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COMPETENCY-BASED EDUCATION

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DEVELOPMENT OF COMPETENCY-BASED EDUCATION

Scholars have been writing about competency-based education (CBE) for more than three decades (Frank et al., 2010). A recent search on EBSCOhost Academic Premier restricted to peer-reviewed manuscripts on competency-based education returned no fewer than 1,500 articles published between 2000 and 2015. Although this was not a rigorous search, it illustrates how competency-based education is an educational priority. Social work (Berkman, 2011; Council on Social Work Education [CSWE], 2008, 2015; Damron-Rodriguez, 2008), medicine (Frank et al., 2010; Iglar, Whithead, & Takahashi, 2012), nursing (Leung, Trevena, & Waters, 2016), psychology (Rudin et al., 2007), and public health (Bennett & Watson, 2015) have all adopted a competency-based approach to learning. Although the operationalization of CBE does vary, there is a consensus that CBE should provide a pedagogy that integrates what the student needs to know with what the student is able to do (Rudin et al., 2007). Demonstrating knowledge transfer to the performance of skills is the goal of all CBE; however, moving from knowledge of theory to practice competence is easier said than done and perhaps even more difficult to evaluate.

To state that there is great variation in the number and content of the competency statements for each health discipline would be an understatement. For example, the 2008 Educational Policies and Standards contained 10 core competencies for foundation and advanced master's practice (CSWE, 2008). More recently, the 2015 Social Work Competencies listed nine competency domains that provide greater clarity of expectations through 31 subcompetencies. The Accreditation Council for Graduate

Medical Education (ACGM) identified the following six areas of competence that are operationalized using 36 subdomains: patient care, medical knowledge, interpersonal skills, communication skills, professionalism, and systems-based practice (Educational Commission for Foreign Medical Graduates, 2012). Last, the American Nurses Association's 2013 statement lists six broad competency domains with 20 competency standards. Given the multiple permutations of competency statements, a detailed description of each is well beyond the scope of this text. This chapter provides a brief review of competency-based education in social work and in the larger arena of CBE in health care by focusing on the work by Englander and colleagues (2013).

CBE IN SOCIAL WORK

The CSWE Educational Policies and Standards (EPAS) describe competency-based education as follows: "Competency-based education rests upon a shared view of the nature of competence in professional practice. Social work competence is the ability to integrate and apply social work knowledge, values, and skills to practice situations in a purposeful, intentional, and professional manner to promote human and community well-being" (CSWE, 2015, p. 6). CSWE mandates that EPAS is to be reviewed and updated every seven years. The 2015 EPAS represents the results of a five-year process to update the original standards established in the 2008 EPAS report. Similar to competency statements in nursing, social work competencies recognize the importance of competencies that address competencies at both the undergraduate and graduate level. Terminology such as "practice behaviors" clearly indicates the importance of demonstrating competence that is grounded in practice and not just demonstrated by mastery of knowledge that is evaluated by an exam. Social work programs are allowed to add to the stated competencies and are encouraged to use an integrated design that is consistent with the mission and goals of the program, the explicit curriculum, the implicit curriculum, and assessment.

The nine CSWE competency domains presented in Table 1.1 are operationalized further by 31 subcompetencies that speak to knowledge, values, skills, and cognitive processes that comprise competency at the generalist level of practice (CSWE, 2015). CSWE accreditation policies and standards provide further guidance distinguishing the expectations for the generalist and specialist levels of education, as well as for the implicit and explicit curriculum, field practicums, and assessment. Guidelines for evaluating CBE emphasize the importance of integrating classroom learning with field practicum. This is most clearly articulated in the Educational Policies section of EPAS, which recognizes field practicum as the signature pedagogy of social work education. As CSWE explains, "Signature pedagogies are elements of instruction and of socialization that teach future practitioners the fundamental dimensions of professional work in their discipline to think, to perform, and to act ethically and with identity" (2015, p. 11). Of relevance to this text, Competency 8, Intervene with Individuals, Families, Groups, Organizations, and Communities, encourages social workers to "use inter-professional collaboration as appropriate to achieve beneficial practice outcomes" and to "facilitate effective transitions and endings that advance mutually agreed-on goals" (CSWE, 2015, p. 9) through person-centered practice.

Table 1.1: Comparison of Core Competencies

CSWE EPAS	IOM	Nursing	ACGME	Englander
Ethical & professional behavior	Patient centered	Assessment	Patient care	Patient care
Engage diversity & difference in practice	Interdisciplinary practice	Diagnosis	Medical knowledge	Knowledge for practice
Advance human rights & social, economic, and environmental justice	Evidence-based practice	Outcome identification	Interpersonal and communication skills	Practice-based learning and improvement
Engage in practice-informed research and research-informed practice	Quality improvement	Planning	Professionalism	Interprofessional communication
Engage in policy practice	Informatics	Implementation	Practice-based learning and improvement	Professionalism
Engage with individuals, families, groups, organizations, and communities		Evaluation	Systems-based practice	Interprofessional collaboration
Assess individuals families, groups, organizations, and communities				Personal and professional
Intervene with individuals, families, groups, organizations, and communities				
Evaluate practice with individuals, families, groups, organizations, and communities				

Notes: CSWE = Council on Social Work Education; EPAS = Educational Policies and Standards; IOM = Institute of Medicine; ACGME = Accreditation Council for Graduate Medical Education; Englander = Englander et al. (2013).

CBE IN THE HEALTH PROFESSIONS

Commentary on the role of CBE in the health professions can be found dating back more than four decades. In 1978, the World Health Organization (WHO) stated, "Defining professional competence is the cornerstone upon which a competency-based programme of medical education is built" (WHO, 1978, p. 21). The report went on to say, "Unless this task is approached both thoughtfully and systematically the medical curriculum is more likely to be a reflection of faculty interests than of student and public needs" (WHO, 1978, p. 21). The Institute of Medicine (IOM) 2003 report *Health Professions Education: A Bridge to Quality* spoke to the importance of a competence-based approach to all the health care professions. This report detailed five core competences to which all the health care professions should aspire.

The proliferation of reports, books, and articles identifying or calling for the establishment of core competencies can leave the consumer of this knowledge quite confused. As such, each of the health disciplines has followed an extensive process similar to that of social work. Surveys, focus groups, and Delphi panels are all used in an iterative, consensus-building process that ultimately declares the core competencies identified with a profession or specialty section within the discipline. Regardless of the profession, the process of arriving at a short list of competencies requires a winnowing down of a broad range of skills and behaviors. In one of the more comprehensive approaches to arriving at a short list of core competencies, Englander and colleagues (2013) started with 153 statements found in a Web search of different competency statements. After eliminating redundancy and overlap of statements, they presented eight competency domains that include a total of 58 subdomains. The eight domains and subdomains are patient care (11 subdomains), knowledge for practice (six subdomains), practice-based learning and improvement (10 subdomains), interpersonal communication and communication (seven subdomains), professionalism (six subdomains), systems-based practice (six subdomains), interprofessional collaboration (four subdomains), and personal and professional competency (eight subdomains).

In addition to the variation in the number and content in each of the health professions, there is a growing trend in CBE within many professions' substantive specialty areas. For example, in addition to general competencies that apply to social work education, there are competency statements that are specific to gerontological social work. Other examples can be found in the John A. Hartford Foundation's collaboration with the discipline of nursing, which developed a series of competency statements specifically focused on geriatric nursing, and the Social Work Leadership Institute's collaboration with the CSWE, which developed foundation and advanced practice competencies in geriatric social work. Both interprofessional and person-centered care are recognized as competencies in geriatric social work and nursing.

Last, it is important to note that in addition to CBE throughout the health professions, there is a growing demand for practitioners to be competent in the delivery of patient-centered care. Although multiple reports from IOM and WHO have addressed the importance of patient-centered care, it has taken policy initiatives such as the Patient Protection and Affordable Care Act of 2010 (ACA; specifically Section 2402a and Section 3506) to ensure that states develop and/or evaluate patient-centered models of care.

Although the concept of patient-centered, participant-directed (PC/PD) care is relatively new in the majority of health professions, the social work profession has historically identified a person-centered approach as the foundation of all competent practice. In her seminal text *Social Diagnosis* (1917), social worker Mary Richmond discusses the importance of the client being in the center of all care. Using concentric circles moving from the client out to the larger environment, Richmond stresses six power sources for the social worker and client: within the household, in the person of the client, in the neighborhood and wider social network, in civil agencies, and in private and public agencies.

CSWE and the National Center for Participant Directed Services collaborated to develop PC/PD competencies in 2013. The PC/PD competencies were designed to be compatible with and expand the previously mentioned social work gero-competencies that were developed in 2008–2009 (National Center for Gerontological Social Work Education, n.d.).

Given that client empowerment and advocacy have a long tradition in social work, it is not surprising that PC/PD principles and competencies in social work education are not new. However, in many of the allied health professions, where the professional has traditionally been considered the expert, PC/PD competencies are not nearly as developed. The specific mention of PC/PD competencies in the ACA has increased the importance of PC/PD. Consequently, PC/PD competencies will be infused into the curriculum of all the health professions.

POST-CERTIFICATE CBE

The health care workforce accounts for more than 10 percent or approximately 14 million health care workers in the United States (U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, 2013). The vast majority of this workforce has had little or no prior interprofessional education or training (Advisory Committee on Interdisciplinary, Community Based Linkages, 2014; IOM, 2008). Given the size of the current workforce (many of whom had no pre-certificate training in interdisciplinary practice), the potentially decades-long span of a practice career, and the rapid development of knowledge, the importance of continuing education (CE) cannot be overstated. Consequently, there has been a growing focus on post-certificate continuing education. Unfortunately, pre-certificate interprofessional education and interprofessional post-certificate CE have evolved in separate silos with little relationship to each other (Barr, 2013). The IOM (2010) report *Redesigning Continuing Education in the Health Professions* stated that the current models of continuing education do not adequately promote the acquisition of the five core competencies for health care: providing patient-centered care, working in interdisciplinary teams, employing evidence-based practice, applying quality improvement, and utilizing informatics.

There are a number of other factors that complicate the provision and regulation of post-certificate CE. In addition to differences in CE requirements by profession, CE requirements and delivery methods also differ by state. For example, at the time of

this writing, New York State requires 36 contact hours of continuing education every three years, while Illinois requires 30 contact hours every two years. New Jersey and Pennsylvania require 100 continuing medical education (CME) hours for physicians every two years, while Arizona, Florida, and Delaware require physicians to obtain 40 CME hours per year.

Interprofessional CE becomes even more complicated because of the lack of a single regulatory authority that spans multiple professions. Consequently, a CE program seeking to provide interprofessional CE must meet the regulatory requirements of each profession. Although there has been a call for a single regulatory body that could credential continuing education across professional disciplines (Hager, Russell, & Fletcher, 2008), there is no consensus as to how this can be accomplished given the multiple professional and state licensing authorities. With such a large number of subspecialties in medicine alone, it is easy to understand the challenge to developing a universal certification of continuing education (Jackson et al., 2007).

EVALUATION OF CBE

Evaluation and assessment of competence is at the root of all CBE for the health professions. Unfortunately, the assessment and evaluation of CBE is a complicated process. Competence is not directly observable, as it can only be inferred from performance that relies on "the integration of general capacities, such as reasoning and making judgments, as well as specific knowledge and individual dispositions" (Gonczi, 2013, p. 1291). The lived experience of practice often requires instantaneous decisions and actions that seldom provide adequate time for reflection. Evaluating competence requires an integrated approach that includes both the evaluation of classroom learning and evaluation of the lived experience of field practicums and internships.

Although methods for evaluation and assessment vary, all share some common elements. The 2015 EPAS identifies six areas of assessment for generalist and specialist levels of education. These include a detailed description of the assessment procedures, a minimum of two measures of assessment, an explanation of how the institution achieves its benchmark, and copies of all assessment measures. Evaluation and assessment strategies include patient surveys, 360-degree evaluation instruments, portfolios, objective structured examinations, and simulation. These strategies can be found in many of the other health professions. Discussions of the evaluations that were used by each of the academic programs featured in this book can be found in chapter 12.

CONCLUSION

Although health education has made tremendous strides in developing and, more recently, evaluating CBE, there remains much work to be done. Integrating PC/PD competencies into the core competencies in the health professions presents a challenge to future health care education. Developing strategies to break down the silos between pre-certificate education and post-certificate education is also essential. This brief review

of the growth of CBE is not intended to be comprehensive but rather to set the stage for understanding the growth and development of interprofessional CBE.

Recognition of the importance of interprofessional education and practice dates as far back as some of the early writing on CBE. IOM called for the advancement of interprofessional practice as far back as 1972, and WHO identified interprofessional (collaborative) practice as a priority as far back as 1978 (see, for example, IOM, 1972, 2000, 2001, 2003; WHO, 1978, 1988, 2006). Yet as recently as 2013, Barr noted, "Designing the learning environment for the health care professionals of tomorrow is less than complete unless and until it includes interprofessional education (IPE)" (p. 9).

As will be discussed in subsequent chapters, terms such as *collaborative*, *multidisciplinary*, and *interdisciplinary* can be found throughout most, if not all, of the health disciplines' competency statements. The degree of specificity and the scheduling of interprofessional learning varies from discipline to discipline. It is common for most interprofessional CBE to include a variety of experiential learning, observational-based learning, case-based learning, and problem-based learning methods (Barr, 2013).

There are many factors contributing to the current push for the inclusion of interprofessional content into health curricula. In addition to being included as a core competency in all health professions, competencies in interprofessional collaboration currently exist in medical specialties such as geriatrics, pediatrics, oncology, and pain management. Similar competencies can be found in the specialty practices of nursing, public health, and social work.

As discussed in Part 3, there are a number of systemic challenges and barriers that must be overcome to support and sustain true interprofessional learning. The exemplars of the five academic programs included in this text are but a sample of what can be accomplished with adequate time and support.

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