Multiskilling: A Survey of Occupational Therapy Practitioners’ Attitudes

Amy Linn Collins

Key Words: managed care programs • organization and administration

Objective. Multiskilling has been identified as one means of reducing the cost of health care. This study examined occupational therapy practitioners’ knowledge of multiskilling, how it is affecting service delivery and quality of care, and how therapists believe the addition of skills should occur.

Method. A questionnaire was constructed for the survey and mailed to a random sample of 200 occupational therapists and occupational therapy assistants, all of whom were members of the American Occupational Therapy Association. Results. The 117 respondents had a moderate understanding of multiskilling. They responded that multiskilling is beneficial to both the occupational therapy profession and the clients it serves, but they were also aware of its potential risks or disadvantages. According to respondents, multiskilling occurs formally through defined protocol and, more commonly, informally, driven by necessity and the desire to treat the client most effectively.

Conclusion. The results indicate a need for the occupational therapy profession to define multiskilling and cross training; develop ways of serving clients that respond to administrative needs and constraints while preserving the uniqueness of occupational therapy; and monitor treatment outcomes of all service delivery methods to provide information regarding efficiency, effectiveness, and client satisfaction.

Multiskilled, defined in this article as “persons cross-trained to provide more than one function, often in more than one discipline” (Blayney, Wilson, Bamberg, & Vaughan, 1989, p. 216), is seen as a desirable way to contain health care costs and increase efficiency by some administrators and others outside the occupational therapy profession. Often, they are misinformed or unaware of the scope of services occupational therapy provides. Many factors drive health care costs; however, inefficiency and the high cost of labor are two of the most notable (Fozo, 1996; Moore & Komras, 1993). The inefficiency is due to waiting, coordinating, scheduling, and duplication of services between departments (Chicago Health Executives Forum, 1991).

Before 1983, hospitals were retrospectively reimbursed for services on the basis of charges by third-party payers, who are usually insurance companies and government agencies. The Medicare and Medicaid Amendments Act of 1982 (Public Law 97–248) established the Prospective Payment System for Medicare. This system is a schedule of payments that are based on diagnosis-related...
sessions, which could increase the quality and consistency of care provided (Cross-Training Task Force, 1996).

Occupational therapy practitioners are targeted for multiskilling partly because of the high cost for their services and salaries. For example, in the public school setting, special education programs, which use occupational therapists, physical therapists, and speech therapists, are currently under fire because they cost twice as much as regular education. Many administrators question whether the delivery of these related services is most efficient and effective (Rourke, 1996).

Vaughan, Fotller, and Bamberg's (1991) survey of 546 hospital administrators found that 25% of the hospitals used multiskilled health practitioners (MSHPs). Additionally, 70% of the MSHPs had been employed less than 5 years, indicating a trend toward increased use of these practitioners. The primary reasons for using MSHPs were flexibility and efficiency in staffing. Next was cost-effectiveness, or being able to reduce the number of employees. Concerns included maintaining multiple skill competencies, scheduling and coordinating between departments, replacing MSHPs who leave, and managing liability issues.

Proponents argue that multiskilling allows administrators to respond with flexibility to census changes by using available staff members in needed areas and providing an alternative to mandatory time off or layoffs (Dirks, Lough, & Moungey, 1995; Makely, 1994; Vaughan et al., 1991). This flexibility could improve access to occupational therapy services to underserved groups (Cross-Training Task Force, 1996). Advocates believe that multiskilling is also more cost-effective and results in higher profit margins because fewer employees are trained to perform more tasks and remain occupied regardless of the hospital census.

Supporters contend that multiskilling also provides an opportunity for professional growth, thereby increasing job satisfaction and decreasing burnout and turnover (Akroyd, Bamberg, & Hall, 1992; Dirks et al., 1995). Some believe that multiskilling provides an opportunity to gain knowledge and understanding from other professions, which could increase the quality and consistency of care provided (Cross-Training Task Force, 1996).

Opponents to multiskilling argue that it requires an initial investment that may not be feasible for some facilities (Dirks et al., 1995). Some facilities may be unwilling or unable to expend the money required to adequately train personnel, resorting to inefficient means, such as failing to allocate the required time or resources to adequately educate or supervise staff members (Cross-Training Task Force, 1996). In addition, the persons targeted for multiskilling may not achieve competency in the new skills because they lack background knowledge or experience. The Intercommission Council (1995) cautioned that, "workplace administrative pressures or a shortage of personnel must not result in inappropriate cross-training" (p. 32). Strohbach (1992) argued against cross training because "although competency might be achieved in a second clinical area, clinical expertise would be sacrificed" (p. 65). It may be difficult to evaluate the success of multiskilling on treatment outcomes or client satisfaction because of the lack of established assessment tools (Cross-Training Task Force, 1996).

Liability also needs to be considered because facilities can put their clients as well as their businesses in jeopardy without sufficient knowledge of or regard for licensure, certification, and other regulations that govern practice. For example, Medicare identifies professionals whom they consider qualified to provide specific services and sets forth certain reimbursement conditions that may not be met by cross-trained personnel (Intercommission Council, 1995). These liability issues could lead to litigation initiated by either clients or other professionals (Cross-Training Task Force, 1996).

Health care workers who have strong identities with their discipline may feel alienated and angered by their facility's attempts to cross train staff members, contributing to job dissatisfaction (Blayney, 1986; Smith, 1995; Yerxa, 1995). According to Makely (1994), specialization tends to result in higher salaries; stronger professional identities; and, in many situations, enhanced job security and job satisfaction when compared with multiskilling.

Yerxa (1995) countered the assumption that health care is the same as any other business seeking higher efficiency at lower cost. She argued:

Health care has a unique ethical responsibility to patients...they often have broad needs that encompass all of their life endeavors...people who need health care [should] receive quality services, not to generate higher profits but because it is the right thing to do. (p. 298)

Yerxa described misconceptions relating to occupational therapy, such as its knowledge base is limited to the physical and natural sciences; its practice is limited to rehabilitation; and it is so similar to physical therapy that the two professions can be merged into one practice, with a core curriculum that teaches techniques needed for practice. She stated that if this happens, the occupational therapy profession risks losing its unique philosophy of treating...
clients as whole beings and using occupation to guide therapy. Therapists may be reduced to performing technical skills on clients instead of involving them in their recovery process.

One of the major premises of occupational therapy is that the ability to act and function creates a need in humans to do so and that failure to use this ability results in dysfunction (Reilly, 1962). According to Fromm (1941), the need to work and produce is part of self-preservation and is deeply rooted in the physiological organization of people. This biological and spiritual need to work and produce is at the core of the profession’s philosophy and is in danger of being disregarded if occupational therapy is combined with another discipline (Yerxa, 1995).

What Does Multiskilled Mean?

Foto (1996) urged American Occupational Therapy Association (AOTA) members to “develop a consensus... as to what multiskilled means and who a multiskilled practitioner is” (p. 7). As a profession, we must examine whether and how multiskilling can be incorporated into present service delivery models in order to provide the most efficient and effective service.

Should multiskilled refer to one who is cross trained to provide services that are traditionally delivered by other professions? One paradigm could be the development of a rehabilitation aide who is educated and trained to provide nonskilled services or skilled services under supervision. The TriAlliance of Health and Rehabilitation Professionals (1996) endorsed the use of multiskilled personnel at the aide level only. Another model might be a therapist who becomes cross trained through an organized program, gaining a greater knowledge of the other disciplines with whom he or she works (Foto, 1996). A third perspective involves the creation of a universal core curriculum in which anatomy, neurology, psychology, development, and general therapy principles are taught. Such a program would culminate in the student either specializing in a specific discipline or obtaining a rehabilitation specialist degree (Foto, 1996). The AOTA Cross-Training Task Force differentiated multiskilling and cross training, although it acknowledged that current literature does not make this distinction. The task force defined cross training as the “learning process that occurs after completion of entry-level education” (Cross-Training Task Force, 1996, p. 2) and defined multiskilling as “the academic preparation of a person to be credentialed at the entry level in more than one profession” (p. 3). For the purpose of this study, the terms multiskilled and cross trained were used synonymously.

There is also the question of interdisciplinary versus intradisciplinary multiskilling. The task force definition of multiskilling describes interdisciplinary multiskilling. Intradisciplinary multiskilling refers to combining skills within a discipline, such as a practitioner providing treatment in both the physical disabilities and mental health settings.

Purpose

This article discusses the results of a survey of occupational therapy practitioners that addressed knowledge of the multiskilling phenomenon, attitudes toward various aspects of multiskilling, and current practice trends. The researcher hoped to answer the following questions: (a) Is multiskilling of occupational therapy professionals already occurring in some form in most facilities? (b) Do occupational therapy practitioners understand the basic concept of multiskilling and the implications it might have on clients as well as the profession? (c) Have occupational therapy personnel taken the initiative to determine whether multiskilling works for them in their facility? and (d) How should training and education occur so that the unique aspects of occupational therapy are preserved and cost containment is not given priority over quality of client care?

Method

Sample

Potential respondents were selected through proportional stratified random sampling. The procedure was computer-generated and completed by AOTA. Because the ratio of registered occupational therapists to certified occupational therapy assistants is approximately 3 to 1 (U.S. Department of Labor, 1994), the number of practitioners in each subgroup was chosen accordingly (i.e., 150 occupational therapists, 50 occupational therapy assistants). The sample included 200 licensed occupational therapy practitioners who worked at least 20 hours per week, lived in the United States, and were members of AOTA.

Instrument

A 21-item questionnaire that included open-ended and close-ended questions was developed for the study. At the top of the questionnaire, the following definition of multiskilled, adopted by the National Multiskilled Health Practitioner Clearinghouse, was provided:

Persons cross-trained to provide more than one function, often in more than one discipline. These combined functions can be found in a broad spectrum of health related jobs ranging in complexity from the nonprofessional to the professional level, including both clinical and managerial functions. The additional functions (skills) added to the original health care worker’s job may be of a higher, lower, or parallel level. (Blayney et al., 1989, p. 216)

This definition is broad enough to allow for some interpretation and permitted the researcher to see how respondents would define multiskilled while providing comments.
The terms *intrdisciplinary* and *interdisciplinary* were defined through examples within the questionnaire. Closed-ended questions were made up of Likert scale, Guttman scale, or personal data questions. The Likert scales provided a finite series of choices ranging from 1 (not at all or completely disagree) to 7 (very much so or completely agree). The Guttman scales provided yes, no, and unsure choices. A comments section was provided at the end of the survey. To improve content and construct validity, the questionnaire was pretested by a convenience sample of five occupational therapists and one occupational therapy assistant. Changes in the wording of the questionnaire were made on the basis of these practitioners' review.

**Procedure**

Questionnaires were coded to distinguish the occupational therapist and occupational therapy assistant respondents. They were mailed to the sample along with a cover letter that explained the purpose of the study and a self-addressed, stamped, return envelope. The study was exempted from human subjects review.

**Data Analysis**

The quantitative data were analyzed with descriptive statistics, such as frequencies and percentages, means, medians, and modes. T test and multivariate analysis of variance (MANOVA) were used to compare groups of data. These statistics were calculated with the Statistical Package for the Social Sciences (1990), Release 4.1. If two consecutive numbers were circled on a Likert scale, the number closest to the midpoint was recorded in order to avoid biasing the results. For example, if a respondent circled 5 and 6, the 5 was chosen for the data set.

**Results**

Of the 200 surveys mailed, 117 were returned for 58.5% response rate. Twenty-five (50.0%) occupational therapy assistants responded, and 92 (61.3%) occupational therapists responded. All returned surveys were at least partially completed.

Overall, the respondents had been in practice for an average of 12.6 years. Therapist respondents had been practicing for an average of 14.4 years, and therapy assistant respondents for 6.1 years. All major areas of occupational therapy practice were represented, with the largest representation being in rehabilitation (see Table 1). Table 2 depicts respondents' average responses to Likert scale questionnaire items.

Typical explanations to the question “Do you consider your OT [occupational therapy] department to be multiskilled?” included:

- “No, there is a fairly clear-cut division of responsibilities between disciplines.”
- “Yes, we work with the whole person, not just the upper extremity.”
- “[We] no longer [have] an OT department, [we have] combined OT and PT into a single department.”
- “We are beginning to look at it and implement it.”
- “With only one OT, all areas of expertise are required to be filled by that person.”

The responses were fairly evenly divided between yes (43.6%) and no (37.6%), with 14.5% answering unsure.

In response to the question “Were you asked if you were multiskilled upon employment at your current facility?” 6.0% answered yes, 89.7% answered no, and 2.6% answered unsure. Because of the small number of respondents answering yes, a comparison was performed between the average length of current employment for those who answered yes or no. The average length for those who answered yes was 2.5 years compared with 4.7 years for those who answered no. When asked to list the areas in which they believed had the most need for additional skills, respondents listed physical therapy (26 times) as the most common area. Next were psychology and psychiatry (10 times each) and speech–language pathology (6 times). Management or administration, pediatrics, and nursing were each cited 4 times.

Some comments in response to the statement “I believe that occupational therapy and physical therapy will eventually merge in the U.S.” included: “As insurance payers become increasingly in charge of health care benefits, a merge [may be] the most beneficial to OT in gaining power by number and knowledge of treatment methods” and “It’s already happening, particularly in rural areas where it’s difficult to attract and retain sufficient OT/PT staff.” One respondent pointed out that “This didn’t work in Canada—two different professional conceptual perspectives—there is enough to do for each—

### Table 1

<table>
<thead>
<tr>
<th>Practice Setting</th>
<th>n</th>
<th>(%)</th>
</tr>
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<tbody>
<tr>
<td>Acute care</td>
<td>20</td>
<td>(17.1)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>26</td>
<td>(22.2)</td>
</tr>
<tr>
<td>Mental health</td>
<td>17</td>
<td>(14.5)</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>42</td>
<td>(35.9)</td>
</tr>
<tr>
<td>Home health</td>
<td>24</td>
<td>(20.5)</td>
</tr>
<tr>
<td>Wellness</td>
<td>4</td>
<td>(3.4)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>47</td>
<td>(40.2)</td>
</tr>
<tr>
<td>School based</td>
<td>26</td>
<td>(22.2)</td>
</tr>
<tr>
<td>Research</td>
<td>3</td>
<td>(2.6)</td>
</tr>
<tr>
<td>Administrative</td>
<td>25</td>
<td>(21.4)</td>
</tr>
<tr>
<td>Faculty or research</td>
<td>7</td>
<td>(6.0)</td>
</tr>
<tr>
<td>Industrial rehabilitation</td>
<td>5</td>
<td>(4.3)</td>
</tr>
<tr>
<td>Hands</td>
<td>19</td>
<td>(16.2)</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>(9.4)</td>
</tr>
</tbody>
</table>

Note. N = 117.
Table 2

Average Responses to Likert Scale Questionnaire Items

<table>
<thead>
<tr>
<th>Question</th>
<th>M</th>
<th>SD</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>How familiar were you with the concept of multiskilling prior to receiving this survey?</td>
<td>3.69</td>
<td>1.83</td>
<td>4.00</td>
</tr>
<tr>
<td>How great a need do you see for multiskilling of occupational therapy at your workplace?</td>
<td>4.17</td>
<td>1.81</td>
<td>4.00</td>
</tr>
<tr>
<td>How beneficial to the client is intradisciplinary multiskilling of occupational therapists?</td>
<td>5.06</td>
<td>1.43</td>
<td>5.00</td>
</tr>
<tr>
<td>How beneficial to the OT profession is intradisciplinary multiskilling?</td>
<td>5.06</td>
<td>1.38</td>
<td>5.00</td>
</tr>
<tr>
<td>How beneficial to the client is interdisciplinary multiskilling of OT?</td>
<td>4.81</td>
<td>1.71</td>
<td>5.00</td>
</tr>
<tr>
<td>I am in favor of becoming multiskilled within the OT profession.</td>
<td>5.15</td>
<td>1.73</td>
<td>5.00</td>
</tr>
<tr>
<td>I am in favor of occupational therapists performing skills traditionally belonging to other health care disciplines.</td>
<td>4.09</td>
<td>1.86</td>
<td>4.00</td>
</tr>
<tr>
<td>I am in favor of other health professionals being trained to perform skills traditionally belonging to OT.</td>
<td>3.80</td>
<td>1.93</td>
<td>4.00</td>
</tr>
<tr>
<td>I believe occupational therapy and physical therapy will eventually merge in the U.S.</td>
<td>3.41</td>
<td>1.91</td>
<td>3.00</td>
</tr>
</tbody>
</table>

Note. N = 117. OT = occupational therapy.

* Generally denotes "not at all"; 7 generally denotes "very much so."

OT and clients would suffer." Another respondent related the question to his or her own needs in terms of health care: "When I seek health-related services, I look for the specialist in the area of need. I want to give as well as receive the most specialized care in any particular area." Another respondent believed that there is a strong need for both services. While collaboration is necessary and useful, it would be a loss to both were the two to merge. In other words, the particulars of [physical therapy] would take away from further knowledge of OT.

Still another respondent looked at occupational therapy's history in health care and said, "OT has worked too hard over many years to identify itself as a separate entity and [gain] respect as a profession." Although the occupational therapy assistants consistently responded higher on the Likert scale questions than the therapists, a MANOVA found no significant differences between the responses of the two groups.

Discussion

Results of this study suggest that occupational therapy personnel have a moderate understanding of the concept of multiskilling as it relates to occupational therapy, but the concept has not reached everyone, as one third of the respondents indicated. A great degree of variability continues to exist about what exactly is meant by multiskilling; respondents used the term to describe many different scenarios of service delivery.

As to the implications of multiskilling on occupational therapy clients and the profession, many therapists responded that although the voluntary addition of some skills would benefit both the client and profession, requiring practitioners to be competent in another complete profession, such as physical therapy, could decrease the level of competence in both areas. Respondents expressed Yerxa's (1995) concerns that other professions are not experienced in using occupation and a holistic model to treat clients, and if occupational therapy skills are taught to those in other professions, the emphasis on these unique qualities is likely to be diminished.

The multiskilling trend appears to be occurring formally through defined departmental protocol and, perhaps more commonly, on an informal basis by doing what needs to be done in order to treat the client effectively. Respondents indicated that their occupational therapy department was multiskilled (a) if there has been some formal departmental training skills traditionally provided by another profession, (b) if one or more therapists have independently sought additional knowledge and skill, or (c) if they believed that their department was multiskilled within the department itself (intradisciplinary multiskilling). It was often not clear how the respondent(s) had gained the additional knowledge and skill, only that these were available to clients. Some who responded that multiskilling is not occurring at their facilities explained that there was an impetus in their departments to prevent duplication of services.

Most of the respondents who were familiar with multiskilling issues had strong opinions regarding what form(s) of multiskilling would be beneficial to clients and the occupational therapy profession. Several responded that the addition of skills should be done voluntarily, not imposed by persons either outside or within the profession. Some believed that as practitioners feel competent in their jobs and desire an increase in their knowledge or skills, then it is appropriate for them to seek multiskilling in an area of their choice. This method of continuing education may create practitioners who are motivated to become multiskilled, are likely to provide better care to clients, and are more desirable to employers.

Implications for Practice

Implications of this study to occupational therapy practitioners are several. Practitioners need to work together within the profession as well as with other health care professions to (a) come to a consensus about how to define multiskilling and cross training; (b) develop methods of service delivery that respond to administrative pressures...
and financial constraints in ways that preserve the unique and valued aspects of the occupational therapy profession; and (c) begin to provide outcome data that address cost-effectiveness, efficiency, quality of care, and client satisfaction of all current service delivery methods.

Limitations

Use of only AOTA members for the sample may have biased results in several ways, including that AOTA members may be more informed than nonmembers and that they may be more likely to have endorsed AOTA’s official position regarding multiskilling. Additionally, the wording of some of the survey questions may have been confusing to some respondents, resulting in surveys that were not returned or questions that were left blank or misinterpreted. This might have been avoided by having the questionnaire reviewed by experts with particular knowledge of multiskilling issues and survey development (e.g., AOTA’s Cross-Training Task Force). Although the response rate was acceptable for this type of survey, it is likely to have been increased by using follow-up mailings.

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