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Increasing Hospitalists' Understanding of Occupational Therapy Services in Acute Care: An Initial Continuing Education Workshop

Author(s)

Colleen Craven, OTD, OTR/L

Jessica D. Asiello, OTD, OTR/L

Author Contact Information

Colleen Craven

colleenmarycraven@gmail.com

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Abstract

Background

There is a paucity of continuing medical education (CME) on collaboration with occupational therapy (OT) in the hospital setting, which could contribute to patient re-admissions and suboptimal functional outcomes. Authors developed and evaluated a CME workshop aimed to increase hospitalist knowledge on the role of OT to improve the appropriate use of OT services.

Methods

A one-hour virtual workshop used a train-the-trainer, Adult Learning Theory-based approach to educate hospitalists on the role of OT. Pre-/post-surveys evaluated physician knowledge of OT and perceived appropriateness of OT consults. An audit of the patient census assessed effects on consulting behavior.

Results

Eleven hospitalist participants in a large urban medical center demonstrated a directional, however not statistically significant, increase in knowledge of OT *(p*=0.18 and triangulated with qualitative content analysis of open-ended survey responses). Fifty-eight percent reported they would increase consults for OT services. The number of patients on the OT census did not demonstrate change (*p* = 1.0). Twelve OTs reported a 5% increase in appropriateness of consults following the workshop (*p* = 0.26).

Discussion

This workshop was an innovative approach to CME with aim to increase hospitalist knowledge on the role of OT. Hospitalists were engaged in the workshop process and interested in a top-down approach for education. Results suggest that a CME workshop was an appropriate education approach to sharing knowledge of OT services and provide an opportunity for post-professional interprofessional collaboration and learning.

Keywords: continuing medical education, hospitalist**,** internal medicine, interprofessional collaboration, interprofessional education, occupational therapy

Background

Nearly 30% of all occupational therapy practitioners (OTPs) in the United States work in hospital settings, and yet the realized value of OTPs and their critical role in improving patient outcomes and quality of care is routinely overlooked. While OTPs touch nearly every aspect of the patient care continuum –from admission to recovery and discharge– gaps in teamwork, interprofessional communication, and collaboration point to ongoing social and systemic issues in acute care settings. Central to these issues is the important role that physicians play in understanding, communicating, and collaborating with OTPs (American Occupational Therapy Association [AOTA], 2017; AOTA, 2020; Leland et al., 2015; Lyon, 2020).

Eighty-three percent (83%) of physicians can identify OT as the profession that performs activities of daily living (ADLs). However, only approximately one-third of physicians can identify the role of OT in additional domains such as cognition, upper extremities, and vision. And concerningly, 30% of physicians are not familiar with OT and only 29% report referring to OT (Abu Tariah et al., 2012; Feldman et al., 2010; Metwalli, 2003). Consequently, suboptimal collaboration with OTPs increases the risk of patient re-admissions, length of stay, inappropriate referrals, decreased quality of care and patient satisfaction, and poor functional outcomes (DePalma et al., 2013; Krumholz et al., 2013; Reeves, 2016; Roberts & Robinson, 2014; Rogers et al., 2017).

Despite these identified knowledge gaps and consequences, there is a paucity of continuing medical education (CME) opportunities for physicians to increase knowledge about hospital-based OT, as well as when to appropriately consult for OT services (Abu Tariah et al., 2012; Britton et al., 2015). There are several factors contributing to the

identified knowledge gap including lack of post-professional interprofessional education (IPE) opportunities. Additionally, poor communication and collaboration amongst interprofessional colleagues, OTPs' lack of confidence in advocating for their profession, and the historical hospital hierarchy within the medical model contribute to the gap.

Lack of Interprofessional Education

IPE during medical school supports an introduction to interprofessional, collaborative practice, and the standards and assessment during medical residency provide oversight for developing skills and knowledge. However, once reaching attending-level physician, there is no requirement for CME regarding interprofessional care and such opportunities for development are sparse despite identified gaps in preparedness for practice (Accreditation Council for Graduate Medical Education, 2020; National Research Council and Institute of Medicine, 2004; Reeves, 2016; World Health Organization, 2018). Team members who are expected to work together should have ongoing opportunities to collaborate, communicate, train, and learn together (Britton et al., 2015; Hobbs et al., 2010; Weller et al., 2014).

Poor Interprofessional Collaboration and Communication

Productivity and efficiency demand limit the time available to thoroughly and effectively communicate roles and, consequently, result in feelings of being undervalued, underutilized, and misunderstood. This misunderstanding creates ambiguity between allied health professionals resulting in inappropriate use of services (Britton et al., 2015; Kingston et al., 2019). Increasing communication and collaboration between interprofessional team members, especially physicians and OTPs, results in

increased satisfaction of and respect for one another, decreased hierarchical disparity, improved patient care, and improved transfer of information between providers, patients, and care plans (Grissinger, 2017a; Shiri, 2006; World Health Organization, 2018).

Confidence in Advocating for the Profession

Acute care OTPs understand their distinct value in the hospital, but often report feeling poorly- or mis-understood (American Occupational Therapy Association, 2015; Cohn, 2019). OTPs lack confidence in promoting the profession and explaining the value of participating in ordinary tasks in new or modified ways. Documenting this important uniqueness is challenging in a system that historically operated on objective measures, reimbursable services, and shortened lengths of stay in the hospital. However, within hospital standards, there is increasing emphasis on the direct relationship between patient functioning and quality care, and OT is well positioned to adapt to this change (Cohn, 2019; Mroz et al., 2015). As OTPs, we must increase confidence in ourselves, educating others, and advocating for our role in the acute care setting despite varying models of care and perceived hierarchies.

Medical Model and Hospital Hierarchy

Historically, rather than treating a person holistically, health systems have been pressured to operate in a medical model that diminishes the importance of meaningful occupations and patient-identified goals. This reductionism consequently minimizes OTPs opportunity to impact patient care and discharge planning (Britton et al., 2015). Additionally, pressure for productivity and prioritizing length of stay has resulted in cost cutting measures, decentralized focus on quantity over quality of care, and

disincentivizes a focus on function (Abu Tariah et al., 2012; Britton et al., 2015; National Research Council & Institute of Medicine, 2004; Shiri, 2006).

Furthermore, hospital settings have operated hierarchically, with physicians at the apex. This superiority has created distinctive communication and collaboration styles, practice methods, theories, and power dynamics (Grissinger, 2017a; Grissinger, 2017b). Medical students have ranked their profession higher in autonomy, training, respect, trust, and competence and have prioritized their job duties while reporting less reliance on other professions (Reeves et al., 2002; Rose et al., 2009). To challenge this hierarchy, facilitate growth, and institute change, appropriate behavior, respect, and collaboration must be modeled in a top-down approach to encourage interprofessional synergy and best practice (Johnson, 2017; Rose et al., 2009; World Health Organization, 2010).

Existing Attempts to Improve Physician Knowledge of Occupational Therapy

Most existing attempts to address the knowledge gap of physicians' understanding of the role of OT are provided pre-professionally. Oldenburg et al. (2020) implemented an educational workshop for fourth year medical students. The workshop was facilitated by an occupational and physical therapist and the goal of the workshop was to increase medical students' exposure to rehabilitation services prior to entering the hospital setting. The students' level of knowledge increased as did confidence for placing referrals, however, the education took place pre-professionally and does not demonstrate a post-professional transfer of knowledge.

West et al. (2016) found the most common interprofessional education, representing 93% of collaborations, occurs between medical and nursing students.

Conversely, 64% of schools coded OT as “other disciplines,” which generalizes allied health professionals and enables role ambiguity. Additionally, the authors discussed limited long-term monitoring and evaluation of education received in medical school that is expected to be applied upon entering acute care practice. The study also emphasized that most IPE focuses on the role that physicians play on care teams rather than educating on the role of additional team members (West et al., 2016). Beyond classroom initiatives, the World Health Organization’s “Framework for Action on Interprofessional Education and Collaborative Practice” (2010) describes actions steps to facilitate interprofessional practice at the system-level including creating policies that encourage post-professional learning, supporting professionals in developing new roles and models of care, and facilitating environments to share best practices and successes.

Physicians are identified as having the narrowest lens and poorest understanding of OT services, in combination with the greatest authority and influence in the hospital setting; therefore, addressing knowledge gaps can serve as a catalyst to optimize interprofessionalism, care, and collaboration. The influences of when and where education occurs is critical to consider because practice and application at the pre-professional level varies considerably from implementation and prolongation at the post-professional level. Experienced attending-level physicians are more specialized in patient diagnoses, familiar with institutional operations, and adept at understanding the continuum of care. Therefore, it is imperative to provide CME opportunities. This quality improvement project was a one group, pretest-posttest design to evaluate if a one-hour CME workshop, led by an occupational therapy practitioner, achieved the aim of

increasing attending physician understanding of OT in the hospital setting to improve appropriate OT consultations for patients on the medicine service.

Methods

Setting and Participants

The workshop took place in a large, urban, teaching hospital with ~100 hospitalists and 12 OTs on staff. It was offered in the context of a monthly CME event series. Participation in the workshop was open to all hospitalists and recruitment took place via email and word of mouth by the Director of Hospital Medicine Continuing Medical Education. Inclusion criteria for physician participation were attending-level physicians on the medicine service. There was no requirement for prerequisite knowledge nor years of experience as an attending. Exclusion criteria were physicians from other specialties and those not yet attending-level practitioners.

Workshop Description

The workshop was deemed quality improvement by Mass General Brigham's Institutional Review Board in 2022. The workshop was conducted virtually by an experienced OT during a one-hour time slot allocated for CME. A train-the-trainer approach encouraged knowledge dissemination to facilitate practice change in the attending-level physician participants, and subsequently impact their junior house staff including residents, interns, and medical students. Guided by Knowles' (1970) Adult Learning Theory (ALT), the workshop was designed to maximize engagement and increase motivation to acquire and apply new knowledge into practice and education. The Rehabilitation Treatment Specification System (RTSS) (Van Stan et al., 2019) was

applied to design key ingredients of the CME workshop and theorize the mechanisms of change for collaboration and consultations (Figure 1).

Figure 1

Specification of the Education Workshop on the Role of OT, Developed Using the Rehabilitation Treatment Specification System (RTSS)

Key Ingredients		Mechanisms of Action, Guided by Adult Learning Theory	Target
Learning Goals	The **objectives** aligned with hospitalists' teaching and learning goals.	**Increasing motivation to learn:** If the course objectives are aligned with the learning goals of the participants, then the teaching intervention will be most effective.	Increased knowledge
Reflection Activities	**Initial thoughts of OT:** "What comes to mind when you think of OT?" **Patient narrative:** an example of how OT helped a patient	**Orientation of learning:** If participants are more oriented to practice and experience, then they are more likely to implement knowledge.	
Learning Activities	**Didactic Content on OT Practice:** supporting literature, OT in the hospital setting, OT Practice Framework	**Increasing motivation to learn:** If participants are more motivated to learn then they will more effectively increase their knowledge.	
Flipped Classroom/ Tool Building	**Clinical Considerations Criteria:** algorithm to assist with clinical reasoning for when to consult OT.	**Activating learning:** If participants are engaged in using the criteria, then they will more effectively increase their knowledge of the content.	Increased appropriate use of OT services
Problem Solving	**Case examples:** problem solving for OT referral and application of Clinical Considerations Criteria	**Learning readiness and learning experiences:** If participants are engaged in problem solving through case scenarios, then they will be better oriented to how to apply knowledge to practice.	

To establish learning goals, workshop objectives were reviewed by physician stakeholders to ensure alignment with hospitalist teaching and learning goals. The three objectives of the workshop were to: 1) Explain the role of OT in the hospital, 2) Identify patients who benefit from OT and why, and 3) Understand clinical considerations and guiding questions for OT consults. As opening reflection activities, participants were asked “What comes to mind when you think of OT?” which allowed the facilitator to acquire a baseline perception of knowledge and initiate engagement. Participants were then provided a brief patient testimonial that illustrated the value of acute care OT services on functioning and quality of life while providing lived experience of a patient.

Next, the facilitator reviewed didactic content on OT including evidence on the scope, clinical value, and specific roles of OT on the medicine service (American Occupational Therapy Association, 2020). An OT Referral Decision Aid (OT-RDA), tailored to the medicine service at this specific hospital, was created to assist clinical reasoning for when to place an OT consult (Figure 2). The OT-RDA was referenced throughout the workshop, including during case examples, and was encouraged to be disseminated for use by junior house staff.

Figure 2

Occupational Therapy - Referral Decision Aid (OT-RDA)

KEY PATIENT CRITERIA	OT REFERRAL CONSIDERATION
☐ DOES PATIENT HAVE **NEW DIFFICULTY WITH ADLS/IADLS** (INCLUDES MEDICATION MANAGEMENT)?	IF **YES** → **CONSULT OT**
☐ DOES PATIENT HAVE **ACUTE COGNITIVE CHANGES?**	☐ AND IS THE ISSUE EXPECTED TO PERSIST >/=48 HOURS? IF **YES** → **CONSULT OT**
☐ DOES PATIENT HAVE **NEW VISION CHANGES/LOSS?**	☐ AND IS THE ISSUE EXPECTED TO PERSIST >/=48 HOURS? IF **YES** → **CONSULT OT**
☐ DO YOU HAVE **CONCERNS** RE: PATIENT **SAFELY** DISCHARGING HOME?	IF **YES** → **CONSULT OT**
☐ **PER CASE MANAGER**, DOES PATIENT'S **INSURANCE REQUIRE** OT FOR DISCHARGE TO REHAB? • *(often required for acute level rehab placement)*	IF **YES** → **CONSULT OT**
☐ **PER CASE MANAGER**, WILL PATIENT DISCHARGE **TO SKILLED NURSING FACILITY IN 24-48** HOURS AND DOESN'T NEED OT EVALUATION TO QUALIFY? • *(per patient progression rounds)*	IF **YES** → **DEFER OT CONSULT**
REACH OUT TO COVERING OT AS NEEDED – **SEARCH "OCCUPATIONAL THERAPY" IN PAGER SYSTEM**	

Case examples were explicitly created to facilitate clinical problem solving on whether an OT consult was indicated (Table 1). The review of cases also provided examples of OT assessment, OT intervention, and hypothetical outcomes resulting from

OT involvement. Comparison cases were also included to provide examples of when OT consults were not indicated. Following the case examples, one slide provided a macro-view of OT's focus on client-centered occupations and function including

Table 1

Portions of Case Examples: Scenarios, Assessments, Interventions, and Outcomes

Case Examples	OT Assessment and Intervention	Outcomes from OT Involvement
Hepatic Encephalopathy (HE): 72-year-old male with cirrhosis, hypertension, Type 2 Diabetes, BIBA after being found by wife. On exam, +asterixis suggestive of cirrhosis decompensated by HE. Admitted for workup and management.	• Cognitive evaluation • Medication management education for patient and family • Discharge recommendations	Improved recall of medication routine, independence with health management, understanding signs and symptoms of HE, reduced readmission, provided with med management resources
Acute Vision Loss: 67-year-old female with diabetes mellitus with neurogenic bladder requiring chronic indwelling foley presenting with lethargy, weakness, and rapid vision loss. Diagnosed with urinary tract infection with bloodstream infection and endophthalmitis.	• Vision assessment • Education for physicians and nursing at bedside • Discharge recommendations	Increased independence in hospital room, improved bedside interactions and safety, improved ability to assist patient with daily needs, connection with community resources
Comparison Case when Acute OT is NOT Indicated: 58-year-old female with history of chronic obstructed pulmonary disorder admitted for shortness of breath and diarrhea. Admitted for +COVID with oxygen requirement. Received 10-day dexamethasone now ready for discharge. Per rounds, PT has evaluated and recommends discharge to skilled nursing facility due to poor activity tolerance. Per case manager, there are no insurance or administrative barriers to skilled nursing placement.	• Acute assessment is deferred due to medical readiness for discharge to a skilled nursing facility where she will receive post-acute OT services. In this specific hospital context, there are no other acute OT needs to be addressed prior to discharge.	By not having to spend time reviewing this chart and communicating with the team about evaluating vs signing off, the OT department saves time that can be allocated to patients who do have acute needs for OT services in the hospital

Note. OT = Occupational Therapy; PT = Physical Therapy

Measures

Survey development was reviewed with the Director of Hospital Medicine Continuing Medical Education who recommended brevity given physician time constraints. Gehlbach's (2015) recommendations were referenced throughout survey development to support optimal use of a short instrument. The hospitalists participated in a pre-knowledge survey with one open-response question ("What is the role of OT for patients on the medicine service?"), then three prompts using a five-point Likert Scale (1 = *Strongly disagree, 5* = *Strongly agree*) to identify the level of agreement with: 1. "I understand the role of OT for patients on the medicine service," 2. "I can explain the role of OT to my patients," and 3. "I can teach the role of OT to my house staff." At the end of the workshop, participants completed the post-knowledge survey including the same items, as well as 4. "As a result of this presentation, I will increase consultations for the OT service."

Inpatient OTPs participated in pre- and post-surveys reporting the perceived percentage of appropriate OT consults from the medicine service once one week prior to and once one week following the workshop. Perceived appropriateness was defined as new evaluation consultations from the medicine service that the OTP determined warranted an evaluation based on diagnosis or needs. Furthermore, to monitor for changes in patient caseload, one week before and weekly for four weeks following the workshop, the OT patient census was audited to determine the number of medicine service consults.

Data Collection and Data Analysis

Data analysis was conducted with IBM® SPSS version 28. For all pre- and post-workshop surveys and census analyses, descriptive statistics and Mann Whitney tests were performed, with $p<0.05$ considered statistically significant. The open-ended physician survey item 1. “What is the role of occupational therapy (OT) for patients on the medicine service?” was coded using qualitative content analysis.

Results

Approximately ten percent of hospitalists participated in the workshop. The participants were a convenience sample as they were already intending to attend the CME programming offered that day. Some hospitalists arrived late, and some had to leave early, resulting in a pre-survey n = 9 and a post-survey n = 7. One hundred percent of OTs within the department participated, all of whom were registered occupational therapists (OTR), resulting in a pre- and post-survey sample size of 12.

Table 2

Quantitative Evaluation Results from Physician Participant Surveys

Item	**Pre-Score**[a] n=9		**Post-Score**[a] n=7		*p*
Physician Survey[a]	Mean (SD)	Median	Mean (SD)	Median	
S1. Understand role of OT for patients	3.3(1.1)	4.0	3.9(1.3)	4.0	0.18
S2. Explain role of OT to patients	3.4(1.1)	4.0	3.9(1.3)	4.0	0.25
S3. Explain role of OT to house staff	3.1(1.1)	3.0	3.7(1.3)	4.0	0.27

Note. Rated on 5-point scale (1 = *Strongly disagree*, 5 = *Strongly agree*); OT = Occupational Therapy

The three quantitative survey items showed a directional increase in scores after the workshop; however, this change was not statistically significant (Table 2). Results for the final post-survey item, “As a result of this presentation, I will increase consultations for the OT service,” showed that 29% of hospitalists strongly agreed, 29% agreed, 28% remained neutral, and 14% disagreed/strongly disagreed.

OTs’ perceived percentage of appropriate consults increased from 68% one week before the workshop to 73% one week after the workshop; however, this increase was not statistically significant (p = 0.26). On the OT census, there were 32 patients on the medicine service one week prior to the workshop and 29-38 patients for four weeks following the workshop with no statistically significant change (p = 1.0).

Table 3

Physician Open-Ended Response

Item	Response Pre-Count n = 9	Response Post-Count n = 7
O1. What is the role of occupational therapy (OT) for patients on the medicine service?	Evaluation (9) Function (5) Cognition (4) Therapy (3) ADLs (2) Discharge (2) Treatment (2) Devices (1) Safety (1) Upper Extremity (1)	Function (4) Evaluation (3) Medication* (2) ADLs (1) Cognition (1) Coping* (1) Delirium* (1) Recovery* (1) Safety (1) Strategies* (1) Vision* (1)

*Note. * Denotes words that were newly reported post-workshop*

Qualitative content analysis of responses on the open-ended survey item on OT's role on the medicine service demonstrated ten baseline response concepts identified via explicit term identification (Table 3). Pre-workshop responses included OT having a role in evaluation, function, cognition, therapy, ADLs, discharge, treatment, devices, safety, and upper extremities. Post-workshop responses revealed the same initial response, as well as six newly reported concepts directly related to workshop content including medication, coping, delirium, recovery, strategies, and vision, including such responses as, "patient recovery and coping," "help with medication management," "help with patients who are confused," and "new vision change training."

Discussion

After the CME workshop, there was a directional increase in hospitalists' perceived knowledge on the role of OT in the hospital. The increase in hospitalist knowledge was not statistically significant, which could be due to an inadequately powered sample size, that the intervention was not sufficiently effective, or that the outcome measure was looking at perceived knowledge change and not measuring actual knowledge change. However, the median Likert rating increased from "neutral" to "agree" on Item S3, "I can teach the role of OT to me house staff," suggesting success of the train-the-trainer approach, and the increased diversity and volume of qualitative survey item responses suggest that hospitalists' understanding of OT scope improved. Notably, responses suggest understanding of OT's role expanded beyond activities of daily living (ADLs), cognition, and upper extremity functioning to also include patient safety, delirium prevention and management, vision rehabilitation, and medication management. These areas of OT practice are particularly relevant for shared

interprofessional goals of decreasing patient morbidity and optimizing functional outcomes to facilitate discharge planning.

OTs' perception of appropriate consults for services also demonstrated a directional, but not statistically significant change. The number of patients on the OT census did not change. This could result from a reduction in inappropriate consultations being balanced out by an increase in new appropriate consultations. Or, the four-week post-workshop measurement timeline was not long enough to demonstrate change, due to physician participants not yet rotating back onto service or having a chance to educate the house staff who place consultations. Existing literature discusses the impact and importance of interactive and multi-component CME; however, there are limited conclusions on the facets required and tools available to impact and measure physician behavior change (Mostofian et al., 2015). Other factors to explain these results could relate to implementation science phenomena such as the gap in knowledge to behavior change, barriers to adoption of content and knowledge, difficulty with the penetration of the physician hierarchy and practice change, and the challenges of sustainability of learned information (Proctor et al., 2011).

Limitations

There were several limitations of this workshop. A significant limitation was low sample size relative to the total population of this given hospital. Participants represented ~10% of hospitalists. CME seminars are not mandatory, and time was reported as a barrier to synchronous participation. Variable attendance led to inconsistent response rates. A power analysis was not completed prior to data

collection, and the small n-sizes therefore may not be sufficient to demonstrate a statistically significant finding.

The knowledge survey was not standardized, which could limit the validity and reliability of results. Additionally, given the course was offered for CME by their supervisors, those that responded to the post survey may have been biased by social desirability to report favorable learning outcomes. Furthermore, institutional cultures impact interprofessional learning (Committee on Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes, Board on Global Health, & Institute of Medicine, 2015). The current workshop took place at a teaching hospital with a positive culture for learning and collaboration; however, this does not exist at all institutions. The results of this evaluation are not generalizable to acute care OT departments at other institutions.

Future Considerations

The current workshop demonstrates a novel approach to education by targeting attending-level physicians in a train-the-trainer, adult learning-oriented approach to post-professional CME. There is a need to continue to address the lack of physician knowledge of OT with higher quality evaluations. Future recommended projects include evaluating the prospective effect of new hospitalist knowledge on house staff learning, and changes in OT productivity, patient care, and systems outcomes when triaging less inappropriate consultations. These considerations could improve acute care OTs' ability to evaluate and treat appropriate diagnoses, improve team dynamics and quality of care, and decrease role ambiguity among care team members which could increase satisfaction and confidence among OT team members. Future iterations of the

workshop could consider expanded collaboration with additional disciplines, as well as an asynchronous format to reach more participants, thereby facilitating a larger sample size with greater statistical power for measuring changes in knowledge and consultation behaviors.

The decision to focus on the medicine service allowed tailoring of workshop content; however, it did not allow for representation of all hospital specialties. In the future, content could be modified to additional specialties for which OT provides services such as neurology, trauma, critical care, oncology, and cardiology. A future direction for this work could be creating specialty-specific workshops offered as professional development through medical societies. Additionally, a workshop series, or a longer single session timeframe, could be beneficial to maximize content, education, and participation to optimally impact physician knowledge of OT. To optimize interprofessional education, participants need to learn about, from, and with one another (Health Professions Accreditors Collaborative & National Center for Interprofessional Practice and Education, 2019). In the future, the workshop could facilitate more learning with, rather than from, those involved.

Implications for Practice

There are several implications for those impacted by acute care including OTPs, physicians, and patients. OTPs and physicians have an opportunity to collaborate more intimately and effectively in the hospital setting. OTPs do not always have a proverbial seat at the table for interdisciplinary collaboration and IPE. This workshop supports how OTPs can initiate conversations with physicians and medical educators for quality improvement and collaborative education opportunities. In turn, physicians have an

opportunity to recognize gaps in knowledge and practice and embrace interprofessional initiatives and learning approaches that are evolving in health professions education which emphasize both depth and breadth of practice (Bierema, 2018). Importantly, evidence suggests that more communication supports improved collaboration, improved collaboration yields better quality of care, and this care results in best practice and patient satisfaction which is the unified goal of all those committed to healthcare.

Conclusion

The aim of this workshop was to introduce an innovative approach to CME to increase hospitalist knowledge on the role of OT. The workshop was provided virtually over one-hour and used a train-the-trainer, Adult Learning Theory-based approach to education. Surveys were used to evaluate physician knowledge of OT and perceived appropriateness of OT consults. Findings suggest implementing this workshop is feasible, learners were engaged in the process, and hospitalists are interested in a top-down approach for education, as well as using resources and interprofessional collaboration to support their learners. Acute care OTPs participating in and providing CME have the potential to not only enhance understanding of OT and use of services, but also to inform improvements at a systems level to improve patient outcomes and quality of care.

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