Variables Affecting the Competency Maintenance Behaviors of Occupational Therapists

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Objective. The purpose of this study was to examine the relationship between work environment and the competency maintenance activities of occupational therapists.

Method. A survey of 121 occupational therapists in three states and interviews with 8 occupational therapists in Ohio were used.

Results. Analysis of survey data indicated that workplace support and the degree of competency monitoring are significant determinants of competency maintenance behavior. State continuing education requirements had no impact on reported levels of competency maintenance. Personal motivation of the therapist emerged as a potentially important moderator of the relationship between environment and competency maintenance.

Conclusions. Although environmental factors enhance competency maintenance activities, active participation in competency maintenance is also related to the personal commitment of the individual therapist. Strategies that reduce barriers to effective competency maintenance and promote a culture of continuing competency in the profession merit further investigation.


The continuing competency of occupational therapists has received considerable attention in recent years. In 1995, a subcommittee of the American Occupational Therapy Association’s (AOTA’s) Commission on Practice released a guide to self-appraisal (Thomson et al., 1995) designed to support and encourage therapists in the process of competency self-monitoring. In 1997, the National Board for Certification in Occupational Therapy created an independent National Commission on Continued Competency in Occupational Therapy to examine issues related to continuing competency and to recommend future strategies for professional regulation (Mayhan, Holm, & Fawcett, 1999). In October 1998, The American Journal of Occupational Therapy® published a special issue devoted to professional competence (Hinojosa & Blount, 1998).

Despite examination of this issue, there remains little concurrence in the field about how continuing competency should be regulated. There is general agreement that primary responsibility for continuing competency lies with the individual professional (Evert, 1993; Thomson et al., 1995; Youngstrom, 1998). However, for a variety of reasons, responsibility is not solely assigned to the therapist. Regulatory boards are legally responsible for the behavior of...
persons they have licensed or credentialed (Grossman, 1998). Employers have both a legal and a moral responsibility to their clients and are accountable to the regulatory boards (i.e., Joint Commission on Accreditation of Healthcare Organizations [JCAHO], CARE...The Rehabilitation Accreditation Commission) from whom they seek approval and legitimacy. Overall, the individual therapist must answer not only to his or her professional conscience, but also to clients, licensure boards, employers, and the general public.

The relevance of environment to human behavior is central to our understanding of human occupation (Christiansen & Baum, 1997; Kielhofner, 1985). Professional competency is therefore understood in the context of the service delivery environment and work roles (Fawcett & Strickland, 1998). Occupational therapy work environments are highly varied in terms of the nature of the facility, area of practice, supervision structure, and available peer network. All of these factors may influence competency by altering work demands and influencing the support structure (Youngstrom, 1998). Organizations can affect individual performance through policies regarding innovation, training, and excellence in performance (Dubin, 1990; JCAHO, 1996). Although structured training is a generally accepted means of maintaining competency, strategies such as mentoring, peer support, and a continuous learning climate in the work environment are other sources of continuing competence (Dubin, 1990; Slater & Cohn, 1991).

Performance evaluation is one aspect of the work environment that may affect competency maintenance in various ways. Beyond its focus on procedural competency, evaluation may indicate the need for remedial training or staff redeployment (McGregor, 1990; Slater & Cohn, 1991). For individual practitioners, evaluation serves as a means of feedback about areas of weakness and strength (Thomson et al., 1995). However, little direct evidence exists that the monitoring activities of organizations and regulatory agencies have a major impact on either competency or competency maintenance activities (Elks & Kirkhart, 1993). Further, with the movement of occupational therapy into noninstitutional service delivery venues, monitoring of practice through traditional supervision strategies is often both impractical and inappropriate.

The degree and extent of competency monitoring varies across work environments and jurisdictions (Grossman, 1998). Although surveys about the requirements of the various licensing boards have been conducted, there is no evidence about the type and extent of competency evaluation approaches used in occupational therapy workplaces. In addition, there has been little attention given to the impact of monitoring and other environmental conditions on therapist competency maintenance behaviors.

The purpose of this study was to investigate the relationship between work environment characteristics and the competency maintenance activities of occupational therapists. Work environment characteristics examined included institutional competency evaluation practices, opportunities for competency maintenance, and organizational support for competency maintenance.

Method
The study consisted of two phases: a survey of occupational therapists from three states (Texas, Idaho, Maryland) and interviews with individual therapists drawn from a range of work environments across the state of Ohio. Information gained from the surveys and interviews was used to construct a profile of competency maintenance in occupational therapy and the environmental characteristics that relate to competency maintenance.

Participants
The sample for the survey phase was identified from state licensure board lists of occupational therapists. The three states were purposively selected to ensure diversity on variables identified in the literature as being relevant to the continuing competency of health professionals. Each of the 50 states in the United States was ranked as having either high, medium, or low managed care enrollment. One state was then selected from each enrollment category. The states were also selected to represent a range of size (large, medium, and small land mass), a range in the number of practicing therapists, varied geographic location, and continuing education requirements. Two of the states (Texas, Maryland) had continuing education requirements for licensure; whereas Idaho did not. Seventy-one therapist names were selected from a computer-generated list of random numbers. Ten more names per state were randomly selected as replacements for surveys that were returned as undeliverable.

The participants for the interview phase of the study were chosen from a pool of occupational therapists nominated by health care professionals in Ohio. Therapists were selected from Ohio because of ease of access and because of the broad range of demographic conditions available. Interviewees came from eight settings that employed the majority (80%) of occupational therapists (as indicated in AOTA's Member Data Surveys from 1973–1996). The settings were a general hospital, a rehabilitation center, a mental health care facility, free-standing outpatient clinic, a school system, home health agency, skilled nursing home, and private practice. The selection of interviewees was also based on years of experience (at least 2), geographic location, and willingness to participate. Participation was sought from various regions of the state.

Data Collection and Analysis

Survey: A 16-item questionnaire was developed for the survey. Items 1 through 6 dealt with the practice environment
(primary employment setting, client mix, primary area of occupational function addressed, funding sources, accreditation status, public or private administration). Item 7 was a double-scaled question that required the respondent to indicate on a 5-point scale the “frequency of use” (1 = not used, 5 = used weekly) and “degree of workplace support” (1 = no support, 5 = strong support) for 12 methods of competency maintenance. The methods listed in this section were drawn from the AOTA publication on maintaining and updating competency (Thomson et al., 1995) and modified through pilot testing. Item 8 asked the respondent to choose the 1 or 2 methods from the list they perceived to be “most helpful” in maintaining competency and to explain this choice.

Item 9 was a double-scaled question that asked respondents to rate the frequency with which nine evaluation methods had been used to assess them during the past year (0 = not used, 3 = three times or more in past year) and the usefulness of the feedback received through each method (1 = not at all useful, 5 = extremely useful; a not applicable option was available). Items 10 and 11 examined factors external to the therapist that might affect practice, such as service delivery restrictions of an insurance provider and opportunities for peer interaction. Therapists were asked to indicate the degree to which each of the first 5 (negative) factors limit practice, and the degree to which each of the second 4 (positive) factors contribute to practice. The final 5 items on the survey requested demographic information and additional comments. Modifications to the survey were based on pilot testing with 18 occupational therapists. Reliability estimates were calculated for the sections of the survey that contained sufficient items for this purpose. The resulting alphas ranged from .712 to .949.

The questionnaires and a cover letter were mailed to the 213 therapists in the survey sample. For each questionnaire that was returned as “undeliverable,” a new name was selected from the replacement list for the state in question. Three follow-up mailings were made to nonrespondents at 2-week intervals. To determine whether differences existed between respondents and nonrespondents, a phone survey was conducted with five nonrespondents from each state (n = 15). Survey responses were analyzed by means of descriptive and inferential statistics.

Interview. A “standardized open-ended” interview protocol (Patton, 1990) was used for the interview phase to address the following topics: the nature of the therapist’s practice and work environment, the meaning of competency in occupational therapy practice, ways of determining and maintaining competency, motivation for maintaining competency, and insights into methods of competency evaluation used in the workplace. The protocol was pilot tested with two therapists before the onset of data collection.

Interviews with the 8 participants in this phase averaged 1 hour in length. All interviews were recorded and transcribed. The full transcript was sent to participants for verification. Transcribed interview data were pattern coded (Miles & Huberman, 1994) and content analyzed. Analysis was aided by the use of a software program that allows for marking of text by multiple themes for later combination and cross comparison. After data reduction and analysis and generation of major findings, the findings were examined by an external qualitative researcher to assure credibility (Lincoln & Guba, 1985).

Results

Survey

Of the 213 questionnaires mailed, 129 (61%) were returned: 46 from Texas, 42 from Idaho, and 41 from Maryland. The sampling error of the mean for the 129 returns was determined using a conservative estimate of variation in response (i.e., 50/50 probability of response). The standard error for these proportions is .04, making the 95% confidence interval ± 8%. The demographics of the respondents closely resembled the demographic distribution of occupational therapists from the AOTA 1995–1996 Member Data Survey (AOTA, 1996). The phone survey of 15 nonrespondents revealed no significant discrepancies from the response patterns of the respondents, except that the latter group (n = 129) had, on average, more years of work experience than the former (M = 11.0 years; phone sample M = 7.9 years).

Competency maintenance activity. When respondents’ use of competency maintenance methods were collapsed into “used” and “not used” categories, workshops, conferences, and seminars were the most frequently reported methods (98%) (see Figure 1). A large number of respondents also reported high levels of more readily accessible sources of competency maintenance, including reading (97%), attending on-site in-services (95%), independent self-reflection (94%), and consulting a mentor or peer (89%). Methods of competency maintenance used less frequently were studying for a specialty exam (10%), conducting research (25%), and academic course work (38%). When mean frequencies were determined for each method, the most often used methods of competency maintenance by the respondent group were reading (M = 3.93), consulting a mentor or peer (M = 3.21) and workplace in-services (M = 3.11). Much lower means were observed with regard to preparing for a specialty exam (M = 1.17) and conducting research (M = 1.39).

Eighty-four percent of respondents indicated which methods of competency maintenance were most beneficial to them. Workshops, seminars, and conferences were the primary choice (79%), followed by consultation with a mentor or peer (30%), in-services in the workplace (17%), and reading (17%).

Institutional evaluation practices. When survey respondents’ ratings of the nine different methods of evaluation listed on the questionnaire were collapsed into “no use” (0 rating) and “use” (ratings of 1 or above), the most frequently used evaluation methods were supervisor ratings
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and practical testing (31.2%).
pared via independent sample managed care funded and accredited settings were com-
tings given by each respondent to the nine monitoring 
ation score was calculated by summing the rat-
were critical path audit (16.3%), written testing (25.0%),
and practical testing (31.2%).
To consider overall trends in evaluation, a “total evalu-
ting by each respondent to the nine monitoring methods. Total scores ranged from 0 to 20. When means for the total evaluation frequency scores of the respondents in managed care funded and accredited settings were com-
pared via independent sample t tests with those in other types of settings, significant differences (two-tailed) at the .05 level were observed for each. Managed care reimbursement and accreditation were both factors that positively influenced the frequency of competency evaluation. Major differences were also observed in total evaluation frequency across work settings. Highest frequencies were seen in structured, traditional settings, such as hospitals (M = 9.45) and rehabilitation centers (M = 10.12) whereas limited competency evaluation of any type was reported by respondents in school settings (M = 4.65) and self-employment (M = 4.80).

Impact of environment on competency maintenance activity. A number of environmental factors were hypothe-
sized to have a potential impact on the competency maintenance behaviors of occupational therapists. One of these was the licensure requirements of the state in which the therapist practiced. Two states (Texas and Maryland) have continuing education requirements for relicensure—Texas requires 15 contact hours per annum, and Maryland requires 36 hours biennially. The reported frequency of use across all methods of competency maintenance was calcu-
lated to provide a total maintenance score for each respond-
ent. When the competency maintenance activity of respondents was compared by state, no significant differ-
ence was found. The total for the one state that did not have a continuing education requirement was, in fact, higher than the totals for the other two states.

The nature of the work setting was another factor hypothesized to influence the extent of competency maintenance activity engaged in by therapists. Although discrepancies in group size did not permit valid statistical comparison across settings, no major differences were seen. The mean total maintenance score for respondents working in occupational therapy education settings (M = 40), however, was noticeably higher than the means for all other groups (M = 29.55, SD = 2.29). No significant differences were found for this variable with respect to employment in managed care settings versus settings that were privately funded or funded through nonmanaged, government enti-
ties. Accreditation status of facilities (i.e., JCAHO, CARF) was similarly not associated with differences in the degree to which therapists engage in competency maintenance behaviors.

The degree of competency monitoring that occurs in work settings was examined to determine whether testing and other methods of accountability resulted in higher levels of competency maintenance activity. Positive, moderate correlations were observed between the total frequency of competency maintenance activity (total maintenance) and the degree to which competency is evaluated (total evaluation score) in the workplace (r = .42, p < .01). Positive, but weaker correlations were identified between competency maintenance activity and formal testing in the workplace (r = .21, p < .05).

Results of the value ratings given to the nine methods of competency maintenance are shown in Figure 3. The value ratings ranged from 2.42 to 3.55, generally in the moderate range, with standard deviations of 1.30 or less. The methods with the highest value ratings were peer assessment (3.55), client satisfaction ratings (3.49), and practical testing (3.24), and the lowest were written testing (2.42), critical path audit (2.88), and quality assessment program (2.98). Pearson correlations between frequency of use and perceived value were positive and significant at the .01 level for all methods except for client satisfaction ratings (signifi-
cant at the .05 level) and supervisor ratings (not significant).

The final environmental variable studied with respect to the extent of competency maintenance behavior was the degree of support provided by employers for competency maintenance activities. Support was defined on the ques-
tionnaire as any combination of financial support, time provided, and other types of encouragement. Support ratings were greatest for workplace in-services (M = 4.06); independent self-reflection (M = 3.80); and workshops, seminars, and conferences (M = 3.67) (see Figure 4). Lowest

Figure 1. Percentage of therapists reporting having been evaluated by selected methods in 1996 to 1997.

Figure 2. Percentage of therapists reporting use of selected competency maintenance methods in 1996 to 1997.
support was reported for conducting research ($M = 2.29$) and preparing for a specialty exam ($M = 2.22$). A total support score was calculated for each respondent and compared with the total frequency of competency maintenance activity (total maintenance). These two factors were positively correlated ($r = .49, p < .01$), indicating that financial and other support for continuing education and other forms of competency maintenance increase participation levels.

When the workplace variables of accreditation status, work setting, managed care, administration type (public or private), total monitoring, and levels of support for competency maintenance were regressed on total competency maintenance activity, only the latter two variables (monitoring and support) contributed significantly to the equation. Overall, the workplace variables combined yielded an $R^2$ of .476, and an adjusted $R^2$ of .418 when regressed on total competency maintenance activity.

Additional information was gained from the survey about the effect of the practice environment on therapists’ abilities to deliver comprehensive, competent services. Service delivery restrictions imposed by the funding source was the environmental factor seen as the most limiting to practice by respondents. More than half of the respondents reported that clinical guidelines supported competent practice at least to a moderate degree, although only 5% thought clinical guidelines “contribute greatly.” Sixty-one percent indicated that time available for competency maintenance was a factor limiting practice.

**Interviews**

**Choice of competency maintenance activity.** The interview data mirrored the results obtained through the survey and provided additional information about choices therapists make with respect to continuing competency and perceptions of environmental mediators. In explaining their preferences for conferences and workshops, participants universally indicated that such experiences were useful only when involving practical, hands-on, or clinically relevant learning experiences. One participant distinguished between short, lecture-style courses that she saw as being of lesser value than longer seminars with limited group size and practical aspects, noting that admission into the latter is more restricted and more expensive. Transfer of training to the practice setting and consolidation of learning were addressed by two participants who both described the benefits of teaching newly learned information to others.

The participants emphasized the importance of peer support, especially in the early stages of their careers or when changing specialty areas. All eight spoke of the educational value of having workplace peers with whom to exchange information and support. Consulting a mentor or peer and on-site in-services were reported to be highly valued, but therapists who work independently or in rural areas needed to find creative means, such as e-mail or periodic meetings, to access these resources.

Clinical practice itself was noted by six of the participants interviewed as being a factor in competency maintenance. All cited the value of experiencing new clients and new challenges and the contribution of daily problem solving to enhanced competency.

**Motivation for competency maintenance.** Seven participants indicated without prompting that their motivation to pursue opportunities to increase competency arose from a sense of awareness that they lacked skills or knowledge in a particular area. External, environmental cues were secondary for all of them. The primary motivator was described as a sense of responsibility. Some saw this as a responsibility to oneself as a professional, as indicated by one participant’s comment: “I didn’t want to become burned out. It makes you do a lot of reading, and a lot of checking with other therapists, but I think it helps to make you well-rounded.”

Some participants reported a sense of responsibility to others, including clients and fellow professionals:

I really see myself as responsible to my patients and accountable to the physician on whose team I’m working. I have a level of responsibility to the director of the rehab nursing unit...to the director of nursing...so even though I may not have a specific boss, there’s a lot of people to whom I’m responsible.

Other comments indicated that members of this group believe that other therapists who lack this drive or sense of commitment do not strive to retain competency.

**Competency evaluation and monitoring.** Among those interviewed, competency testing programs existed only in institutional settings (i.e., in two hospitals, with one under development in a skilled nursing facility associated with a...
hospital group). Participants practicing in those settings provided insights into the testing process from their experience. Testing was done at two levels: (a) technical performance related to specific, high-risk tasks or high-volume tasks, or both performed in that particular work setting (all practical in nature) and (b) knowledge of safety information and hospital procedures (written testing). Participants gave low credibility ratings to evaluation methods that did not pertain directly to the skills of an occupational therapist. The possibility that written testing may relate primarily to issues unrelated to occupational therapy practice may, in part, explain the low ratings given to this method by survey respondents.

Little credence was given to a number of other methods of competency evaluation. In particular, all but one participant reported that supervisor ratings had limited validity, especially when the supervisor was not an occupational therapist or had no direct knowledge of the participant’s work. One said, “I guess I feel like if nobody has actually come to sit and watch me work, then they really don’t have anything all that helpful to say.” Another stated, “It’s [supervisor rating] very vague. You’d have to be really close by to really know what I’m doing.”

For most of the participants, self-awareness of competency was determined in an unstructured, “gut-level” manner. As one stated, “I just have an intrinsic thing—inside me. I know when I’m being competent and when I’m not being competent. And I don’t like that feeling. It’s just an emotional response to my work, my performance.”

Discussion
The results of this study indicate the variety of situational and individual factors that affect competency and its maintenance. The complexity of contemporary practice and the changing nature of service delivery environments present numerous challenges to the therapist who strives to maintain competency throughout his or her career.

Data gathered across both phases of this study support the hypothesis that environmental factors play a role in determining choices made about competency maintenance methods and the frequency with which such activities are pursued. For example:

• Therapists make the most frequent use of practice methods that receive highest support in the workplace.
• Higher overall levels of competency maintenance are seen in workplaces with highest overall levels of support.
• Peers in the workplace are perceived to be the most important source of information and support.
• Therapists who are exposed to higher levels of monitoring in the workplace report higher total levels of competency maintenance.

Other situational factors in the work environment that influence the frequency and types of competency maintenance activities include time available to pursue competency maintenance, availability of valued options, and financial resources. Interview participants indicated that these factors influenced the nature of the competency maintenance methods they used, choices they made with respect to workshops and conferences, and the degree to which they participated in any one method. Populations of special concern include independent practitioners, therapists practicing in nontraditional areas, and therapists in rural practice who frequently work without direct peer contact and may lack external support for continuing education.

Preferred methods of competency maintenance as revealed through this study are consistent with prevailing practice and theory in human resource development (Dubin, 1990; Slater & Cohn, 1991). For both study samples, workshops, conferences, and seminars emerged as the most valued methods of competency maintenance, followed closely by peer-dependent methods such as consultation with mentors or peers and workplace in-services. As would be expected, the methods that are used with greatest overall frequency are those that are most readily accessible, (reading and consultation with another therapist).

In an era when our profession is moving toward evidence-based practice as the core of competency, it is of concern that survey respondents reported receiving little support for and participated very little in research activities and independent learning. Further, they have little time for reflection on practice, for conducting literature searches, or for performing independent research. The changing culture of the workplace, with a prevailing emphasis on reimbursable activities, is a factor that appears to limit progress in this regard and is deserving of further study. Additional research might also explore the skills and attitudes of practitioners with respect to research and review of clinical approaches in current practice.

The Role of Monitoring
The results raise questions about the relevance of various methods of competency monitoring to both competency maintenance behavior and competency in practice. The latter question can be addressed only through further research as to the clinical practices of therapists in workplaces with high and low levels of monitoring. Competency maintenance behavior appears to be increased by monitoring; however, this may be an artifact of the nature of the settings in which higher levels of monitoring occurs (i.e., institutional settings) and the high levels of access to sources of ongoing competency that typically exist in this type of setting. The competency maintenance methods that were reported to occur with greatest frequency were reading, consulting peers, and workplace in-services, the latter two of which are more readily available in traditional settings with large numbers of therapists and internal resources.

Supervisor ratings, although the most frequently
reported method of monitoring in workplaces, received low ratings on the survey and were poorly regarded by all but one interviewed participant. Written testing also received low ratings from both samples. Highest credibility ratings were given to methods that involved feedback from a peer or mentor about aspects of direct service delivery. If peer-directed methods, such as peer review, practical testing, and chart audit, are the most respected sources of feedback, these areas should be further examined and developed to ensure validity and effective practical application. The implications of this finding for the many therapists who work without direct peer interaction are of some concern and suggest that alternative models for mentoring and peer review be developed.

Examination of workplace testing methods, through the interviews, indicated that such testing often deals with high-risk, high-volume tasks with technique-focused content. Although this serves a purpose in terms of workplace liability and may help to develop consistency among therapists, the relationship of this type of testing with less technical aspects of professional practice and clinical reasoning is uncertain. More intensive study of workplace competency testing is needed in the area of key professional tenets of occupation and client-centered practice.

Interviewed participants indicated that their primary source of information about knowledge or skill deficiencies came from an internal sense that they were unfamiliar with a situation or lacked sufficient skills to deal with a particular problem. This internal sense of awareness is an inherent part of the clinical reasoning process through which the therapist conducts ongoing appraisal of situational demands and moves toward appropriate actions (Fleming & Mattingly, 1994). More complex situations, or those in which applied strategies do not yield desired outcomes, will indeed result in an awareness of the need for additional information and expert input. However, the validity of judgments made by individual therapists depends on several factors, including the therapist’s level of experience, ability to make skilled judgments, and awareness of viable approaches and solution strategies. Use of internal cues is a critical source of needs identification but must be used in combination with information from external sources. Overall, it is apparent that therapists require the skills to critically assess their work and that of others. Skills in critical analysis and evaluation should be developed at the level of professional education programs, and used throughout the years of practice.

The fact that levels of competency maintenance did not differ significantly among the three state samples, despite differing levels of access to continuing education, peers, and financial resources, suggests that despite widespread support for mandatory continuing education requirements do not necessarily change participation levels. The benefits of continuing education requirements, which may be significant for a subset of professionals, merit further investigation as the field examines various accountability models.

**Individual Factors and Competency Maintenance**

All of the environmental factors examined accounted for only 41% of the variance in competency maintenance behavior. Only two factors (workplace support and monitoring) were strongly associated with competency maintenance activity, leaving a sizable portion of the variance unexplained. Qualitative data gained through the survey and the individual interviews suggest that factors internal to the therapist may account for a portion of the unexplained variance in competency maintenance behavior. Comments received from interview participants and through open-ended survey questions suggest that individual motivation may account for a large portion of the unexplained variance. Several interviewed participants reported that if the individual doesn’t “care about people” or “see it as a professional responsibility” he or she isn’t likely to pursue continuing competency.

Scissons (1982) observed that if persons are going to pursue continuing education, they must first be motivated toward skill enhancement, recognize a need, and perceive available training as relevant to their needs. The same might be said for competency maintenance in occupational therapy: A therapist must first have a positive orientation toward lifelong learning, recognize deficiency or need areas, and discern viable, valued options for addressing those needs.

Personal motivation appears to be an important precipitating factor for competency maintenance, with the environment either supporting the therapist in competency maintenance activities or encouraging the therapist who lacks high levels of internal drive. Personal commitment to a profession and to excellence are more difficult concepts to identify and foster. Rouiller and Goldstein (1993) described the concept of a “continuous learning culture,” which is found in organizations where new learning is valued and promoted at all levels. They found that this attitude in an organization not only encourages new learning, but also promotes transfer of learning to the work performed. Such a climate can be promoted at the level of the organizations where therapists work, and the results of this study suggest that this is already the prevailing attitude in some agencies. To be effective on a broader level throughout the profession, this type of culture may need to derive from our professional education programs and be nurtured through our professional organizations. Models for development of an orientation toward continuing competency have not been explored in this field.

**Limitations**

This study relied on self-report data, and as such, determinations cannot be made of the quality of competency main-
tenance activity or its relationship with environmental conditions. A cluster sampling approach was used to collect survey data. A representative sample of therapists in three states was sought on four criteria: level of managed care penetration into the health care market, size and population base of the state, region of the United States and state requirements for continuing education. Because data collection was limited to three states, it does not permit generalizing the findings to the U.S. population of occupational therapists. The method used for the second phase of the study (interviews) also does not permit generalization.

Conclusion

Our results support the premise that professional responsibility of the individual therapist serves as a critical factor driving competency maintenance. Several environmental factors play an important role, however, in supporting efforts toward continuing competency and in encouraging competency maintenance behaviors. The continuing education requirements of state licensure boards did not prove to be a factor in increasing competency maintenance behaviors for this sample, although the potential benefits for the minority of professionals who may lack professional commitment cannot be discounted.

It is suggested that models for building a culture of continuous learning should be developed through further examination of this construct. Methods that promote and support competency should also be exploited, by overcoming reported barriers to continuing competency maintenance, promoting peer support networks, and developing meaningful avenues of feedback for practicing therapists. The field must promote effective strategies for assisting those therapists who work in settings with low inter-collegial support and with limited financial support of continuing competency efforts. ▲

References


