A Call to Shift to Competency-Based Education

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This column explores the concept of competency-based education (CBE). A shift to CBE is a key trend for the future of health care education. Health care professions that have adopted, or started to adopt, a CBE framework include physical therapy, speech-language pathology, social work, medicine, nursing, pharmacology, and dentistry. Internationally, many occupational therapy programs are in the process of shifting to, or have shifted to, a CBE model. This column discusses how although select occupational therapy programs in the United States may individually be considering shifting to, or have shifted to, a CBE framework, there is no national movement to explore adopting the model for occupational therapy or a consensus on defined outcomes for the profession.

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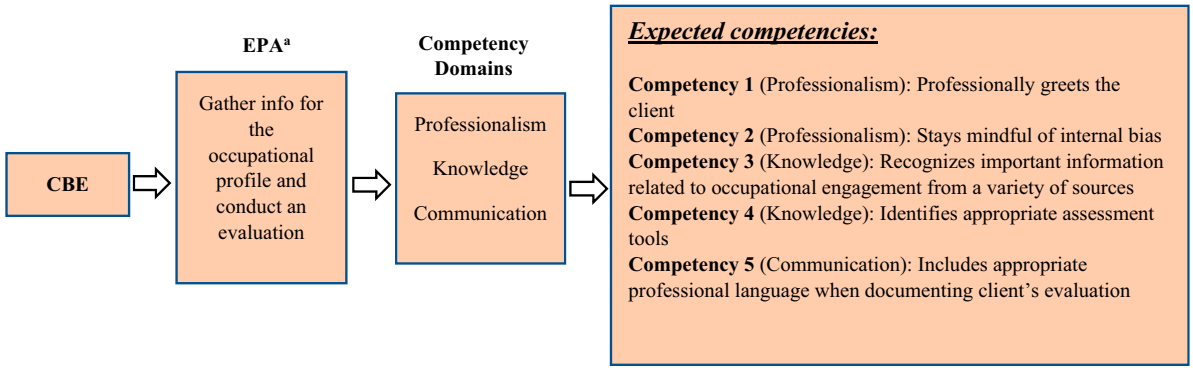
Competency-based education (CBE) is not a new concept. Its origins date back many years (Frank et al., 2010), with some sources tracing its roots back to the Morrill Land Act of 1862 (Gervais, 2016). Likewise, iconic scholars in occupational therapy in the United States have discussed CBE models and their role in building creativity (Barris, 1978) and learners' clinical skills in preparation for occupational therapy practice (Hinojosa, 1985) decades ago. More recently, a shift to competency-based time-variable health professions education has been identified as a key trend for the future of health care education (Thibault, 2020). Health care professions that have moved, or started the shift, to CBE include physical therapy (Timmerberg et al., 2022), speech-language pathology (Walden, 2020), social work (Gervais, 2016), medicine (Frank et al., 2010; Pugh et al., 2017; Van Melle et al., 2019), nursing (Gravina, 2017), pharmacology (Katoue & Schwinghammer, 2020), and dentistry (Tonni et al., 2020).

Internationally, many occupational therapy programs are in the process of shifting to, or have shifted to, a CBE model (Jung et al., 2015). For example, Jung et al. (2015) investigated the adoption of CBE models among international programs and found that 85% of respondents reported using CBE as an educational framework. Although select occupational therapy programs in the United States may individually be considering moving to or have made the move to CBE, there is no national movement to explore a CBE framework for occupational therapy or a consensus on defined outcomes for the profession.

Defining and Identifying Components of CBE

CBE is a learner-centric approach to educational design whereby learner progression occurs only when competency is demonstrated (Thibault, 2020). CBE requires a framework that includes defined performance outcomes and a process to assess whether competence has been demonstrated. Examples of ways to define outcomes include competencies, which are organized into domains, and entrustable professional activities (EPAs). A *competency* is defined as "a characteristic or feature of an individual . . . an observable ability of a health professional to do something successfully or efficiently" (Timmerberg et al., 2022, p. 2). These competencies are generally grouped under similar themes known as *domains of competence*. All of the domains combined capture the essence of a profession. An *EPA* is a task or responsibility (in daily practice) that can be entrusted to a learner once a sufficient level of a specific competence has been reached to allow for unsupervised execution (ten Cate, 2013). CBE targets outcomes that are identified in response to the needs of communities and populations (Thibault, 2020). These outcomes guide curricular designs, fieldwork (FW) education, and the evaluation of educational programs

Figure 1. Example of using EPA, competency domains, and competencies in CBE.



Note. CBE = competency-based education; EPA = entrustable professional activities. [a]Adapted from the Association of American Medical College's core EPAs (Amiel et al., 2022).

(Timmerberg et al., 2022). The absence of a competency-oriented approach can result in unwarranted variation in the performance of learners first entering clinical practice, inconsistent occupational therapy practices, and subpar service quality (Hinojosa, 1985).

Competencies may be difficult to measure in isolation because they are influenced by context. The Association of American Medical Colleges (AAMC) established a framework that uses core EPAs expected of all medical graduates transitioning to medical residency (Amiel et al., 2022). EPAs prepare learners to be confident entry-level practitioners early in their professional careers. The first core EPA identified by the AAMC is "gather a history and perform a physical examination." Using occupational therapy terminology, an EPA for a CBE can be "gather information for the occupational profile and conduct an evaluation" (see Figure 1).

Reasons for Shifting to CBE

The traditional teaching approach develops a curriculum on the basis of content areas defined by accrediting bodies. Progress has been made on the use of backward design (Wiggins & McTighe, 2005) to guide occupational curricula development (American Occupational Therapy Association [AOTA], 2021), and CBE uses a backward-design model that places the needs of society at the forefront. Despite the complexities of the U.S. health care system and the increasing strains on reimbursing occupational therapy services, our profession has not yet made the move to adopt CBE. With the need to deliver culturally relevant quality care, bias-free professional communication, and other skills related to diversity, equity, inclusion, and justice, the need to move to a more accountable approach to occupational therapy education is imperative. In this column, we call for the profession to declare a shift to CBE, adopting an evolved approach to occupational therapy education, and thus propelling occupational therapy practice toward the highest standards. In the sections that follow, we highlight some of the pressing reasons for the shift.

Enhancing Quality of Care and Accountability

The lack of defined standard performance outcomes for all occupational therapy practitioners entering clinical practice has inevitably led to occupational therapy practitioners entering the profession with variable levels of performance. Therefore, not all clients are receiving the highest quality care. CBE would increase public awareness of occupational therapy practitioners' role as a member of the health care team and reduce the amount of unwarranted variation of learners entering clinical practice, thus ensuring consistent service delivery. The effectiveness and outcomes of occupational therapy treatment can then be better assessed, justifying payment for occupational therapy services.

Learner-Centered Education

A hallmark of CBE is the establishment of defined performance outcomes across the continuum of learners. Although the outcome of a training program would be standardized, the format and time to complete it can vary. Accommodating the diversity of learners' abilities and experiences allows for alternate pathways to achieve the outcomes and flexibility and contributes to an inclusive teaching environment (Anderson, 2018; Columbia Center for Teaching and Learning, 2017). CBE provides a framework for faculty and learners to become true partners in the educational experience (Curry & Docherty, 2017). Transferable learning objectives empower learners (Rogers, 2021; Sturgis & Patrick, 2010), resulting in more confident clinical professionals (Hinojosa, 1985). Assessment is a meaningful and positive learning experience for learners, and learners receive timely, differentiated support that is based on their individual learning needs and competency level (Rogers, 2021; Sturgis & Patrick, 2010).

Consistency of Evaluating FW Education

In traditional FW education, learners' performance is assessed using

the Fieldwork Performance Evaluation form (AOTA, 2020). This form uses scales that rely on the FW educator's perception of satisfactory performance in clinical settings. Hence, the evaluation of FW education in occupational therapy may lack robust reliability to assess the overall competency for entry-level practice. Scales developed for evaluating EPA, such as an entrustment supervision scale (ten Cate et al., 2020) may increase reliability and the ability to distinguish learners on the basis of their performance. A CBE-oriented approach to assessing FW experiences may increase reliability in distinguishing learners on the basis of their performance.

How Do We Do It? Preliminary Action Steps Toward CBE

Transitioning to CBE from traditional teaching models is a major undertaking. Although challenges are inherent to any change, there must be a strategic plan to mitigate these challenges. A shift toward a CBE model will require a comprehensive approach to changes in both the culture and curriculum structure within occupational therapy and occupational therapy assistant educational programs. In the sections that follow, we offer suggestions for how to make the shift.

Culture

The pedagogical culture in occupational therapy education must shift from sequential learning, with little variation or flexibility, to customized education to meet the individual learner's needs, while recognizing that learners demonstrate competence at different times. AOTA can call for the shift to CBE by creating informative material on CBE frameworks and offering resources to programs to prepare for the transition. AOTA's Commission on Education can form a task force to gauge interest in this shift, identify domains of competence and expected competencies, and develop EPAs.

Stakeholders

To identify domains of competence, competencies, and EPAs, there must be a shared understanding and vision of CBE across all stakeholders. Vital stakeholders (e.g., the Accreditation Council for Occupational Therapy Education and the National Board for Certification in Occupational Therapy, both of which comprise a diverse group of occupational therapy leaders, educators, practitioners, FW educators, researchers, learners, and consumers of occupational therapy services) must engage in a collaborative process of establishing a shared language specific to CBE. Once EPAs are defined, an entrustment supervision scale needs to be developed for the assessment of EPAs. This scale should indicate how much supervision a learner will need to perform a given EPA safely and effectively. It is noteworthy that identifying the core EPAs and corresponding competencies can be a lengthy process that requires input from several groups of stakeholders to ensure a comprehensive set of outcomes that meet societal needs. To establish this common language, and determine the collective opinion of all stakeholders, it will be necessary to use a Delphi survey method (Shariff, 2015). Support from AOTA in such a process is critical.

Educational Research Agenda

Once the profession has clearly identified domains of competence, competencies, EPAs, and assessment scales for EPAs, the profession must develop an educational research agenda for CBE. The findings can help support "widespread adoption, informed and refined processes, understanding, and infrastructure development" (Jensen et al., 2022, p. 334). Dissemination of these findings can further generate a shared understanding of and trust in CBE for the occupational therapy profession (Bryk et al., 2015).

With the evolving state of health care, the national and global shift to CBE in health care education, and the need to establish clear entry-level competencies, a shift to a more accountable, robust, and transferable education is paramount. We call for the profession to consider a shift to CBE to prepare competent practitioners, ensure superb service delivery, and solidify the role of occupational therapy within the health care team.

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