Any discussion about competency conjures up all kinds of images, expectations, and demands: Consumers presume that their therapists are competent; payers expect and demand competent practitioners; family caregivers watch for evidence of competency, or lack thereof; credentialing bodies, both governmental and private, require it; and we as occupational therapy practitioners defend our professional integrity with it. Measuring our own competency and that of our colleagues both within and outside the profession of occupational therapy is an important aspect of our professional responsibility, but it remains, for the most part, elusive—difficult to define, challenging to measure, and troublesome to react to when a deficiency is uncovered. Competency is too often informally measured simply by subjective perception, without any objective or standardized approach. Yet, measuring competency objectively is a task that must be achieved particularly in the home health arena because of all practice settings, home health is the most isolating, with little or no on-site supervision, monitoring, or mentoring. Standards of care require that therapists’ competency be validated before accepting a case into the agency, and assigning the client to the proper therapist preserves the unique character and professional integrity of the home health industry.

Measuring competency among all staff members is an aspect of home health administrative duties that receives a lot of attention today. As the home health industry matures, there is greater internal and external pressure to address competency measurement. Home health managers and owners are asking: What are the elements that create a competent therapist? How do we collectively measure and evaluate competency in home health? Are there professional, clinical, and personal factors and attributes that contribute to competency? Can those elements and characteristics be itemized and then objectively quantified? What actions can be taken to remedy incompetent behavior or practices?

One excellent reference found in the rehabilitation discipline literature is Developing, Maintaining, and Updating Competency in Occupational Therapy: A Guide to Self-Appraisal (American Occupational Therapy Association [AOTA], 1995). This document provides a broad and generic starting place for establishing competency measurement activities. It defines the issues related to competency in occupational therapy, provides methods to achieve competency (and measures to document competency evaluation), and suggests self-evaluation checklists that divide performance into several areas.

The guide confirms that competency not only is an evaluation of clinical skills, but also includes skills and expectations associated with patient evaluation and intervention, practitioner work and behavior, and updating clinical competency. A professional development plan is also offered in this user-friendly publication.

The guide should be adapted to specific practice sites, individualizing competency evaluation activities for each agency. The home health agency’s scope of service, reimbursement sources, and clinical and administrative expectations and the practitioners’ menu of skills will define the parameters of expected competencies for each location. Occupational therapy practitioners can approach their superiors and propose a task force or committee of occupational therapy peers...
and other agency personnel (e.g., the agency’s rehabilitation services supervisor, quality improvement staff members) to lead the development of a competency evaluation program. It is my experience that home health administrators would welcome such a proposal. Defining the competencies necessary for the practice of occupational therapy should not be left to non–occupational therapy professionals.

After a committee is established, it can discuss what elements constitute measures of clinical, employment, and administrative competency in their agency; quantify them on paper; and outline a process. The resulting self-evaluation checklist would identify newly hired practitioners’ strengths and weaknesses. In addition, a proficiency examination, in writing and by physical demonstration, could be conducted to assess the job candidate’s level of expertise in appropriate areas. For example, a written exam would reveal job candidates’ previous professional duties with regard to diagnoses, age, and theoretical frames of reference used. A demonstration exam conducted in the agency office would assess their skills in range of motion or manual muscle testing activities, and a demonstration exam conducted in the client’s home during a visit would assess their bedside manner and splint-making skills, for example. Unless some form of performance is demonstrated, competency cannot be fully determined and subsequently documented.

After collecting data on valid licensure and certification, on minimum numbers of years of related experience, from self-evaluations, and from on-site and off-site demonstration of proficiency activities, a picture of the candidate’s competency would become evident. The picture will suggest what population of clients are appropriate for this practitioner’s skills or which of his or her skills are available for the agency to tap into. More sophisticated home health agencies may use aggregate results from infection control and patient satisfaction studies to cue them into a problem area a practitioner may have after he or she has been out in the field. Any areas of deficiency must result in a roster of activities that a practitioner must complete in order to establish or achieve competency. This list may include reading specific articles, watching orientation and training videotapes, attending conferences and seminars, taking advanced specialty and certification examinations, and so forth. After the practitioner completes competency preparation, the learning process is validated again with demonstrations of proficiency.

Until competency is established, home health agencies should not assign the practitioner to clients who require skills not yet verified, and practitioners should not accept a referral knowing that they may be incompetent to care for that particular client. Consider the following common occurrence: An occupational therapist is hired to care for an agency’s primarily geriatric population with physical disabilities. After a competency evaluation and measurement process, the agency and therapist validate that the therapist possesses many or all the skills necessary to carry out a physician’s order for a specific set of client problems. However, one day an elderly client with a primary condition of a psychiatric illness is referred for occupational therapy services. Although the agency offers a mental health program with supervision and visits conducted by other qualified staff members, including a registered nurse and medical social worker, the occupational therapist was never evaluated for competency in mental health care provision. What action should the agency supervisors take? Should the therapist accept the client for fear of losing his or her position or good standing in the agency? Admitting that one does not have the competency to perform a skill is not always an easy task. Should the referral to occupational therapy be canceled, leaving the patient without needed care? Should the agency consult with another occupational therapist who has the appropriate experience?

The most effective method to avoid these potentially uncomfortable circumstances is to be proactive about evaluating competency relative to the entire scope of services the agency offers. In this case, if the organization was aware of the need for mental health occupational therapy services at the time of referral, it should not have accepted a referral that it cannot serve with qualified and competent staff validation. In addition, the agency and therapist should have had enough vision to anticipate requests for occupational therapy services in their mental health program and address competency issues early (e.g., to evaluate the occupational therapist’s skills in the mental health arena upon hire). It is not appropriate for a therapist without mental health skills to accept this case because harm could come to the client (and subsequently to the agency). In this case, the best answer for all parties is to quickly find another therapist to satisfy the client’s needs or refuse the referral.

Maintaining and updating competency is a dynamic and collaborative process. It involves broad commitment and the combined efforts of national associations, regulatory agencies, employers, and the individual practitioner (AOTA, 1995). The primary responsibility for quantifying skills and demonstrating competencies lies with each practitioner. Competency changes with the demands of each new job or duty or as the body of knowledge expands on the care of persons with disabilities. Regular attention to updating or practicing skills will best serve all parties in home health care.

In summary, there are eight steps to addressing competency in home health:

1. Consult the AOTA-referenced document.
2. Apply agency-specific expectations for competency in all areas (clinical, administrative, employment, etc.).
3. Create self-evaluation checklists, dividing performance expectations into specified areas (subjective).
4. Create demonstration activities and written proficiency examinations (objective).
5. Document strengths and weaknesses from subjective and objective findings.
6. Create a professional development plan to address weak areas.
7. Prepare for reexamination to vali-
date competencies.
8. Maintain competencies with a continuing education plan. ▲

Reference

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