# What's in the Fridge? Unique Competencies of Community-Based Occupational Therapists

Sunny R. Winstead
*Keuka College - USA*, winstead.sandritter@gmail.com

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## Credentials Display
Sunny R. Winstead, MS, OTR/L

## Introduction: The Case of Mr. L.

The purpose of this article is to highlight findings in the literature related to community-based occupational therapy competencies, and to suggest the importance of addressing these competencies in the educational preparation of occupational therapy practitioners.  This article was inspired by an interaction in the occupational therapy classroom, where I recently introduced the following case in a lecture about home health care:

*I was completing a home evaluation with Mr. L., an older man with multiple sclerosis.  I had known Mr. L. for several years, since he received services from the vocational agency where I contracted.  However, he had never received occupational therapy, and this was my first visit to his home.  The day was hot, his apartment was small and cramped, and it was clear Mr. L. had very limited financial resources.  After finishing the evaluation, we chatted for a few minutes in the kitchen, and Mr. L. asked me if I would like a nice cold Coke before I left.*

I used this simple case in class to illustrate one unique element of home health care practice: The balance between being a clinician and being a guest in an individual's home.  As I had hoped, the case generated some lively discussion about whether or not to accept the Coke, and why or why not. Eventually, the students wanted to know what I had done, and I told them yes, I had accepted the Coke.  And then I asked this question: When Mr. L. opened the refrigerator to get the Coke, what was inside the refrigerator? The students had a lot of guesses (drugs, a weapon, junk food, a dead animal), but none was correct.

This classroom experience got me thinking, and so I told the same story of Mr. L. to three friends, each a clinician in community-based practice.  It is interesting that all three of my friends knew what was in the refrigerator.  This was in no way scientific, but it sparked my interest.  In particular, I began wondering if clinicians in community-based settings (such as home health care, early intervention, community mental health, or vocational services) need somewhat different competencies than their colleagues in institution-based settings (such as hospitals, schools, or nursing homes).  If so, what are these unique competencies? And how can we as educators most effectively prepare students for current and future opportunities in community-based practice?

## General Competencies in Community-Based Occupational Therapy Practice

Although not extensive, the current literature suggests that community-based occupational therapists (OTs) have competencies in common with their colleagues in other settings, but that they also have competencies that are unique to working in the community.  Lysack, Stadnyk, Paterson, McLeod, and Krefting (1995) published the earliest study located for this review.  The study was based on a survey of 130 community-based Canadian OTs.  Job skills identified by the respondents as the most important included communication, networking, client assessment, consultation, client education/treatment, charting, staff education/inservices, and individual counseling (Lysack, Stadnyk, Paterson, McLeod, & Krefting, 1995).  While the authors acknowledged sampling limitations, this study was one of the first to add

specific data to the question of what makes community-based occupational therapy unique.

More recent studies have provided additional insights. Holmes and Scaffa (2009a) used the Delphi method to gather specific information about competencies and competency development from a group of 23 occupational therapy panelists. Through three rounds of responses, the panelists identified competencies in the following categories: (a) knowledge; (b) performance skills; (c) critical reasoning; (d) ethical reasoning; (e) interpersonal abilities; and (f) traits, qualities, and characteristics (Holmes & Scaffa, 2009a). In most of the categories, analysis showed that participants rated general-practice competencies highly. For example, the highest-ranking competencies in the knowledge category included knowing occupation-based practice and applying theory to intervention (Holmes & Scaffa, 2009a), both skills that apply equally well to institutional-based practice or to community-based practice. The authors' analysis also identified competencies unique to the community. For example, in the knowledge category participants valued program development, an understanding of community systems, and knowledge of public health (Holmes & Scaffa, 2009a), all skills that are specific to community-based practice. The traits category also yielded interesting results, with participants rating self-direction, adaptability to new situations, ability to step outside the medical model, confidence, and perseverance most highly (Holmes & Scaffa, 2009a).

There was significant overlap between the personal traits identified by Holmes and Scaffa (2009a) and those found by Ramsey (2011), with both studies highlighting the importance of a flexible, self-directed, and persistent approach to occupational therapy practice in the community. Ramsey conducted semi-structured interviews with community-based OTs in order to explore their experiences and perceptions. The following themes emerged: (a) respondents liked the autonomy of their work, (b) respondents valued the opportunities for creativity that their work provided, (c) respondents found it satisfying to be able to motivate clients toward goals, (d) respondents felt specific personal traits facilitated their success in community-based practice, and (e) respondents felt the need for more professional support and recognition (Ramsey, 2011).

Scaffa (2014) drew on the results of the Holmes and Scaffa study (2009a) in combination with the American Occupational Therapy Association's (AOTA) *Standards for Continuing Competence* (2010) to create a framework of competencies and characteristics needed for community-based and emerging practice. These competencies cluster in six categories: (a) knowledge; (b) performance skills; (c) critical reasoning; (d) ethical reasoning; (e) interpersonal abilities; and (f) traits, qualities, and characteristics (Scaffa, 2014). Five of these categories align with the AOTA's *Standards for Continuing Competence* (2010). The sixth category—traits, qualities and characteristics—was drawn from the Holmes and Scaffa (2009a) study, and is also consistent with the personal qualities identified by Ramsey (2011). The framework developed by Scaffa is a comprehensive identification of unique

competencies based on the current literature. As such, it could be a starting point for more fully integrating research on community-based competencies into occupational therapy curricula.

## Clinical Reasoning in Community-Based Occupational Therapy Practice

Scaffa (2014) identified critical reasoning and ethical reasoning as among the unique competencies for OTs in community-based practice. A number of studies have examined clinical reasoning in occupational therapy generally, but the research specific to community-based practice is limited. In a 2010 scoping review, Carrier, Levasseur, Bédard, and Derosiers found that both internal and external factors influenced community-based OTs' clinical reasoning. Practice context (an external factor) had a particularly strong impact on community OTs' clinical reasoning (Carrier, Levasseur, Bédard, & Derosiers, 2010), suggesting that because community-based practice occurs in many settings, it requires unique reasoning. Carrier et al. also found that in comparison to OTs in other practice settings, community-based OTs used interactive reasoning more often, and they tended to use different dimensions of clinical reasoning simultaneously (Carrier et al., 2010).

Other authors have drawn similar conclusions, noting that the use of multiple forms of clinical reasoning at once suits the complex decision making required in early intervention (Hanft & Anzalone, 2001) and home health care (Mitchell & Unsworth, 2004). Although much remains unknown, the existing literature suggests that community-based OTs may have a unique approach to clinical reasoning, and this approach

may be related to the diversity of contexts in which community-based practice occurs. Teaching students how to identify contextual factors and incorporate these into clinical reasoning may be one practical application of this research.

## Setting-Specific Competencies in Community-Based Occupational Therapy Practice

In addition to the general competencies already outlined, several studies have examined competencies in specific areas of community-based practice. In a 2013 systematic review, Adam, Peters, and Chipchase found that occupational and physical therapists in work-related practice needed (a) workplace knowledge related to injury management and prevention, (b) communication skills, (c) work assessment and intervention skills, (d) clinical reasoning skills, and (e) professional behaviors (self-reflection, presence, and confidence). While much of the necessary knowledge identified in this study was context specific (such as injury prevention techniques and ergonomics), the more general competencies identified were consistent with findings from other research. These competencies included ethical behavior, adaptability, communication, and clinical reasoning. Therapists and employers identified many of these same competencies in a subsequent qualitative study of work-related practice (Adam, Strong, & Chipchase, 2014). Bowman (2014) also noted that OTs in community-based ergonomic practice need to be skilled at assessing and responding to multiple environments, suggesting the need for the context-specific clinical reasoning identified by Carrier et al. (2010). These studies suggest that while setting-specific knowledge is a

critical competency, educators should also emphasize competencies that cut across community-based practice settings, including clinical and ethical reasoning, communication, and personal qualities, such as adaptability and self-reflection.

## Perspectives of OTs in Community-Based Practice

Several studies have examined the perspectives of OTs in community-based practice using exploratory or qualitative methodology. Findings have illuminated OTs' perceptions of preparation for community-based practice, the perceived rewards and challenges experienced in community roles, and therapists' recommendations for preparing students. In general, OTs have reported that their educational programs prepared them effectively for traditional practice but less so for non-traditional or community-based practice (Ramsey, 2011; Wood, Fortune, & McKinstry, 2013). Respondents have identified the need for additional training in the areas of consultation, advocacy, use of community resources, health promotion, and "macro-level" services to populations (Ramsey, 2011; Wood et al., 2013).

Rewards identified by community-based practitioners have included workplace autonomy, opportunities for creativity, and the satisfaction of helping clients achieve goals (Ramsey, 2011). In addition, the OTs in the Holmes and Scaffa study (2009b) identified promoting the profession, acting as change agents, serving under-served communities, and educating students as unique rewards experienced in community-based practice.

The perceived challenges identified in the literature have been wide ranging, including lack of reimbursement, insufficient funding and staffing, lack of understanding of the OT's role, feeling unsupported (Homes & Scaffa, 2009b; Ramsey, 2011; Wood et al., 2013), lack of preparation based on entry-level education (Adam et al., 2014), and a loss of discipline specialization due to the team-based approach that characterizes community-based mental health practice (Fox, 2013). On the one hand, several of these challenges may be linked to the nature of community-based practice: Occupational therapy practitioners may work without the professional support of other OTs and may work in systems that lack traditional funding structures. On the other hand, the same factors that create challenges can also create opportunities, such as the increased autonomy, creativity, and sense of purpose noted in the literature.

Although there is a need for continued research, there is credible scholarship to support a preliminary understanding of the perceptions of OTs who work in community-based practice, and this scholarship has the potential to inform occupational therapy education. For example, study participants have identified a need to develop specialized skills, such as knowledge of health promotion, awareness of emerging areas of practice, self-directed learning proficiency, business and leadership skills, grant writing, and program development (Holmes & Scaffa, 2009a; Ramsey, 2011; Scaffa, 2014; Wood et al., 2013). Educators could (and do) use this knowledge to tailor classroom learning activities, fieldwork education, and curricular models.

## Summary of Key Literature

Many scholars have called for additional research to better understand the complex issues surrounding community-based practice and emerging areas of practice (Adam et al., 2013; Carrier et al., 2010; Holmes & Scaffa, 2009a; Ramsey, 2011; Wood et al., 2013). Although not extensive, the current literature supports the conclusion that there are competencies and skills unique to those OTs who practice in the community (as compared to their occupational therapy colleagues in institutional settings). These competencies include specialized knowledge, specific patterns of communication, personal traits, and multiple forms of clinical reasoning. In other words, the skills needed to successfully provide occupational therapy to Mr. L. in his home are somewhat different from the skills needed to treat Mr. L. in a hospital or other institution-based setting.

Because some community-based competencies appear to be unique, students may need specialized curricula to prepare for this area of practice, and clinicians working in the community may need tailored professional development resources. There have been recommendations for student preparation (Hanft & Anzalone, 2001; Holmes & Scaffa, 2009a; Holmes & Scaffa, 2009b) and ongoing professional development (Holmes & Scaffa, 2009a; King, 2009). Descriptions of fieldwork education models, educational projects and assignments, curricula, and program models also have been published. However, there remains limited evidence to show which competencies should be taught, or to indicate which models and approaches are most effective in preparing OTs for community-based practice. The next step may be taking advantage of what is already known about competencies to begin designing and evaluating educational opportunities to better prepare OTs for community-based practice.

## Future Practice Trends and Implications

The majority of occupational therapy practitioners currently work in institution-based settings, such as hospitals, nursing homes, and schools. About 15.8% of OTs work in community-based settings (AOTA, 2015b), with only a small fraction of that number in settings that might be considered emerging areas of practice. Practice patterns are not stagnant, however. With ongoing changes in health care, including the implementation of the Affordable Care Act of 2010 (ACA), OTs may have opportunities to move into new practice areas (Brown, 2014; Fisher & Friesema, 2013; Lamb & Metzler, 2014). For example, the ACA identified 10 essential health benefits (U.S. Department of Health and Human Services, n.d.), three of which could offer particular opportunities for community-based OT: rehabilitation and habilitation, mental health services, and preventive and wellness services. In addition, the ACA outlined a number of initiatives designed to improve quality of care while containing costs. Several of these initiatives, including the Independence at Home Project, the Community-Based Care Transitions Program, and several primary care initiatives, have the potential to involve OTs in community-based models (Lamb & Metzler, 2014). Other examples of new opportunities include the recent inclusion of

occupational therapy as suggested staff for certified community behavioral health clinics (AOTA, 2015a), New York's 2015 legislation allowing OTs and physical therapists to provide telehealth services (New York State Assembly, n.d.), and the Jimmo versus Sebelius settlement, which clarified that Medicare does not support an "improvement standard" as the sole basis for claims determination, thereby allowing additional clients to receive skilled therapy in settings that include their homes and communities (Metzler, 2015). As these and other opportunities evolve, OTs have the potential to strengthen their presence in traditional community-based practice and perhaps move into new niches as well. It will be important for educational programs to continue to follow emerging trends and to prepare new graduates for both current and future practice.

## Conclusion

Community-based occupational therapy practice is complex. It includes a wide range of practice settings, services to both individuals and populations, and the need to understand systems and factors that are beyond the entry-level training of many clinicians. Although there are credible studies, dedicated scholars, and innovative educational programs, our understanding of this area of practice is still developing. Further research is not only recommended by scholars in the field, but is also consistent with the AOTA's education research agenda, which includes a call for research that enhances instructional methods, improves understanding of learner competencies, and promotes more effective socialization to the profession (AOTA, 2014). Strengthening our

understanding of community-based practice through scholarship and experience may contribute to the development of curricular designs and professional development opportunities that more effectively prepare OTs to flourish in diverse community-based settings.

So what was in the fridge? Well, it was nothing as dramatic as the students guessed. In fact, it was something quite simple, reflective of a proud older man of very limited means who nevertheless wanted to be a good host to a guest in his home. Readers who have worked in community-based practice have probably already guessed: When Mr. L. opened the refrigerator I saw that it was almost entirely empty, except for the brand-new six-pack of Coke that he had purchased specifically for my visit.

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*Sunny Winstead, MS, OTR/L is Assistant Professor of Occupational Therapy at Keuka College in Western New York. She is also a third-year doctoral student in the EdD program at the University of New England, where her dissertation research explores the development of unique competencies in community-based occupational therapy practice.*

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