This is the Author’s version of the paper published as:

Author: C. Wilding, L. Somerville and R. Bourne
Author Address: c.wilding@csu.edu.au
l.somerville@alfred.org.au
Ralda.Bourne@svhm.org.au
Title: Credentialing, competency, and occupational therapy: what does the future hold?
Year: 2007
Journal: Australian Occupational Therapy Journal
Volume: 54
Pages: ppS98-S101
ISSN: 1440-1630
URL: doi: 10.1111/j.1440-1630.2007.00679.x
Keywords: acute healthcredentialingcompetencyoccupational therapyprofessional standard
Abstract: There is no abstract for this article
Viewpoint

Credentialing, competency, and occupational therapy: What does the future hold?

By Lisa Somerville, Clare Wilding & Ralda Bourne

Introduction

This paper aims to explore the issue of measuring competencies via credentialing and it also outlines an approach to credentialing that is currently being put into action in some hospitals in Melbourne, Australia. Through presentation of our experiences with implementing credentialing, we are intending to contribute to the debate about the way that credentialing is manifested within occupational therapy.

It is widely accepted that a condition of membership of a profession, such as occupational therapy, is dependent upon an individual attaining competence in the knowledge and practices of the chosen profession. OT AUSTRALIA (1994, p. 3) defines competence as “…a complex interaction and integration of knowledge, judgement, higher order reasoning, personal qualities, skills, values and beliefs… Competent professionals will recall and apply facts and skills, evaluate evidence, create explanations from available facts, formulate hypotheses and synthesise information from a rich and highly organised knowledge base… as such it is a construct which is both abstract and tangible”. A competency (and its plural, competencies) is a specific task that may be measured through a credentialing process. One way of evaluating competence is to demonstrate proficiency in a range of competencies.

Credentialing is a term that has become part of the commonplace vernacular of modern health services. Credentialing is “a process for assigning specific clinical responsibilities (scope of practice) to health professionals on the basis of the training, qualifications, experience and current practice, within an organisational context” (New Zealand Ministry of Health, 2003). Competence denotes the skills a practitioner has attained, and these abilities may be measured as credentials; that is, the process of measuring competence is credentialing and the outcome is a credential.

Why credential?

There are a number of reasons that underpin the desire for Australian occupational therapists to be involved in a credentialing process that is additional to the awarding of basic occupational therapy qualifications. An initial degree in occupational therapy establishes that an occupational therapist has developed a level of proficiency as a novice or entry-level therapist, but this is only the beginning of the journey of learning and
development. New graduate practitioners require ongoing guidance, and structured learning goals to build on the skills they have begun to develop as students into those that are demanded of practising occupational therapists. It is also recognised that “initial competence does not assure continuing competence” (Youngstrom, 1998, p. 717). Competence should be seen as an ongoing cyclical process; an occupational therapist will clearly need to engage in lifelong learning (Brown, Esdaile & Ryan 2004; Youngstrom, 1998). The awarding of credentials formalises and offers public acknowledgment that ongoing learning has been undertaken and that continuing competence has been achieved.

It is clear that occupational therapy is a profession that contributes to a diverse range of practice settings, and therefore, without doubt, new learning must occur for therapists to achieve competence to practice within a designated practice area in which they have not previously worked; for example, hospital-based practice, community-based practice, working in a school setting, working in a specialist mental health facility. These different practice settings may desire that occupational therapists are credentialed to practice within such specialised contexts.

Modern health services and government funders require that professionals are highly accountable to the public that they serve. They want to be certain that health professionals are proficient and consistent in their particular speciality of service delivery (Anderson 2000; Evert 1993; Holm 2000). The trend in health care delivery driven by a more litigious society is towards a risk management approach, in which policy and governance principals emphasise risk minimisation and explicit quality standards. This has resulted in managers and senior health executives working towards processes such as credentialing of health workers to ensure that a high quality, professional service that is low in risk for patients, is provided.

In addition to these obvious external drivers of credentialing, we propose that there are also a number of internal motivators for occupational therapists to take on credentialing. For example, credentialing can be a natural outcome of a supervision process. Supervision is a usual and regular activity in many practice settings. We suggest it would be only a small step to formalise the outcome of learning that occurs within supervision into a credential that can be used to demonstrate the learning that has been achieved. An example of how this may be accomplished will be discussed later in this article. The attainment of a credential could also be used to formalise, focus, and gather resources to support occupational therapists in learning a particular desired skill or ability. A credential is a clear outcome for occupational therapists who engage in a particular professional development activity. This may make continuing professional development activities more attractive to those managers who need to be assured that there will be an outcome from such undertakings.

**Challenges of credentialing**

As has been outlined there are advantages to credentialing, and there are many advocates of credentialing. However, the implementation of credentialing can also pose many challenges and raises questions that are not easily answered; for example, who
determines the standards of competence that the credentials measure? Is it the occupational therapist or the occupational therapist’s work that is being assessed? (And is it actually possible to differentiate between therapists and their occupational therapy practice?) How are the acts of competence sampled? Does the demonstration of a competency mean that a practitioner can actually be credentialled as a competent practitioner in a broader sense? Is it possible to reduce a complex practice such as occupational therapy to a series of competencies?

Despite the existence of these perplexing questions, there is a sense that within the current political and economic climate there is a certain inevitability that occupational therapists will be required to engage in credentialing. The solution may be that some models of credentialing are better suited to occupational therapy than others. In particular it is important to find ways that the complexity of occupational therapy can be acknowledged within the credentialing process, so that practice is not perceived by others to be easy, routine or overly technical to the detriment of the artistic and ethical dimensions of practice (Rogers, 1983). In addition, we believe that it is important to guard against credentialing becoming an empty process that on the surface appeases others, but that underneath has no real meaning; the process must be useful in assisting occupational therapists’ practice to be true best practice.

**Credentialing models**

There is a profusion of approaches that occupational therapists and other professions have utilised to enhance the competence of their practitioners, including: testing and examination (Salvatori, Baptiste & Ward, 2000; Siker, 1999); simulation exercises (Siker, 1999); accreditation (OT AUSTRALIA, 2001); registration/certification (Siker, 1999); peer review; patient outcome studies; self appraisal (Youngstrom, 1998); reflective practice and journaling (Brown et al., 2004); apprenticeship model (for credentialing new graduate therapists) (Evert, 1993); and, portfolios demonstrating continuing professional development (Brown et al., 2004). It is not possible in this article to debate the various pros and cons of this panoply of methods of credentialing. Instead, we will provide a sketch outline of a method that is currently being trialled within a number of hospitals in Melbourne. We adopted the approach described here since we believed that the biggest challenge we faced in the credentialing process was being able to capture the clinical reasoning that underpins occupational therapists’ performance of skills and tasks.

**A proposed approach for credentialing occupational therapists**

In April 2005, a group of occupational therapy managers and senior occupational therapists employed in acute public health services in Melbourne formed a collaborative to develop a credentialing programme that was relevant to these services and that aimed to enable a reliable, consistent and professional level of occupational therapy service provision within these facilities. At this early phase, the group is aiming to achieve a “seal of approval” (American Speech Language Hearing Association, 1997-2006) credential level for some aspects of staff competence. The process established by the collaborative requires each health service to document competencies around identified
key clinical behaviours or tasks, and develop a credentialing tool for that competency. To date, the group has developed processes for credentialing skills in completing initial and home assessments and prescribing equipment. The members of the credentialing collaborative have agreed that they will acknowledge and recognise credentials awarded within each other’s facilities. Thus, if an occupational therapist resigns from one member health service and gains a position with another member health service, then their credentials will be recognised.

The framework developed for assessing competence and determining a credential has been to use a process similar to the Chart-Stimulated-Recall Tool (Salvatori et al., 2000). Prior to the therapist commencing the credentialing assessment, some preliminary steps must occur, including: orientation to relevant documents, policies and protocols and an opportunity to observe an experienced occupational therapist completing the task. Then, the first step of the credentialing process is for the applying occupational therapist to discuss with their supervisor the case story of a client that the applicant is currently working with. The focus of the presentation should be on the applicant’s ability to produce a clear, articulate and well-justified explanation of their clinical reasoning process. The applicant should explain how theory and evidence (from research and/or practice experience) underpins their decision-making, as a demonstration of the applicant’s competence in this area of practice. At this point the applicant’s supervisor may identify areas or issues that the applicant has omitted and any flaws in the applicant’s reasoning process. The applicant would be required to follow-up on these suggestions thus undertaking further learning and development of their skills. The preliminary steps and the credentialing process occur as a part of the staff member’s regular supervision. At the conclusion of the credentialing process, the supervisor signs off that the occupational therapist has achieved the credential and is therefore deemed competent in that aspect of practice.

This credentialing process has been trialled in two of the collaborating health services. It was found that whilst this program in its current format is not dissimilar to the process of supervision that many occupational therapists undertake, anecdotal feedback from participants indicates that it enhanced the supervision process by introducing more structure for learning and a more rigorous process of orientation to specific aspects of occupational therapy practice within an acute setting. It assisted with the development of greater accountability for learning and more explicit demonstration of clinical reasoning through the case discussion. In addition, the system formalises the process of induction and provides the applicant and the employer with a clear outcome of attainment of proficiency; the credential.

**Potential for further development**

While the process outlined in the previous section represents the point to which the group has currently progressed, we would like to be able to take credentialing an extra step so that learning within the whole department, as well as within individuals, may be stimulated. So, a further step could be, once applicants have developed the case story analysis to a level that they and their supervisors are satisfied with, an appointment is
made to present the case story to a broader and larger audience; for example, to a meeting of occupational therapists. Within the public forum, the applicant presents the case story, emphasising their analysis and illustrating the application of occupational therapy theory and philosophy, research, and practice experience in making decisions, as opposed to just a description of the client’s story. After the presentation, the audience is encouraged to critically examine and question the applicant’s decision-making. The point of this is that having successfully answered a critical peer review, the applicant can be confident that their process of reasoning is sound, robust and of high quality. Through this private and public debate, their competence is tested and thus applicants can be publicly credentialled.

Conclusion
The issue of determining professional competence through a credentialing process is complex, complicated and potentially very contentious. There is a profusion of ways in which credentialing may be undertaken. In this article we have presented some of our beginning thoughts and actions undertaken in relation to credentialing for occupational therapists within Australian acute hospital settings. As we aim to take a proactive approach to meeting our organisations’ demands for credentialing, we are also hoping to make this a process that is meaningful and relevant to daily occupational therapy practice, rather than an inane organisational hurdle.

References


