McKinstry et al., 2009; Moonasar & Underwood, 2018). In these types of peer relationships, “peers in the workplace are perceived to be the most important source of information and support “(Lysaght et al., 2001, p. 33). Almost every therapy practitioner

learns from another. The act of mentoring, supervising an OT or OTA student, or building a peer-to-peer relationship makes this already common practice more intentional.

Research participation and student supervision are also important cornerstones to the profession of Occupational Therapy (Hall et al., 2016). All students of Occupational Therapy must complete fieldwork affiliations (Accreditation Council for Occupational Therapy Education, 2011). All practitioners of Occupational Therapy must utilize evidence-based practice (American Occupational Therapy Association, 2017a). By limiting the amount of continuing professional development credit that can be applied to mandatory continuing education requirements, the State of Georgia is simultaneously reducing its perceived importance. Additionally, since these activities are not formally viewed as continuing professional development by the Georgia State Board of Occupational Therapy, limited tracking of their actual use has been located.

Research by Coffelt and Gabriel (2017) found that the Occupational Therapy practitioner's work environment played a role in the development of clinical competence. Much informal learning happens in the workplace as seasoned therapists provide informal guidance and mentorship to newer practitioners. Interdisciplinary discussions and plans are also made in these environments which bolster learning and practice of skills. Socializing with other therapy peers has been a form of informal professional development that happens daily. They further found that continuing education courses are not as widely available as informal training opportunities that happen organically in the work environment.

Research from Pettersson et al., (2015) about physiotherapists found that often after attending a formal professional development event, practitioners found that there

was not as much new information presented as was expected. Further, practitioners often reported knowing more about a topic than they realized before the continuing education event. The researchers of this study used Knowles adult learning theory to include work experiences as a learning tool for professional development (Knowles M. S., 1970).

Pettersson et al. (2015) found that the scope of learning activities for health care providers was too narrowly focused on formal educational activities and overlooked the learning that took place informally, such as professional socialization, as well as tacit educational opportunities in the workplace. This study examined knowledge gained in the work environment and its contribution to the CPD of seasoned practitioners.

Pettersson et al. also found a theme arising that practitioners used experience and prior knowledge to change how they approached a problem that had been encountered previously. In other words, they used learning gained from a prior experience to adjust the inputs into the treatment to try to have a better outcome. This happens with time and experience. It also stems from working alongside other practitioners who have different experiences and knowledge to share.

Pettersson et al. (2015) further found that informal learning opportunities do not just happen at work, but also in conversations and reflections that can happen outside of work hours and even during social events. Each time a practitioner works with a patient, new knowledge is gained and applied or generalized to future treatment interventions.

McKinstry et al. (2009) introduced the concept of professional socialization as part of CPD. Professional socialization affords therapy practitioners the opportunity to discuss their treatment interventions with others as well as assists with identifying areas of need for expanded skill or education in an informal way.

Pettersson et al. (2015) found that the majority of actual continuing professional development is opportunistic for the practitioner and informal. The informal learning opportunities are not often formally captured, however, and many therapy practitioners do not even recognize it as professional development and learning. As a result of this, therapy practitioners still report formal learning experiences as their preferred learning method. This practice supports the adult learning principle of Malcolm Knowles (1970), which theorized that adult learners would seek out new learning when new learning is needed. This is also the principle of life-long learning that is so important to the AOTA *Code of Ethics*. Unfortunately, this is an emerging area of continuing professional development study, and there are gaps in the literature related to this form of continuing professional development. Additional research with OTPs in the state of Georgia will elicit a better understanding of the viewpoints and beliefs of OTPs and their use of nonformal continuing professional development use.

Best Practices in Continuing Professional Development

The Institute of Medicine of the National Academies holds the position that health care practitioners including Occupational Therapy Practitioners must continue advancing their skills and stay abreast of current research and field-related developments to maintain the professional currency required to properly care for their patients (Institute of Medicine of the National Academies, 2010). They further state that “the nation’s approach to CE for healthcare fails to support the professions in their efforts to achieve and maintain proficiency” (p. 1) and that “CE has become structured around health professional’s participation instead of performance improvement” (p. ix). Because of these findings, health professionals are likely not “receiving care of the highest possible quality and safety” (p. ix).

The Josiah Macy Jr. Foundation held a conference in 2007 that brought the stakeholders from continuing professional health education together. This conference resulted in the formation of The Institute of Medicine's Committee on Planning a Continuing Health Care Professional Education Institute (Institute of Medicine of the National Academies, 2010). This committee found that "the science underpinning CE for health professionals is fragmented and underdeveloped . . . [making] it difficult, if not impossible, to identify effective educational methods . . ." (p.2-3). The committee further recommended the development of a new vision for professional development to "replace the culture that now envelops continuing education in health care" (p. 3).

Current CPD in healthcare has been found to focus on meeting regulatory requirements and not focused on personal knowledge gaps (Institute of Medicine of the National Academies, 2010). This can be evidenced by the state licensure law in Georgia requiring all OTPs to obtain twenty-four hours of continuing education every biennial renewal cycle (State of Georgia, 2017). These hours are further restricted by the practice act to include a maximum of eight hours of education that is not considered to relate to direct patient care, along with a minimum of two hours relating to ethics in Occupational Therapy. This requirement is part of the narrowly defined competencies that are of concern to the Institute of Medicine of the National Academies (p. 5). Similarly, research conducted by Hall et al., in 2016, indicated a disparity with Occupational Therapy CPD regulations around the nation treating all practitioners as equal. It did not account for the variances in professional development activities needed by an OTP in academia being different from one in management, regulatory affairs, or direct patient care provider. Hall et al. (2016) recommended that CPD regulations be adjusted to ensure that each practitioner was regulated to obtain the development he or she needed.

Additional findings by the Institute of Medicine's Committee on Planning a Continuing Health Care Professional Education Institute are also supported by other research studies related to Occupational Therapy and continuing professional development. Findings included the use of didactic learning methods, pedagogical (teacher-led) instruction, and questionable relevance to the clinical setting. The committee found little information related to the best way to support learning, nor the best way to measure the effectiveness of the current methods (Institute of Medicine of the National Academies, 2010, p. 4). *Health Professions Education: A Bridge to Quality* (2003), also published by the Institute of Medicine of the National Academies, determined what was then termed continuing education shift to continuing professional development continuum (Institute of Medicine of the National Academies, 2010). With this shift in terminology also came a shift in the recommended practice. This IOM report recommended that best practice for continuing professional development shift its focus to competency-based practice. Five-quality goals were developed to serve as the footings for improving continuing professional development (Institute of Medicine of the National Academies, 2010; Institute of Medicine of the National Academies, 2001). They are:

1. Provide patient-centered care
2. Work in interprofessional teams
3. Employ evidence-based practice
4. Apply quality improvement
5. Utilize informatics

(Institute of Medicine of the National Academies, 2010, pp. 45-46)

The IOM expected that this new concept would be more focused on the needs of individual practitioners. A more holistic approach accommodates the various learning methods, skill bases,

and specific needs of each health care professional. The expectation is that it will improve patient outcomes, increase patient safety, and provide a higher return on the investment of continuing professional development resources (Institute of Medicine of the National Academies, 2010).

These recommendations were made in 2003. This was the same timeframe that I was obtaining my Occupational Therapy Assistant education. Fifteen years later, I have not yet experienced this type of continuing professional development. The state of Georgia has not updated its practice act to include these best practices (State of Georgia, 2017). It appears that other state Occupational Therapy practice acts have not been updated to reflect this either (American Occupational Therapy Association, 2014b). National level NBCOT certifications as of this writing are also rooted in development opportunities that are more didactic in nature (National Board for Certification in Occupational Therapy, 2017b). The National Board for Certification in Occupational Therapy (2017) does recognize non-didactic continuing professional development opportunities such as participation in research, publications, textbook reviews, or formal mentorship programs as options for meeting their certification renewal requirements.

Additionally, AOTA has taken notice of the IOM's urging to change continuing professional development practices it supports. Neil Harvison, Ph.D., OTR/L, and Chief Academic and Scientific Affairs Officer of AOTA, spoke at the 2018 AOTA National Conference in April 2018. Dr. Harvison presented findings that AOTA needed to address CPD within the context of the needs of a changing health care system. He further stated that OTPs needed continuing professional development opportunities that were accessible inside the demanding practice environments in which they work. Additionally, he presented support of the concept that best practice for CPD in the field of Occupational Therapy is a competency-based system (Harvison, 2018). The professional body responsible for CPD recommendations for OTPs in the

United States has determined it is time for a change in continuing professional development in Occupational Therapy in 2018. The change is the same change initially recommended by the IOM in 2003 (Institute of Medicine of the National Academies, 2010). Conducting qualitative research studies with OTPs can assist stakeholders in the development of a future competency-based CPD system that increases patient safety and outcomes while simultaneously moving CPD for OTPs into the 21st century.

Chapter III

METHODOLOGY

Population & Sample

Eleven Occupational Therapy practitioners licensed in the state of Georgia were studied related to their participation in and use of CoP as an informal method of learning and continuing professional development. Maxwell (2013) instructed the qualitative researcher to use an “inductive approach” with the desire to “understand the meaning,” “contexts,” and “processes” of the participants (p. 30). Inclusionary criteria for participation in this study required the participant to have experience with Occupational Therapy related continuing professional development/continuing education, OTP licensure in the state of Georgia, as well as current NBCOT certification or registration. State of Georgia statute does not differentiate between the assistant and therapist level for CE requirements, requiring 24 hours every two-year renewal cycle (State of Georgia, 2017). Similarly, NBCOT does not differentiate between levels of practice, requiring 36 competency assessment units every three-year renewal cycle (National Board for Certification in Occupational Therapy, 2017c). Since no differentiation is made between practice levels for the purposes of CPD/CE participation, this study did not differentiate between participant practice levels.

Purposive sampling, introduced by Palys (2008), was used to source study participants. Purposive sampling is a type of non-probability sampling by which participants are selected based on the characteristics of the population being studied. It is especially useful when conducting exploratory qualitative research and when resources are limited (Lavrakas, 2008). Purposive sampling was selected as the best method for participant selection so that the participants could be “selected deliberately to provide information that is particularly relevant” (Maxwell, 2013, p. 97) to the research topic, and “can’t be gotten as well from other choices” (p. 97). Selected participants have been licensed in the state of Georgia for a minimum of ten years. This criterion was implemented to ensure participants had time to have developed work experience and identities as professional OTPs while simultaneously developing separation from their formal educations. Participants with this level of experience have participated in state license renewal a minimum of five times. This timeframe provided a deep and rich variety of experiences with which the participant could base their responses. This precedent was set with research conducted by Pettersson, Laksov, and Fjellstrom in 2015 related to professional development with physiotherapists. Those researchers selected practitioners with at least ten years of experience in the field as an arbitrary number that gave the participants a length of experience which had established some insights into continuing professional development as well as working in their field. The practitioners had also been separated from their education by at least a decade, which was likely to ensure changes or additions to the educations received (Pettersson et al., 2015).

Participants were initially notified of the proposed research via email. Prospective participant email addresses were collected in multiple ways. First,

participant recruitment was completed by requesting OT/OTA schools in the state of Georgia to email a recruitment email to OTPs in their school databases. These databases are compiled of former students and clinical partners. Second, a recruitment email and request for publication was sent to the GOTA Research Chair for publication on the GOTA research project website. Recruitment was initially focused on three geographical areas (North West Georgia, South Georgia, and Eastern Georgia) within the state to ensure participants from around the state were invited to participate in the gathering of data.

Setting

The researcher has elected to complete three focus groups of approximately four to eight participants to obtain data from OTPs in the State of Georgia. Kruger and Casey (2000) suggested the use of three focus groups of five-to-eight participants lasting a minimum of ninety minutes for optimal discussion. To that end, the focus groups were conducted in an attempt to gather participant rich data from Occupational Therapy practitioners licensed in Georgia.

According to the 2017 United States Department of Labor Bureau of Labor Statistics webpage regarding Occupational Employment and Wages, the areas of Georgia with the highest number of OTRs and COTAs include the metro-Atlanta area, Augusta-Richmond county, and Albany/South Georgia (United States Department of Labor, 2017a; United States Department of Labor, 2017b). The Metro-Atlanta area was the most populated area with the other two areas considerably smaller, yet similar to one another in OTP populations. Participants for each focus group were solicited from those geographic areas.

Though participants were recruited from three geographic areas in Georgia, responses were only received in numbers adequate to complete the research in the metropolitan Atlanta area. As a result, three focus groups were held in three distinct geographic areas of the metropolitan-Atlanta area: Marietta, Georgia; Dallas, Georgia, and John's Creek, Georgia. These settings were based upon respondent's locations.

Two focus groups were conducted in meeting spaces at local community college locations. A third focus group was held in a meeting space at a local business. These locations were selected due to proximity to research participants and cost-effectiveness to the researcher. Utilizing educational/business settings assisted with setting a professional tone to the focus groups.

Measures

Creswell (2014) taught that qualitative research is focused on personal experience rather than variables or measures. Despite this, a component of this study is to relate the personal continuing professional development experiences of Occupational Therapy practitioners in the state of Georgia. To that end, an impact evaluation will be conducted to determine what perceived impact CoP are having on the informal professional development needs of the Occupational Therapy practitioners in the state of Georgia.

The Center for Disease Control and Prevention (2009) issued an evaluation brief that indicated an impact evaluation is the most appropriate measurement for this study. Stakeholders, who in this case are identified as OTPs in the State of Georgia, have been interviewed concerning their experiences with CoP, an informal type of continuing professional development. The CDC indicated several vital items that should be addressed by an impact evaluation (2009). When

applying the role of an impact evaluation to this study, the essential items that will be addressed include:

- The ultimate impact of a CoP on the professional development of OT practitioners
- Provision of evidence of use for the recommendation for future policy decisions
- The impact of CoP use in knowledge translation to skilled OT intervention

The information for the impact evaluation will be determined as part of the data coding and analysis process that was conducted after the transcription of the focus groups has concluded. Emerging themes were then identified, and any themes relating to these indicators will be presented.

Procedures

University Institutional Review Board (IRB) approval was sought by the investigator prior to the collection of data related to this study. The IRB of Valdosta State University granted the investigator an exemption from further IRB committee approval (See Appendix A).

Three focus groups were conducted over a one-month period. Each focus group was audio-recorded using a digital recording device as well as the digital recording feature of the researcher's personal cellular device. Following each focus group, the researcher personally transcribed each recording in preparation for data analysis using NVivo Transcription services to facilitate the translation of audio files to text files. Digital recordings of the focus groups were deleted from both the digital recording device and voice recording files of the investigator's personal cellular phone after the transcribing process was completed and verified. Transcripts from each focus group were emailed to the participants of the group for member checking verification, as suggested by Lincoln and Guba (1985).

Before each focus group started, participants answered a short series of questions (Appendix B) related to continuing professional development. The form included a definition of continuing professional development. Participants were asked to create a list of continuing professional development opportunities they have recently participated in, and their reasons for participation. Participants were subsequently asked to rank their participation reasons by order of importance. These completed lists then served as catalysts for discussions about their experiences participating in nonformal learning activities (Pettersson et al., 2015). These ranked lists were completed and collected in addition to audio data for contribution to the analysis of data.

A pilot study was conducted with two separate individual OTPs to address focus group question content (Appendix B and Appendix C). Question content was then reviewed to ensure that questions were limited in scope to elicit answers to questions most desired as well as to ensure question format and wording provokes answers being sought. Additionally, as suggested by Pettersson et al., (2015), the pilot study created the opportunity to ensure the interview questions created a dialog to elicit rich data rather than merely questions followed by answers. This pilot study contributed to the content validity of the larger focus group format (Patton, 2015).

Data Analysis

The data analyzed the experiences of Occupational Therapy practitioners in focus groups using several techniques. The expectation was to understand better both their individual experiences and perceived value related to CPD in OT followed by the overall group experiences with OT related CPD. These analyses were then used to understand and make meaning of the experiences of the OTP participants with CoP.

Transcription of each focus group transpired the same night as the focus group itself. The Audio files were converted to .wav files, saved, and then uploaded to NVivo Transcript for review and correction. The NVivo software created a transcript using the uploaded audio file. Each file had to be then reviewed for content accuracy and corrected. Speaker pseudonyms also needed to be added when individuals spoke during each focus group.

The coding of the data for each focus group began during the transcription process. Initial coding for themes in each focus group began while the researcher reviewed the transcripts for accuracy. Some general data coding also took place as part of the suggested member checking recommended by Krueger and Casey (2000). At the end of each focus group, the researcher re-capped the participant responses to the questions and grouped their answers in overall question related themes.

Ranked lists were distributed and then collected as part of each focus group. The lists were distributed at the beginning of each focus group for completion by participants prior to the beginning of the focus group. These lists were reviewed for common themes and ranked item importance. To assist with determining the essential topics from the ranked list, a word cloud analysis was conducted to visually describe the most prevalent themes (Cherrstrom, Robbins, & Bixby, 2016). Though “most prevalent” will not address ranking, it will provide insight into the most common themes to later cross-reference with the results of coding from the audio transcripts. This cross-referencing will assist the researcher with avoiding the trap common to focus groups of expecting the concept(s) taking the most time to be the most important to the participants (Krueger & Casey, 2000).

Focus group interview transcripts were processed by the researcher following Creswell's (2014) method of data review. Focus group interviews were hand-coded after being printed. First, each focus group transcript was reviewed for clusters of meanings that surrounded the phenomenon of CoP. Following the coding of each individual focus group, themes were listed and evaluated for commonality. A list of common themes was created. Next, the researcher grouped the three focus groups together before reviewing the transcripts again as a whole and repeating the coding process. A list of common themes was then created from the larger transcript file. This list was further refined with a third review of the focus group transcripts.

The data collected was reviewed for important information and themes. Since the concept of importance is not directly measurable in this phenomenological study, the determination of how to operationalize the concept of importance was determined by the researcher (Bridgman, 1982). The concept of importance for this study was inferred while studying the phenomenon of CoP as professional development in three main formats. The first method, data collected from ranked lists, was addressed in the preceding paragraphs. The remaining two formats related to focus group data.

First, the direct use of the word *important* by the research participants is recorded in the focus group transcripts. This word choice is selected by various participants during the course of verbally answering focus group questions. In these instances, the frequency of use of the word *important* in the descriptions of information will indicate the concepts being discussed are central to the ideas the respondent selects to share with the researcher.

Aside from counting the number of times the term *important* is used, the concept of importance is not directly measurable. In cases such as this, the concept must be inferred after reviewing available empirical data (Bridgman, 1982). The concept of importance will be operationalized in this study by the frequency in which concepts related to the theme are mentioned by research participants during the analysis of the focus group transcripts. This analysis will take place first during open coding for each individual focus group. It is followed by secondary coding of the data when all transcripts are treated as one set of data for a second analysis.

Validity

Participant selection is the first validity issue. Participants were selected using purposive sampling (Seidman, 2013). Participation was requested from a variety of Occupational Therapy practitioners that meet the inclusionary criteria of ten years of experience as a state of Georgia licensed Occupational Therapy practitioners. Distribution of the request for participation was completed by email using the researcher's network of OTPs. Distribution assistance was also requested of the Academic Fieldwork Coordinators and Program Directors of three Occupational Therapy Assistant Programs and two OT programs in the targeted geographic areas identified. Due to the nature of the OTA faculty jobs, faculty members are connected to an extensive network of OTPs in their surrounding communities. There are no guarantees that the faculty distributors did not pre-select the participants despite the researcher's lack of knowledge about them.

Additionally, as a researcher and OTP in the metro-Atlanta area, the researcher is exposed to a large group of Occupational Therapy practitioners. Many of these OTPs have already requested to assist with this pending research. Had more than the required

number of participants volunteered, randomized sampling of the participants would have been implemented to select participants for each focus group location.

Participant recruitment was also attempted using the GOTA Research committee. Per the bylaws, the Research Committee is expected to support the research efforts of GOTA members by distributing research study information and participant requests via the listserv and by listing participant recruitment opportunities on the GOTA webpage. The researcher contacted GOTA via email and requested support with research recruitment but did not receive a response to her request. Additionally, her recruitment email was not distributed on the GOTA listserv, nor posted on the GOTA research webpage.

The second validity issue with this research is the decision to utilize OTPs at all education levels. Though OTPs in the state of Georgia are all required to obtain the same number of continuing education hours per renewal (State of Georgia, 1976), and expected to be life-long learners per the American Occupational Therapy Association (2014a) Practice Framework, education level could be a threat to validity. Landers et al., (2005) and Puetz (1983), reported that their research showed that practitioners with the highest education levels were more likely to support continuing professional development participation. Occupational Therapy practitioners with all degree levels of post-secondary education from associate to doctorate levels participated in the focus groups. To better understand if this phenomenon is present within the research participant pool selected for this study, participants were also asked to disclose their education level as part of the initial screening process (Appendix D).

The third threat to validity is group thinking. Since focus groups were used to obtain data from the research participants, it is possible that verbal participation resulted in all participants reporting similar feelings about the questions asked of them. It is also possible that if a charismatic participant contributed an answer, that other participants might have felt this person possessed the correct answers, and then subsequently modeled their answers to match this participant. The researcher attempted to address this threat in multiple ways. First, the ranked lists collected were completed at the beginning of the focus groups by individual participants. These lists were analyzed separately from the transcribed sessions. Second, Lincoln and Guba's (1985) concept of member checking was implemented with all participants for continuity at the end of each focus group, and again after the transcription and initial coding. Member checking took place with a closing summary question in the focus group itself as well as after the transcription and coding of each focus group has been completed, as recommended by Krueger and Casey (2000). Third, three focus groups were conducted in an attempt to follow Seidman's (2013) advice on obtaining data saturation before ceasing participant research.

The fourth threat to validity concerns the participant providing answers that are truthful rather than what each participant thinks the researcher wants as an answer. To address this validity threat, a variety of semi-structured interview questions that require the participant to provide answers that are rich in data from their personal experiences with CoP was employed (Maxwell, 2013; Patton, 2015; Seidman, 2013). Further, detailed instructions at the beginning of each focus groups related to the purpose of the research as well as a proper disclaimer that it is being undertaken by a student of Valdosta State University's Adult and Career Education Program, and it is in no way

affiliated with the American Occupational Therapy Association (AOTA), National Board for the Certification of Occupational Therapy (NBCOT), Georgia Board of Occupational Therapy, Georgia Occupational Therapy Association (GOTA), nor the researcher's current employer was included in the recruitment email and read aloud at the beginning of each focus group.

An additional threat to validity that must be accounted for is the researcher's personal bias on the research topic. Heideggerian principles of phenomenology accommodate the belief that bias is always present in the human experience (Horrigan-Kelly, Millar, & Dowling, 2016). Wright (2012) taught that "human beings are always grounded in their own history and language and cannot set aside biases" (p. 3). As an American born and educated Occupational Therapy practitioner with over ten years of continuing professional development experience, the researcher has her own opinion about CPD in general as well as state and national regulations. She had to keep these feelings balanced with an unbiased approach to the research conducted. To remedy this, a peer reviewer of the research plan and focus group questions was deployed before implementation. The reviewer was an OT educator who is familiar with the practice of qualitative research. After the peer review was conducted satisfactorily for embedded biases, a pilot study with another peer OTP was conducted. The focus of the pilot study was to ensure the focus group task as well as questions created met the goals of the study and garnered the types of answers being sought by the research questions.

A final threat to validity is the novice status of the researcher as focus group leader. The researcher has personally participated in approximately twelve focus groups for consumer product market research and medical device research in the past. This was

her first time engaging in research as the focus group leader. To prepare for this role, the researcher educated herself on best practices for conducting focus groups. She planned and implemented her focus group using recommended methods from Krueger and Casey's manuscript *Focus Groups: A Practical Guide to Applied Research* (2000). In addition, a variety of research studies were located in which focus groups were used as the method of data collection. These studies were reviewed by the researcher to obtain a better understanding of using focus group design and implementation as a research method.

Ethical Issues

Though this study used human subjects, the ethical considerations of the study are few. Participants volunteered to participate in this research after being provided a brief overview of the purpose of the research. Because of this, the researcher considered the personal motive for participation as an ethical issue. Some participants may be motivated to participate in research to assist the researcher, to support the field of Occupational Therapy, or they may have more personal agendas needing a voice and outlet.

It must also be considered that not all participants understand and report CPD/CE participation correctly to the State of Georgia Board of Occupational Therapy. Through the course of the research, the researcher, an Occupational Therapy practitioner bound by ethical standards herself, may have encountered negative information related to continuing professional development practices of the participants. Though the purpose of this research was not to determine reporting practices related to state-mandated continuing professional development, it may be a byproduct of conducting this research. The Occupational Therapy practitioners were not protected from this disclosure to other

Occupational Therapy practitioners. The researcher, however, acted in a confidential manner as her role is that of the researcher rather than an Occupational Therapy practitioner.

Data Presentation

The data collected in the three focus groups were coded first as individual sessions, followed by a subsequent round of coding, treating the three focus groups as a singular data set. The data will be presented as one final set of data that details the experiences of OTPs in the State of Georgia with the CoP phenomenon. The roots of phenomenology are intended only to describe the data that has been collected in research (Grand Canyon University, n.d.). The researcher has included an interpretation of the data. From that data, she then presents the results developed regarding the impact of CoP on the professional development of Occupational Therapy practitioners in the State of Georgia.

Chapter IV

RESULTS

This chapter contains the results of the phenomenological study designed to answer the following research question:

Research Question: How does informal learning in a Community of Practice influence the professional development of Occupational Therapy practitioners in the state of Georgia?

To understand the experience, sub-questions have also been created. This study further sought to answer the below sub-questions.

Sub-Question A: How do informal learning opportunities influence the knowledge translation of Occupational Therapy practitioners in the state of Georgia?

Sub-Question B: What are the prevailing attitudes and values of Occupational Therapy practitioners in Georgia toward learning from a community of practice?

Sub-Question C: With what frequency do Occupational Therapy practitioners in the state of Georgia participate in formal and informal professional development activities?

The results of this study were determined by analyzing the experiences of OTPs in focus groups using several techniques. These techniques were designed to understand better both the individual beliefs and experiences related to informal CPD/CoP in OT and then to understand the overall group beliefs and experiences with Occupational Therapy related to continuing professional development.

Recruitment

A series of three focus groups were held at three different geographic locations. A recruitment email (Appendix E) was sent to OT faculty at the three OT programs, and three OTA education programs located in Georgia. Included with this recruitment email was a request from the researcher to distribute the recruitment email to OTPs in their network. The researcher is a member of the GOTA. An additional recruitment attempt was made by contacting the GOTA Research Committee for the posting of recruitment information on the GOTA webpage dedicated to school and research projects, which is broadcast statewide to other GOTA members and posted on the GOTA webpage.

According to the United States Department of Labor (2017a), all three OT programs in the state of Georgia are located in the most densely populated geographic areas of Georgia for OTPs. Further, three of four OTA programs are located in the same three geographic regions in Georgia (United States Department of Labor (2017b)). The fourth OTA program is within sixty miles of the Atlanta metropolitan area, the most densely populated area of Georgia for OTPs. As a result of this proximity, and a professional courtesy to support research in the field of OT, faculty at these OT and OTA programs were well suited as a cost-effective mechanism to reach potential participants. To recruit from the metro-Atlanta area, the researcher, also faculty for an OTA Program, contacted all of the OTPs in her personal and professional network requesting participation. In addition to the above recruitment efforts, the researcher requested her recruitment email be posted on the GOTA research page of the organization website and be included in a GOTA listserv posting. To date, the researcher has not had a response

from GOTA to her formal request for assistance in recruiting OTPs for this research study.

The recruitment email requested interested participants to complete a questionnaire and return it to the researcher via email (Appendix D). Recruits were invited to attend the focus group closest to their geographic area. Geographic areas of focus were pre-selected based upon the density of OTPs and included Metro-Atlanta, East Georgia, and South-East Georgia. Participants were also given the option to write in their geographic location in the event recruits desired to participate but did not feel their geographic location was represented.

This questionnaire also collected data related to the OTP's years of practice. The number of years in practice was collected to ensure that the research sample had an adequate frame of reference with professional development in the focus groups. Focus group participants were expected to have a minimum of ten years of experience working as an OTP. The ten-year minimum would have included at least five bi-annual licensure renewal cycles under the Georgia statutes governing the practice of OT.

The level of OT education earned by participant volunteers was similarly collected. Research conducted by Puetz (1983) indicated that nursing staff who had earned the highest levels of education also reported placing the highest value in education. This data was collected to assist with determining if there was a similar correlation between education level obtained and participant value of professional development.

Finally, recruits were queried regarding their work histories outside the state of Georgia. Each state in the United States regulates the practice of OT differently.

Participants who had also worked in other states may have frames of reference related to professional development that differ from practitioners who have only held a license to practice OT in the state of Georgia.

Sample

Twenty-four potential participants responded to the request for participation in this research study. Of those, eleven participants were included in this study. Two responses were received from the Augusta area. An additional response was received from both the Albany and Macon areas. The balance of respondents (20) were located around the metropolitan Atlanta geographic area. As a result of the small sample sizes recruited, the Eastern Georgia and Southeastern Georgia locations were abandoned. To better match the sites of participant recruits, three focus groups were scheduled in the metropolitan-Atlanta area.

The twenty participant recruits from the metropolitan-Atlanta area were divided up by locations. It was determined that six potential recruits resided close to Dallas, Georgia. An additional seven lived near Marietta, Georgia. The final seven recruited participants lived near the North Fulton County area of John's Creek. A classroom at a local technical college was secured to hold the focus groups at the Dallas location. A conference room at a local technical college was secured to hold the focus group at the Marietta location. The focus group in John's Creek was held in the conference room of a local insurance agent who offered meeting spaces to community members. To schedule the dates/times of the focus groups, first, the researcher secured available dates/times for the meeting spaces. Next, she emailed potential participants a list of three available dates/times. Recruits were asked to provide availability for each date on the list. The date/time with the highest number of available participants was selected for each location.

Six potential participants were recruited for the first focus group, held in Dallas, Georgia (Focus Group 1). Focus Group 1 was held in the conference room of a local technical college at 5:30 PM on a Tuesday in the Spring, 2019. Focus Group 1 had a final sample size of four participants. One of the original respondents was eliminated due to not meeting all of the inclusionary criteria. An additional respondent canceled her participation on the day of the scheduled focus group due to an unexpected personal matter. This event lasted two hours and eight minutes with one hour and forty-five minutes of audio recording of the focus group itself.

Seven potential participants were recruited for the second focus group, held in Marietta, Georgia (Focus Group 2). Focus Group 2 was held in the conference room of a local technical college at 6:00 PM on a Thursday in the Spring, 2019. Focus Group 2 had a final sample size of four participants. Three potential participants canceled their participation due to scheduling conflicts that arose after the date was selected. This event lasted one hour and fifty-eight minutes with ninety-nine minutes of audio recording of the focus group itself.

Seven potential participants were recruited for the third focus group held in John's Creek, Georgia (Focus Group 3). Focus Group 3 was held in the conference room of a local small business at 6:00 PM on a Thursday in the Spring, 2019. Three potential participants self-eliminated their participation due to their full-time employment in the OT field being all at the same OT program. This self-elimination transpired after the focus group had been scheduled. An additional recruit canceled her participation while in transit to the focus group as a result of a family emergency. This event lasted two hours and one minute with one hour and thirty-two minutes of audio recording of the focus group itself.

Focus groups 1 and 2 had a sample size of four participants each. The third focus group had a sample size of three participants. All participants (100%) were of the female gender. This is

not uncommon in the field of OT. According to Data USA, less than ten percent of OTRs (2016a), and about ten percent of COTAs (2016b) in the United States are of the male gender. The researcher attempted to recruit male study participants; however, no male OTPs responded to the recruitment postings/emails, nor were any male OTPs suggested by participants who responded to the final question in the recruitment email asking who else should be contacted for this research project.

Study participants were from all educational backgrounds currently available in OT education (Table 1). The participant breakdown was equitably distributed amongst participants, with approximately 27% of each of three of the four OTP educational backgrounds represented. Three participants (27%) were COTAs and held Associate degrees. Three participants (27%) were OTRs who held bachelor’s degrees. Three participants (27%) were OTRs who held entry-level master’s degrees. One participant (9%) was an OTR who held a post-professional master’s degree, and one OTR participant (9%) held a post-professional Doctorate. Having an equitable distribution of OTP educational backgrounds addresses the concern that participants with the highest level of education value education at a higher level than peers with lower levels of education introduced in research conducted by Landers et al., (2005) and Puetz (1983). The education distribution also indicates that data collection focused on a wide variety of OTP levels within the sample.

Table 1
Focus Group Participants Education Levels

Level of Education	# of participants	% of participants
Associate Degree COTA	3	27%
Bachelor’s Degree OTR	3	27%
Entry Level Master’s Degree OTR	3	27%
Post-Professional Master’s Degree OTR	1	9%
Entry Level Doctorate Degree OTR	0	0%
Post-Professional Doctorate Degree OTR	1	9%

Note. 11 participants were queried regarding their level of Occupational Therapy education.

All participants reported having upwards of 10 years of experience (Table 2). OTPs were required to have a minimum of ten years of experience as a requirement for study inclusion. Research conducted by Landers et al., (2005) set a precedent for using ten years of professional experience as a benchmark for the study of professional development. That ten years of professional expertise provided therapy practitioners with separation from their didactic educations as well as provided the practitioner with a breadth of personal experience with professional development.

Participants in this study reported having ten to thirty-four years of experience as an OTP. Two participants (18%) had higher than thirty years of experience as an OTP. One participant (9%) had twenty-seven years of experience. Two participants (18%) had between twenty and twenty-four years of experience. Three participants (27%) had fifteen to nineteen years of experience, and an additional three OTPs had between ten and fourteen years of experience.

Table 2

Professional Experience of Sample

Number of years as OTP	# of participants	% of participants
10-14 years	3	27%
15-19 years	3	27%
20-24 years	2	18%
25-29 years	1	9%
30-34 years	2	18%
35+ years	0	0

Note. 11 participants queried regarding number of years of experience in Occupational Therapy.

Data Collection

The research data was sourced from the eleven focus group participants. Three focus groups were held in three different geographic areas in metropolitan Atlanta, Georgia. Locations were determined based upon participant's self-identified settings. Focus Group 1 was held in Dallas, Georgia, and included four participants. Focus Group 2 was held in Marietta, Georgia. It also included four participants. Focus Group 3 was held in John's Creek, Georgia, and included three participants. Data collected included audio files of participants answering focus group questions as well as written questionnaires.

For consistency, all focus groups were set up and implemented using the same format. Upon arrival at each focus group meeting space, participants were greeted by the researcher. The greeting included the instructions to self-select a pseudonym to use during focus group participation. Self-selected pseudonyms were added to reduce the likelihood of collecting identifying information of participants during the research. Participants were instructed to refer to themselves using their pseudonym during focus group proceedings and to use the pseudonym on written documents collected during the meeting as well. Participants were then invited to the conference table to select their seat and enjoy refreshments before the focus group's start.

Each focus group opened with the researcher introduced herself and reading aloud the recruitment information related to the research study previously provided to participants during recruitment (Appendix E). Participants were then requested to complete a paper version of the Recruitment Questionnaire (Appendix D) included in the recruitment email using their pseudonyms. Following the completion of the Background Questions, participants completed the Pre-Focus Group Participant Questionnaire (Appendix B). This questionnaire included the definition of professional development used in this research and followed with a series of questions related to the participant's use of professional development. This questionnaire requested participants to create a list of professional development activities in which each participant had participated. Later, participants were instructed to draft a list of reasons for participation in the listed professional development activities and to rank those reasons in order of importance. The researcher collected completed forms and then began the focus group interview.

After paper forms were collected, the researcher began the interview portion of each focus group. This portion was documented using audio recordings. Audio recordings of each focus group interview were created using a portable RCA brand digital audio recorder, and the voice recording features standard on a Samsung S8 cellular device. Recording devices were placed in the center of the conference table, with each device positioned to capture sound from opposite directions. The interview portion began with the researcher turning on both recording devices and then reading aloud the *Research Consent Statement* required by Valdosta State University (Appendix F). Participants each verbally responded with consent after this reading, and the first question began. After all the participants had concluded their answers to the last question, recording devices were turned off, and participants were thanked and dismissed.

Following each focus group, data handling began. Paper documents collected were scanned as PDF documents, then saved into location folders stored on a secure digital storage device. Paper documents were subsequently destroyed. Next, the audio files were prepared for conversion to text files.

First, each audio file on the digital recorder was converted to .wav file using system software included with the recording device. These .wav files were labeled by group location and saved to the secure digital storage device. Audio files captured on the cellular device were also labeled by site and saved to the secure digital storage device using the .wav format. Recordings were subsequently deleted from the source devices after the researcher verified the .wav files had been stored on the secure digital storage device.

Once each file had been securely saved to the digital storage device, the transcription process began. The researcher secured the use of NVivo Transcription (QSR International, 2019) for the conversion of audio files to written transcripts. Each digital recording file was uploaded to NVivo Transcription. NVivo Transcription used artificial intelligence to create written transcripts of audio files (QSR International, 2019). NVivo Transcription provided the researcher with the transcription text, and an included audio recording overlay. Each of the written transcripts from NVivo Transcription was reviewed and corrected for accuracy, and then exported as Microsoft Word files for further analysis.

Data Analysis

Qualitative data analysis techniques were implemented to discover the influence informal learning from a CoP has on the professional development of the OTP in Georgia. A variety of techniques were used, including member checking, open coding, and word cloud analysis. Coding was completed manually by the researcher.

As recommended by Krueger and Casey (2000), the initial general data coding was completed as part of the suggested member checking that took place in the final focus group question in each focus group. During the final moments of the focus group, the researcher recapped what she determined she heard the participants state during the interview. She provided a summary of the overall answer to each question asked in the focus group. Following this, a request was made for participants to correct or confirm the researcher's summary of the focus group.

The transcription of each focus group was completed before the onset of the next focus group to ensure the accuracy of the data collected. The next round of data coding began with the initial transcription processing of each focus group. In addition to replaying the audio files to correct the transcripts, this effort served as the second round of open data coding by allowing the researcher to note general themes that emerged from each focus group.

The researcher began open coding while correcting the digital transcript files created in NVivo Transcription (QSR International, 2019). This process required the researcher to listen to each audio recording and correct errors in the transcription conversion. During the transcription verification process, open coding of data simultaneously transpired. Upon completion of each transcript correction, the researcher made a list of the common threads she believed she had noticed during the correction process.

Following transcript correction, the focus group interview transcripts were processed using Creswell's (2014) method of data review. The focus group interviews were reviewed by the researcher while looking for "clusters of meaning" (Creswell, 2014) or themes that surrounded the use of professional development and the phenomenon of CoP. Each transcript was printed and reviewed by the researcher. Colored pens

were used to notate each time a response linked to a specific word or phrase from the initial list made during the transcript correction process. Separate written notes were made of concepts or overarching themes that emerged from the discussions portrayed in each of the transcripts. Notes were made of the emerging themes for each focus group during the file correction as part of the open coding process. This transcript correction process/open coding process was repeated following each focus group. Each transcription process culminated in a list of themes related to informal professional development relayed by the group's participants.

The transcript, along with the list of emerging themes the researcher determined were relevant from the transcript were then emailed to the participants of each focus group for the second round of member checking. Members of each focus group were asked to review the transcript and confirm their responses appeared to be correct and in context. Members were also provided with the list of phrases that the researcher believed to be most relevant from the discussion transcript. The researcher asked all members to confirm the list appeared to be valid based upon their participation. The members of each focus group responded supporting the transcript provided from the focus group as well as the themes determined as meaningful by the researcher. This process of confirming the interpretation of the data by the research participants supported the validity of the data collected (Creswell, 2014).

After the second round of member checking was completed, the focus group interview transcripts were then combined into one document. In this transcript version, the respondent discussions were combined into one document using question then answer format. This process was repeated for each item. After compiling this larger, master transcript, the document was

printed. The researcher again used manual coding and reviewed this single transcript document using colored ink pens to identify data and categorize the major themes of the combined transcript.

Ranked lists were also collected on the Pre-Focus Group Participant Questionnaire (Appendix B) as part of each focus group. Participants were asked to make a list of reasons in which she participated in professional development. Following the construction of the list, participants were asked to rank the reasons for participation by order of personal importance. Lists were completed and collected at the beginning of each focus group before the interview questions.

In addition to the audio recording transcripts, the ranked lists were compiled and reviewed as part of the data analysis. The data on the ranked lists were used to corroborate information reported in the focus group interviews. In an effort to decrease the influence of potential group thinking, some of the questions were used to corroborate information provided in the focus groups. Specifically, this information included the types of professional development activities in which participants engaged, reasons for participation in activities, and the rankings of the reasons for participation. Question C on the *Pre-Focus Group Questionnaire* related to changing one thing about the professional development experience. Answers reported to this question related to barriers to participation.

These ranked lists were also reviewed for common themes and ranked item importance as part of the analysis of data. To assist with determining the essential topics from the ranked lists, all listed items were collected into one document, and a word cloud was created (Appendix G). The word cloud was created after uploading the combined list of reasons for professional development participation in word cloud creation software on the internet. Cherrstrom et al., (2016) cultivated this research methodology. Word

cloud analysis provided the researcher with a visual depiction of the most common reasons reported by the respondents for participation in professional development. Though “most prevalent” cannot address ranking, it provided insight into the most commonly reported themes. These themes were then cross-referenced with the results of coding from the focus groups. Topics in the ranked lists were consistent with five of the major themes that emerged from the data collected in the focus group interviews.

Six major themes emerged from the data collected. The major themes included participation frequency, interdisciplinary communication, knowledge translation, peer support, and patient outcomes. Additionally, a sixth theme was noted in Focus Group 1 that revolved around future practitioner training.

Research Themes

Five main themes were identified from the research collected in the three focus group interviews and collected in the ranked lists of focus group participants. These five themes were found to influence the use of communities of practice as an informal professional development tool by the Georgia base OTPs studied. The major themes include participation frequency, interdisciplinary communication, knowledge translation, peer support, and patient outcomes. Additionally, a sixth theme was noted in Focus Group 1 that revolved around future practitioner training. Each of these themes details an essential way that a CoP is successfully contributing to the informal professional development of the OTPs studied.

Participation Frequency

The researcher sought to find out how often OTPs participated in both formal and informal professional development opportunities related to their practice of occupational therapy. Research sub-question C specifically addressed this question. Without knowing the frequency of

participation of OTPs in both types of professional development activities, the researcher is unable to adequately determine the prevalence of the involvement in either model.

Informal Professional Development Frequency. For this research, informal professional development activities were defined as activities that included mentoring a peer, being mentored by a peer, peer-to-peer instruction, internet searches, listserv communications, or professional socialization either live or virtually. Research participants in all three focus groups reported their frequency of participation to range from multiple times per day to weekly in frequency. Diamond said, “. . . informal? I love it! . . . I seek it; it is something that I do quite often. Literally . . . on a daily basis, for various reasons”. Madeline reported learning from her OT community “all the time, or at least several times per week” when asked to estimate how many times per year she participated in informal professional development activities.

Beth, who works as a COTA treating children in a school system, conveyed frequently relying on her online CoP. Beth described having limited live access to peers, as she is the only OTP assigned to the school in which she works. As a result, she reported seeking information from the community of OT peers in social media-based groups. She said: “*A nice part about the Facebook group . . . especially if you worked in a facility where you’re the only one . . . I think [is] having the ability to type in a question . . . and get an answer. It just pops up and alerts you when there is a response. I check it daily.*” Ann, who works in an adult rehab setting, reported using virtual communication in the form of text messaging with her CoP due to limited access to peer OTPs as well. “*In my setting, it is the availability . . . the OTs are spread across multiple buildings, and so there’s not a whole lot of face-to-face interaction*”. Ann reported using social media groups and text messages as her most common methods of gaining treatment knowledge from other OTPs.

Sallie Mae also communicated her use of social media groups as part of her CoP. She described being a member of several OT related Facebook groups and interacting with them regularly. She reported, however, finding herself providing information or advice to other OTPs more often than seeking specific information in social media groups. She further communicated that though she provided much information to peer OTPs, social-media groups offer her learning opportunities as well. Sallie Mae stated that “*at least once a week, things will pop up, and I’ll say...now that’s interesting*”. It may not be information she can use immediately, but it is material she has for a later time.

Participants in all three focus groups reported company driven expectations to participate in informal professional development. These reports involved meetings in which colleagues, recently returned from a formal professional development event, informally shared the knowledge gained with his or her peers. Madeline, Sallie Mae, Copperlia, Ginger, Mocha, Jasmine, and Ann all mentioned gaining information from work colleagues during informal presentations dubbed “*Lunch & Learns*.” Madeline spoke of attending five to eight *Lunch and Learns* per year. She further explained that “*we actually do in-services when someone has gone to a course. During lunch, they present to the rest of the group on it, or we’ll have someone come in and speak on a specific topic. It’s not CEU based or anything, it’s informal, just to help enhance our learning,*” she said. Copperlia referred to informal learning activities that happened at her workplace every week at lunch, as well. “*We do have some kind of meeting during lunch on almost every week. It could be about documentation, or whatever topic is of concern*”. Though formats were different, respondents reported these *Lunch & Learns* were informal, peer-driven, and took place frequently.

Participation in Communities of Practice. Research participants were queried regarding the various ways they each participated in CoP. A variety of methods of engagement were reported. All participants who worked shared clinic space with another OTP or interdisciplinary team member reported engaging in face-to-face conversations with members of their work team. This method excluded the two OTPs who reported working alone, and the two OTPs who reported being the only OTP in their therapy department.

All participants (100%) reported using text message or telephone conversations to communicate with various members of their CoP. Text message use was reported to be used by more participants than telephone calls. The same four OTPs who reported working alone also reported using phone calls to peers.

The virtual context also houses CoP. The methods reported by respondents included listservs and Facebook groups. Two participants (18%) reported engaging in listserv communication such as that in AOTA's CommunOT. In addition to the listserv, Facebook groups were popular with the OTPs studied. A variety of Facebook groups exist related to OT, or interdisciplinary rehab science groups (Occupational Therapy/Physical Therapy/Speech-Language Pathology). Nine out of eleven participants, or 81%, reported being members of Facebook based CoP groups.

Formal Professional Development Frequency. Though informal professional development frequency was reported to transpire daily to weekly, formal professional development participation was less frequent. The majority of participants reported formal professional development activity participation to be one to two times per year. This number appeared both on the written questionnaires and in verbal answers provided by focus group participants. Both Opal and Diamond reported their participation in formal professional development activities dropped below one to two times per year if able to attend a multi-day professional conference out of state. Cost of attending out of state, multi-day conferences were reported to be higher than local events, according to Diamond. Opal also informed the researcher that multi-day conferences generated more professional development units than single-day events, therefore requiring her to attend fewer events. This statement related to the requirement for OTPs in the State of Georgia to obtain twenty-four CEUs every bi-annual licensure renewal period via participation in formal professional development activities (State of Georgia, 1976).

Participation in formal professional development was reported to be driven by licensure requirements. OTPs are required to be licensed in the State of Georgia to practice OT. To maintain that license, OTPs are required to complete twenty-four continuing education units (CEUs) per bi-annual licensure renewal period (State of Georgia, 1976). The current state statutes prohibit the earning of CEUs from informal professional development activities in the State of Georgia. Diamond spoke of this requirement when she stated: *“Sometimes it’s frustrating because when it comes to continuing education, sometimes I feel . . . bored-taking classes just to keep my license.”* This led to further discussion that participants reported engaging in CEU activity that was not of interest to them, or class topics not related to the population in which they were currently working to meet the state’s CEU requirements.

Several participants reported having some kind of CEU funding as an employee benefit. One participant described a paid subscription to a service that offered CEU activities online as a benefit. Two participants reported the granting of paid time to attend CEU events that took place on scheduled workdays. Five participants reported having an employer pay for all or part of the cost of attendance at a formal continuing education course. The remaining three participants did not receive any support from their employer for CEU participation.

This employer benefit, it was reported, is not without strings. Copperlia addressed a considerable difficulty with formal professional development: CEU as an employee benefit. She reported receiving funding for the CEU course but also said that *“depending on what company I may be working for; I may not necessarily have a choice in what particular professional development courses I choose. There have been times when I was told ‘no, you cannot do that because it’s not going to benefit a company. You need to choose something else.’ You have to get your CEUs in, so you go ahead with that . . .”*. She further explained that she would be required to personally fund her course attendance and use her PTO balance to attend courses if not approved by her employer. This employer benefit comes with the expectation that employees continue to participate in course topics in which the learner is already familiar to benefit her employer. It also limits the professional’s ability to develop skills in an area of personal interest.

Ginger and Sallie Mae reported that finding live format formal professional development opportunities rather than online courses is becoming more difficult. The State of Georgia’s statutes limit the number of CEUs that can be reported from participation in online courses (State of Georgia, 1976). This rule combined with a decreasing number of live format courses is a concern to participants. Ginger stated that *“actual onsite courses have been harder and harder to find.”* Several participants reported that they used to get advertisements in the mail for local continuing

education courses, but those mailings have declined. Sallie Mae confirmed she has more difficulty as well now stating “*it’s usually . . . a Google search . . . and trying to get it to match up to my schedule and all, that is a challenge*”. Sallie Mae also reported she had increased her Google searching in general, both for formal professional development opportunities as well for informal learning needs.

Interdisciplinary Communication

A second theme that arose from this research was interdisciplinary communication. All respondents reported sharing information with other team members impacting the delivery of care to patients. Interdisciplinary team members mentioned included physical therapy practitioners, speech-language pathologists, nurses, teachers, or doctors.

Opal stated she always desired to speak to the other members of each of her patient’s care teams. In speaking with the PTP or SLP, she reported being able to communicate about common problems and shared goals and discuss how each discipline was addressing them. Mocha summed up her experience with having interdisciplinary team members as part of her CoP as a great way to learn additional information about the patient. Each encounter with a patient provides a team member with one piece of information. Communicating those various bits of information offers all team members a glimpse of the larger picture. Ginger concurred with Mocha and then added her own experience. “*With our team . . . we’ll share [our findings] with the group . . . I think we are real good at problem-solving and learning new things together*”.

Madeline and Mocha both broached the subject of mutual respect concerning interdisciplinary knowledge sharing in their respective focus groups. Mocha shared her thoughts about successful interdisciplinary communication, stating, “*I think, first of all, mutual respect for what other people are doing is important. I mean, I never feel out of place going to another discipline,*

whether it be PT, Speech, Nursing, or guidance from my supervising OT. You know, I think . . . I think those are my resources, and they make me a better therapist and at helping the patient along". Sallie Mae agreed that willingness to learn is essential. Mocha, Ginger, and Beth concurred with Mocha adding that *"you can learn from anyone . . . a patient, a housekeeper, a [certified nursing assistant]"*.

Sallie Mae and Jewels both indicated their desire to seek out interdisciplinary team member opinions and guidance. *"A lot of times, you know somebody else on the team, so they're from a different profession. So somehow, sometimes because they have a different framework, they see it differently. And so, I think that just provides better patient care because, given your different professional trainings, you just think differently. I think sometimes we see things they don't, and they see things to bring to us at times too"* stated Sallie Mae about the interdisciplinary team with whom she works. She later added that she had the joy of working in a department with multiple OTs and PTs with long professional histories in one shared space. The shared space allowed for frequent interactions between therapists, even while performing patient care.

Madeline, Copperlia, and Jewels detailed similar environments in their workplaces. They recalled the benefits of seeing other practitioners deliver interventions. Observing other team members offered additional treatment ideas to the respondents and provided the OTPs the opportunity to see if patient performance changed between practitioners.

Beth, Jewels, and Ann also spoke about seeking out knowledge from team members outside of the OT profession to improve their knowledge, skills, and patient care. Jewels reported seeking out opportunities for participation in interdisciplinary activities. Madeline also said interdisciplinary learning activities were of high importance to her, especially as she transitioned into a new clinical role. Beth spoke about reaching out to a vision therapist to facilitate her skilled intervention with a visually impaired student. Ann mentioned seeking information from an

Assistive Technology Professional (ATP) for a client she was working with at an Assisted Living Facility. The client needed new durable medical equipment to be more independent with her self-care, and Ann needed the guidance of an ATP to select the most appropriate equipment.

Jewels took her desire for interdisciplinary learning beyond informal learning activities that happened organically at work, or by chance. She feels that interdisciplinary knowledge in a CoP is so necessary; she started a therapy networking group explicitly for this purpose. The purpose of the group is to bring PT, OT, and Speech-Language pathology practitioners in the metro-Atlanta area together for monthly professional socialization events. Jewels found limited access to CoPs for many therapy practitioners, particularly in outpatient clinics. *“Almost everywhere that an OT works, there’s only one. Whereas, in a lot of settings there are multiple physical therapists. OT is a lot like Speech therapy; there’s usually only one in each clinic . . . you have to work a little bit harder to build relationships,”* Jewels stated. Participants in her networking group build relationships across many practice areas. They also created a virtual CoP for a member via the group’s social media presence.

Knowledge Translation

A third theme that developed from this research was that OTPs consult their CoP when there is an imminent need for knowledge translation. The World Health Organization defines knowledge translation as closing the “know-do gap” (World Health Organization, 2019). In other words, translating information one has learned to hands-on practice. Informal professional development was the catalyst to close the know-do gap, according to the research participants. This gap could be in the form of knowledge-seeking or knowledge provision.

All participants reported times in which they sought information from a peer as well as times in which their expertise was provided to a peer. Opal explained, *“ . . . a lot of times [speaking*

with a peer] means as much to me as going to a course . . .". She went on to describe the value of having a peer available when she had a knowledge gap. She found this especially valuable as a COTA with an OTR to whom she could direct questions.

Many respondents spoke about the benefits of having a peer immediately available to query when a knowledge gap arose. That peer was able to discuss the issue and provide additional support and education quickly. Jasmine verbalized her thoughts about peer-supported KT by sharing "*when you're doing something in real-time, you're able to . . . try it out and see what's happening . . . It's happening in real-time and has to deal with real patients in real situations*". Conversely, participants also agreed that KT happened much slower when participating in formal professional development. The translation of knowledge to skill after a formal event requires the scenario of the right patient, the right setting, right tools. Respondents reported that members of a CoP were able to respond to immediately, and with the right tools, right context, and the right patient already present.

All participants reported having their own CoP—a private peer to peer network or former colleague who was contacted when knowledge was imminently needed. Jasmine and Opal both mentioned having a "*network of OT friends,*" who Opal further added were "*the people [she] is going to email, text or Facebook message and just be like, 'hey you know, I have a question.'*" Each participant affirmatively responded to further developing their OT knowledge from their peer network.

Some participants reported speaking with current colleagues to gain the understanding or skills required for patient treatment. Jasmine divulged that she uses her CoP more often as she gains experience rather than less often. She stated, "*the older you get, the more, the more people that you revolve around to be able to get information.*" She then went on to cite two recent

examples that required she contact a member of her CoP for patient treatment intervention recommendations.

Copperlia, who works in a large OT department, agreed with Jasmine. She reported that at her facility *“in the clinic, we know when to go to a peer or peers. Just talking about a particular patient that we have, and we try to problem-solve right there. We have people on different [specialty] teams like dementia, cardiopulmonary, stroke, and so we go to that person to get some kind of feedback on what to do. This happens almost every day!”* Her employer has developed a CoP within the OT department, with each team member having a specialty area. Each expert is expected to share his or her knowledge with the team and guide team members while upskilling the team member when the skill possessed are inadequate for the patient care need.

Jewels also reported contacting a former OT colleague for treatment advice before seeing her first patient with facial burns. Jewels did not possess the skills necessary to properly treat the patient on her caseload. She sought help from a member of her CoP with extensive experience in treating burns. As a result of this interaction, Jewels was introduced to the best practices to use on facial burns with a simple phone call. She was also able to share information in real-time and get immediate feedback on the techniques she was implementing from the practitioner coaching her.

In these examples, Jasmine, Copperlia, and Jewels were emphatic that their CoP had a substantial role in filling their individual know-do gaps. The OTPs had patients with specific needs. Needs that each OTP felt inadequate to meet. Each OTP reported gaining knowledge and then applying that knowledge quickly after consulting with a peer expert. No formal meetings were held. Knowledge was transferred by phone or electronic communication that positively influenced patient care.

Several participants also reported engaging in social media groups related to the practice of OT to gain treatment or knowledge application ideas. As discussed previously, social media CoP groups were used by OTPs with more autonomous positions. Facebook Groups, in particular, were mentioned by both OTPs who worked autonomously and those who did not. Opal specifically mentioned their use as a more extensive form of a CoP. She stated, “*there’s a whole bunch of them! There’s like thousands of OT practitioners on there*”. These CoP Facebook Groups include those related to specific patient populations, specific treatment settings, specific treatment interventions, and even OTP students or newly graduated practitioners.

Social Media based CoPs can have greater than ten thousand members. Opal enjoys quick response times in large CoP groups on Facebook. She finds, “*you can literally post a question, and . . . and a couple minutes later you’re going to have some responses and ideas rolling in . . . so that’s pretty cool!*”. Diamond also mentioned Facebook groups and the CommunOT Listserv, to seek knowledge from the broader OT community when she encountered specific situations in the past. The CommunOT Listserv is a membership benefit for AOTA members with threads collected and distributed daily via member email.

The OTPs studied all shared experiences where they, themselves, had knowledge gaps. As Sallie Mae mentioned, it is impossible to know about everything one could potentially encounter. Each OTP has an area of specialization. Some have more than one.

Madeline and Jewels both talked about knowledge sharing with OTPs who were seeking knowledge. Both OTPs recounted the mentoring relationships cultivated with OTPs that were working towards a certification they both already held. In these instances, the knowledge seeker was able to demonstrate knowledge translation quickly by applying the knowledge taught in real-time under the supervision of their peer mentor with real patient interaction and progress measures.

Peer Support

Peer support was the fourth theme that frequently emerged in all three focus groups. Peer support, in the context of health care providers, can be defined “as the giving of assistance and encouragement by an individual considered equal” (Dennis, 2003). The participants in each of the three focus groups broached the topic of peer support as an essential aspect of participating in their CoP. Opal introduced the concept in her focus group by emphasizing the importance of “*knowing that you have other practitioners out there . . . who’s knowledge you can tap into if you need it, and knowing that they have your back and that they’re going to advise you wisely.*” This thought was met with emphatic agreement to which Diamond quickly added: “*and without judgment.*” The concept of having a judgment-free space to express one’s vulnerability and lack of knowledge about something was vital to the OTPs studied.

Jasmine further elaborated about a critical characteristic of peer support- honesty. Honesty in peer support is crucial to the relationship. It was discussed that often in their work, expertise across the breadth of OT related topics is the expectation. Frequently, this is not the case, and OTPs routinely rely on members of their CoP to advance knowledge and skills. It is crucial when improving this knowledge informally that peers are honest about their personal knowledge, skills, and abilities.

Jasmine’s thoughts that “*just the idea that they are going to tell you if they don’t know something . . . they are never going to just tell you something to give you an answer*”, was met with unanimous agreement. This conversation continued with Jasmine stating, “*just realizing that if you don’t know something that they’re asking . . . you . . . you can . . . not, and not feel uncomfortable as well saying that you don’t know it*”. Opal then opined that “*there’s that level of respect between*

peers that it is ok to not know and it's OK to know. Like you were saying, there's not any judgment".

Peer support discussions centered around judgment as well as honesty. In terms of judgment, the emphasis from the respondents revolved around a *lack* of judgment in peer support experiences. This idea went hand in hand with honesty. Respondents reported peer support to be unique in that it provided a place to express their concerns, emotions, and needs related to providing OT related services. Jewels summed up the group's opinion stating it was essential to have a *"peer group or network that you [felt] like you [could] ask questions of them, and they're not going to judge you-not too harshly, but help guide you and correct you."* In her focus group, Copperlia spoke about her peer support being non-judgmental as well. She added supporting a peer meant *"... making sure you have that sense of being, of humility, you know, and knowing that I guess we are all in this together, are ready for that patient, for the profession."*

Patient Outcomes

The final theme that surfaced from this research was the use of CoP to advance patient outcomes. Improved patient outcomes were reported as a motivator for participation in all types of professional development. Patient outcomes are measured in various ways. At its core, OT related patient outcomes can be defined as the change in performance that occurs between the onset and discharge of skilled OT services (Institute of Medicine of the National Academies, 2010). It can also be viewed as the impact the OT services provided had on the patient.

The most commonly reported theme chronicled in this study was the use of a CoP to increase or enhance hands-on skills for the improvement of patient outcomes in OT treatment. Participation in professional development is an expectation of the field of OT (American Occupational Therapy Association, 1999; State of Georgia, 1976). Study participants exemplified

this expectation. Sallie Mae referenced using her personal CoP because she was motivated to improve the quality of life of the patients with whom she worked. She stated, “*we have a moral obligation as therapists . . . we are trying to find ways that we’re going to provide the best care possible!*”

Mocha agreed with Sallie Mae’s appraisal of the moral obligation of therapists to provide care that impacted the patient’s outcome. Mocha further reported that she sought new information and novel techniques from peers of all disciplines” to *get the patient more mobile, or standing longer, or getting transferred better . . .*”. Sallie Mae stated that she believed that her peers provided her with the information needed to provide better care. Other participants reported similar beliefs about their CoP. Sallie Mae further explained that even the peers that had professional opinions that differed from her challenged her thinking and sometimes her therapeutic approach. She expanded on that thought by stating her peers get her to “*just open [her] mind to think of it all a different way . . . because I mean, at the end of the day, it’s all about the best patient outcomes*”.

This theme also included sharing knowledge with less seasoned practitioners. Copperlia expands upon this idea. She found herself refining her skills and sharing her expertise with practitioners who have more recently entered the field. “*Now it’s more about trying to improve my skills, trying to comprehend the change in healthcare climate, a more complex patient, and I think as a seasoned therapist who . . . who’s been in the industry for a few years it’s making sure I understand the complexity of stuff in order to guide the younger therapists out there . . .*”, Copperlia stated.

Participants agreed that supporting less seasoned practitioners in their selection and use of OT interventions was important. Many reported still needing guidance themselves from time to time to provide the best patient outcomes. Despite having over ten years of experience, it was not

uncommon for participants to encounter patients whom they were unprepared to treat. As a result, the CoP was consulted. Jasmine said that she often contacted members of her personal CoP whenever she encounters a patient or condition that she has not worked with previously. She stated, “. . . I’m afraid I’m going to miss something . . . so, it’s just, give me anything that you can to make sure I’m actually doing the best I can for this patient”.

Opal related Jasmine’s experiences with desiring to impact patient outcomes to her recent experience as a new adjunct instructor for a local OTA program. She spoke of working with the full-time and other part-time faculty to ensure that she was interpreting grading rubrics correctly as well as that her expectations of the students were appropriate for their learning. She summed up her experience with collaborating for improved outcomes by stating, “*having another practitioner in there with me is always really cool. It’s like having a second brain!*” Other participants concurred with her “second brain” sentiment. Copperlia also received a unanimous agreement with her statement that “*you know you just want to make sure everyone gets to his or her fullest potential!*”

Future Practitioner Training

A sixth theme that emerged from Focus Group 1 is future practitioner training. Though student supervision itself is considered a formal professional development activity, for this study, participants discussed the informal learning that takes place while supervising students. Several respondents reported learning about new, updated treatment information, theory, or evidence-based practice from the students they are supervising for fieldwork. Additionally, a respondent reported the importance of learning to accept that she was not all-knowing and that being all-knowing was not expected. Sallie Mae summarized the group’s thoughts by stating, “*you have to be willing to admit when you are unsure...you never know everything*”. Ginger further explained, “*the students are learning new things that we might not know about, so, you have to always keep an open mind*

that...maybe you just don't know, and they can teach you something". Mocha concurred with this agreeing she supervised OTA students to assist with keeping her skills up and to "learn things that they didn't teach us when I was in OTA school thirty years ago."

Further, it was discussed that informal professional development also takes place when working alongside students from other disciplines, such as Physical Therapy. Madeline and Mocha both reported increasing their knowledge about a specific patient after co-treating a patient with a Physical Therapy student and the subsequent interdisciplinary discussions that followed the treatment. Ginger concurred and reported that working alongside a PTA student while problem-solving a client's need assisted her with developing a piece of adaptive equipment and increasing the patient's independence.

Summary

This chapter contains the results of the data analysis resulting from the phenomenological study of eleven Georgia based OTP's use of CoP for informal professional development. Three focus groups were conducted and coded to determine the central themes of this phenomenon. Additionally, demographic questionnaires and ranked lists were collected from research participants to contribute to the data analysis.

As indicated when conducting phenomenological research, the data were manually coded by the researcher. Initial general data coding was conducted during the conversion of audio files to transcripts. The second round of general data coding was completed after the transcripts were correct and exported. Thematic coding was then conducted using all three focus group transcripts to identify the six themes reported in this chapter. Member checking, as suggested by Lincoln and Guba (1985) and Krueger and Casey (2000), was introduced at several points as well to facilitate validity and to reduce groupthink.

The Proficiency Theory of adult learning was used as the theoretical framework for this research study. Proficiency Theory indicates that adult learners will seek out training when it is noted that there is a lapse in needed skill, or proficiency (Knox, 1980). When this theory is applied to the research questions of this study, it is found that proficiency theory is congruent with the main themes indicated through analyzed data. The themes found in this study related to participating in CoP parallel the adult learner's theoretical need to obtain additional training. The OTPs studied reported participating in CoP due to having the immediate need to be more proficient in skilled delivery of OT services. Members in their CoP provided the information needed to increase their proficiency in skilled OT service delivery.

The six themes stemming from this study summarize the influences informal learning in a CoP has on the professional development of OTPs in the state of Georgia. Those themes include participation frequency, interdisciplinary support, knowledge translation, peer support, patient outcomes, and future practitioner training. OTPs reported using their CoP daily to weekly in their quest to improve patient outcomes, learn from future practitioners, support peer learning both in and outside of the OT field, and to meet imminent KT needs of the participants studied. The training of future practitioners was also included as an informal professional development influence. Chapter 5 consists of the impact evaluation and summary of findings related to these six themes.

Chapter V

CONCLUSIONS

The purpose of this phenomenological study was to understand and describe how OTPs in the state of Georgia utilized CoP as a method of informal continuing professional development. This chapter includes a discussion of the noteworthy findings related to the use of CoP as well as an Impact Evaluation related to the perceived value of CoP on the informal professional development needs of OTPs in Georgia. This chapter concludes with a discussion related to the limitations of the study, future research areas, and a summary.

This chapter encompasses the discussion of, and future research possibilities related to the following research question and sub-questions:

Research Question: How does informal learning in a Community of Practice influence the professional development of Occupational Therapy practitioners in the state of Georgia?

Sub-Question A: How do informal learning opportunities influence the knowledge translation of Occupational Therapy practitioners in the state of Georgia?

Sub-Question B: What are the prevailing attitudes and values of Occupational Therapy practitioners in Georgia toward learning from a Community of Practice?

Sub-Question C: With what frequency do Occupational Therapy practitioners in the state of Georgia participate in formal and informal professional development activities?

This phenomenological study found multiple themes related to how informal learning in a Community of Practice influences the professional development of OTP in the state of Georgia.

Explicitly, six themes were identified. They included participation frequency, interdisciplinary communication, knowledge translation, peer support, patient outcomes, and future practitioner training. Additionally, barriers were also identified and briefly discussed by participants. These themes provide a greater understanding of how informal learning in a CoP influences the professional development of OTPs in the state of Georgia.

Interpretation of the Findings

Occupational Therapy is an Allied Health profession in which the use of everyday activities, also known as occupations, are performed as interventions to assist people across the lifespan to engage in activities that they want or need to do in order to live a fulfilling life (American Occupational Therapy Association, 2017c). OTPs must have graduated from an accredited program of study and successfully completed a national certification exam before applying for licensure in the state in which the practitioner plans to practice OT. Each state has its own laws governing the practice of OT. These laws include the scope of practice in which an OTP can engage, the number of years the license is valid, requirements to renew the license, licensure fees, and professional development related regulations (American Occupational Therapy Association, 2019). The state of Georgia requires that each OTP it licenses complete twenty-four hours of formal CE credit bi-annually for licensure renewal (State of Georgia, 2017). Because the state of Georgia's professional development requirements only applies to OTPs licensed in Georgia, this study limited its focus to participants who were OTPs licensed in Georgia.

This research study used focus groups to study the phenomenon of the CoP as a means of informal professional development for OTPs in Georgia. Eleven participants were interviewed through focus groups and written questions during the course of this research. Though research participants hailed from various locations, a myriad of practice areas, had diverse practice interests,

and an assortment of experience levels, six key themes were identified as factors influencing the use of professional development in a CoP by OTPs in Georgia. Each theme indicated how OTPs used their personal CoP as an informal professional development tool.

Communities of Practice (CoP) are defined as “groups of people informally bound together by shared expertise and passion for a joint enterprise” (Wenger & Snyder, 2000, p. 139).

Ranmuthugala et al. (2011a) added that CoPs are “a group of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise on this area by interacting on an ongoing basis” (p. 1). Each participant in this study indicated that she had a personal CoP in which she consulted for various reasons.

CoP were reported to meaningfully impact the informal professional development of the OTPs interviewed in this study. CoP were called upon by participants a minimum of weekly. Some respondents reported consulting with their CoP daily or even multiple times per day. Respondents reported their CoP were primarily composed of previous OT colleagues, classmates from post-secondary training, current OT colleagues, mentors, as well as former and current colleagues in other disciplines. These CoP members were accessed in a variety of ways, including face-to-face conversation, telephone calls, email correspondence, or text message exchange. Some of the OTPs studied also engaged with virtual CoP through the AOTA Listserv: CommunOT, or through CoP groups on Facebook. The major influencing factors that arose from the use of CoP to facilitate professional development are discussed in the following pages.

Participation Frequency

Formal professional development participation

Sub-Question C specifically queried the frequency OTPs in the state of Georgia participated in formal and informal professional development activities. Respondents

reported participating in formal professional development activities one to two times per year. These activities were further reported to be predominantly driven by the need to meet licensure requirements. This ranking position placed the need to fill a knowledge gap below the need to meet licensure requirements by respondents in this study.

In the State of Georgia, OTPs are required to complete twenty-four formal continuing education units that meet specific criteria every biennial licensure renewal period (State of Georgia, 2017). As a result of this requirement, OTPs studied reported in their ranked lists that though the course topic was a consideration, more important considerations for selecting formal continuing education opportunities included the number of CEU hours earned by attendance, associated costs, and geographic location. Participants did indicate that they sought out formal learning opportunities that were of interest to them. This reason, however, was not one of the top three ranked reasons on the list.

These findings substantiated reports from the Institute of Medicine of the National Academies (2010), which found that continuing professional development in healthcare focused on meeting regulatory requirements more frequently than filling personal knowledge gaps. The United States Agency on International Development (USAID) reported in its September 2012, Technical Brief, that participation in PD that stemmed from meeting regulatory requirements, such as mandated CE hours, was an ineffective CE methodology (United States Agency on International Development, 2012). The USAID report expanded, affirming that nurses studied who had mandated CE requirements ended up taking courses that did not directly correlate to their specialty to ensure CE regulations were met. This resulted in nurses with the requisite CE hours; however, they did not also

demonstrate increased clinical competency in their roles from this participation. The correlation to this pattern can also be made from the reports made by the OTPs studied. They are meeting the regulatory requirement for hours, but not necessarily increasing their clinical competence in the process.

Participants who received CEU benefits from employers did report weighing topic choice more heavily than participants who did not receive employer funding for formal CEU participation. Funding included travel expenses, CEU event registration fees, and paid time off for attendance. These participants further explained that attendance at these formal events required the event topic to be something of benefit to the employer or patient population of the employer. This requirement precluded the OTPs from selecting CE of interest to their personal professional development goals if their goals were divergent from their current employer. This finding aligns with reports from the Institute of Medicine of the National Academies (2010) in which it was detailed that in the health care fields studied, the focus is on CE. CE has a narrow focus that confines the practitioner's learning to a narrow scope of didactic courses.

Participants in this study reported receiving less employer support for professional development compared to earlier in their OT careers. Participants Copperlia, Sallie Mae, and Madeline all reported receiving funding from their employer to attend a formal CE event in the past year. Only three of the eleven participants reported their employer-provided CE resources, such as time off for participation or funding. This question was not asked explicitly in the focus groups; however, at least one participant in each focus group mentioned participating in employer-sponsored activities in some way. Each participant who received CE benefits from their employer also reported working full-time for one of the large hospital groups in the metro-Atlanta area.

This information is consistent with previous literature indicating that the facility provided professional development resources are trending down (Coffelt & Gabriel, 2017; Viljoen et al., 2017). The decrease in employer-sponsored CE is placing a greater burden on OTPs to locate and fund CE courses required to maintain licensure. It can be inferred that with this increased financial and time burden, OTPs are focusing more on the price and location of CE offerings rather than the content and its relation to personal knowledge gaps when seeking formal professional development opportunities.

Informal professional development participation

One of the gaps in literature found during this research was related to participation in informal professional development activities by allied health practitioners, including OTPs (Anderson, 2001; Clarke, 2005; Janssens et al., 2016; Skule, 2004). This includes the informal professional development tool known as CoP. CoP are considered to be a social learning processes by which groups of people who share a common interest collaborate in an effort to increase the professional practice of the group members (Jeffs, et al., 2016; Johnson et al., 2015; Li, et al., 2009; Wenger, 1998; Wenger & Lave, 1991; Wenger & Snyder, 2000).

Research participants were provided with a definition of informal professional development before the query of questions related to it. Participants were then asked about their frequency in participation in the informal professional development activities defined. Respondents reported the frequency of participation to range from multiple times per day to weekly in occurrence. This participation occurred both in person and in the virtual context with similar regularity. Participation was often opportunistic, and participants serve both as an information seeker and an information giver.

Respondents also reported informal learning that took place outside of the workplace. Several participants mentioned participating in topic-specific OT groups on Facebook or in the CommunOT listservs hosted by the AOTA. Participation in these virtual groups combined professional learning with entertainment and socialization. All participants who reported engaging in a virtual CoP participated in the groups outside of working hours partially for knowledge exchanges and partially for socialization purposes. Being a group member in a virtual OT related CoP falls under the umbrella of professional socialization introduced by McKinstry et al., (2009). These researchers found professional socialization afforded therapy practitioners the opportunity to discuss treatment interventions ideas with others as well as assist with identifying areas of need for expanded skill or education in an informal way outside the confines of the workplace.

Nine of eleven participants, or 81%, reported having a virtual CoP through participation in social media groups/listservs. This high percentage supports research conducted by Nguyen in 2015. He hypothesized that more learning would be taking place in the virtual realm after identifying a trend that more educational material was shifting to the virtual environment. His research further found no significant difference in learning that took place in the virtual versus face-to-face environments.

This evidence supports previous research related to accessing informal professional development by healthcare workers. USAID (2012) reported that engaging in informal professional development, such as participating in a CoP, is an “essential aspects of the healthcare worker’s professional development” (p. 1). As reported by OTPs, USAID reported that many times, these informal interactions are spontaneous interactions stemming from a bout of self-reflection by the practitioner to increase his or her professional currency. Practitioners who have

greater access to healthcare peers benefit from having more opportunities to interact with their peers resulting in more frequent spontaneous learning moments (Ndedge, 2006).

Conversely, practitioners in smaller practices have fewer opportunities to develop a CoP. McNamara (2007) concluded that virtual communication is linking these practitioners to a broader peer community and increasingly linking healthcare workers into a more substantial CoP with whom to knowledge share. This information could account for the variations in CoP participation by OTPs. Some participants worked in larger rehab departments with constant access to peers. Other participants held positions in which she was the only OTP or even only rehab professional at her place of employment. OTPs studied also reported using the virtual context as their CoP. Some respondents reported supplementing their face-to-face interactions with listservs and interactions in Facebook groups. Others reported interacting in the virtual context almost exclusively for CoP interactions.

Interdisciplinary Communication

The second theme that emerged from this research was interdisciplinary communication as a form of informal professional development. Past research on interdisciplinary teams in healthcare has indicated that the team-based approach to health care delivery is superior to the individual approach (Kuziemy, Borycki, Purkis, Black, Boyle, et al., 2009; Mato & Woolley, 2016). The American Medical Association Journal of Ethics published research reporting that interdisciplinary healthcare teams maximized patient care outcomes via the shared intelligence that stems from practitioners framing each patient's need through their specialty's lens. Previous research has further demonstrated interdisciplinary communication has been proven to elevate the knowledge and skills of health care providers working in a team above the level of a lone practitioner (Institute

of Medicine Committee on Quality of Health Care in America, 2001). The respondents support these findings.

The saying that *it takes a village* would be apropos with this theme. Study participants divulged numerous ways in which they learned from professional peers in other disciplines. Though Physical Therapy practitioners and Speech-Language Pathologists were the most commonly discussed, doctors, nurses, and certified nursing assistants were also frequently mentioned as essential team members with whom to communicate. Study participants indicated that it took all of the team members, holistically to address the patient's safety, goals, and outcomes. It was believed that almost every conversation between two team members uncovered more pertinent information or assisted in reframing a problem.

The findings of this study support the historical literature findings of interdisciplinary communication being an integral part of the OTP's CoP. Lysaght et al.'s 2001 findings indicated that peers in the workplace were perceived to be an essential source of information and support (p. 33). Coffelt and Gabriel's 2017 research also found interdisciplinary teams to be relevant to the development of clinical competence. Their findings support the assertions of study participants that much informal learning happens through interdisciplinary teams both in structured team meetings and organically during the workday. Respondents reported having interdisciplinary team members in their CoPs. These team members were considered to be the norm rather than the exception to the norm by respondents. With the rising population of aging patients entering the health care system, coupled with the rise in treatment of chronic illnesses, therapy practitioners will become more reliant on the members of their interdisciplinary teams (Kuziemy, et al., 2009). The OTPs studied are acutely aware of the benefit of having interdisciplinary team members in their CoP, as well as

the multi-pronged approach to patient treatment required to optimize the patient's care and outcomes.

Knowledge Translation

Knowledge Translation (KT) emerged as the third theme of this research. KT, as defined by the Canadian Institute of Health Research (2017), is the process of moving knowledge from an education/research product to implementation by the user. In other words, how quickly one applies knowledge gained from a learning activity. This study concluded from historical literature from Anderson (2001), Fisher (2000), Institute of Medicine of the National Academies (2010) and Lysaght et al., (2001) that participation in formal CE activities does not automatically equate to KT. In fact, KT relies upon health care professionals having the right set of circumstances to use new learning after participating in a formal learning activity. Only two of eleven respondents reported quick KT conversion after a formal CE event. These two respondents, however, worked predominantly with specific patient populations and attended formal CE events related to such.

Informal learning activities are reported to have a higher perceived rate of KT than formal learning activities (Anderson, 2001; Institute of Medicine of the National Academies, 2010; le May, 2009). The OTP participants in this research study supported these findings. All participants reported using their CoP to fill their personal *know-do* gap when an immediate need arose. Information related to the use of the CoP to assist with KT was one of the most reported data points analyzed in this study. Research conducted by Khoddam, Mehrdad, Peyrovi, Kitson, Schultz, et al., (2014) indicates that Health Care and KT are both a “social process” (p. 4) that requires the building of relationships in order to exchange information. This definition further supports the need for CoP by OTPs in order to exchange the knowledge needed to deliver high-quality OT services.

OTP participants reported consulting their CoP when lacking the knowledge to treat a patient, or when desiring additional knowledge to supplement treatment interventions currently utilized. One participant even light-heartedly named her CoP the *brain-trust* that she contacted on a daily or weekly basis to further refine her clinical skills. The respondent group as a whole reported using their CoP on a daily to weekly basis to augment personal knowledge. Despite having at least ten years of experience, all OTP respondents reported that regularly, patient needs fell outside their personal skill/knowledge base, and immediate new learning was required to treat a patient. Having access to a CoP provided opportunities to gain knowledge and translate that knowledge for instantaneous use. Conversely, participating in a formal professional development activity would require the OTP to find and locate an event that could be weeks or even months into the future—likely well after discharging the current patient from OT services in the first place.

Peer Support

A fourth theme that developed from this research was the topic of peer support. Peer support from the CoP partially addresses research sub-question B: *What are the prevailing attitudes and values of Occupational Therapy practitioners in Georgia toward learning from a community of practice?* All participants found their CoP necessary and placed value in it. One surprising area of peer support that developed from this study related to the psychosocial value of the peer support gained from a CoP. Multiple participants spoke about being able to share ideas in an environment where she would not feel judged, could admit she did not know something and felt she would be built up rather than torn down. The feeling of being vulnerable was common enough to be mentioned organically in each of the three focus groups.

The participants of this study did not differentiate between which peers—either former colleagues, virtual peers, peers within the current OT department, or the larger interdisciplinary

rehab team. Peer support closely aligns with interdisciplinary communication. To that end, it was used by the OTPs studied to share knowledge, ask questions, and gain feedback. The comments related to knowledge sharing were consistent with Swap et al.'s (2001) research that indicated that workers ask for information to assist with increasing job performance from others in the workplace (p. 99). This same concept has been found to apply to emotional support in the workplace.

Research conducted in the nursing field has found an essential link between peer support in the healthcare workplace and patient outcomes. Franciscan Missionaries of Our Lady University (2017) reported that inadequate peer support following a stressful event could lead to additional patient harm. Having a peer support system, face-to-face or virtual allows for peer to peer interactions and emotional support that facilitate stress management, feelings of grief, frustration with the health care system, or feelings of inadequacy when the healthcare provider is unable to facilitate an improved patient outcome.

It is of concern that the participants verbalized the importance of having a safe space as an outlet to feel vulnerable. The implication here can lead one to think that OTPs desire more opportunities for peer support. This topic is being studied in the nursing field, but similar studies in the allied health professions have not been found. Johns Hopkins University Hospital has created a program of peer support for nurses who have experienced distress after an adverse patient event in the hospital (Franciscan Missionaries of Our Lady University, 2017). OTPs also have concerns about the care they are delivering to patients. They too may benefit from a formal peer support program.

It can also be inferred that OTPs spend so much time and energy applying their therapeutic use of self to optimize the patient's outcomes, that it is taking a toll on the OTP. Therapeutic use of self can be defined as a "therapists' conscious effort to optimize their interactions with clients"

(Taylor, Lee, Kielhofner, & Ketkar, 2009, p. 198). When an OTP must consistently present herself as an expert in patient care, there is little room for the self-care and vulnerability needed to prevent compassion fatigue (Smith P. , 2017). Compassion fatigue is considered to be a moral injury that results from a health care worker internalizing the traumatic events of others (Smith, 2017). The American Institute of Stress, (2019) identified peer support as an essential aspect of managing compassion fatigue. A CoP has an inherent value of also being a community of peer support.

Patient Outcomes

Patient outcomes were the fifth theme that emerged from the data collected in all three focus groups. Improved patient outcomes were reported as a motivator for professional development participation by research participants. Literature consistently states the purpose of continuing professional development is to improve patient outcomes (Anderson, 2001; Clarke, 2005; Coffelt & Gabriel, 2017; Fisher, 2000; Institute of Medicine of the National Academies, 2010; Lysaght et al., 2001; Viljoen et al., 2017). The most recorded theme by participants was to consult peers to increase or improve hands-on skills for the purpose of improving a patient's outcome in OT treatment.

Ross et al. (2013) found that professional development that was mandated resulted in a focus on hours needed for legislative purposes, not on patient outcomes. The participants who responded to this study about using a CoP, however, reported improvement in patient outcomes as the main reason for participation in a CoP. Conversely, the same group reported regulatory requirements as the main reason for participation in formal CPD.

Ultimately, the other themes uncovered in this research all relate back to patient outcomes. The frequency of participation, interdisciplinary communication, knowledge translation, peer support, and even future practitioner training all relate to improving patient outcomes. Moon

(2004) alleged that the attitudes of health professionals equated to their effectiveness. Specifically, those health professionals who were intrinsically motivated to perform their job had the best outcomes. Participants in this study described their internal motivation to increase patient outcomes by using the resources or *brain trust* of their CoP. Research conducted by Jeffs et al. (2016) further substantiates this assertion with research that emphasizes that health care professionals who use CoP to bridge their *know-do gaps* improve the clinical care they deliver as well.

The Institute of Medicine of the National Academies (2010) affirmed that continuing education expectations were created with the ultimate goal of “helping healthcare professionals provide the best possible care, improve patient outcomes, and protect patient safety” (p. 3). This is the same edict that the National Advisory Commission on Health Manpower (1967) gave with the recommendation that all healthcare professionals participate in activities to further develop clinical competence after exiting post-secondary training. There is much evidence indicating that formal professional development activities are falling short of this goal. The use of informal professional development, such as participating in a COP, by study participants focused almost exclusively on activities related to improving patient outcomes. This form of CPD, however, is not being tracked or supported by the regulatory agencies in the OT profession.

Future Practitioner Training

Future Practitioner Training was the final theme emerging from this research related to CoP. This topic was present in one of the three focus groups. This topic was raised frequently enough; however, it was deemed a critical impacting factor of CoP use. Participants reported having a sense of duty to teach future practitioners who were at their facilities participating in experiential learning activities. Though student supervision is considered a formal professional development activity, participants divulged their feelings of duty related to assisting in the education

process of students who were being supervised by other OTPs, or other disciplines such as Physical Therapy, Speech-Language Pathology, or nursing. This concept falls in line with the AOTA Code of Ethics (American Occupational Therapy Association, 2017a) principle of fidelity in which OTPs have an ethical duty to support others in their learning. This ethical duty can be applied to other students in the profession, patients, caregivers, or student practitioners in other fields.

A critical aspect of being a life-long learner that can be applied to this research is that life-long learners develop an “expertise in learning to learn” (Collins J. , 2009, p. 616). To this end, the OTPs studied recognize that as experts in their field, they must not only have a strong foundational knowledge base; they must continue to build professional currency. Professional currency is built upon by exposure to new and different information, skills, and resources. This new learning content is being provided by students to OTPs who recognize that personal learning can take place through a collaborative relationship with a student.

Research conducted in the field of social work supports the idea of students teaching practitioners in the same clinic. Beddoe, Ackroyd, Chinnery, and Appleton (2011), detailed the collaborative relationship between students and clinical instructors in which the student learned from the practitioners, but also the students taught other practitioners while present. It was believed by research participants in the study conducted by Beddoe et al. (2011), as well as respondents in this study that students coming out of classes had more recent exposure to didactic materials including guest lectures, field trips, and lecture/lab-based on more current theory than what was current when practitioners were in school. This is especially common when students complete their experiential learning with practitioners who completed their post-secondary education before a notable change related to the field. Specifically, with OTPs who studied the AOTA’s Uniform Terminology (American Occupational Therapy Association, 1994), which has since been replaced

by the Practice Framework (American Occupational Therapy Association, 2017d), or the 2013 release of the DSM-V (American Psychiatric Association, 2013), which replaced the DSM-IV-TR (American Psychiatric Association, 2000). These changes spurred fundamental changes to how aspects of OT are documented, practiced, and reimbursed. These changes also prompted textbook revisions, new program accreditation standards and new concepts for teaching students of the OT profession.

Implications for Proficiency Theory

Malcolm Knowles, an expert in adult learning, or Andragogy, held the belief that adult learning is intrinsically motivated by the needs of the learner (1970). Proficiency Theory is an adult learning theory developed by Knox, that built upon Knowles assertion by stating that internal motivation escalates when a gap is noted between one's current aptitude and the desired level of proficiency required to perform (Institute of Medicine of the National Academies, 2010; Merriam et al., 2007). Proficiency theory is also one of the learning theories that serve as the foundation for many forms of professional development offerings.

The results of this research demonstrate that the use of CoP by the participants is entrenched in Proficiency Theory. The OTPs studied repeatedly reported that they consulted the members of their CoP when their current aptitude did not meet the patient's needs in an attempt to gain a higher level of skill. This process stemmed from the desire to increase professional currency to that required for optimal patient success. OTPs, being self-reflective, were keenly aware when they needed to be making improvements in the delivery of skilled therapeutic interventions and, ultimately, patient outcomes.

As documented throughout this study, an identified potential patient care deficit resulted in a CoP consultation. Respondents reported that these knowledge transfers took place on a daily to

weekly basis within their CoP and that KT was immediate as well. OTPs reported using the new information gained during the patient's next appointment. This report is vastly different from what the literature states regarding KT in formal, didactic CE. The literature indicated that KT in formal CE did not happen immediately, and may not have ever taken place due to the lack of immediate patient availability (Coffelt & Gabriel, 2017; Institute of Medicine of the National Academies, 2010; McKinstry et al., 2009; The Lewin Group, 2008; Wheeler & Chisholm-Burns, 2018). Based upon the results of this study, the data related to the OTP's participation in CoP operationalizes the proficiency theory of adult learning. The participants reported that a needed gain in proficiency was the main motivator driving the contact of their CoP.

Impact Evaluation

An Impact Evaluation was conducted to determine the perceived quality and value a CoP has to the OTPs who participated in this study. Due to the qualitative nature of this research, the *perceived* value reported by participants was evaluated. Impact Evaluations are appropriate evaluation tools to employ when there is a need to understand the impact of an intervention (Better Evaluation, ND). The criteria for an impact evaluation include measuring the impact, both positive and negative, that are produced by the intervention being evaluated. This includes direct and indirect effects as well as the intended and unintended effects (OECD, n.d.). Further, sustainability is to be addressed. The OECD (n.d.) indicates that sustainability must mean environmental sustainability and financial sustainability sources from local resources.

The OECD (n.d.) and Better Evaluations (n.d.) listed key evaluation questions (KEQs) that should be answered by an impact evaluation. For the purposes of answering these questions, *the intervention*, as listed in the questions below, will be considered a CoP. The KEQs that can best be applied to this evaluation include:

KEQ2: How well was the intervention implemented and adapted as needed?

KEQ6: How valuable were the results to the service providers, clients, the community, and or organizations involved?

KEQ7: To what extent did the intervention represent the best possible use of available resources to achieve results of the greatest possible value to participants and the community?

KEQ8: Are any positive results likely to be sustained?

(Better Evaluation, n.d., Table 3)

KEQ2 questions how well the intervention was implemented and adapted as needed. By definition, a CoP forms from “groups of people informally bound together by shared expertise and passion for a joint enterprise” (Wenger & Snyder, 2000, p. 139). As such, they are fluid and organic, with members entering and leaving the community as their professional needs change. Respondents each reported having a personal CoP composed of current and past OTPs and other interdisciplinary members when needed. These CoP members were consulted as needed. CoP use stems from the need to increase KT or to gain peer support with an overarching effort to positively impact patient outcomes. Multiple participants also reported being members of online CoP that were specific to various OT related topics. These online groups connected each OTP with thousands of other OTPs with whom they could interact.

The unstructured on-demand style of CoP consultation is what drives this method of informal professional development for the OTP. It has been determined that the use of CoP that meets the specific needs of the OTP user is exceptional in terms of implementation and adaptation. Access to one’s CoP is virtually unlimited, with OTPs accessing their CoPs in a variety of ways (face-to-face, text message, email, telephone, facetime, social media post, listserv entry, etc.).

Adaptations happen naturally as the needs of the community members change. Members can switch from information seeker to provider as topics change. The relationships in CoP are more clustered responses than linear responses, as answers gained from the membership are reported to come from those members with the correct experience to respond.

KEQ6 deals with the construct of value to the service providers, clients, community, and organizations involved. For this research, the value was reported by participants, and therefore is captured as a perceived value rather than a quantitative value measurement. Participants reported their personal CoP was invaluable. More value was assigned to the OTP's CoP than more formal professional development methodologies. Participants opted to consult their CoP on a daily to a weekly basis to address deficits, or to add to the information needed for team communication, KT, peer support, and to improve patient outcomes.

It is surmised that the perceived value of a CoP by the OTPs who participated in the study would carry over to benefit clients, community members, and organizations involved. As discussed in the findings, participating in a CoP was reported to improve patient outcomes. Patient outcomes are driving forces in the health care organizational arena, the public/community health arena, as well as the individual therapy practitioner/client relationship. In fact, the Center for Medicare and Medicaid Services has just changed its reimbursement model in October 2019 to be driven by patient outcomes.

KEQ7 addresses the use of CoP as a representation of the best possible use of available resources to achieve the results of the greatest possible value to participants and the community. OTPs have an ethical duty to provide evidence-based interventions to their patients/therapy participants (American Occupational Therapy Association, 2017a). As a result of this, health care organizations should expect some of each OTP's day to be spent on non-billable activities related to

developing treatment interventions. OTPs reported engaging with their CoP both during work and during personal time. Some participants in a CoP share knowledge as a professional obligation as well as participating in CoP as a form of personal entertainment and fulfillment.

With the various methodologies employed to consult one's CoP, OTPs can access their personal resources with a limited impact on their productivity. Frequently, participants reported asynchronous communications rather than face-to-face communications that took place synchronously. CoP members accessed their communities when it was convenient for the individual members. Additionally, no CoP studied had required membership dues or fees for accessing the community members. The lack of financial cost and asynchronous communication are indicators that the financial resources lost engaging with a CoP are minimal.

Furthermore, if practitioners are sharing updated patient data or healthcare information, with an interdisciplinary team, for example, this CoP use is a necessary and expected part of the workday. Opportunity costs were also incurred as multiple OTPs reported engaging with CoP, including social media-based CoP as entertainment. Financial costs, however, were negligible, as there are no direct financial costs to the informal learning gained from a CoP. Patients and other stakeholders benefit from the KT reported by OTPs during treatment interventions. CoP fills a prominent KT gap that is not easily replaced by formal professional development activities that also come with higher financial and opportunity costs for both the OTP and her employer.

The final KEQ addressed in this impact evaluation relates to the sustainability of positive results. In speaking with the participants related to this research, there is no indication that the practice of consulting a CoP for informal professional development will be slowing down or stopping any time soon. The virtual environment is exploding with new methods to engage with OTPs around the country and even the world on an ongoing, as-needed basis.

CoP practice groups can be found on many social media platforms, including but not limited to Facebook, LinkedIn, Twitter, YouTube, Tumbler (Ventola, 2014). Additional opportunities to engage in a CoP are arising from online communities and membership-based services such as the CommunOT for OTPs who are AOTA members and the GOTA Listserv for OTPs who have active GOTA memberships. Ventola (2014) found that social networking sites are continuing to expand with more medically focused CoP entering the virtual space each year. He further found that costs for these sites were minimal to participants “with financial support often being provided by professional associations, advertising or data sales, research funding, and pharmaceutical companies” (p. 491-492). Further, virtual CoP groups are composed of members from around the world. This indicates that these groups are not limited by time zones or geographic area. It also provides an almost limitless exposure to recently published evidence-based research. The expectation is that the use of CoP in live and virtual formats will be beneficial to practitioners as well as self-sustaining for the foreseeable future.

It has been determined that the use of CoP as a vehicle for professional development is having an important impact on the respondents who participated in the study. OTPs studied reported having used informal, readily available resources in CoP to improve their delivery of patient care by speeding up their translation of evidence-based knowledge to application, improving their communication with team members, and offering support in a manner not supported by the literature surrounding formal professional development activities. All of these reported activities ultimately come under the larger purpose of professional development-to positively impact professional development.

Limitations

Though this researcher firmly believes that qualitative research was the best choice for the conduction of this study, there were some limitations. The phenomenological approach was selected to begin exploring the concepts of informal professional development, CoP, and how they are used by the OT community within the state of Georgia. As a result of this method, the results cannot be generalized to the larger OT population in or outside of Georgia. The data compiled from this study can catalyze future related quantitative research.

A second limitation of this study was the abandonment of two of the three geographic areas initially intended for this study. The research was initially designed to take place in three geographic regions around the state of Georgia (Atlanta Metro Georgia, Augusta, Georgia, and Albany, Georgia) based upon the density of OTPs in those areas. Though a variety of recruitment methods were attempted, less than two potential volunteer respondents were collected at the Augusta and Albany, Georgia locations. As a result, they were abandoned, and three different locations of the Atlanta Metro area were used instead. A broader participant pool may have resulted in more abundant data or greater insight or resulted in additional data themes.

A third limitation of this study is the total number of participants. Though this study was qualitative, a larger sample group may have contributed to a broader, more vibrant collection of data. The intended sample size for each focus group was targeted at a minimum of six participants. In reality, the sample sizes for two focus groups were four, and the final focus group has a sample size of three participants.

A fourth limitation with the methodology executed for this study is the reporting of *perceived* benefits and *perceived* improved patient outcomes by respondents. OTPs who participated reported their personal perceptions of experiences with improving patient outcomes as

a result of consulting their CoP. These improvements in patient outcomes were not substantiated by patients themselves.

Recommendations for Further Research

Several areas for future research have been identified to add to the findings of this study and begin filling gaps in the literature related to the OTP's use of CoP as informal professional development. Firstly, more research is needed on the use of informal methods of professional development in the field of OT, as well as healthcare in general. Secondly, a systematic review of the potential impact of informal professional development participation in other healthcare professions would be beneficial to the OT community. An additional focus on tracking methodologies of informal professional development in OT and other allied health fields would facilitate practitioners' understanding of how and when they learn. Not only was the use of and need for a tracking system for informal professional development activities discussed in the 2018 GOTA conference, but many of the research participants in this study also requested a way to measure and track users as well.

This Qualitative data revealed how CoP are used and why they are used with a small number of respondents (n = 12). Future study of the use of informal professional development using quantitative or mixed methodologies would be beneficial to add credibility and strengthen the data uncovered with this study. Further, now that we know the reliance of the sample group on their CoP, it would be beneficial to develop research tools to measure the effectiveness of CoP and informal learning in the general OTP population. These results could then be compared to formal professional development activities.

An additional area for future research that arose from the conduction of this study stemmed from the sample group's inclusionary criteria. Members of this sample required ten or more years

of experience for participation. As a result, both new, and early-intermediate practitioners with zero to ten years of experience have not been studied related to their participation in CoP. This subgroup of OTPs may employ CoP use differently than their intermediate to advanced practicing peers.

Supplementary research is also needed related to the use of virtual CoP. A large percentage of participants in this study reported participating in virtual CoP, such as those found on Facebook. These virtual communities are easily accessible to OTPs. These groups are often composed of a network of hundreds to thousands of members across the globe which has the potential to greatly expand the network to which an OTP is exposed when compared to the CoP they have developed personally.

Participants in this research study reported using the CoP to fill gaps in their skill set, and to maintain professional currency. A question also arose related to using the members of CoP to validate knowledge and skills already in one's possession. This idea was not specifically reported. It could be inferred however, that members of a community of practice use each other to corroborate their planned interventions or even their psychosocial interactions with other peers, patients, and caregivers. This is an area of study that could be further researched.

It was difficult to facilitate the thinking of participants in the focus groups related to informal professional development activities. They reported having a difficult time recognizing the activities discussed as forms of professional development. This idea is following literature related to various types of PD (Pettersson et al., 2015). This theme indicates a need for the development of a formal measurement tool to capture informal learning activities that are also professional development activities.

The 2018 GOTA Annual Conference and Business meeting included the formation of a task force in October 2018, to investigate types of informal professional development, including

developing a system for tracking participation for CE credit with the State Licensure Board. To date, no additional information about this task force has been reported, nor meetings held with taskforce volunteers. This research could serve as the catalyst for the GOTA Research Committee to begin working on additional related areas, including a larger-scale study to determine the membership's understanding of informal professional development activities and their participation in the various common types. This information could then be used to assist with the updating of licensure requirements for the Georgia State Board of Occupational Therapy in upcoming years.

Conclusions

This research found that CoP have a positive impact on the immediate learning needs of the OTPs studied. It is further indicated that CoP are also central in the social support structure of the OTPs studied. This research study sought to explore how the informal learning that takes place in CoP is perceived to influence the professional development of a group of OTPs in the State of Georgia. This concept was further unpacked to address the frequency of use, KT that transpires when consulting a CoP, and the prevailing attitudes related to the use of a CoP by OTPs in the State of Georgia.

In addition to the conclusions above, the results of this study pose the following findings:

- Participants in this study had at least one CoP in which they participated
- CoP substantially impacted the professional development of OTPs studied on a daily to weekly basis
- Participants engaged in their CoP in a variety of ways
- CoP were composed of a variety of members from the OTPs experiences
- Participation in CoP is multifaceted
- CoP are used to maintain professional currency

- CoP are used for routine knowledge translation
- CoP are used to gain/provide peer support
- CoP demonstrate the proficiency theory of adult learning to improve patient care

The participants in this study had at least one community of practice in which they participated regularly. Many respondents reported engaging with more than one community. Participants engaged in their CoP regularly and reported that their CoP were a substantial part of their practice of OT. CoP use was reported to be a minimum of one time per week and up to multiple times per day. The membership of the CoP reported by the participants were reported to be composed of current and past colleagues, former classmates, team members from other disciplines (both current and past), mentors, mentees, professional organization members, or even virtual strangers who have OT related knowledge to share in the virtual environment.

Participation in CoP is multifaceted. OTPs served as both the seeker of information and as well as a topic expert as discussions changed. OTPs used these discussions to develop their consciousness of craft and to stay current on the topics required by their everchanging patient caseloads. When an OTP noted a gap in her craft, rapid knowledge translation took place allowing the OTP to seek and find new information to apply.

The overarching rationale for engaging in a CoP was to influence patient outcomes. OTPs reported participation in CoP for a variety of reasons, all of which revolve around improving some aspect of their patient's care. Whether the CoP was live or virtual, inclusive of well-known current/past colleagues, or virtual strangers on social media, the interactions were valued. Participants were bound together by their shared interest in and knowledge of the OT profession.

The use of CoP aligns with Wright's (2012) research that quantified that OTPs have a consciousness of craft that requires practitioners to understand what is required of them to be a

member of the profession (p.12). This consciousness includes knowing when additional knowledge or training is required. She further theorized that consciousness of craft frequently developed in non-formal learning activities. The development of current day consciousness of craft can be attributed to the frequency of use of a CoP. Participation frequency was one of the research questions, as well as a key theme that was identified. Participants reported using their CoP network with much higher frequency than formal professional development opportunities. It was reported that formal professional development events were attended one to two times per year, but a CoP was used weekly, and sometimes daily. Participants indicated that the frequency of participation in the CoP was multi-faceted. Sometimes they were the ones seeking knowledge, but other times they were the knowledge sharer instead. This concept segued well into additional themes that emerged from this study.

When addressing the prevailing attitudes and values of the OTPs who participated in this study toward learning from a CoP, it was determined that the CoP(s) one develops and engages in are highly valued by the OTPs studied. Precisely, themes related to interdisciplinary communication and the informal side of future practitioner training were uncovered as important constructs that developed out of one's CoP. Knowledge and idea exchanges were common examples shared between practitioners as a bolster to patient outcomes. The peer support experienced by being a member of a CoP was also highly valued by study participants. Peer support and communication between practitioners are findings that appear to be missing from the literature related to OTP participation in formal, didactic professional development activities.

The final research question addressed the influence of KT of the OTP when participating in informal learning opportunities such as CoP. The Proficiency Theory of adult learning is what leads the OTP to participate in informal learning and consultation of a CoP. Practitioners operating

with a deficit in the professional currency identify a skill gap. The literature related to formal professional development consistently indicated that formal professional development opportunities are failing to ensure KT needs are being met. Formal professional development activities are not always available when needed. A CoP is filling this gap. CoP members are both seeking information when needed and providing knowledge in an on-demand format to the under-skilled practitioner. This on-demand style of learning allows for information to be translated from knowledge to application almost instantaneously. This could be in real-time with CoP members engaging synchronously, or in a more asynchronous format, as is common to virtual environments. Either way, the skill deficit is mitigated in a short time.

Conversely, common barriers reported for participation in formal professional development events included scheduling, cost, and availability of the course in one's geographic area in a timely manner. This type of scheduling slows down KT as a multitude of factors influence the OTP's ability to access and apply formal learning (Anderson, 2001; Coffelt & Gabriel, 2017; Lysaght et al., 2001). It is not surprising that as a result, OTPs ranked participating in formal CE events in order to meet licensure regulatory requirements highest on the list of reasons for participation. This is higher than increasing patient outcomes, skills deficits, or personal interest in the topic.

Ultimately, the use of formal professional development and informal professional development activities such as CoP by OTPs all traced back to the theme of patient outcomes. Patients are the reason OT is in existence. Treating patients and having each patient leave, having remediated his or her skill deficits is the end goal of the OT intervention process. All of the participants in this study reported that the driving factor for seeking information from their CoP was to improve the outcome for one or more patients. Each participant could provide a specific example

of when she had last done this. Each participant emphasized how important it was to have a CoP from whom she could request patient-specific intervention information. This concept is well reported as the intended purpose of professional development in healthcare (Institute of Medicine of the National Academies, 2010; Institute of Medicine Committee on Quality of Health Care in America, 2001; National Advisory Commission on Health Manpower, 1967). Unlike formal professional development, the use of informal professional development, such as a CoP, has now been formally identified as a positive influencing factor in improving patient outcomes.

It is becoming commonplace for payor sources to reimburse for services based upon patient outcomes (Center for Medicare & Medicaid Services, 2019). Improving patient outcomes was the driving force for the National Advisory Commission on Health Manpower (1967) to recommend a continuing education system for healthcare providers in the first place. Evidence from the Institute of Medicine of the National Academies (2010) indicated that patient outcomes were not being improved through the use of formal professional development activities. The Institute of Medicine of the National Academies further stated that research must be conducted related to CPE in healthcare to determine what works and what must be strengthened. Five best practice quality goals were developed by the Institute of Medicine of the National Academies in 2010 to help improve the CPD efforts in healthcare. The results of this research study show parallels with three of the five goals.

Specifically, the Institute of Medicine of the National Academies addresses goals with a focus to provide patient-centered care, to work in interprofessional teams, and to employ evidence-based practice (p. 45-46). The informal professional development activity of being a member of a CoP has been found to powerfully impact the skills, communication, knowledge translation, and peer support of the OTPs participants queried. Addressing these areas has culminated in these same

participants reporting their CoP membership, ultimately impacting patient outcomes. As healthcare shifts to be more outcomes-driven, it is time to also shift the focus of CPD to those activities that are reported by consumers such as OTPs to have the greatest impact on patient outcomes. Informal professional development has been around since learning has been measured. Now is the time for informal professional development tools such as the CoP to be formally recognized in the healthcare professional development community.

Final Thoughts

In conducting this research, there was a degree of expectation related to several of the findings of this study. There were also a few unexpected findings. As an OTP conducting research with other OTPs, I was surprised to discover the theme of peer support in this research. The OTPs studied reported it was vital to have a place to be vulnerable and divulge weaknesses or knowledge gaps. This surprised me, as I did not realize how common it was to feel that as an OTP one had to be an expert at all times in front of stakeholders.

The participants also spoke about the peer support being free from judgment and their reliance on this judgment-free space. This too was surprising as I had not previously thought about needing a space such as this in my delivery of OT services. I reflected on this idea and realized that I had this type of space in my own CoP but had not actualized this as a benefit. Though this finding is thought to not directly related to informal professional development, CoP definitions do include emotional support as part of the definition of the shared experience (Ranmuthugala, et al., 2011b). Additionally, the peer support provided in mentoring a fellow OTP can be viewed as incidental learning, in which the support is a by-product of the mentor-mentee relationship itself.

An unexpected finding was the altruistic nature of the OTPs studied for this research. Though participants do have an ethical duty to be lifelong learners and to teach future

practitioners, the level of support demonstrated by research participants was the genuine desire to support their peers, both current and future. Several respondents spoke about participating in virtual CoP as a form of entertainment, not just as a format for addressing a gap in their current knowledge needs. The use of CoP for entertainment included the desire to share knowledge with others who are essentially strangers in the virtual CoP. These knowledge exchanges are more or less the giving of one's personal knowledge to an anonymous screen name. There is no expectation of reciprocation nor gratitude on behalf of the knowledge recipient. This leads this researcher to believe the benefit of this exchange for the OTPs studied is the selfless concern for the welfare of an unknown patient or other OTP.

If the opportunity arose to conduct this research again, a few changes would be made. I would change the recruitment method in an attempt to gain a larger sample size from a larger geographic area. In order to gain a broader and deeper sample of OTPs in Georgia, I would time recruitment efforts with the annual GOTA conference in the fall of each year. This would provide the opportunity to directly reach a larger target audience in one location, face-to-face.

The second change I would recommend would be to conduct a focus group pilot study. This would serve two main goals. It would provide the researcher the opportunity to pilot the focus group format itself; and adjust accordingly. It would also provide an opportunity to test the focus group questions with a group of people rather than just a single pilot interview. This would allow for the questions themselves, delivery style, or question order to be adjusted to fit a group discussion.

A third change I would implement is to include more information regarding the definition of informal professional development and communities of practice. The participants in this study had difficulty with the concept of informal professional development, despite being provided with a

working definition at the start of each focus group. It is more difficult to discuss a concept with a group of people when that group of people has limited exposure to the working concept of the research.

A final change I would make would be to lengthen the research window and add an additional set of meetings. I would have the first round of focus groups mirror those conducted for this study. The questions would largely focus on informal professional development and formal professional development in general. Following the focus group interviews, I would provide additional information related specifically to communities of practice. Participants would then be requested to return in four to six weeks and participate in a second focus group specifically targeting their experiences with their CoP since the last focus group. All of the changes combined has the potential to provide a richer pool of data for analysis.

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APPENDIX A

APPENDIX B

Pre-Focus Group Participant Questionnaire Sample

Professional development is defined as activities that provide the individual with opportunities to improve his or her competence, skills, knowledge or effectiveness. Formal professional development includes but is not limited to organized education events such as lectures, continuing education classes, presentations, supervising a fieldwork student or online courses. Informal professional development includes but is not limited to mentoring a colleague, being mentored, peer to peer instruction (in person, writing, or virtual), internet searches, listserv communications, professional socialization (i.e., lunch breaks or happy hours, etc.)

- A. Based on the definition above, what types of professional development activities do you participate in/have you participated in?

- B. What was your most favorite learning activity since entering the OT profession? Why was it your favorite?

- C. If you could change one thing about your experience with professional development, what would it be?

- D. Why did you participate in the activities listed above in question A?

After you have created a list of participation reasons, please rank those reasons in order of importance, using a numerical order of 1 being most important and the largest number being least important.

APPENDIX C

Focus Group Questions Sample

[Map the territory Questions]

1. What motivates you to participate in continuing education/professional development?
2. Tell me about your experiences with obtaining professional development.
3. In what ways/How do you value your continuing education training/professional development?

[Read to the group prior to asking the next questions]

Remember that Professional development is defined as activities that provide the individual with opportunities to improve his or her competence, skills, knowledge, or effectiveness. Formal professional development includes but is not limited to organized education events such as lectures, continuing education classes, presentations, supervising a fieldwork student or online courses. The following questions are going to focus on your experience with informal professional development. Informal professional development includes but is not limited to mentoring a colleague, being mentored, peer to peer instruction (in person, writing, or virtual), internet searches, listserv communications, professional socialization (i.e. lunch breaks or happy hours, etc.) Are there any questions?

CoP Questions:

4. How many times per year do you participate in *FORMAL* continuing education/professional development on average?
Follow up: How did you participate? Live, Face to Face? Online? Distance Learning? Etc,
5. How did you typically select the professional development/continuing education in which you participated?
6. Why do you use this method of professional development?
7. How would you prefer to participate in continuing education/professional development?
8. Why do you/don't you participate in your preferred method?
9. How Many times per year do you participate in *INFORMAL* professional development?
Follow up: How did you participate? Live, Face to Face? Online? Distance Learning? Facebook groups?

10. Tell me about a time in the last week where you either sought or provided professional knowledge with another practitioner?
Follow-up: How often does this happen?
11. What does peer support mean to you?
12. What factors contribute to a successful knowledge exchange between your peers?
13. How do you feel that you apply what you learn from your peers (nonformal learning activities) to your work?
Follow up: How soon after this learning do you apply and use the information?
14. Tell me about a time in the last six months that you needed to learn about how to better care for a specific client (no identifying information, please).
Follow up: How did you gain the needed knowledge?
Follow up: What delivery format was used for this?
15. How would you describe the value of the information you get from your peers during informal learning activities?
16. What barriers do you have to participating in peer knowledge exchange?
17. Is there anything you would like to add that I did not ask?
18. Recap answers heard during a focus group for first round of member checking.

APPENDIX D

Participant Recruitment Questionnaire Sample

Please reflect your interest in participation by returning answers to the following questions to Amy Shaffer, COTA/L, principal investigator at alshaffer@valdosta.edu

1. How long have you been employed in the field of Occupational Therapy?

2. With what level(s) of practitioner education have you practiced OT? Choose all answers that apply.
 - a. COTA
 - b. OTR with Bachelors
 - c. OTR with entry-level Masters
 - d. OTR with post-professional Masters
 - e. OT with entry-level Doctorate
 - f. OTR with post-professional Doctorate

3. In what geographic area do you reside?
 - a. Metro Atlanta (within 60 miles/60 minutes of Atlanta)
 - b. South Georgia (within 60 miles/60 minutes of Albany)
 - c. Eastern Georgia (Within 60 miles/60 minutes of Augusta)
 - d. Other: _____

4. Have you ever worked as an OT practitioner outside the state of Georgia?
Yes
No

6. Is there anyone else you think we should ask to participate in this research?
Name/contact info:

APPENDIX E

Participant Recruitment Email Sample

Dear Occupational Therapy Practitioner,

Valdosta State University Department of Adult and Career Education is seeking Registered Occupational Therapists OR Certified Occupational Therapy Assistants who are currently licensed in the state of Georgia and have ten or more years of experience in OT to voluntarily participate in a research study. The purpose of this study is to examine the experiences OT practitioners have with Communities of Practice as a form of professional development.

Participation in this study involves:

- Completing a short, written form related to your most recent professional development experiences
- Participation in a live 90-120-minute Focus Group with other OT practitioners
- Coming to one of three focus group locations (Marietta, GA; Augusta, GA; Albany, GA)

Information collected via this research study is for the sole purpose of fulfilling the requirements for a doctorate degree through Valdosta State University's Adult and Career Education department. The principal investigator is not affiliated with NBCOT, AOTA, GOTA, any employer, nor the Occupational Therapy licensing board for the state of Georgia.

Questions regarding the purpose or procedures of the research should be directed to Amy Shaffer at alshaffer@valdosta.edu. This study has been approved by the Valdosta State University Institutional Review Board (IRB) for the Protection of Human Research Participants. The IRB, a university committee established by Federal law, is responsible for protecting the rights and welfare of research participants. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 229-253-2947 or irb@valdosta.edu.

Thank you,
Amy Shaffer, COTA/L
Principal Investigator

Study Title: *Asking for a Friend: The Phenomenon of Communities of Practice as Professional Development for the Georgia Occupational Therapy Practitioner*

APPENDIX F

Researcher Consent Statement Sample

(to be read aloud by the researcher at the onset of each focus group prior to engaging participants in the first focus group question)

You are being asked to participate in a focus group as part of a research study entitled, “Asking for a Friend: The Phenomenon of Communities of Practice as Professional Development for the Georgia Occupational Therapy Practitioner,” which is being conducted by Amy Shaffer, a *student* at Valdosta State University. The purpose of the study is to better understand the use of peer to peer teaching and learning as a tool for professional development by occupational therapy practitioners. You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about how informal professional development impacts the practice of occupational therapy. There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life. Participation should take approximately 90 minutes. The focus group will be *audio and videotaped* in order to accurately capture concerns, opinions, and ideas that are offered by the group. Once the recordings have been transcribed, the tapes will be destroyed. No one, including the researcher, will be able to associate your responses with your identity. Your participation is voluntary. You may choose not to participate, to stop responding at any time, or to skip any questions that you do not want to answer. You must be at least 18 years of age to participate in this study. Your participation in the focus group will serve as your voluntary agreement to participate in this research study and your certification that you are 18 years of age or older.

Questions regarding the purpose or procedures of the research should be directed to Amy Shaffer at alshaffer@valdosta.edu. This study has been exempted from the Institutional Review Board (IRB) review in accordance with Federal regulations. The IRB, a university committee established by Federal law, is responsible for protecting the rights and welfare of research participants. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 229-253-2947 or irb@valdosta.edu.

APPENDIX G

APPENDIX H

CITI Program Completion Reports

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2 COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

• **Name:** Amy Shaffer (ID: 5900204)
• **Email:** alshaffer@valdosta.edu
• **Institution Affiliation:** Valdosta State University (ID: 475)
• **Institution Unit:** Adult & Career Education
• **Phone:** 6784670542

• **Curriculum Group:** Human Research
• **Course Learner Group:** IRB Basic
• **Stage:** Stage 1 - Basic Course
• **Description:** This course is suitable for Investigators and staff conducting SOCIAL / HUMANISTIC / BEHAVIORAL RESEARCH with human subjects. The VA module must be completed if you plan to work with subjects at a VA facility.

• **Report ID:** 21125327
• **Completion Date:** 10-Oct-2016
• **Expiration Date:** 10-Oct-2019
• **Minimum Passing:** 80
• **Reported Score*:** 97

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• **Name:** Amy Shaffer (ID: 5900204)
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• **Curriculum Group:** Human Research
• **Course Learner Group:** IRB Basic
• **Stage:** Stage 1 - Basic Course
• **Description:** This course is suitable for Investigators and staff conducting SOCIAL / HUMANISTIC / BEHAVIORAL RESEARCH with human subjects. The VA module must be completed if you plan to work with subjects at a VA facility.

• **Record ID:** 32408222
• **Completion Date:** 23-Aug-2019
• **Expiration Date:** 22-Aug-2022
• **Minimum Passing:** 80
• **Reported Score*:** 89