APTA American Physical Therapy Association

Competency-Based Education in Physical Therapy: Essential Outcomes for Physical Therapist Entrance Into Practice

A Report From the American Physical Therapy Association

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Competency-Based Education in Physical Therapy: Essential Outcomes for Physical Therapist Entrance Into Practice

About This Report

Competency-Based Education in Physical Therapy: Essential Outcomes for Physical Therapist Entrance Into Practice (CBEPT) is the product of a multiyear, collaborative effort initiated in 2017 by the American Physical Therapy Association (APTA), the APTA Academy of Education, and the American Council of Academic Physical Therapy (ACAPT), along with additional organizations represented in the Education Leadership Partnership (ELP) (2016-2022). This work responds directly to the call outlined in A Vision for Excellence in Physical Therapy Education[1] to establish a profession-wide framework for implementing competency-based education (CBE) in physical therapist professional education. The intended purpose of a transition to a CBEPT framework is to enhance learner development, reduce variability in graduate performance, and ensure that all physical therapist graduates are ready to meet the complex demands of contemporary practice. The resulting framework is intended to guide the development, implementation, and continuous improvement of CBEPT, with a specific focus on entrance-into-practice readiness.

American Physical Therapy Association (2025). Competency-Based Education in Physical Therapy: An Entrance Into Practice Framework.

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Executive Summary

The American Physical Therapy Association, the APTA Academy of Education, and the American Council of Academic Physical Therapy collaborated with other physical therapy education stakeholders to initiate the development of a national framework for competency-based education in physical therapy that supports consistent and observable readiness for entrance into professional practice. This work responds directly to a key recommendation in A Vision for Excellence in Physical Therapy Education, which calls for clearly defined outcomes that align learner development with contemporary health care needs.

CBEPT shifts the focus of education from time-based progression to one that emphasizes performance on essential tasks and competencies. Central to this approach are entrustable professional activities (EPAs)—the fundamental tasks of a physical therapist and a set of domains of competence that organize the knowledge, skills, and attitudes required for professional practice in the form of competencies. Together, these elements provide a structured, assessable, and transparent way to prepare learners for unsupervised clinical practice.

> This report is meant for use by learners and academic and clinical faculty of DPT programs. Our goal is to provide a clear set of performance outcomes for physical therapists at entrance into practice.

This report includes:

- Nineteen EPAs that students should be entrusted to perform without supervision before graduation
- Eight domains of competence and 54 associated competencies refined through national consensus and iterative validation to ensure clarity and observability
- Supporting information related to CBE, its application and potential value to physical therapy education and patient outcomes, the process for developing this resource, case vignettes specific to each EPA, and considerations for curriculum and assessment

This initiative is grounded in decades of dialogue among health professions educators, rigorous education research, and widespread stakeholder engagement, including representation across academic, clinical, and interprofessional education sectors. This report is a compilation of the work of 3 panels formed in 2019: domains of competence and competencies, EPAs, and research. The work of the panels is built upon best practices of other health professions that have adopted competency-based models.

This framework supports individualized learner progression based on a comprehensive assessment of performance and encourages learner agency—ownership of one's learning experience—to support development of critical reflection, self-assessment, and lifelong learning skills. While this framework provides standardized outcomes for DPT education, the remaining core components of a CBE framework (curriculum, assessment, and implementation) are determined at the program level.

Ultimately, this report offers both a philosophical foundation and a practical road map to guide an initial transition to CBEPT. It represents a profession-wide opportunity to enhance learner development, reduce variability in graduate performance, and ensure that all physical therapist graduates are ready to meet the complex demands of contemporary practice.

Joint Statement on Competency-Based Education in Physical Therapy

As organizations committed to excellence in physical therapy education, certification, and practice, we recognize the growing relevance and potential of competency-based education (CBE) as a philosophy and approach to support learner development, ensure practice readiness, and serve societal health needs.

CBE emphasizes educational progression based on demonstrable abilities and skills, rather than time-based measures alone.[2] Its principles, such as transparency in expectations, individualized progression, and authentic workplace assessment, are well-aligned with our shared responsibility to prepare physical therapists and physical therapist assistants who can demonstrate the knowledge, skills, and professional behaviors required to meet the complex demands of contemporary practice.

This report focuses specifically on CBE within the context of entrance into physical therapist practice. At the same time, we acknowledge the potential broader value of CBE as a guiding framework across the full educational continuum for the physical therapist and physical therapist assistant—from early exposure to postprofessional learning—as described in A Vision for Excellence in Physical Therapy Education.[1] We affirm the importance of supporting exploration and evaluation of CBE models and tools, such as EPAs and domains of competence, that hold promise for improving educational assessment, educational outcomes, enhancing patient outcomes and safety, and advancing the profession.

American Physical Therapy Association

APTA supports the exploration of competency-based education as an approach that aligns with the association's vision of transforming society by optimizing movement to improve the human experience. CBE offers a learner-centered model that promotes adaptive expertise through continuous development and may improve transparency in learner expectations, readiness for practice, and public trust in the profession. As the national professional association, APTA is committed to fostering innovation and collaboration to support educational models that enhance learner development and ensure competent, compassionate practitioners.

Commission on Accreditation in Physical Therapy Education

CAPTE welcomes innovative educational models that align with the mission, vision, and intended outcomes of accredited programs. It recognizes the potential of competency-based education to enhance the preparation of learners in meeting accreditation standards and professional practice expectations. As the accrediting body for physical therapist and physical therapist assistant education programs, CAPTE encourages the thoughtful exploration and

implementation of CBE principles, such as outcomes-based assessment and individualized learner progression. CAPTE will continue to support innovative efforts to improve program quality, uphold public protection, and ensure compliance with accreditation requirements.

APTA Academy of Education

The APTA Academy of Education supports the continued exploration of competency-based education (CBE) models in physical therapy education as a means of advancing educational innovation and excellence in learner outcomes. In alignment with the academy's mission to lead excellence in physical therapist and physical therapist assistant education and with its strategic plan objectives to foster innovation, promote evidence-informed practices, and support lifelong learning, the investigation of CBE offers a potential avenue for innovative educational delivery to meet the needs of learners and evolving health care environments. This exploration must be grounded in rigorous scholarship for both physical therapist and physical therapist assistant education, interested physical therapy community partners' input, and attention to equity, accreditation, and workforce readiness. As such, the academy encourages ongoing dialogue, pilot initiatives, and collaborative research to assess the opportunities and challenges of CBE in the context of physical therapist and physical therapist assistant education.

American Board of Physical Therapy Residency and Fellowship Education

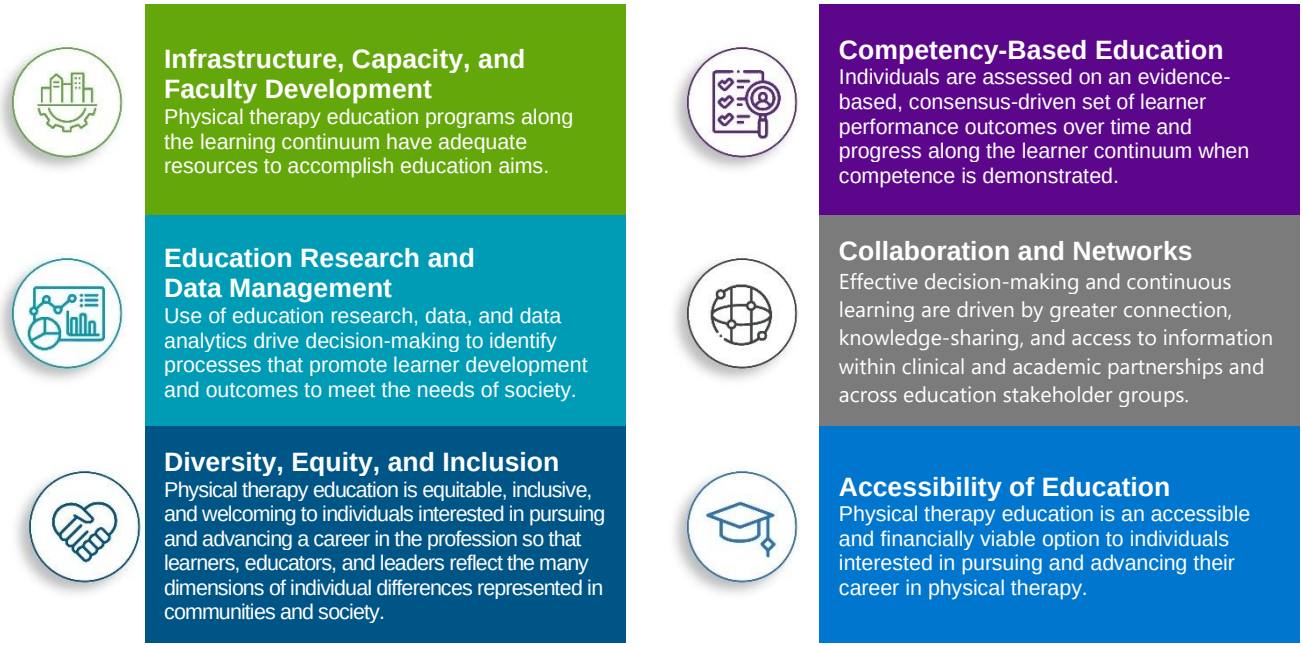
The American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE) adopted CBE in 2018 for residency education. ABPTRFE acknowledges the importance of competency-based education in advancing postprofessional clinical training and development. While its primary focus is on residency and fellowship education, ABPTRFE supports the foundational exploration of CBE principles at entry into practice to create a smoother and more aligned progression into postprofessional pathways. Competency-based frameworks offer opportunities to strengthen accountability, enhance mentor-mentee relationships, augment/individualize learner progression, and ensure consistency in professional development expectations and lifelong learning throughout one’s career.

American Board of Physical Therapy Specialties

While the American Board of Physical Therapy Specialties (ABPTS) focuses on the credentialing of board-certified clinical specialists, the organization recognizes the value of competency-based education principles in shaping professional development across all stages of a physical therapist's career. The development of competencies and observable performance expectations at entry into practice provides a strong foundation for specialization. ABPTS supports a vision in which early and consistent use of CBE principles may facilitate lifelong learning, clearer pathways to advanced clinical roles, and improved outcomes for patients and clients.

Introduction

The evolving needs of society necessitate that health professions education prepare learners who are adaptive and can navigate complex systems and meet present and future needs of patients, communities, and society. In 2017, the American Physical Therapy Association, the APTA Academy of Education, and the American Council of Academic Physical Therapy facilitated the creation of A Vision for Excellence in Physical Therapy Education,[1] which identifies 6 pillars (themes) that would guide educational development for the profession in the future—competency-based education being one of those pillars. Although CBE is a distinct pillar, 3 of the 5 remaining pillars strongly support its successful implementation: Collaborations and Networks, Education Research and Data Management, Capacity, Infrastructure, and Faculty Development.[1]



The foundational step for developing a CBE model in physical therapy (CBEPT) is identifying a common set of consensus-based outcomes that recognize the unique identities and contributions of physical therapy to the health care system and society.[4] This report presents the CBEPT framework developed through a multiyear national consensus process used to identify a core set of essential outcomes that all graduates of DPT programs would be entrusted to do unsupervised upon completing their entry-level, professional education. Having a foundational platform of performance outcomes for DPT graduates is something the profession has not had until now. This baseline for entrance into practice serves as a springboard for a career of lifelong learning. This framework is based on observable and assessable abilities and consists of 19 EPAs and 54 essential competencies within 8 domains.

"Competency-based education begins with an uncompromising focus on translating the needs of contemporary society for improved health care into competencies that must be mastered by health professionals across all disciplines." [5] (Thibault)

A clear need for standardized performance expectations for physical therapist graduates has existed for years.[7-10] In response, a national consensus framework has been developed to define outcomes that can guide doctor of physical therapy program curricula and ensure learner readiness. Transitioning to a CBEPT approach does not necessarily require major curricular changes; courses that are currently effective in supporting learner development to achieve performance outcomes will still be successful. In a CBE model, curricula should provide learners with explicit opportunities to practice, reflect and self-assess, and seek feedback on their performance.[4] While these opportunities can be acquired through low-risk experiences in laboratory and simulated environments, assessment of an EPA requires learning opportunities with patients and clients in authentic workplace settings.[11] Ongoing clinical educator assessment, coaching, and feedback on performance are critical to learner development. Collectively, learner performance data on EPAs from many low-stakes assessments will be used to make a summative, high-stakes decision on whether the learner can be entrusted to perform that professional activity unsupervised.[11,12]

The current variability in curricula, program outcomes, and time in formal education within DPT programs is a context that likely results in unwarranted variation in graduate performance and contributes to unwarranted variation in clinical practice. Establishing a core set of standardized performance outcomes that are observable and assessable defines what learner readiness is to enter physical therapist practice.

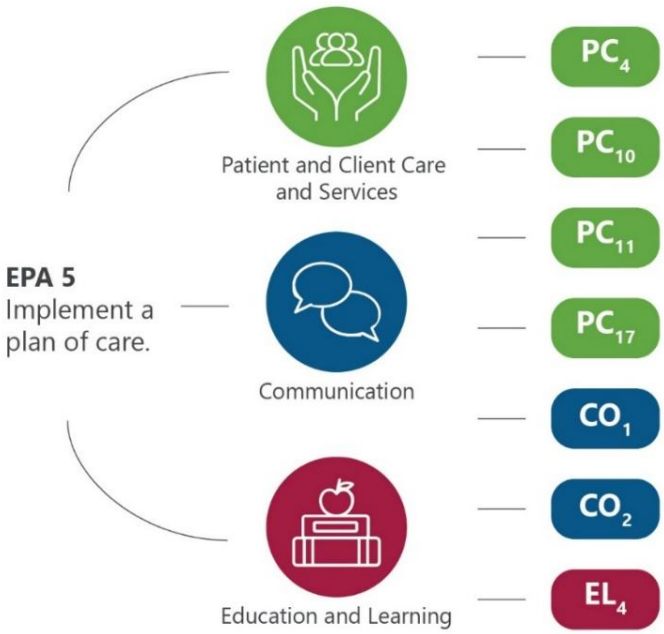
Our Profession's Opportunity to Standardize Outcomes of Graduates

Having a core set of standard performance outcomes for DPT graduates can increase public awareness of what to expect from physical therapists. Once learners have been entrusted with this core set of outcomes, they may have the opportunity, depending on institutional policies, to enter clinical practice or residency education earlier, potentially reducing the cost of professional education, or they may achieve additional outcomes that help distinguish them from other graduates. Clinical facilities could utilize this standard set of physical therapy outcomes to help create targeted learning experiences in the clinic, something that has been difficult to do when every program has a unique set of outcomes.

Rationale for this National CBEPT Framework

There are numerous ways to define outcomes in a competency-based model. Competencies, or characteristics of an individual, organized into domains of competence, are a common method.[3] However, there are challenges in assessing individual competencies using this framework that led to the development of an additional method for teaching and assessing outcomes: EPAs.[13] For these reasons, the EPA model was selected. EPAs are the real-world essential physical therapist clinical tasks (or units of work)—the tasks that all physical therapists were trained to perform and can be expected to do unsupervised at entrance into clinical practice.[13] A full description of an EPA includes the critical competencies needed within the individual performing the task mapped to it.[14] An EPA framework therefore contains both the activity and the necessary competencies the person completing the task must possess. (Graphic below) Evaluation of these essential tasks assesses the integration of multiple critical competencies mapped to it in aggregate.[14]

CBEPT mapping: Example of the relationships between competencies deemed critical to the performance of an EPA. (See Figure to the right.)



Building on the Profession's Past

For decades, physical therapy clinical educators have made ad hoc (in the moment) entrustment decisions (clinical judgments) intuitively and routinely about student performance and the need for supervision. Ad hoc entrustment decisions consider the competence of the student and the complexity of the task at

hand to determine the amount of supervision required.[11] Given that physical therapists make judgments of how much supervision a learner needs to perform an activity safely on a regular basis, a transition to an assessment tool that documents the supervision needed for a learner should come naturally.

This CBEPT framework holds promise for the profession and should be valued for its identification of the core essential elements of practice that all physical therapist graduates should be expected to perform unsupervised. While each of these EPAs was identified through a rigorous, consensus approach, now is the opportunity for our physical therapy education community to explore how our education efforts can ensure that graduates meet these expectations that are grounded in societal need. This transition provides an opportunity for curriculum review and renewal, academic and clinical faculty development, professional discourse, and education research to guide future work to advance learner development and assessment through CBEPT.

Brief Background on Competency-Based Education

CBE in Health Professions

Competency-based education is a learner-centered, patient-focused outcomes educational approach that prioritizes what learners can do with their knowledge, skills, and attitudes, rather than how long they have spent in training.[15] Building on this foundation, the value of CBE lies in its clear, outcomes-based structure. It ensures that every learner achieves a defined set of competencies before progressing.[4] This fosters more reliable, consistent performance among learners and better aligns education with the needs of patients, clients, and health care systems.[4] CBE also supports a more personalized learning journey, enabling learners to have additional opportunities to practice and receive targeted feedback through ongoing formative assessments to further develop specific skills they need.[15]

While the concept of CBE has deep roots, its formal adoption in many of the health professions education emerged in the late 20th century—spurred by evolving health care needs, increasing clinical complexity, and concerns about variability in graduate readiness.[16] Its emergence in medical education was formalized with initiatives like the CanMEDS (Canadian Medical Education Directives for Specialists) framework,[16] the ACGME (Accreditation Council for Graduate Medical Education) Core Competencies,[17] and more recent developments like the Association of American Medical Colleges' Core Entrustable Professional Activities (EPAs) for Entering Residency,[18] the AAMC-AACOM-ACGME Foundational Competencies for Undergraduate Medical Education,[19] the AAVMC Competency-Based Veterinary Education

framework,[20] and the AACN's Nursing Essentials framework.[21] These efforts emphasize clearly defined learning outcomes, continuous assessment, and readiness for practice.[22]

The 5 core components of CBE, as described by Van Melle et al,[4] are a useful model to look at CBE in the health professions. The components include the following:

1. Clearly articulated outcomes.
2. A curriculum that is organized to progressively build learners' competence over time.
3. A curriculum that includes tailored learning experiences to meet the needs of each learner.
4. Competency-focused instruction teaching designed to foster and assess the development of key abilities.
5. A comprehensive program of assessment where multiple data points are collected over time and synthesized to make decisions about learners' progress and readiness for unsupervised practice.[4]

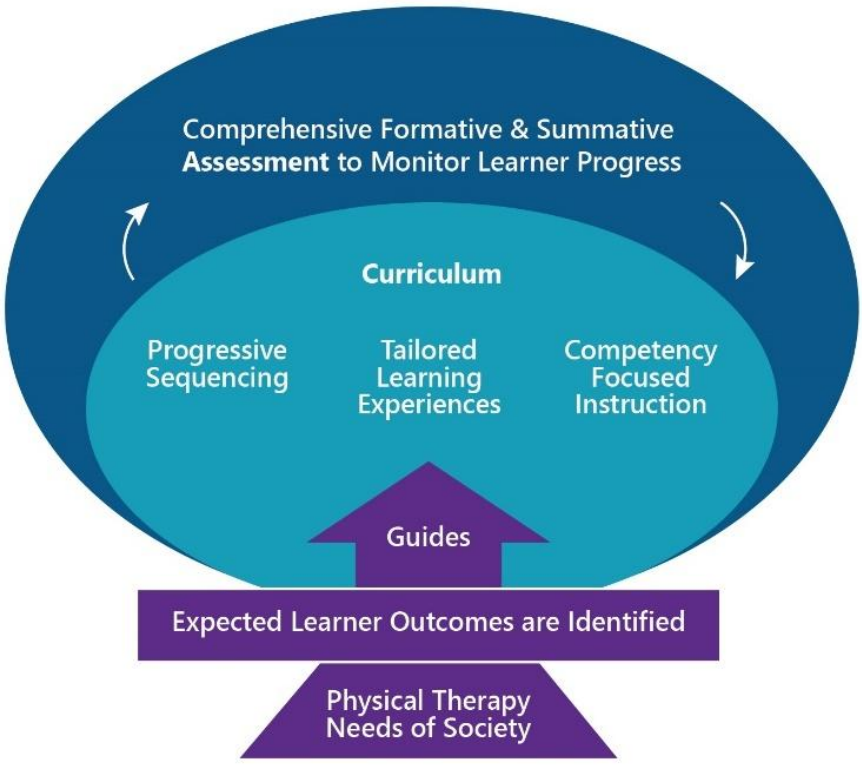


Figure: The Van Melle model applied to physical therapy education.

Health professions education has shifted toward a CBE framework to better prepare practitioners for the real-world complexities of modern health care.[15] Traditionally, training followed time-based models that emphasized completing coursework and rotations within fixed timelines. However, this approach often failed to ensure that all learners had achieved the same level of readiness for clinical practice.[23] CBE emerged as a response to this gap, emphasizing what learners can do with their knowledge, not just what they have been exposed to.[15]

While much of CBE focuses on performance outcomes of a profession, there may be additional outcomes that health professional education programs may have that meet their individual missions and visions. Some programs have adapted the Royal Australasian College of Physicians' framework of Do, Know, and Be.[24] This is similar to the habits of the hand, head, and heart.[25] The "Do" (hand) component would be the essential tasks or EPAs; the "Know" (head) is the knowledge necessary to complete the EPAs; and the "Be" (heart) are the behaviors, values, and practices expected of a health professional.[25] This highlights that not every outcome is an EPA, assessed by a workplace-based assessment. Those additional outcomes would be assessed via an alternate method.

The benefits of CBE to society are substantial. CBE produces practitioners who are not only knowledgeable but also ready to apply their skills safely and effectively in diverse and evolving health care environments.[15] This approach promotes public trust in health care professionals, reduces variability in graduate capabilities, and improves consumer outcomes by ensuring that every provider meets a standard minimum threshold of demonstrable competence before practicing independently.[4]

Competency-based education requires learners to take an active role as advocates and agents of their own learning. Rather than passively progressing through a fixed curriculum, learners in a CBE model are expected to seek out feedback, engage in frequent assessments, and reflect on their performance to identify areas for growth. This self-directed approach encourages them to pursue targeted learning opportunities, deliberately practice skills, and continuously seek additional feedback to advance their competence. In doing so, learners develop a growth mindset and take ownership of their professional development, which mirrors the lifelong learning expected in health care practice.

While awareness and potential benefits of CBE have been discussed widely, many potential misconceptions about these models have evolved.

Common Myths and Facts About CBE

Myth	Fact
CBE reduces academic rigor.	The model increases rigor by requiring sustained performance across domains over time.[15]
All learners will finish faster.	While flexible, CBE allows learners to adjust the pace of their learning journey; some may finish faster, others may need more time.[4]
CBE eliminates standards.	CBE reinforces high standards by ensuring that learners demonstrate competence in varied settings and scenarios before progressing.[22]
CBE means no structure.	CBE applies a highly structured framework grounded in competencies and developmental sequencing.[4]

In health professions, CBE ensures that learners are not only knowledgeable but also capable of applying their skills effectively in real-world clinical settings.[23] In sum, CBE aligns learner development with health care system priorities by producing professionals who are equipped not only with knowledge but also with the capability and confidence to meet evolving patient and societal needs.

A Brief History of Competency-Based Education in Physical Therapy

While often viewed as a recent innovation, CBE has long been part of professional dialogue and practice in physical therapy education in the United States.[26] In the 1970s, CBE gained traction across health professions' education through federally funded projects focused on interdisciplinary collaboration among allied health fields.[27] These efforts aimed to minimize redundancy and maximize learning outcomes.

In 1973, the American Physical Therapy Association's House of Delegates adopted a position paper supporting the use of competency testing to uphold high standards in clinical practice.[28] This was followed by the 1977 publication of Competencies in Physical Therapy: An Analysis of Practice—commonly referred to as the "Red Book"—developed by APTA's Committee on Competencies.[29] This document laid foundational groundwork for articulating the knowledge, skills, and attitudes expected of physical therapists.

Although these early efforts reflected core CBE principles, such as criterion-referenced evaluation and a focus on observable behaviors,[27-29] the movement was short-lived. The 1970s approach was heavily influenced by behaviorist theory, emphasizing task-based checklists and rigid thresholds (eg, 80%-90% minimums) with insufficient attention to integrating clinical reasoning, communication, and professionalism.[30] These reductionist models did not align with the complex, integrative demands of clinical practice, which require the "habits of head, hand, and heart" demonstrated through a "know, do, be" approach to learning.

A Call for Standardization

Since the 1960s, multiple leaders and professional efforts have called for greater clarity and consistency in performance expectations for physical therapy students and graduates. These efforts include the contributions of Catherine Worthingham[31-36] and Helen Hislop,[8] as well as major APTA-led initiatives: the Excellence in Physical Therapy Education Task Force (2015),[37] the Best Practices in Physical Therapy Clinical Education Task Force (2017),[38] national surveys and strategy meetings of the Education Leadership Partnership (2017–2021),[1] and the National Study on Excellence and Innovation in Physical Therapy Education.[7]

In 2018, the APTA Board of Directors charged the Education Leadership Partnership with developing a long-term plan for the future of professional and postprofessional education. One result of this charge was the Vision for Excellence in Physical Therapy Education,[1] which—building on the recommendations of previous task forces and a national study[7] —identified CBE as one of 6 strategic pillars.

Competency-based education has gained widespread adoption in physical therapy education across numerous countries, including Canada,[39] Australia,[40,41] Singapore,[42] and the Netherlands,[43] reflecting a global shift toward outcomes-driven health care training. Canada and Australia adapted the CanMEDS physician competency framework for use in physical therapy and are now incorporating EPAs, while Singapore and the Netherlands are utilizing an EPAs-based framework.[39,40,42,43] In the United States, APTA developed a competency framework for postprofessional residency education across all specialty types.[44]

Framework Development Process

Two key Education Leadership Partnership events, the Education Research Strategy Meeting (2017) and the Outcomes Strategy Meeting (2019), which had representation from multiple stakeholder groups, further recommended developing a unifying framework for outcomes across the learner continuum. Among their specific recommendations were the following:[1]

- Incorporating both EPAs and domains of competence into a cohesive framework for CBEPT.
- Anchoring initial framework development at the point of entrance into practice, allowing for targeted curriculum review and forward-looking implementation across the learner continuum.
- Establishing 3 expert panels to facilitate this work: Domains of Competence Panel, Entrustable Professional Activities Panel, and CBEPT Education Research Panel.
- The work of these panels was completed between 2019 and 2025, and each group submitted its findings for publication in a peer-reviewed journal to document methods, evidence, and results for public use.

Panel Manuscript References

[45]Jensen G, Jette D, Timmerberg J, et al. Competency-based education in physical therapy: developing a framework for education research. *J Phys Ther Educ.* 2022;36(4):334–340. doi: 10.1097/JTE.0000000000000254

[46]KnoXS, Bridges P, Chesbro S, et al. Development of domains of competence and core entrance-to-practice competencies for physical therapy: a national consensus approach. *J Phys Ther Educ.* 2025 Jun 3. doi: 10.1097/JTE.0000000000000420 [Online ahead of print.]

[47]Fitzpatrick J, Chesbro SB, Jensen GM, et al. Development of entrustable professional activities for entrance into physical therapist clinical practice: applying a national consensus approach. (Forthcoming.)

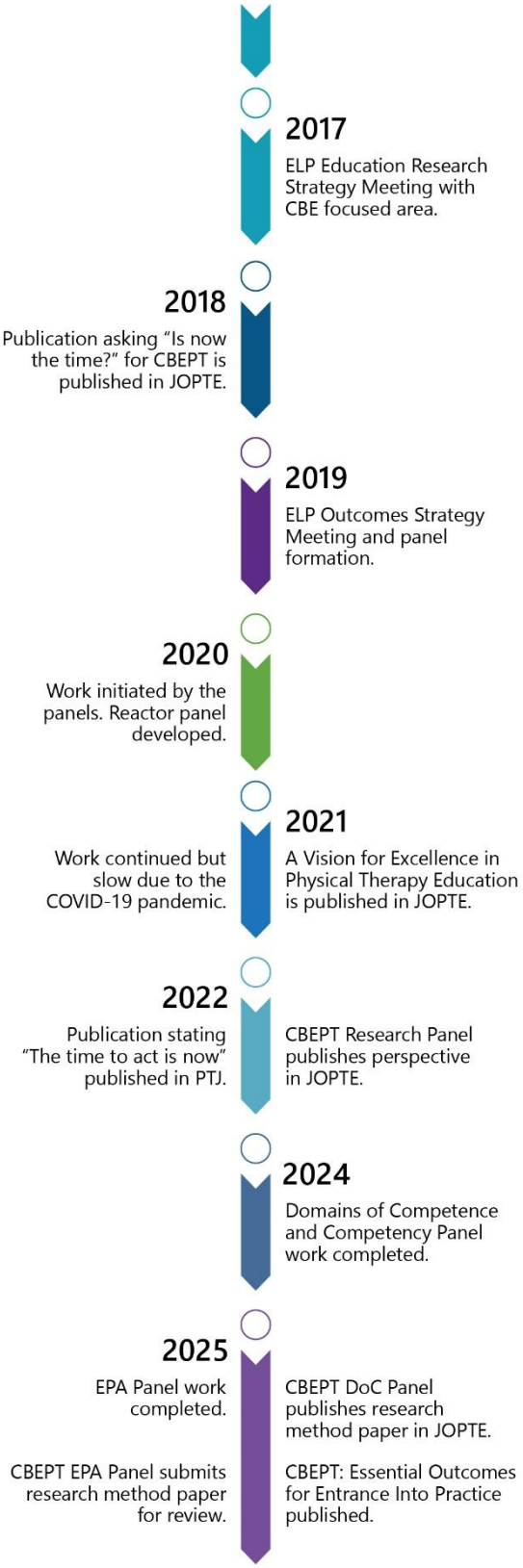
While this work was underway, the Education Leadership Partnership finalized and published A Vision for Excellence in Physical Therapy Education.[1] As previously mentioned, this vision surrounded 6 pillars or themes, one of which was competency-based education:

> **Competency-Based Education**
> Operational definition: Individuals are assessed on an evidence-based, consensus-driven set of learner performance outcomes over time and progress along the learner continuum when competence is demonstrated.[1]
>
> **Guiding Principles**
> - There is a defined set of standard performance outcomes for learners across the learner continuum in physical therapy education.
> - Education research is used to inform the competency-based education approach in physical therapy.
> - Physical therapists and physical therapist assistants demonstrate continuing competence, ensuring consistency in practice.

This report, along with the accompanying panel manuscripts, addresses one of the key objectives of the first guiding principle under CBE: there is now a defined set of standard performance outcomes for doctor of physical therapy graduates at the point of entry into practice.

> "We must set up absolute standards of clinical performance rather than remain lost in the morass of relativity."
>
> —Helen Hislop, PT, PhD
>
> *The Not-So-Impossible Dream (1975)*
> Tenth APTA Mary McMillan Lecture

A timeline of CBEPT development activities.



The development of the CBEPT framework, including the 19 EPAs, 8 domains of competence, and 54 competencies, was grounded in a rigorous, consensus-driven process designed to ensure relevance, credibility, and applicability across the continuum of physical therapist education and practice. The process was led by subject matter experts in physical therapy education, clinical practice, assessment, and competency-based education, and followed best practices for framework development in the health professions.

A modified Delphi approach guided the identification and refinement of the framework components. Over the course of multiple rounds, working groups proposed initial drafts of EPAs, domains, and competencies. These drafts were

[48]Chesbro S, Jensen GM, Boissonnault W. Entrustable professional activities as a framework for continued professional competence: is now the time? *Phys Ther.* 2018;98(1):3–7. doi: 10.1093/ptj/pzx100

[1]Education Leadership Partnership. A Vision for excellence in physical therapy education. *J Phys Ther Educ.* 2021;35(Supplement 1):1–35. https://journals.lww.com/jopte/toc/2021/12001

[49]Timmerberg J, Chesbro S, Jensen G, Dole R, Jette D. Competency-based education and practice in physical therapy: the time to act is now. *Phys Ther.* 2022;102(5):pzac018. https://doi.org/10.1093/ptj/pzac018

iteratively reviewed and revised based on structured feedback from a national reactor panel composed of more than 130 stakeholders across academic, clinical, and regulatory settings, as well as educators from other health professions. Reactor panelists provided input across up to 8 rounds of review, focusing on clarity, alignment, comprehensiveness, and applicability.

To further broaden input and transparency, an open public comment period was conducted, inviting feedback from the wider physical therapy community and the public. The combined use of expert-led development, structured consensus-building, and broad stakeholder engagement resulted in a set of performance expectations that reflect shared professional standards and are intended to support competency-based progression toward practice readiness.

Regular conference presentations were made throughout the development of this CBEPT framework to keep the community informed of the progress of the work: 5 presentations at APTA Combined Sections Meeting between 2019 and 2025[50-54]; 9 presentations at the Education Leadership Conference between 2018 and 2024[55-63]; and 3 presentations at other conferences between 2020 and 2023.[64-66]

The subsequent sections Domains of Competence and Associated Competencies and Entrustable Professional Activities provide the defined outcomes for entrance into practice. While these concepts are different, they are intertwined: To perform an essential task (EPAs) you need a physical therapist with a set of characteristics (competencies) to be able to perform it.[3]

The Mutual Dependence Between Entrustable Professional Activities and Competencies; as a foundation of this CBEPT Framework

Highlights of the development process:

- Included subject matter experts from the profession, the majority of whom were clinicians representing various specialties and practice settings.
- Included subject matter experts on competency-based education from medicine and pharmacy.
- Used a national consensus approach, leveraging a reactor panel of varied stakeholders that were nominated by various organizations within the profession. Over a 4-year period, 8 rounds of feedback were provided.
- Gathered public feedback during an open comment period and through ongoing presentations at national physical therapy conferences.

Domains of Competence and Associated Competencies

Introduction: Anchoring Learning and Assessment in the Core Dimensions of Professional Practice

In physical therapy education, clearly defining what learners must be able to do[67] and who they must become, at the point of graduation, is essential to ensure readiness for unsupervised clinical practice. While EPAs focus on the essential tasks of the profession, domains of competence articulate the broad capabilities that physical therapists must consistently demonstrate across contexts. These domains reflect the complexity of practice and the integration of knowledge, skills, attitudes, behaviors, clinical reasoning, and values.

The domains of competence framework presented in this report defines the essential areas of performance for the physical therapist and includes 8 domains, which in total capture the essence of the profession, and 69 associated competencies that describe observable characteristics of the learner expected at the point of entry into practice.[22,68] Through a consolidation process the associated competencies were reduced to 54. These domains serve as an organizing structure for assessment, curriculum planning, and professional development, and they underpin the competencies mapped to each EPA.[22]

This domains of competence framework spans the learner continuum and is designed to support individualized progression, faculty observation, and shared understanding of what it means to be prepared for contemporary physical therapist practice. Collectively, competencies from varied domains support a learner's performance in the workplace, which is assessed in an EPA.

What Is a Domain of Competence?

A domain of competence is a conceptual category that captures a foundational aspect of physical therapist practice.[22] Each domain:

- Represents a distinct area of responsibility or capacity expected of a physical therapist.
- Contains multiple competencies—observable abilities that integrate knowledge, skills, attitudes, and values.
- Reflects performance across academic and clinical learning environments.
- Provides a consistent language to evaluate learner development over time.

The associated competencies articulate the behaviors, decisions, and reasoning processes that define a competent physical therapist. These competencies can be taught, observed, practiced, and assessed, supporting learners' progression toward readiness for professional responsibility. Collectively, assessment of learner performance within a cohort can be used to identify gaps or inconsistencies within a curriculum.

How the Domains and Competencies Were Developed

Development of the domains of competence framework followed an 8-phase, iterative process conducted by a national work group and reactor panel composed of physical therapist educators, clinicians, and learners. Key components of the process include the following:

- Literature reviews of CBE frameworks across health professions[3,22,48,69-80]
- Iterative drafting and revision of domain titles, descriptions, and competencies
- Multiple rounds of structured feedback using quantitative thresholds and qualitative input
- Open comment periods involving a broad group of stakeholders
- Integration of over 4,000 comments and ratings, with 90% or more agreement for clarity and essence across final framework components

The framework was constructed using a mixed-methods design and a modified Delphi process to ensure consensus, clarity, and validity.

Intended Use of the Domains of Competence Competencies

The associated competencies in these domains of competence framework are designed to:

- Define expectations for entry-level performance across 8 key areas of professional practice.
- Guide teaching and curriculum planning across didactic and clinical settings.
- Support individual and programmatic assessment by aligning observable behaviors with broad professional goals.
- Provide a structure for feedback, self-assessment, and reflection for learners and educators.
- Support mapping to EPAs and enhance integration between competencies and the essential tasks of the profession.

The domains of competence should be utilized across the learner continuum, allowing for alignment with postprofessional education (such as residencies), continuous professional development, and licensure-related assessment. The associated competencies in each domain provided within this report are specific to entrance into practice. (**Note:** In this section, G refers to the Glossary.)

Knowledge for Practice

Communication

Patient and Client Care and Services

Professionalism

Practice Management

Reflective Practice and Improvement

Education and Learning

Systems-Based Practice in Health Care

Knowledge for Practice

Physical therapists demonstrate the ability to identify, organize, synthesize, integrate, and apply knowledge and skills specific to physical therapist practice, as well as related knowledge from other disciplines, to improve health care for patients and populations.

Entrance to Practice Competencies

KP 1 Integrates comprehensive knowledge in foundational, behavioral, social, and clinical sciences across diverse patient populations or practice settings.

KP 2 Demonstrates knowledge of the profession of physical therapy's distinct point of view and where shared perspectives exist with other disciplines and professions.

KP 3 Demonstrates scholarly inquiry[G] and scholarly activities[G] to integrate physical therapy theories, knowledge, and evidence with information from other appropriate sources to inform clinical judgment.

KP 4 Discriminates the efficiency, efficacy, and value of new technology and skills and considers the ethical application within practice.

Communication

The physical therapist communicates using verbal, nonverbal, and written communication demonstrating cultural humility,[81G] to effectively exchange information and enhance therapeutic and professional relationships in varied situations and circumstances.

Entrance to Practice Competencies

CO 1 Uses modes[G] and mediums[G] of communication, including communication technologies, to meet the needs of individuals and populations.

CO 2 Evaluates and adapts communication strategies to meet the needs of individuals and populations.

Patient and Client Care and Services

Physical therapists apply principles of evidence-based practice[G] and clinical reasoning[G] to the Patient and Client Management Model,[82] through shared decision-making to achieve desired health outcomes.

Entrance to Practice Competencies

PC 1 Fosters physical and emotional safety of the patient or client.

PC 2 Prioritize patient and client management strategies to optimize patient or client outcomes.

PC 3 Empowers patients and clients, families, significant others, and caregivers to participate in care and shared decision-making.

PC 4 Uses evidence-informed practice[G] when making clinical decisions regardless of the depth or breadth of available evidence.

PC 5 Incorporates the characteristics of the patient or client characteristics to develop and implement a person-centered, comprehensive examination[G].

PC 6 Interprets laboratory data, imaging studies, and other tests required for the area of practice.

PC 7 Evaluates examination[G] findings to establish a diagnosis and prognosis.

PC 8 Integrates examination findings, diagnosis, prognosis, and patient or client preferences to establish a management plan/plan of care.

PC 9 Incorporates concepts of health promotion and wellness into the plan of care to reduce the impact of disease and disability.

PC 10 Synthesizes ongoing examination findings to modify interventions to meet patient or client needs according to the individual's presentation, goals, and resources.

PC 11 Uses a continual process of patient and client assessment that includes appropriate outcome data to direct the progression of the plan of care.

PC 12 Recognizes urgent and evolving situations and determines appropriate responses.

PC 13 Assesses the personal, legal, regulatory, and organizational appropriateness to carry out services when supervising physical therapist assistants and other support personnel.

PC 14 Complies with legal, organizational, and payer regulations when documenting in the patient or client record.

PC 15 Facilitates the transfer of patient and client care and services across settings and concludes the episode of care as appropriate.

PC 16 Maintains patient and client privacy.

PC 17 Identifies the need for interprofessional and intraprofessional collaboration, consultations, or referrals.

Professionalism

Physical therapists demonstrate cultural humility[G] and a commitment to high standards of ethical behavior, exhibit appropriate professional conduct, and advocate for a health system that enhances the well-being of the patient and client, society, and the profession.

Entrance to Practice Competencies

PR 1 Practices according to the APTA Code of Ethics for the Physical Therapist.

PR 2 Complies with all federal, state, local, payer, and organizational requirements regulating the practice of physical therapy.

PR 3 Advocates for the health needs of individuals and society locally, nationally, or globally.

PR 4 Acknowledges the impact of personal well-being on professional roles and responsibilities.

PR 5 Recognizes how differences in background, experience, and access to resources impact care.

PR 6 Serves as a mentor and role model for professionalism.

PR 7 Recognizes misconduct and responds appropriately.

PR 8 Integrates leadership skills to advance the physical therapy profession.

Practice Management

Physical therapists prioritize needs and manage resources[G] to ensure safe, legal, ethical, effective, and sustainable services.

Entrance to Practice Competencies

PM 1 Manages the physical therapist practice in accordance with regulatory, legal, and organizational requirements and professional standards.

PM 2 Balances patient or client needs with caseload volume, considering available time, equipment, and personnel when providing services.

PM 3 Evaluates access to services, caseload management, payment, and availability of resources when providing physical therapist services.

PM 4 Identifies risks and continuously seeks opportunities to mitigate hazards in the workplace.

PM 5 Adheres to individual, team, and system-level[G] safety and infection control practices.

PM 6 Contributes to orientation, training, and ongoing development of personnel involved in providing physical therapist service delivery.

PM 7 Provides appropriate direction and supervision to personnel delivering physical therapist services.

PM 8 Maintains comprehensive, accurate, and timely records.

PM 9 Maintains confidentiality and manages access, storage, retention, and destruction of health records, data, or protected information.

Reflective Practice and Improvement

Physical therapists appropriately evaluate the care and services of patients and clients to continuously improve practice and outcomes throughout their careers.

Entrance to Practice Competencies

RP 1 Demonstrates self-awareness, emotional intelligence, and accountability for one's own decisions, actions, and errors in clinical performance and seeks external feedback and opportunities to learn.

RP 2 Uses internal and external sources of information to develop expertise that promotes the ability to adapt to unknown or evolving situations.

Education and Learning

As educators, physical therapists demonstrate teaching skills that facilitate learning by patients and clients, caregivers, colleagues, students, and communities.

Entrance to Practice Competencies

EL 1 Educates patients and clients, families, significant others, caregivers, other health care professionals, and society about the role of physical therapy.

EL 2 Identifies audience learning needs, considering preferences and abilities, the role of culture, family-related constructs, environmental factors, and personal factors, to develop a plan.

EL 3 Establishes learning goals in collaboration with the learner.

EL 4 Applies effective teaching strategies for cognitive, psychomotor, and affective domains of learning.

EL 5 Assesses if the patient's or client's educational needs have been met.

EL 6 Modifies plans based on the learner's ongoing educational needs.

Systems-Based Practice[G] in Health Care[83]

The physical therapist demonstrates awareness of and responsiveness to the larger context of health care systems and health policy and engages in quality improvement to provide care and services that are of optimal value.

Entrance to Practice Competencies

SB 1 Uses outcomes data collection and analysis to guide the provision of physical therapist services and for practice improvement.

SB 2 Appraises the relationship between social determinants of health[G] and the health system in which the physical therapist practices.

SB 3 Incorporates concepts of health promotion and wellness into physical therapist practice to reduce the impact of disease and disability on society.

SB 4 Appraises system-level[G] costs, risk-benefit, and outcomes that impact patient and client and/or population-based care and services.

SB 5 Participates in identifying system errors and quality/performance improvement initiatives and responds constructively to change.

SB 6 Fosters a culture of valuing differences in background, experience, and access to resources within and across the health care system.

Entrustable Professional Activities for Entrance Into Practice

Introduction: Linking Competence to Real-World Clinical Activities

In physical therapy education, bridging the gap between a learner's academic preparation and readiness for independent clinical practice is essential. While competencies describe the qualities of a learner,[3] what they know, value, and can demonstrate, there was a need to translate competencies better into the practice of everyday work in health care. EPAs define the real-world clinical tasks that a physical therapist must be able to perform.[13,23] EPAs allow for the integration of multiple competencies that have been mapped to it to help bridge the gap between well-elaborated competency frameworks and clinical practice in patient care.[14] EPAs have transformed the landscape of CBE by redefining program goals, shifting the focus beyond individual competencies to include real-world PT clinical tasks, and emphasizing assessment through entrustment decisions related to clinical responsibilities.[11] This can provide a holistic view of a learner's readiness to engage in safe, effective, and professional clinical care.[11,13]

What Is an EPA?

An EPA is a key task of the profession that:

- Is observable and measurable in their process and outcome during routine clinical practice
- Has a beginning and an end (you can see the activity start and end)
- Requires the integration of multiple competencies within numerous domains of competence
- Are entrusted to learners to perform independently after comprehensive assessment indicates consistent, sufficient competence has been demonstrated.[11-14]

EPAs serve as an important tool for educators, mentors, and clinical supervisors to make informed entrustment decisions, judgments about whether a learner is ready to carry out essential tasks independently.[11] In contrast to traditional checklists or time-based progression, EPAs enable assessment that is performance-based, context-sensitive, and aligned with professional expectations.[11,13,14]

By identifying a common set of EPAs for the profession, this framework helps reduce variations across educational programs and clinical training sites. It offers a shared language for assessing learner readiness for practice and fosters consistency in expectations across the learner continuum.[11,13]

The 19 EPAs included in this report represent observable and essential activities that learners within DPT programs should be entrusted to perform, without the need for supervision, at some point during their DPT training, prior to graduation. Each EPA reflects routine, day-to-day responsibilities encountered across physical therapy practice settings and is grounded in

professional standards, ethical expectations, and the movement system expertise that defines the profession.

Each EPA in this framework is presented with:[14]

- A title and description of the activity
- The critical competencies, organized into domains, deemed necessary within an individual to perform the EPA
- Limitations or scenarios for that EPA where an entry-level physical therapist is not expected to perform without the need for supervision
- Examples of potential learning activities to support learner progression
- Information sources to assess learner progress
- An entrustment supervision scale to assess learner performance of a given EPA
- Examples of behaviors that do and do not merit entrustment for each EPA

How Were the 19 EPAs Developed?

An iterative, 4-phase process was used to identify and describe the 19 core EPAs for entering clinical practice for the first time (entry-level), regardless of setting. Each phase included initial work by an EPA drafting work group of physical therapy educators and clinical experts. This work was followed by a modified Delphi that was used to attain national consensus among a reactor panel made up of professional colleagues, including clinical educators, academic faculty, and recent graduates.

As part of the process to align the domains of competence and their associated competencies with the newly developed EPAs, a thorough review and refinement of the original set of competencies was undertaken by the Entrustable Professional Activities Panel. Initially, 69 essential competencies were identified across the 8 domains by the domains panel. However, during the mapping exercise that is a critical step in linking each EPA to the 5-7 competencies deemed most critical to its performance,[14] the panel identified competencies that overlapped in content or intent.

To improve clarity and reduce redundancy, the Entrustable Professional Activities Panel conducted a careful competency pairing process. Competencies that were conceptually similar or covered overlapping characteristics were merged, resulting in a more streamlined and cohesive set. This effort reduced the total number of essential competencies from 69 to 54, enhancing usability for academic and clinical faculty while maintaining the breadth and depth of professional expectations across the 8 domains.

The panel noted competencies that used verbs such as "appreciates," "considers," or "values." While these terms reflect an important internal state of the learner, they are not directly observable in clinical practice and therefore do not align with the goals of assessment through an EPA. To ensure that each competency could be observed and assessed reliably by educators in actual clinical settings, these descriptors were revised to use action-oriented language (eg, replacing "appreciates" with "recognizes" or "demonstrates"). These changes support a more practical and consistent approach to assessing learner performance and readiness for unsupervised clinical practice.

Together, these refinements ensure that the essential competencies are both meaningful and measurable, supporting their effective use in teaching, learning, and assessment within the CBEPT framework.

Intended Use of the EPA Framework

The 19 EPAs are designed to:[11-14]

- Clarify the activities entry-level physical therapists should be able to perform independently.
- Facilitate teaching, learning, and assessment of the critical competencies identified for each EPA.
- Provide explicit and clear expectations for students.
- Provide consistent, explicit, and clear expectations for clinical faculty teaching and performing workplace-based assessments of learner performance.
- Guide academic programs to assess whether their curriculum provides the necessary knowledge, skills, and attitudes that would result in learners developing the competencies or if there are any gaps that need to be filled.
- Facilitate opportunities for learners to practice, self-assess, and be provided feedback on their performance of the EPAs with patients or clients in authentic clinical environments or settings.
- Support assessment practices that document the developmental acquisition of competencies and workplace-based assessments of EPAs' performance.

"I really think you all have completed one of the best processes I have seen for a profession's development of EPAs and the outcome is excellent and will serve your community both theoretically and practically."

—Robert Englander, MD, MPH
Adjunct Professor of Medical Education
University of Illinois College of Medicine

EPAs for Entrance into Physical Therapist Practice

The following are 19 EPAs essential for entrance into physical therapist practice, encompassing key skills and responsibilities that ensure high-quality patient care.

1	**Obtain informed consent from a patient or client.**
2	**Perform an initial examination of a patient or client.**
3	**Establish a diagnosis within one's personal, professional, and jurisdictional scope of practice.**
4	**Develop a management, plan including plan of care.**
5	**Implement a plan of care.**
6	**Perform physical therapy procedures/interventions.**
7	**Establish a home, self-management program.**
8	**Document a patient or client encounter.**
9	**Refer a patient or client to additional health care professionals.**
10	**Educate others (patients and caregivers, families, significant others, other health professionals, community).**
11	**Supervise others (physical therapist assistants, aides, technicians, and junior learners).**
12	**Assess and determine outcomes of the plan of care.**
13	**Concludes an episode of care for a patient or client.**
14	**Identify system failures (real and potential errors) and activate the system for improvement.**
15	**Formulate recommendations for preventative health.**
16	**Bill for a patient or client visit.**
17	**Triage care to prioritize resources to patients most in need.**
18	**Complete a patient handoff to transition care.**
19	**Recognize and respond to an urgent or emergent change in status.**

The full description of each EPA is provided below in the following format:[14]

1	**EPA title**
2	**EPA specification: full description of the activity**
3	**Limitations: Contexts where a learner is not expected to perform without supervision**
4	**Critical competencies, within different domains, that have been mapped to the EPA**
5	**Some examples of possible learning experiences for learners to practice the activity**
6	**Some possible information sources to assess the progress of the learner**
7	**Use an entrustment supervision scale for use in physical therapy (eg, TRUST PT)**
8	**Expiration date: a period of time where, if there is a lapse in practice of the activity, the recommendation would be that the clinician be reassessed to determine competence.**

Items 5–7 are fully described in EPA 1 below and are the same for all 19 EPAs.

Clinical scenarios and sample behaviors that do and do not merit entrustment are then provided for each EPA.

Entrustable Professional Activity 1:

Obtain informed consent from a patient or client.

Description of the Activity (Specification)	Physical therapists provide patients or clients with information on the diagnosis, prognosis, treatment options, and risks and benefits of treatment options. Respecting patient and client autonomy in decision-making, "informed consent occurs when communication between a patient and provider results in the patient's authorization or agreement to undergo a specific intervention."[84]
	
	Component Steps
	• Identify when informed consent is required (eg, initial consent, ongoing consent).
	• Determine the influence of culture, family, significant others, environmental factors, and personal factors on decision-making.
	• Identify barriers to informed consent (eg, communication, guardianship, parental consent) and respond accordingly.
	• Confirm legal competence and/or patient's or client's capacity for decision-making.
	• Follow all professional standards and jurisdictional laws that apply to informed consent.
	• Engage the patient or client or their decision maker in a meaningful discussion regarding:[85]
	  ○ The planned examination, evaluation, diagnosis, and prognosis (including treatment plan).
	  ○ The intervention/treatment to be provided, including associated risks, expected benefits, alternative treatment options, timeframes, and costs.
	• Document the informed consent encounter, including the information given by the physical therapist, confirmation of patient's or client's understanding of given information, and the patient or client or decision-maker's decision, which may include modification or refusal of treatment.[85,86]

Limitations	None

Most Relevant **Domains of Competence and Critical Competencies**	**Patient and Client Care and Services** **PC 3** Empowers patients and clients, families, significant others, and caregivers to participate in care and shared decision-making. **PC 14** Complies with legal, organizational, and payer regulations when documenting in the patient or client record. **Communication** **CO 2** Evaluates and adapts communication strategies to meet the needs of individuals and populations. **Practice Management** **PM 1** Manages the physical therapy practice in accordance with regulatory, legal, and organizational requirements and professional standards. **Education and Learning** **EL 2** Identifies audience learning needs, considering preferences and abilities, the role of culture, family-related constructs, environmental factors, and personal factors, to develop a plan. **Professionalism** **PR 1** Practices according to the APTA Code of Ethics[87] for the Physical Therapist. **PR 5** Recognizes how differences in background, experience, and access to resources impact care.
Most Relevant Experiences	Possible examples: • Role-play in simulated setting (lab) • Standardized patients • Satisfactory performance on an Objective Structured Clinical Examination/practical examination • Clinic or hospital experiences where performance of the EPA can be observed • Community-based activity where performance of the EPA can be observed

Information Sources to Assess Progress and Ground a Summative Entrustment Decision	Some suggested assessment methods:
	• Non-workplace-based assessments:
	  ○ Written/online knowledge testing
	  ○ Simulation/skills testing
	• Workplace-based assessments:
	Programs should determine the number of formal assessments (eg, 5-10) for each EPA that should take place across all patient and client exposures that a student may experience within their DPT curriculum (eg, part-time clinical exposure throughout a semester and curriculum (ICEs), full-time experiences). It is recommended that the formal assessments take place in more than one setting, and, if possible, by multiple assessors. Examples include:
	  ○ Direct observation of performance (Entrustment Supervision scale completed)
	  ○ Case-based or entrustment-based discussion
	  ○ Evaluation of student generated artifacts (eg, sample documentation, education modules produced, draft plan of care)

Entrustment at which level of supervision at which stage of education?	Example TRUST PT: An entrustment supervision scale for physical therapy.[88] • Level 1 (ready to observe) • Level 2 (ready to co-perform) • Level 3 (ready for direct supervision) • Level 4 (ready for indirect supervision) • Level 5 (ready for unsupervised practice) • Level 6 (ready to supervise others)
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 1:

Obtain informed consent of a patient or client.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not explain the patient's or client's diagnosis, prognosis, or risks and benefits of potential treatment options to the patient or client. • Steers a patient or client to a decision. • Relies on implied consent. • Does not engage the patient or client or their caregiver(s) in meaningful discussion so that an informed decision can be made. • Documentation does not reflect informed consent being received.	• Explains the patient's or client's diagnosis or prognosis. • Informs the patient or client of proposed benefits, risks, and alternatives to interventions being proposed. • Emphasizes the patient's or client's role in decision-making. • Determines capacity and ability of the patient to make informed decisions and identifies appropriate guardian/proxy as needed. • Devotes time and effort to support the shared decision-making process. • Recognizes when changes in communication need to occur to match patient's preferred learning style or cognitive ability. • Documents information given and patient's comprehension and consent to intervention.

Clinical Sample Scenario

As the clinical instructor in an outpatient clinic, you have been asked to observe and assess a physical therapist student, Reilly, obtain informed consent from a new patient. The patient, Alex, is a 40-year-old female with a history of hypothyroidism and depression who presents with sudden-onset dizziness with suspected benign paroxysmal positional vertigo (BPPV).

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• The student provides incomplete information to the patient about the risks and benefits of the maneuvers. • The student does not seek informed consent.	• Provides education on suspected source of symptoms and explains the use of testing to diagnose BPPV.

• The student does not document that informed consent was received.	• Provides options for alternative testing positions if patient reports intolerance to suggested positions. • Provides alternative options when the patient does not provide consent. • Discloses the risks associated with positional testing. • Receives and documents the patient provided informed consent.

Entrustable Professional Activity 2:

Perform an initial examination of a patient or client.

Description of the Activity (Specification)

Physical therapists perform an initial examination of a patient or client that is comprehensive, consistent with and supported by evidence, and considers the individual factors and characteristics unique to the patient or client.

Performance of this EPA is predicated on the practitioner possessing the ability to perform a history, review of systems, and examination, including systems review and tests and measures accurately, as well as the knowledge of normative data to analyze and interpret outcomes.[68,89]

Component Steps

- Gather a history.
  - Review medical record and available relevant clinical documentation.
  - Interview patient or client to elicit responses to inform a comprehensive past medical, surgical, medication, and social history as well as history of present illness.
  - When necessary, communicate with others to gather additional pertinent medical, surgical, medication, and social history, as well as history of present illness.
- Perform a systems review.
  - Based on patient or client history, determine which systems (eg, neurological review, musculoskeletal review) need to be reviewed and under what condition.
  - Complete a comprehensive review of identified systems.
  - Interpret results of systems review(s) and determine which systems require further examination/evaluation.
- Recommend, perform, and interpret common diagnostic and screening tests and measures.
  - Perform diagnostic and screening tests and measures both as informed by evidence and systems review and in consideration of history of present illness.
  - Interpret outcomes of the diagnostic and screening tests and measures performed.
  - Identify when results of diagnostic tests and measures are abnormal and require further action.
  - Determine when additional care or support is required beyond PT scope and make relevant referrals (eg, radiographic studies, urgent and emergent findings, additional medical or social services).

Limitations	At entrance into practice, a physical therapist is not expected to perform an initial examination of a patient or client in clinical cases where (a) additional clinical training or certification is required beyond the entry-level physical therapist (eg, electromyography, dry needling, pediatrics-neonatal intensive care unit) and (b) clinical cases that present with medical complexity beyond the entry-level scope of practice.
Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 4** Uses evidence-informed practice[G] when making clinical decisions regardless of the depth, breadth, or ambiguity of available evidence. **PC 5** Incorporates the characteristics of the patient or client to develop and implement a person-centered, comprehensive examination.[G] **PC 6** Interprets laboratory data, imaging studies, and other tests required for the area of practice. **PC 12** Recognizes urgent and evolving situations and determines appropriate responses. **PC 17** Identifies the need for interprofessional and intraprofessional collaboration, consultations, or referrals. **Knowledge for Practice** **KP 1** Integrates comprehensive knowledge in foundational, behavioral, social, and clinical sciences across diverse patient and client populations or practice settings. **Systems-Based Practice in Health Care** **SB 1** Uses outcomes data collection and analysis to guide the provision of physical therapist services and for practice improvement.

Most Relevant Experiences See page 34
Information Sources to Assess Progress See page 35
Entrustment Supervision Scale See page 35

Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 2:

Perform an initial examination of a patient or client.

Behaviors that do not merit entrustment	Behaviors that merit entrustment

• Completes a chart review but may forget to review portions of the medical chart or dismisses the importance of abnormal findings.
• Does not ask supervising clinician questions as warranted.
• Appears overly confident when encountering new patients with compleXmedical or functional presentations.
• Does not demonstrate knowledge beyond a very basic understanding of common medical diagnoses.
• Does not ask follow-up questions if the patient has not provided an adequate response to questions during the interview.
• Frequently turns their back to the patient during the interview when documenting or faces away from the patient when communicating via an interpreter.
• Misses signs of potential abuse or neglect, eg, doesn't ask about the presence of suspicious bruising, extremely underweight appearance, fearful behavior.
• Does not tailor the examination to the patient's presentation, eg, overscreens or performs unnecessary tests and measures.
• Does not use proper body positioning of self or patient during examination, eg, the therapist is on the opposite side relative to the patient's extremity being examined, or the individual performs strength testing on a patient only in gravity-assisted position.
• Does not describe the normal or expected outcomes for commonly used tests and measures, eg, normal range of motion at all the joints.
	• Demonstrates the ability to review the medical record and/or relevant clinical documentation and identify pertinent information to inform physical therapy practice.
	• Consistently seeks guidance when encountering unfamiliar situations, terms, or diagnoses.
	• Demonstrates knowledge of common medical diagnoses and their impact on the examination.
	• Demonstrates ability to formulate questions that will elicit a comprehensive medical, surgical, and social history, as well as history of present illness from patient or client.
	• Asks clarifying questions in response to information provided by the patient or client.
	• Identifies when communication with others is needed to gather additional pertinent information related to medical, surgical, and social history, as well as history of present illness.
	• Identifies situations where abuse or neglect could be present.
	• Answers questions from the patient or client throughout the initial examination.
	• Communicates based on the level of the listener throughout the initial examination, including:
	  ○ Utilizes plain language rather than compleXmedical jargon throughout the encounter.
	  ○ Ensures use of people-first language.
	  ○ Faces patient or client and, when possible, maintains eye contact when

• Does not respond to nonverbal signs exhibited by the patient, eg, the patient reports no pain during the interview but winces when moving.	communicating, even when working with an interpreter. • Identifies all systems (eg, neurological, musculoskeletal, cardiovascular) requiring review based on the information gathered from the patient's or client's history. • Performs screening of identified systems to determine when more detailed examination is indicated. • Demonstrates knowledge of which tests and measures, patient-reported outcomes, or procedures should be performed to complete a comprehensive review of the identified system. • Performs or administers all indicated tests and measures (eg, proper physical therapist hand and body position, proper patient position, verbal, and nonverbal cues to the patient or client). • Demonstrates knowledge of normative data associated with all tests and measures performed during the examination. • Interprets results of tests and measures and identifies when the patient's or client's results obtained are outside of the normal or expected range, based on defined patient characteristics. • Identifies when findings suggest additional care is required that is outside the scope of physical therapy and communicates this to both the patient and other members of the patient's care team.

Clinical Sample Scenario
As the clinical instructor in the acute care hospital, you have been asked to observe and assess a physical therapy student, Daija, perform an initial examination of a patient, Harold, in the general medicine unit. Harold is an 82-year-old male who was admitted to the hospital 2 days ago following a fall at home. He presents with a current urinary tract infection, which is being treated with antibiotics, as well as some abrasions and contusions on his face. Harold lives alone in an apartment but reports that his family visits "frequently" to "help him out." Harold's past medical history is significant for a prior cerebrovascular accident, chronic obstructive pulmonary disease, hypertension, and diabetes mellitus.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Summary of the chart review is missing several key elements of the medical history, including details of the recent fall and prior history of falls, home environment, and available equipment at home. • Examination is incomplete and not tailored to the patient history, including not removing the patient's socks to do skin inspection, which was indicated due to his DM and his recent fall, and assessing sensation (light touch) on bilateral lower extremities while the patient watched, invalidating the results.	• Completes a comprehensive medical record review and gathers additional pertinent information during the history. • Assesses the necessary systems and, based on this review, completes relevant tests and measures. • Communicates with the patient throughout the session, facing them when speaking and maintaining eye contact; uses clear commands when performing tests and measures; and responds appropriately when the patient expresses any concerns. • Identifies that the patient may not be safe at home alone due to this recent fall and initiates a conversation with the clinical instructor about the need to discuss the case with a social worker to get more information about the assistance he receives from his family and recommend home health services. • Notes the location of the bruises on his face and the need for the patient to be observed over time, secondary to the potential for developing complications such as subdural hematoma.

Entrustable Professional Activity 3:

Establish a diagnosis within one's personal,* professional,* and jurisdictional* scope of practice.

Description of the Activity (Specification)	Physical therapists establish a diagnosis for each patient or client encounter that reflects identified signs, symptoms, and/or impairments in body structures and function.[90] Performance of the EPA is predicated on the ability to organize and interpret all relevant information that is part of the diagnostic process (obtaining relevant history, performing systems review, and selecting and administering specific tests and measures).
	Component Steps
	• Uses a systematic process to establish an evidence-based physical therapist differential diagnosis by:
	  ○ Synthesizing findings.
	  ○ Considers multiple diagnostic considerations relevant to the client's presentation and context and the referral.
	  ○ Identifies additional plausible diagnoses (differential diagnosis).
	  ○ Establishes a working diagnosis for initial and ongoing care.
	• Physical therapist diagnosis is made within the bounds of legal and professional standards, including all federal, state, and institutional regulations related to patient and client care.
	• Synthesize findings from the examination or reexamination, and for a working diagnosis outside one's personal scope of practice, consult other PT or health professionals to establish/confirm the diagnosis and direct therapy.
	• Educates the patient or client regarding diagnosis.

Limitations	At entrance into practice, a physical therapist is not expected to establish a diagnosis in clinical cases where: • Additional clinical training or certification is required beyond the entry-level physical therapist (eg, electromyography, dry needling, pediatrics-neonatal intensive care unit). • Clinical cases that present with medical complexity beyond the entry-level scope of practice.

* Terms: Personal, professional, and jurisdictional scope of practice. An individual physical therapist's scope of practice is influenced by professional, jurisdictional, and personal scopes of practice. https://www.apta.org/apta-and-you/leadership-and-governance/policies/position-scope-of-p

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 4** Uses evidence-informed practice[G] when making clinical decisions regardless of the depth, breadth, or ambiguity of available evidence. **PC 7** Evaluates examination[G] findings to establish a diagnosis and prognosis. **PC 17** Identifies the need for interprofessional and intraprofessional collaboration, consultations, or referrals. **Knowledge for Practice** **KP 3** Demonstrates scholarly inquiry[G] and scholarly activities[G] to integrate physical therapy theories, knowledge, and evidence with information from other appropriate sources to inform clinical judgment. **Practice Management** **PM 1** Manages the physical therapy practice in accordance with regulatory, legal, and organizational requirements and professional standards. **Education and Learning** **EL 1** Educates patients and clients, families, significant others, caregivers, other health care professionals, and society. **Professionalism** **PR 2** Complies with all federal, state, local, payer, and organizational requirements regulating the practice of physical therapy.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 3:

Establish a diagnosis within one's personal, professional, and jurisdictional scope of practice.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Unable to determine a physical therapy differential diagnosis that is evidence-based. • Focuses on a single patient presentation and does not consider ruling out other possible diagnoses. • Uses only select information for establishing the physical therapy diagnosis. • Unable to synthesize the findings that suggest the diagnosis is outside one's personal, professional, and/or jurisdictional scope of practice and does not refer.	• Synthesizes findings from examination and evaluation to establish an evidence-based physical therapy differential diagnosis. • Identifies multiple diagnostic considerations and selects the one that aligns with the patient or client presentation. • Identifies all of the information needed to support the diagnosis and shares it with the patient or client. • Synthesizes findings to determine if the diagnosis is outside personal, professional, and/or jurisdictional scope of practice.

Clinical Sample Scenario

As the clinical instructor in the outpatient clinical setting, you have been asked to observe and assess a physical therapy student, Emily, who is evaluating an 8-year-old, Danny, with cerebral palsy. Danny's parent is concerned that Danny is unable to fully straighten his lower extremities, and it is becoming more challenging for him to walk. Danny uses a rollator walker for walking inside his home and in the community.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Makes a physical therapy diagnosis related to the flexion contractures and develops a plan of care for stretching. • Does not consider other probable causes. • Does not consider personal scope of practice and engages in interventions without consulting other health professionals.	• Synthesizes the information from the initial evaluation and determines, based on scope of practice, that the patient needs to be seen by another health care professional. • Determines that the contractures are related to spasticity and not related to an orthopedic problem that she can address within her personal scope of practice.

	• Identifies and collects information needed for making a referral and discusses with the parent and makes the referral.

Entrustable Professional Activity 4:
Develop a management plan, including the plan of care.

Description of the Activity (Specification)	Physical therapists formulate a management plan that includes a plan of care. Performance of this EPA is predicated on the ability to obtain information through the history and physical exam to formulate a diagnosis. Developing a plan of care is an iterative process based on the best available evidence that requires synthesis of medical, ethical, legal, and economic factors, as well as knowledge of the strengths and limitations of the patient or client, physical therapist, team, and facilities.
	
	Component steps:
	• Establish a prognosis that includes a predicted level of improvement, an established timeline, and goals.
	• Codevelop goals with the patient or client through education and shared decision-making.
	• Identify the targeted level of improvement and define the outcome measures that will be used to track progress.
	• Describe interventions that are necessary to reach the goals and outcomes.
	  ○ Duration and frequency of each intervention are specified.
	  ○ Incorporates concepts of health promotion and wellness as appropriate.
	• All requirements for a plan of care are met and documented (eg, professional, jurisdictional, institutional, and payer/insurance).
	• Plans for referral, consultation, or comanagement are identified, along with a communication plan to ensure follow-up.

Limitations	At entrance into practice, a physical therapist is not expected to develop a plan of care when the physical therapist is being consulted for expert opinion or advice or for diagnostic or physiologic testing. In such situations the physical therapist documents the reason(s) that the plan of care was not created.

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 8** Integrates examination findings, diagnosis, prognosis, and patient or client preferences to establish a plan of care. **PC 9** Incorporates concepts of health promotion and wellness into a plan of care to reduce the impact of disease and disability. **PC 17** Identifies the need for interprofessional and intraprofessional collaboration, consultations, or referrals. **Knowledge for Practice** **KP 1** Integrates comprehensive knowledge in foundational, behavioral, social, and clinical sciences across diverse patient and client populations or practice settings. **KP 3** Demonstrates scholarly inquiry[G] and scholarly activities[G] to integrate physical therapy theories, knowledge, and evidence with information from other appropriate sources to inform clinical judgment. **Communication** **CO 1** Uses modes[G] and mediums[G] of communication, including communication technologies to meet the needs of individuals and populations. **Education and Learning** **EL 3** Establishes learning goals in collaboration with the learner.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 4:

Develop a management plan, including a plan of care.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Plan of care is incomplete. • Plan of care is not explained to the patient. • Plan of care is not guided by the assigned diagnosis. • Goals are not measurable. • Does not use outcome measures, or the measure is not appropriate for the problem. • Interventions are not specified or evidence-informed. • Documentation of the plan is unclear or incomplete.	• Discusses and develops the plan of care with the patient or client consistent with the functional outcome goals. • Codevelops goals with the patient or client through education and shared decision-making. • Identifies the targeted level of improvement, and the outcome measures that will be used to track progress are clearly defined. • Describes evidence-informed interventions that are necessary to reach the goals and outcomes. • Specifies the duration and frequency of each intervention. • Incorporates components of health promotion and wellness when necessary. • All components of a plan of care are met and documented. • Plans for referral, consultation, or comanagement are identified and include follow-up communication. • Obtains informed consent to the plan from the patient or client.

Clinical Sample Scenario

As the clinical instructor in an outpatient setting, you have been asked to observe and assess a physical therapy student, Jordan, develop a plan of care for patient Ashley. Ashley is a 24-year-old with a physical therapy diagnosis of left shoulder labral tear. The results of the examination are consistent with symptom reproduction during impaired scapulohumeral rhythm movements. Symptoms are improved with manual correction of these impairments. All other testing is unremarkable. During screening, Jordan finds that Ashley has high blood pressure that they were not aware of and that is not managed by another provider.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Develops an incomplete plan or does not adequately explain it to the patient. • Goals are not measurable or are not developed with the patient. • Interventions do not match the diagnosis or best available evidence. • Outcome measures are not identified or are not repeated to assess the plan. • The plan lacks a clear timeline for reassessment. • Documents high blood pressure but does not follow up with it in the plan. • Does not monitor or document blood pressure throughout the plan of care implementation. • Does not document the plan completely or in compliance with regulatory requirements.	• Discusses the findings of the examination and diagnosis and determines the plan of care that would best address the patient's problems. • Discusses each goal with the patient, considering the patient's preferences and response. • Includes interventions that are informed by evidence and are guided by the diagnosis. • Identifies outcome measures and a planned timeline for goal achievement and reassessment. • Documents the plan of care per regulatory requirements. • Includes within the management plan a referral for further testing of the high blood pressure. • Obtains consent from the patient to move forward with the plan.

Entrustable Professional Activity 5:
Implement a plan of care.

Description of the Activity (Specification)	Physical therapists implement a plan of care that is predicated on the development of a plan of care (by oneself or another physical therapist) that addresses problems and activity limitations identified through examination and evaluation. **Component Steps** • Selects interventions appropriate to patient or client goals consistent with evidence-based practice, including educating the patient, client, or caregiver. • Communicates and delivers treatment to the patient or client in an organized sequence. • Coaches the patient or client on therapeutic interventions to practice independently. • Coordinates physical therapy supports (eg, equipment, environment) required for ongoing treatment. • Assess the effectiveness of intervention delivery and adjust intervention as needed (eg, revise the frequency and duration of treatments, reevaluate a patient's or client's progress toward goals, and collaborate with referring providers for new or corroborating data).
Limitations	At entrance into practice, a physical therapist is not expected to implement a plan of care in clinical cases where (a) additional clinical training or certification is required beyond the entry-level physical therapist (eg, electromyography, dry needling, pediatrics-neonatal intensive care unit) and (b) clinical cases that present with medical complexity beyond the entry-level scope of practice.

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 4** Uses evidence-informed practice[G] when making clinical decisions regardless of the depth, breadth, or ambiguity of available evidence. **PC 10** Synthesizes ongoing examination findings to modify interventions to meet patient or client needs according to the individual's presentation, goals, and resources. **PC 11** Uses a continual process of patient and client assessment that includes appropriate outcome data to direct the progression of the plan of care. **PC 17** Identifies the need for interprofessional and intraprofessional collaboration, consultations, or referrals. **Communication** **CO 1** Uses modes[G] and mediums[G] of communication, including communication technologies to meet the needs of individuals and populations. **CO 2** Evaluates and adapts communication strategies to meet the needs of individuals and populations. **Education and Learning** **EL 4** Applies effective teaching strategies for cognitive, psychomotor, and affective domains of learning.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 5:

Implement a plan of care.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not assess patient or client for response to treatment. • Plan of care not adjusted for optimal response. • Effectiveness of intervention delivery not considered, nor intervention adjusted. • Does not consider the need for collaboration with other providers.	• Assessment of the patient or client, including the response to PT, occurs at every treatment session. • Modifies interventions for optimal patient response. • Assesses the effectiveness of intervention delivery and adjusts as necessary. • Incorporates personal and environmental factors into implementation of the plan of care. • Communicates connections between interventions and the patient's or client's goals. • Modifies plan of care if progress is not obtained, which may include new referrals.

Clinical Sample Scenario

As the clinical instructor in a home health setting, you have been asked to observe and assess a physical therapy student, Blake, implement a plan of care for a physical therapy session of the patient, Patrick. Patrick is a 74-year-old male who presents in their home with complaints of left knee pain and difficulty walking. Patrick has a history of congestive heart failure, R carpal tunnel repair, and peripheral neuropathy.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not take into consideration the patient's current presentation and modify the planned session as needed. • Does not focus attention on the observation of the patient's performance. • Functional outcome goals are not considered in intervention plans.	• Is proactive with exercise progressions prior to today's treatment and can voice rationale for plan. • Checks in with the patient to determine the patient's performance, acceptance, and adherence to the home exercise program. • Discusses with the patient what functional activities are improving, what remains to be worked on, and any changes the patient has in

	their goal achievement. The plan of care is then adjusted accordingly. • Assesses the effectiveness of interventions and the patient's response, modifying interventions to optimize patient performance.

Entrustable Professional Activity 6:

Perform physical therapy procedures/interventions.

Description of the Activity (Specification)	Physical therapists select, prescribe, and implement interventions targeted to established goals and based on the available evidence, examination findings, diagnosis, and prognosis.[91] Physical therapists must also adhere to the personal,* professional,* and jurisdictional* scope of practice and institutional, state, and federal guidelines.[92]
	
	Component steps:
	• Prescribe selected interventions, including positioning, dosing, frequency, and duration.
	• Implement evidence-informed interventions.
	• Procedural interventions:[93]
	  ○ Adaptive and assistive technology
	  ○ Biophysical agents
	  ○ Functional training/transfer training
	  ○ Integumentary repair and protection techniques
	  ○ Manual therapy (eg, soft tissue massage, joint mobilization techniques)
	  ○ Motor function/gait and locomotion/movement training
	  ○ Respiratory and ventilatory techniques for enhanced respiratory function
	  ○ Therapeutic exercise
	• Determines the efficacy of the intervention.
	• Adjusts the intervention (eg, type, intensity) based on the patient's performance and response in that given session, including responding to emergency situations.

Limitations	At entrance into practice, a physical therapist is not expected to perform physical therapy procedures/interventions in clinical cases where (a) additional clinical training or certification is required beyond the entry-level physical therapist (eg, electromyography, dry needling, pediatrics-neonatal intensive care unit) and (b) clinical cases that present with medical complexity beyond the personal scope of practice.

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 4** Uses evidence-informed practice[G] when making clinical decisions regardless of the depth, breadth, or ambiguity of available evidence. **PC 10** Synthesizes ongoing examination findings to modify interventions to meet patient or client needs according to the individual's presentation, goals, and resources. **PC 12** Recognizes urgent and evolving situations and determines appropriate responses. **Knowledge for Practice** **KP 4** Discriminates the efficiency, efficacy, and value of new technology and skills and considers their ethical application within practice. **Practice Management** **PM 1** Manages the physical therapy practice in accordance with regulatory, legal, and organizational requirements and professional standards. **PM 5** Adheres to individual, team, and system-level safety and infection control practices. **Reflective Practice and Improvement** **RP 1** Demonstrates self-awareness, emotional intelligence, and accountability for one's own decisions, actions, and errors in clinical performance and seeks external feedback and opportunities to learn.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 6:

Perform physical therapy procedures/interventions.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not describe intensity, duration, or frequency of prescribed interventions. • Does not utilize an evidence-informed approach when prescribing interventions. • Includes interventions in the plan of care that are not allowed based on state practice act (eg, including dry needling in the treatment plan in a state where it is prohibited). • Does not provide comprehensive, evidence-informed rationale for interventions to patients, their families, or other health care providers. • Continues to provide the same intervention in multiple therapy sessions without adjusting based on patient performance or response to treatment (eg, does not increase the complexity of the activity when the current activity appears easy for the patient or fails to increase weight (or decrease) when the patient is performing resistance exercises.) • Performs procedures/interventions in an incorrect and/or unsafe manner.	• Prescribes interventions for a session reflective of best available evidence, targeted goal, and patient's current presentation. • Is intentional in identifying activities for treatment, prioritizing activities that the patient enjoys and align best with the patient's goals. • Performs all prescribed treatment interventions using correct techniques, patient position, and therapist position to ensure safety and effectiveness of activity. • Educates the patient on the appropriate and not appropriate responses of the intervention and the importance of communicating that response to the PT. • Educates the patient and caregiver(s) about treatment, including why activities were chosen, evidence to support interventions, and updates the patient regarding progress toward goals. • Educates the patient and caregiver(s) in the performance of the exercise program and checks for learning/correct performance of the exercises to ensure efficacy.

Clinical Sample Scenario
As the clinical instructor in the outpatient unit, you have been asked to observe and assess a physical therapist student, Stephen, perform a transfer from bed to chair on a patient, Li Yuen, who had a cerebral vascular accident and indicated difficulty transferring at home independently. Li Yuen is experiencing lower extremity weakness, decreased balance, and impaired coordination. Li Yuen has a history of colorectal cancer and atrial fibrillation.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not prepare the patient or treatment environment prior to the session. • Does not utilize the proper equipment during the transfer activity (eg, gait belt, transfer board). • Unable to describe how to progress or regress the activity based on the patient's performance during the session. • Uses improper body mechanics during transfers. • Does not provide rationale for future adjustments of the intervention or plan of care based on the patient's response to the intervention.	• Prioritizes performing transfers from bed to chair with the patient, as patient expresses this goal. • Conducts an upper and lower extremity scan to reassess the patient's functional strength to estimate the amount of assistance needed with the planned activity. • Educates the patient on the component steps of the transfer from bed to chair, including highlighting how they should be positioned to perform the activity to ensure safety, and educated the patient's sister, who was present during the session, about how to monitor Li Yuen's performance during the activity. • Educates the patient and family member on how often they should practice this activity at home. • Prepares the treatment environment with the necessary equipment and space to perform the transfer safely. • Positions patient and self in a manner that optimizes safety and performance. • Transfers the patient from bed to chair utilizing proper body mechanics and safe patient handling. • Recognized components of the transfer that were challenging (eg, decreased strength of left upper extremity, decreased balance during transfer) and indicated they would add targeted interventions.

Entrustable Professional Activity 7:

Establish a home, self-management program.

Description of the Activity (Specification)	Physical therapists provide an evidence-based comprehensive home program based on a given patient's or client's presentation, symptoms, activity limitations and participation restrictions to address their stated goals of rehabilitation. This program considers health promotion and wellness needs, the patient's or client's goals, comorbidities, available resources, and stage of healing. Instructions are provided in the appropriate mode (written or electronic) at a level commensurate with the patient's or client's preferred learning style, language, and education level. **Component steps:** • Identify and prioritize the impairments or services requests. • Provide the rationale for each intervention to the patient or client. • Demonstrate each component, providing clear instructions. • Observe the patient performing each component and provide verbal and tactile cues as needed to optimize performance. • Provide the dosage for each activity prescribed, including but not limited to sets, reps, frequency, and hold time. • Identify adverse effects of intervention activities to the patient or client. • Provide the home program in written or electronic format commensurate with the patient's or client's preferred learning style, language, and education level. • Give the patient or client the opportunity to ask questions and demonstrate understanding of each component of the home program. • Explain the importance of adherence to the home program prescribed to the patient or client.
Limitations	None

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 3** Empowers patients and clients, families, significant others, and caregivers to participate in care and shared decision-making. **PC 11** Uses a continual process of patient and client assessment that includes appropriate outcome data to direct the progression of the plan of care. **Communication** **CO 1** Uses modes[G] and mediums[G] of communication, including communication technologies to meet the needs of individuals and populations. **Education and Learning** **EL 2** Identifies audience learning needs, considering preferences and abilities, the role of culture, family-related constructs, and life stage and develops a plan. **EL 4** Applies effective teaching strategies for cognitive, psychomotor, and affective domains of learning. **EL 5** Assesses if the patient's or client's educational needs have been met. **Systems-Based Practice in Health Care** **SB 3** Incorporates concepts of health promotion and wellness into physical therapist practice to reduce the impact of disease and disability on society.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 7:

Establish a home, self-management program.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not provide a home self-management program. • Does not consider the patient's ability to interpret or perform exercises included in the program. • Does not provide appropriate Frequency Intensity Time and Type (FITT) principles. • Does not consider safety when instructing the patient on performance. • Does not sufficiently review proper performance of program. • Does not assess patient understanding/carryover. • Does not focus on impairments, activity limitation, and participation restrictions. • Does not reassess appropriateness and effectiveness of exercises and adjust/modify as needed.	• Provides a home self-management program that reflects both the patient's and therapist's goals. • Develops exercises that emphasize impairments, activity limitations, and participation restrictions. • Develops a program and instructions within the patient's preferred learning style and language. • Provides an exercise program at an appropriate point within the POC. • Applies Frequency Intensity Time and Type (FITT) principles. • Ensures that the patient can safely and accurately perform exercises in the program. • Reviews the program with the patient, ensuring understanding and carryover/performance. • Adjusts the self-management program as needed based on patient performance.

Clinical Sample Scenario

As the clinical instructor, you have been asked to assess a physical therapist student, Kara, as they create and provide a self-management program for a patient, John. John is visually impaired and attending outpatient physical therapy to increase his strength and mobility after a total hip replacement with a goal of using stairs to visit his grandchildren.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not provide John with a home exercise program. • Includes components to the self-management program that are not tailored to the patient's targeted needs and goals.	• Provides a self-management program to the patient in a format that accommodates their visual impairments (eg, verbal recording or written with increased text and figure font).

• Does not include clear instructions for the program, including frequency and duration of activities included. • Does not adjust the program when the patient notes pain. • Does not assess ability to perform the self-management program safely and effectively.	• Designs a self-management program so that it is accessible for the patient who has visual impairment. • Reviews each exercise with the patient, ensuring comprehension. • Activities and exercises selected address impairments and targeted goals identified. • Determines appropriate frequency, intensity, time, and type of activities and exercises based on the patient's performance. • Instructs the patient on the performance of each activity and exercise, ensuring proper form and performance.

Entrustable Professional Activity 8:
Document a patient or client encounter.

Description of the Activity (Specification)	Physical therapists are accountable to provide accurate, focused, and context-specific documentation of each patient or client encounter in either written or electronic formats.[94-96] The patient or client record is a legal document that is a critical form of communication that supports the ability to provide continuity of care to patients or clients.
	
	Component steps:
	• Identify and prioritize information requiring documentation following an encounter.
	• Document the data following the standard physical therapy documentation structure/template:
	  ○ Patient, client, or caregiver history and perspective
	  ○ Relevant collateral information (eg, social and cultural determinants that affect the health of the patient or client)
	  ○ Systems review, tests and measures performed, and subsequent outcomes
	  ○ Evaluation findings, including a problem list or a statement of assessment with key factors (eg, cognitive factors, comorbidities, social support) and diagnosis
	  ○ Plan of care with goals and prognosis, considering patient or client preferences
	  ○ Detailed description of treatments provided, clinical observations, and the patient's or client's response
	  ○ Justification for ongoing treatments
	• Documentation is legible and done in a timely manner.
	• All professional, jurisdictional, institutional and payer or insurance requirements for documentation are met.
	• Collaborator(s) involvement is identified and documentation from the encounter provided to them.

Limitations	None

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 8** Integrates examination findings, diagnosis, prognosis, and patient or client preferences to establish a management plan/plan of care. **PC 13** Assesses the personal, legal, regulatory, and organizational appropriateness to carry out services when supervising physical therapist assistants and other support personnel. **PC 14** Complies with legal, organizational, and payer regulations when documenting in the patient or client record. **Practice Management** **PM 8** Maintains comprehensive, accurate, and timely records. **PM 9** Maintains confidentiality and manages access, storage, retention, and destruction of health records, data, or protected information. **Reflective Practice and Improvement** **RP 1** Demonstrates self-awareness, emotional intelligence, and accountability for one's own decisions, actions, and errors in clinical performance and seeks external feedback and opportunities to learn. **Professionalism** **PR 2** Complies with all federal, state, local, payer, and organizational requirements regulating the practice of physical therapy.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 8:

Document a patient or client encounter.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Missing key components within documentation. • Insufficient documentation of the patient's or client's desired goals. • Inadequate documentation of the overall assessment of the patient, including any improved outcomes or adverse events. • Documentation does not support or align with the billing codes. • Documentation includes numerous grammatical errors. • Documentation is not legible. • Professional, jurisdictional, institutional and/or payer requirements for documentation are not met.	• Obtains and documents informed consent. • Documents the review of medical history. • Documents the patient's or client's desired goals. • Documents the complete dataset of assessments. • Documents procedures/interventions are performed or prescribed. • Documents the overall assessment of the patient, including any improved outcomes or adverse events. • Documents patient and family/caregiver education. • Submits documentation in a timely submission.

Clinical Sample Scenario

Bradley, a physical therapy student, had just completed an initial examination of Paul, an 82-year-old male seen in the outpatient ortho clinic for an initial examination for complaints of neck pain. The patient has Medicare as their primary insurance provider. Following the examination, Bradley documented the encounter and asked his clinical instructor to review and provide feedback.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Documents the visit with several grammatical or formatting errors. • Does not document the review of medical history, informed consent, and prior and current level of function. • Does not provide rehabilitation potential, client understanding, and functional goals within documentation.	• Provides comprehensive documentation detailing all components of the examination. • Submits documentation without grammatical errors in a timely fashion. • Follows all Medicare guidelines, including the review of medical history, informed consent, and verification of patient understanding.

• Documentation of several assessments/tests performed during the initial examination were missing. • Establishes goals that are not functional or realistic.	• Reports systems review, tests and measures performed, and subsequent outcomes. • Includes examination and evaluation findings, a summary of current and anticipated problems, and differential diagnosis. • Includes a plan of care with goals and prognosis, considering the patient or client preferences. • Includes a detailed description of the treatments provided, including patient education and review of HEP.

Entrustable Professional Activity 9:

Refer patients or clients to additional health care professionals.

Description of the Activity (Specification)	At any point in an episode of care, or in a long-term or ongoing physical therapist-patient or client relationship, a physical therapist may use the knowledge from assessments performed to refer patients and clients to other professionals when they require intervention or assessment, including the need for emergent care. This may include consultation with or referral to other health care professionals or a physical therapist colleague with advanced expertise, or additional postprofessional education or certification (eg, board-certified clinical specialist). **Component steps:** • Identifies a patient or client requiring physical therapy skills that are outside the individual physical therapist's personal scope of practice. • Identifies a patient or client requiring care outside physical therapy. • Collects and prioritizes information that will be required for consultation or referral to other services. • Refers to the appropriate service based on physical therapy examination findings, patient's or client's goals, and other relevant factors. • Advocates for the health services and community resources needed by the patient or client and caregivers. • Collaborates with the referral provider for coordination of patient or client care. • All professional, jurisdictional, institutional, and payer/insurance requirements for direct or indirect referral to other services are met.
Limitations	None

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 8** Integrates examination findings, diagnosis, prognosis, and patient or client preferences to establish a management plan/plan of care. **PC 12** Recognizes urgent and evolving situations and determines appropriate responses. **PC 15** Facilitates the transfer of patient and client care and services across settings and concludes the episode of care as appropriate. **PC 17** Identifies the need for interprofessional and intraprofessional collaboration, consultations, or referrals. **Knowledge for Practice** **KP 2** Demonstrates knowledge of the profession of physical therapy's distinct point of view and where shared perspectives exist with other disciplines. **Reflective Practice and Improvement** **RP 2** Uses internal and external sources of information to develop expertise that promotes the ability to adapt to unknown or evolving situations. **Professionalism** **PR 2** Complies with all federal, state, local, payer, and organizational requirements regulating the practice of physical therapy.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 9:

Refer patients or clients to additional health care professionals.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not identify the need for services from other health care professionals. • Unable to collect or prioritize the information required for consultation or referral to other health care professionals. • Unable to identify the appropriate health care professional for the referral based on the physical therapy examination/evaluation. • Unable to identify resources needed to successfully hand off the patient.	• Describes the rationale for referring service to another health care professional, including physical therapists. • Collects and prioritizes information that will be required for consultation or referral to other health care professionals, including physical therapists. • Makes an urgent referral when indicated. • Refers to the appropriate service based on physical therapy examination findings, patient's or client's goals, and other relevant factors. • Facilitates the handoff of a patient or client, ensuring that all regulatory requirements have been addressed.

Clinical Sample Scenario

As the clinical instructor at an acute care hospital, you have been asked to assess a physical therapist student, Juan, on their ability to evaluate and determine the need for a referral to a mental health professional. Maria is a 40-year-old Hispanic single mother of 2 being seen for ambulation following a motor vehicle accident. She has a fractured tibia and can ambulate with partial weight-bearing. As she is being seen, she expresses severe anxiety and suggests harming herself.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Identifies a limited list of risk factors and does not recognize the significance of the patient's statement. • Focuses only on the physical needs and physical therapy interventions. • Fails to document the components of the interaction and need for a mental health referral.	• Identifies the risk factors warranting a need for referral (expressed potential for self-harm, severe anxiety). • Identifies the health care professional to best address the patient's needs. • Communicates with team members regarding the need for a referral.

• Fails to communicate with the team.	• Documents critical information in the medical record for coordination of care with the mental health professional.

Entrustable Professional Activity 10:

Educate others (patients, caregivers, families, significant others, other health professionals, community).

Description of the Activity (Specification)	Physical therapists inform, educate and train others, including patients and clients, caregivers, communities, families, significant others, and other health care providers, as a component of practice. The physical therapist teaches in a way that can be appreciated by the learners (eg, cognition, knowledge, language) and considers domains of learning (cognitive/knowledge, psychomotor/skills, affective/attitudes).[97] **Component steps** vary based on audience and context (eg, patient or client, other health care provider): • Identify learners' needs. • Consider the learners' preferences in taking in new information. • Identify potential barriers to a teaching-learning encounter. • Identify resources that may be needed. • Provide education based on contextual needs and the environment, such as availability of technology and resources, learner characteristics, and other instructional implications. • Apply principles of motivational interviewing when indicated. • Use evidence-based education strategies as available. • Facilitate practice of skill development, if appropriate. • Assess adherence to or understanding of the education provided. • Revise educational approach, if needed. • Document the educational intervention, if applicable.
Limitations	None

Most Relevant Domains of Competence and Critical Competencies	**Communication** **CO 1** Uses modes[G] and mediums[G] of communication, including communication technologies to meet the needs of individuals and populations. **Education and Learning** **EL 1** Educates patients and clients, families, significant others, caregivers, other health care professionals, and society. **EL 2** Identifies audience learning needs, considering preferences and abilities, the role of culture, family-related constructs, environmental factors, and personal factors, to develop a plan. **EL 3** Establishes learning goals in collaboration with the learner. **EL 4** Applies effective teaching strategies for cognitive, psychomotor, and affective domains of learning. **EL 5** Assesses if the learner's educational needs have been met. **EL 6** Modifies the plan based on the learner's ongoing educational needs.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 10:

Educate others (patients and caregivers, families, significant others, other health professionals, community).

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not assess learners' wants and needs. • Does not prepare the environment for educational activities. • Does not provide citations or references for materials provided. • Does not document the educational encounter.	• Adapts the educational activity based on the audience's experience and needs. • Modifies the approach to educational activity to address potential individual, societal, or environmental barriers. • Assessed the audiences' understanding of the new information presented through repeat-back or teach back. • Documents the outcome of the educational activity.

Clinical Sample Scenario

Jayden is a second-year DPT student on an integrated full-time clinical experience within an orthopedic hospital. The student has been assigned to provide a group preoperative total knee replacement education session to 9 individuals. The clinical instructor is present to observe and support.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not prepare the environment for the session. • Does not assess postop living supports. • Materials provided are not at the appropriate reading level. • Does not engage the audience in meaningful activity. • Information provided is not accurate.	• Provides the audience with education beneficial to prepare them for joint surgery. • Provides appropriate references for the information provided. • Provides the audience with contact information for subsequent questions. • Incorporates knowledge and psychomotor activity to reinforce and assess the learning of information and skill. • Responds to questions from the audience with accurate information.

Entrustable Professional Activity 11:

Supervise others (physical therapist assistants, aides, technicians, and junior learners).

Description of the Activity (Specification)	Physical therapists supervise physical therapist assistants, aides, technicians, and junior learners (eg, high school/college/PT students). Proper supervision ensures safe and effective delivery of physical therapy services. The physical therapist maintains responsibility for patient and client management at all times, consistent with jurisdictional rules and laws governing supervision.[98-100]
	
	Component steps:
	• Discusses/reviews jurisdictional rules and laws with licensed personnel, support staff, and junior learners as it pertains to the episode of care.
	• Evaluates the level of expertise licensed personnel, support staff, and junior learners possess, dictating the level of supervision required.
	• Delegates tasks in compliance with jurisdictional and institutional rules and laws, to licensed personnel, support staff, and junior learners.
	• Maintains responsibility for patient and client management at all times.
	  ○ Ensures that patient and client outcomes are progressing as expected.
	  ○ Monitors the outcomes of patients and clients receiving physical therapy services delivered by licensed personnel (eg, physical therapist assistant) and support staff and provides feedback for areas of improvement.
	  ○ Provides supervision consistent with the situation and intervenes when necessary.
	  ○ Provides oversight of all documentation.
	  ○ Revises management plan and plan of care as appropriate.
	• Communicates levels of supervision and expectations of the individual being supervised.

Limitations	None

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 13** Assesses the personal, legal, regulatory, and organizational appropriateness to carry out services when supervising physical therapist assistants and other support personnel. **Communication** **CO 2** Evaluates and adapts communication strategies to meet the needs of individuals and populations. **Practice Management** **PM 1** Manages the physical therapy practice in accordance with regulatory, legal, and organizational requirements and professional standards. **PM 6** Contributes to orientation, training and ongoing development of personnel involved in providing physical therapist service delivery. **PM 7** Provides appropriate direction and supervision to personnel delivering physical therapist services. **Professionalism** **PR 2** Complies with all federal, state, local, payer, and organizational requirements regulating the practice of physical therapy.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 11:

Supervise others (physical therapist assistants, aides, technicians, and junior learners).

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not identify appropriate tasks to delegate to support staff. • Delegates responsibilities that must be borne solely by a physical therapist. • Does not remain accessible/available to the aide/tech/learner during times of delegated patient management. • Does not assume responsibility for patient management provided by support staff or learners. • Assigns patient care tasks to others in a manner that is contradictory to applicable laws and rules.	• Meets organizational applicable laws and rules related to delegation to and supervision of support staff and licensed personnel. • Communicates with support staff and other personnel without prompting. • Fully reviews and provides feedback on documentation of support staff and learners. • Monitors the outcomes of services provided by others and engages in discussion about progression and status. • Considers complexity, patient stability, plan of care, and billing restrictions when scheduling and delegating patients. • Identifies when violations of legal and professional standards related to supervision of others are occurring.

Clinical Sample Scenario

During the final weeks of your student's terminal clinical experience, another physical therapist calls out sick. You ask your student, Jeromy, to verbalize how they would delegate patients and tasks among the remaining physical therapist assistants and techs when adjusting the schedule for the day.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Attempts to delegate the initial examination to a physical therapist assistant. • Does not demonstrate regard for the level of supervision required of support staff when making decisions.	• Determines patients who require a physical therapist to personally render services given the plan of care. • Considers patients for whom it would be more prudent to reschedule appointments to deliver safe and thoughtful care to each patient.

• Does not adequately review the caseload of the absent physical therapist to determine the acuity and complexity of each patient. • Delegates a portion of the caseload to a PTA/support staff that is inconsistent with professional scope of practice.	• Engages in communication with the physical therapist assistant to determine comfort and experience with the patient diagnosis and treatment plan. • Delegates portions of the plan of care to the physical therapist assistant who is within the physical therapist assistant's jurisdictional, professional, and personal scopes of practice. • Seeks guidance from the clinical instructor when they have questions or concerns that need to be discussed.

Entrustable Professional Activity 12:

Assess and interpret outcomes of the plan of care.

Description of the Activity (Specification)	Physical therapists assess and interpret the outcomes of a plan of care and determine whether continued physical therapy is indicated or if the patient's episode of care should be concluded. Performance of this EPA is predicated on the practitioner possessing the ability to relate the patient's current ability and performance to normative data while considering results of the initial evaluation and all established goals. **
	
	Component steps:
	• Assess outcomes by comparing results of reassessment(s) with data obtained during the initial evaluation.
	• Interpret outcomes of the plan of care.
	  ○ Determine the degree to which short-term, long-term, and stated patient or client goals were achieved.
	  ○ Evaluate the potential for continuation of the episode of care, considering diagnosis, prognosis, goal attainment, and highest prior level of function.
	• Based on interpretation of the plan of care, determine whether to continue physical therapy or conclude the episode of care and initiate transfer.

Limitations	At entrance into practice, a physical therapist is not expected to assess and interpret the outcomes of the plan of care in clinical cases where (a) additional clinical training or certification is required beyond the entry-level physical therapist (eg, electromyography, dry needling, pediatrics-neonatal intensive care unit) and (b) clinical cases that present with the medical complexity beyond the personal scope of practice.

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 2** Prioritize patient or client management strategies to optimize patient or client outcomes. **PC 4** Uses evidence-informed practice[G] when making clinical decisions regardless of the depth, breadth, or ambiguity of available evidence. **PC 10** Synthesizes ongoing examination findings to modify interventions to meet patient or client needs according to the individual's presentation, goals, and resources. **PC 11** Uses a continual process of patient or client assessment that includes appropriate outcome data to direct the progression of the plan of care. **PC 15** Facilitates the transfer of patient or client care and services across settings and concludes the episode of care as appropriate. **Education and Learning** **EL 5** Assesses if the learner's educational needs have been met. **Systems-Based Practice in Health Care** **SB 1** Uses outcomes data collection and analysis to guide the provision of physical therapy services and for practice improvement.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

** Physical therapists are not able to assess and interpret the outcomes of a plan of care in the event that:

- There is a significant interruption in provision of services.
- There is a significant change in the patient's or client's ability to participate in physical therapy (eg, change in health status, new illness/injury, change in access to services).
- The patient or client discontinues physical therapist services.

Sample Behaviors for Entrustable Professional Activity 12:

Assess and interpret outcomes of the plan of care.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not use evidence-informed practice in assessing outcomes. • Does not modify interventions when the patient or client presentation indicates a need for change or goals are not being met. • Inconsistent process of patient or client reassessment that directs the plan of care. • Discharge plans are not supported by reassessment data and progress toward goals.	• Completes a final reassessment to determine patient status and progress toward goals. • Interprets reexamination findings to determine the degree to which short-term and long-term goals were met. • References normative data as part of the assessment process. • Based on interpretation of the plan of care, determine whether to continue physical therapy or conclude the episode of care and initiate transfer when indicated.

Clinical Sample Scenario

As the clinical instructor at a skilled nursing facility, you have been asked to assess Avery, a physical therapist learner, on their ability to assess and determine progress toward the stated goals and plan of care. Anne is an 81-year-old who recently had a total knee replacement and has type 2 diabetes and a history of breast cancer and mastectomy. Anne's goal is to return to her home, which is in a rural, mountainous area. Her spouse also has type 2 diabetes and is non–weight-bearing following a recent surgery on his foot.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not assess the patient's home situation as part of their decision to continue or conclude the episode of care. • Does not gather assessment data necessary for the complexity of the patient presentation. • Recommends discharging the patient without referral for further services when further support is required.	• Uses evidence-informed practice about the patient diagnoses and normative data to assess the outcomes of the plan of care. • Assesses the patient's home situation as part of their decision to continue or conclude the episode of care. • Uses applicable outcome measures to determine that the patient is ready for discharge from the skilled nursing facility. • Recommends and refers to home health care based on the patient's needs at discharge.

Entrustable Professional Activity 13:

Concludes an episode of care for a patient or client.

Description of the Activity (Specification)	The physical therapist concludes an episode of care (ie, discharge, transition) when the goals and outcomes for the patient or client have been achieved, when the patient or client is unable to further progress toward goals, or when the physical therapist determines that the patient or client will no longer benefit from physical therapy. Conclusion of a single episode of care may not, in some circumstances, signal the end of a patient- or client-provider relationship (ie, the patient may continue services for another diagnosis). Physical therapists, in collaboration with the patient or client, determine discharge recommendations for a patient or client that are supported by evidence and individual outcome data from the patient or client encounters and consider the individual factors and characteristics unique to the patient or client. This recommendation may include optimal settings for physical therapist services and equipment needed by the patient or client. **Component steps:** • Summarize outcome data and ensure that goals have been met. • Identify ongoing physical therapy needs after conclusion of the current episode of care, including evaluation of available resources. • Determine if a patient or client needs a management plan beyond the current episode of care. • Communicate the final plan to the patient or client and interprofessional team and other appropriate parties. • Document recommendations and the final patient encounter in compliance with all federal, state, and institutional regulations.
Limitations	None

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 3** Empowers patients and clients, families, and caregivers to participate in care and shared decision-making. **PC 11** Uses a continual process of patient and client assessment that includes appropriate outcome data to direct the progression of the plan of care. **PC 15** Facilitates the transfer of patient or client care and services across settings and concludes the episode of care as appropriate. **Knowledge for Practice** **KP 3** Demonstrates scholarly inquiry[G] and scholarly activities[G] to integrate physical therapy theories, knowledge, and evidence with information from other appropriate sources to inform clinical judgment. **Practice Management** **PM 3** Evaluates access to services, caseload management, payment, and availability of resources when providing physical therapist services. **Education and Learning** **EL 2** Identifies audience learning needs, considering preferences and abilities, the role of culture, family-related constructs, environmental factors, and personal factors, to develop a plan. **Professionalism** **PR 2** Complies with all federal, state, local, payer, and organizational requirements regulating the practice of physical therapy.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 13:

Concludes an episode of care for a patient or client.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Documentation regarding goal attainment is unclear and is not linked to defined outcomes. • Outcome data is incomplete. • Does not consider needs after discharge. • Incomplete communication with relevant team members regarding the conclusion of an episode of care. • Discharge documentation is missing or incomplete.	• Summarizes outcome data, documenting whether or not goals have been met. • Identifies ongoing physical therapy needs after discharge from the current episode of care. • Determines if the patient needs a management plan beyond the current episode of care. • Initiates a transition of care if the patient has a need. • Communicates the final plan to the patients, caregivers, families, significant others, and relevant team members. • Documents recommendations and final patient encounter in compliance with all federal, state, and institutional regulations.

Clinical Sample Scenario

As the clinical instructor in the outpatient setting, you have been asked to observe and assess a physical therapy student, Tracy, discharge a patient, Megan. Megan is a 24-year-old female being seen for wrist pain. Megan's plan of care has continued for 1 month, and today is her last scheduled visit.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not measure the relevant outcomes or measures outcomes that are not connected to the goals. • Does not clearly communicate the final findings to the patient. • Does not document the discharge or send communication to the relevant team members. • Does not discharge the patient when sufficient time has passed since the patient's last visit.	• Reassesses the relevant outcome measures to ensure that the goals have been met. • Communicates these findings with the patient and ensures agreement on the conclusion of the plan of care. • Communicates with the referring provider, if applicable, and documents the discharge. • Follows up with the patient if the patient does not show for a final visit or reassessment.

Entrustable Professional Activity 14:

Identify system failures (real and potential errors) and activate the system for improvement.

Description of the Activity (Specification)	Physical therapists identify opportunities for improvement within all aspects of care, identify patient safety incidents, and offer solutions to address them. All care situations involve chances for errors to occur that can affect the patient's health or the course of care. Identifying, responding to, analyzing, documenting, and addressing avoidable process failures is important to protect and promote patient safety.[101-103] **Component steps:** • Identify actual and potential ("near miss") errors in care. • "Speak up" in the face of real or potential errors. • Report/document the event based on policies and procedures (eg, event reporting systems, chain of command policies). • Advocate for and participate in improvement activities. • Analyze contributing factors/root causes to the system failure. • Engage in preventative daily safety habits (eg, universal precautions, hand washing). • Admit one's own errors, reflect on one's contribution, and develop an improvement plan.
Limitations	None

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 1** Fosters physical and emotional safety of the patient or client. **PC 12** Recognizes urgent and evolving situations and determines appropriate responses. **Practice Management** **PM 4** Identify risks and continuously seeks opportunities to mitigate hazards in the workplace. **PM 5** Adheres to individual, team, and system-level[G] safety and prevention and infection control practices. **Professionalism** **PR 7** Recognizes misconduct and responds appropriately. **Systems-Based Practice in Health Care** **SB 4** Appraises system-level costs, risk-benefit, and outcomes that impact patient and client and/or population-based care and services. **SB 5** Participates in identifying system errors and quality/performance improvement initiatives and responds constructively to change.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 14:

Identify system failures (real and potential errors) and activate the system for improvement.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not engage in safety habits. • Does not recognize their responsibility to report errors. • Does not document when an error occurs. • Does not recognize when they have made an error.	• Identifies when errors occur by self, others, or within the environment. • Reports when a real or potential error is identified to the appropriate individual(s) following established guidelines. • Recommends solutions for the identified error. • Participates in continuous process improvement.

Clinical Sample Scenario

Kaylee is a third-year DPT student on a terminal clinical experience in an acute care hospital. The student saw a patient in the intensive care unit secondary to sustaining a traumatic brain injury during a motor vehicle accident 3 days prior. The clinical faculty observed the student work on transfers from supine to sit with the patient.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not coordinate with necessary personnel prior to initiating treatment as needed. • Does not recognize one's limitations and ask for help when needed. • Does not understand the mechanism that triggered an alarm. • Does not prepare the environment prior to the start of care.	• Recognizes abnormal lab value during chart review and consults with nurse. • Organizes all lines and tubes to ensure safety. • Acknowledges when they are unaware of the cause of a triggered alarm. • Alerts the patient care team for the need for wound care precautions secondary to the patient's lack of mobility.

Entrustable Professional Activity 15:

Formulate recommendations for preventative health.

Description of the Activity (Specification)

Physical therapists' roles in prevention and promotion of health, wellness, and fitness range from encouraging healthy behaviors in individuals without conditions to helping individuals with chronic conditions engage in physical activity. Physical therapists conduct screening(s)* to determine the need for primary, secondary, or tertiary prevention services; further examination, intervention, education, or consultation by a physical therapist; or referral to another practitioner.[104]

Component Steps

Screening activities:

- Identify environmental and lifestyle factors—such as access to food and health care, level of physical activity, eating habits, sleep, stress, and fitness—that may lead to increased risk for health conditions or affect rehabilitation outcomes.
- Identify risk factors based on the individual or population.
- Identify individuals or populations who may require an additional examination (interprofessional or intraprofessional referral).
- Identify and conduct screening assessments.
- Generate recommendations based on screening findings.

Prevention, Health Promotion, Wellness, and Fitness Activities:

- Assess healthy lifestyle behaviors that can improve or sustain well-being and prevent or reduce risk for chronic conditions. These behaviors include but are not limited to physical activity, healthy eating, smoking or substance use cessation, sleep hygiene, mental and emotional well-being, and adherence to recommended and prescribed medical treatments.
- Develop and deliver healthy lifestyle interventions and programs to prevent the development of conditions in individuals.
- Develop and deliver healthy lifestyle interventions and programs to individuals and populations to reduce the sequelae in individuals with chronic conditions. (This may include programs for chronic conditions, such as hypertension, arthritis, diabetes, and obesity).
- Provide health coaching to support the development of sustainable positive behaviors that prevent disease and disability and enable achievement of life goals, including productive contributions to society.
- Provide broad-based consumer education and advocacy programs to prevent health problems, such as preventing concussion or other head injury by promoting the use of helmets and preventing pulmonary disease by encouraging smoking cessation.

Limitations	None
Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 5** Incorporates the characteristics of the patient or client to develop and implement a person-centered, comprehensive examination. **PC 9** Incorporates concepts of health promotion and wellness into the management plan to reduce the impact of disease and disability. **PC 17** Identifies the need for interprofessional and intraprofessional collaboration, consultations, or referrals. **Education and Learning** **EL 2** Identifies audience learning needs, considering preferences and abilities, the role of culture, family-related constructs, environmental factors, and personal factors, to develop a plan. **Professionalism** **PR 3** Advocates for the health needs of individuals and society locally, nationally, or globally. **Systems-Based Practice in Health Care** **SB 2** Appraises the relationship between social determinants of health[G] and the health system in which the physical therapist practices. **SB 3** Incorporates concepts of health promotion and wellness into physical therapist practice to reduce the impact of disease and disability on society.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

* In consideration of one's professional, jurisdictional, and personal scope of practice.

Sample Behaviors for Entrustable Professional Activity 15:

Formulate recommendations for preventative health.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not provide education on health and wellness. • Does not identify screening assessment tools/measures. • Does not follow screening tools/measures guidelines. • Generates a management plan but does not incorporate all findings. • Does not provide continued support, coaching, or education to achieve targeted goals set in the management plan. • Does not provide recommendations for skilled physical therapy or other referrals, as needed.	• Demonstrates knowledge of health and wellness recommendations. • Identifies associated risk factors. • Identifies whether the individual is a member of a population that requires additional examination as noted in the literature. • Identifies and conducts the correct screening assessment tools/measures. • Generates a comprehensive management plan based on findings. • Demonstrates knowledge of referral process to primary, secondary, and tertiary services. • Recommendations include healthy lifestyle behaviors, focusing on preventing the development of a condition as well as reducing the sequelae of chronic conditions.

Clinical Sample Scenario

As the clinical instructor at a skilled nursing facility, you have been asked to assess a physical therapist learner, Nancy, on their ability to screen and provide recommendations for preventive health for an individual at the facility. Sally is a 67-year-old obese Asian female with a history of peripheral vascular disease, myocardial infarction, and high cholesterol. She transfers independently and ambulates with a straight cane on level surfaces and utilizes a walker when outdoors ambulating with grandchildren on uneven surfaces.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Identifies a limited list of risk factors. • Fails to identify the increased risk of the development of diabetes given that the patient is Asian.	• Identifies a comprehensive list of risk factors, including risk of falls, elevated BMI, and hypertension. • Identifies that because the patient is Asian, they may be at a higher risk for the development of diabetes. Additional risk

• Identifies some but not all screening assessment tools/measures. • Conducts screening assessments but needed cuing to perform as defined. • Generates a limited management plan based on the findings. • Developed an incomplete management plan based on identified factors and anticipated needs. • Provides encouragement throughout the session but does not include educating the patient on the importance of following the prevention program. • Does not utilize strategies to assess patient understanding.	factors would then include altered blood glucose, altered sensation, and poor nutrition. • Identifies and conducts the correct screening assessment tools/measures as described. • Generates a comprehensive management plan based on findings. • The developed management plan includes healthy lifestyle behaviors. • Provides continued encouragement throughout the session and educates the patient on the importance of following the prevention program and communicating with their health care team in the event of a status change. • Utilizes a teach-back strategy to assess for patient understanding.

Entrustable Professional Activity 16:

Bill for a patient or client visit.

Description of the Activity (Specification)	The physical therapist evaluates access to services and utilizes billing procedures that are in compliance with governing rules and regulations, and consistent with the ethics of the profession. **Component steps:** • Identify the payer. • Identify billing rules as negotiated by the contract between the provider and the payer (including what services can be provided by different individuals). • Select the procedural (eg, CPT) codes consistent with the complexity and duration of treatment provided. • Submit the bill within the facility system in a timely fashion. • Ensure billing submitted is consistent with documentation. • Maintain confidentiality when billing. • Identify billing errors and take steps to rectify.
Limitations	None

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 14** Complies with legal, organizational, and payer regulations when documenting in the patient or client record. **Practice Management** **PM 1** Manages the physical therapy practice in accordance with regulatory, legal, and organizational requirements and professional standards. **PM 3** Evaluates access to services, caseload management, payment, and availability of resources when providing physical therapist services. **PM 8** Maintains comprehensive, accurate, and timely records. **PM 9** Maintains confidentiality and manages access, storage, retention, and destruction of health records, data, or protected information. **Professionalism** **PR 2** Complies with all federal, state, local, payer, and organizational requirements regulating the practice of physical therapy. **PR 7** Recognizes misconduct and responds appropriately.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 16:

Bill for a patient or client visit.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not bill. • Does not follow billing policies and procedures. • Documentation does not support or align with the billing codes. • Does not provide evidence or support for the services provided. • Unaware of the billing rules that pertain to the payer(s) and what services can be covered. • Does not answer questions from the patient or client related to payment. • Does not demonstrate accurate billing procedures when non-PTs are involved in care delivery.	• Demonstrates knowledge of regulations as it pertains to billing. • Demonstrates understanding of the variations across payers. • Documents/uses billing procedures that identify the payer(s). • Uses billing codes that are consistent and align with the documentation of the services provided. • Documentation is legible and timely. • Submits the bill in a manner compliant with rules and regulations. • Demonstrates knowledge of coding parameters to ensure reimbursement commensurate with services. • Completes accurate, timely billing that is in accordance with each payer's requirements. • Advocates for patient or client needs through communication with payers and providers.

Clinical Sample Scenario

As the clinical instructor in the outpatient unit, you have been asked to observe and assess a physical therapy student, Alex, bill for a PT session of the patient Craig. Craig is a 44-year-old male who presents today to the clinic with complaints of low back pain and limited mobility for his initial examination.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Documents the visit but exhibits several errors and omissions in the billing process. • Utilizes the evaluation (CPT Code) for the initial evaluation, though the documentation lacks	• Documents all aspects of the visit meticulously, ensuring accuracy and completeness for billing purposes. The services provided were billed as follows:

detail on the assessment findings and treatment plan.
• Utilizes the appropriate timed billing codes (eg, Therapeutic Exercise, Manual Therapy, Neuromuscular Re-education, Therapeutic Activity) and provides the time spent, but specific exercise parameters (eg, reps or sets) and patient response were not documented. Adequate justification or description of the techniques used was not clear.
• Notes lack detail on the specific exercises performed and the patient's response to treatment. The exact time spent on each modality and exercise was missing, leading to discrepancies in the billed time versus the actual treatment time. Used incorrect billing codes that did not accurately reflect the services provided. For instance, billed for manual therapy without sufficient justification or documentation of the techniques used. Overall, the notes did not provide enough detail to support the billed services. Specific exercises, techniques, and patient responses were missing. Required verbal cues to make them aware and to complete the documentation accurately.
	• Provides an Evaluation (CPT Code) for the Initial evaluation and includes a comprehensive assessment and development of a treatment plan.
	  ○ Utilizes the appropriate timed billing codes (eg, Therapeutic Exercise, Manual Therapy, Neuromuscular Re-education, Therapeutic Activity) and provides the time spent, justification, specific exercises parameters (eg, reps and sets). The number of units follow billing parameters (eg, 1 code > 8-22 min, 2 codes 23-38 min).
	  ○ Utilizes the appropriate not timed codes (eg, Electrical Stimulation) with the appropriate justification to support the applied code.
	  ○ Ensures that each CPT code accurately reflected the specific services rendered and the time spent on each activity.
	  ○ Includes detailed notes on the patient's progress and response to treatment to support the billing claims.
	• Adheres to the clinic's guidelines and regulatory requirements for billing and documentation.
	• Reviews the billing entries for accuracy and compliance before submission.
	• Any discrepancies or missing information were addressed promptly to avoid billing errors or delays in reimbursement.

Entrustable Professional Activity 17:

Triage care to prioritize resources to patients most in need.

Description of the Activity (Specification)	The application of systematic triage systems in the delivery of therapy services to patients while maintaining the highest level of quality is essential. A physical therapist recognizes and triages services based on resources, patient need, urgency, and complexity. **Component steps:** • Review patient caseload assigned, including new referrals. • Assess each patient's potential to engage in a meaningful therapy session. • Determine if an intervention would lead to significant improvement in a reasonable timeframe and align with the patient's goal. • Create a list of patients who are deemed to be the highest priority of need for physical therapist services that day. • Adapt and reprioritize based on unexpected changes. • Identify the appropriate timing that day for the provision of physical therapist services for patients on that list (if not scheduled, eg, a patient concluding the episode of care, pain management, provide physical therapist services around optimal medication dosing). • Communicate physical therapist's schedule to appropriate stakeholders (patient, family, other health care providers).
Limitations	At entrance into practice, a physical therapist is not expected to triage care to prioritize resources to patients most in need in clinical settings with a high caseload miXof patients that present with high medical and/or psychosocial complexity.

Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 10** Synthesizes ongoing examination findings to modify interventions to meet patient or client needs according to the individual's presentation, goals, and resources. **PC 11** Uses a continual process of patient or client assessment that includes appropriate outcome data to direct the progression of the plan of care. **Knowledge for Practice** **KP 3** Demonstrates scholarly inquiry[G] and scholarly activities[G] to integrate physical therapy theories, knowledge, and evidence with information from other appropriate sources to inform clinical judgment. **Communication** **CO 2** Evaluates and adapts communication strategies to meet the needs of individuals and populations. **Practice Management** **PM 2** Balances patient or client needs with caseload volume, considering available time, equipment and personnel, when providing services. **PM 3** Evaluates access to services, caseload management, payment, and availability of resources when providing physical therapist services. **Systems-Based Practice in Health Care** **SB 4** Appraises system-level costs, risk-benefit, and outcomes that impact patient and client and/or population-based care and services.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 17:

Triage care to prioritize resources to patients most in need.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not triage patients. • Does not assess patient's potential to engage in a meaningful therapy session. • Unable to differentiate patients with good versus poor prognosis. • Unable to adjust/reprioritize planned daily schedule of patients based on changes in patient status or the addition of new patients referred for physical therapy. • Does not consider scheduled timing of provision of physical therapy as it affects external factors, such as medication, family training, documenting functional performance so patient can move to the next level of inpatient care. • Does not communicate rationale for schedule.	• Applies triage management. • Reviews caseload and identifies factors needed for triaging. • Demonstrates their approach to triaging and consistently uses that approach to schedule patients for physical therapy. • Considers prognosis when creating schedule of patients. • Recognizes factors that could change a specific patient's priority level for physical therapy on a particular day. • Adapts schedule to accommodate new patients referred for physical therapy at an appropriate time and frequency. • Communicates with other team members about rationale for creation of daily patient schedule.

Clinical Sample Scenario

As the clinical instructor in the acute care unit, Greg was asked to observe and assess a physical therapy student, Komal, on their ability to prioritize the patient care schedule on a low staffing day.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Has difficulty adding patients to her schedule when more patients were referred for evaluation. • Does not consider scheduled timing of provision of physical therapy as it affects external factors, such as medication, family training, and documenting functional performance.	• Triages the patients on her schedule based on those with the highest priority of need. • Adapts and reprioritizes schedule based on unexpected changes in patient status or other factors. • Communicates rationale for changes in the schedule to patients, family, and other necessary personnel.

• Struggles when communicating with family members and others about changes in the schedule.	

Entrustable Professional Activity 18:

Complete a patient handoff to transition care.

Description of the Activity (Specification)

Effective and efficient handoff communication is critical for patient care. Handoff communication ensures that patients continue to receive high-quality and safe care through transitions of responsibility from one health care team or practitioner to another. Handoffs are also foundational to the success of many other types of interprofessional and intraprofessional communication, including discharge from one provider to another and from one setting to another. Handoffs may occur between settings (eg, hospital to outpatient/homecare; pediatric to adult caregiver) or within settings (eg, floor to ICU; day treat to outpatient, inpatient rehab to day treat; school system to outpatient).

Component steps for transmitter of information:

- Verify preferred method of communication ensures access to that method, ie, EMR, Zoom/teams, long-distance phone call).
- Adhere to HIPAA rules and regulations and jurisdictional/institutional rules and laws.
- Conduct handoff communication that meets the patient's/client's unique needs and minimizes known threats to transitions of care (eg, by ensuring that you engage the listener, avoiding distractions).
- Follow a structured handoff template for verbal communication.
- Provide succinct verbal communication that conveys, at a minimum, medical condition and management to date, illness severity, functional status, patient goals, potential barriers, provider team roles and contact information in the situation a question, concern, or adverse event arises, and equipment use.
- Have the receiver of the handoff repeat back the instructions/information to demonstrate understanding.
- Ensure that all up-to-date records and results are available to the receiving clinician.
- Document—and update—an electronic handoff tool.

Component steps for receiver of information:

- Provide feedback to transmitter regarding one's preferred method of communication to ensure that informational needs are met.
- Adhere to HIPAA rules and regulations and jurisdictional/institutional rules and laws.
- Ask clarifying questions.
- Repeat back to ensure closed-loop communication.

	• Ensure that the health care team (including patient/family) knows that the transition of responsibility has occurred. • Assume full responsibility for required care during one's entire care encounter. • Document the handoff conversation.
Limitations	None
Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 15** Facilitates the transfer of patient and client care and services across settings and concludes the episode of care as appropriate. **PC 16** Maintains patient and client privacy. **PC 17** Identifies the need for interprofessional and intraprofessional collaboration, consultations, or referrals. **Knowledge for Practice** **KP 2** Demonstrates knowledge of the profession of physical therapy's distinct point of view and where shared perspectives exist with other disciplines and professions. **Communication** **CO 2** Evaluates and adapts communication strategies to meet the needs of individuals and populations. **Practice Management** **PM 8** Maintains comprehensive, accurate, and timely records. **Systems-Based Practice in Health Care** **SB 6** Fosters a culture of valuing difference in background, experience, and access to resources within and across the health care system.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 18:

Complete a patient handoff to transition care.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
Transmitter of information	**Transmitter of information**
• Does not follow jurisdictional/institutional rules and laws related to protecting and accessing patient information. • Conducts handoff communication while distracted, does not ensure that the listener is engaged in the communication. • Lacks consistency in verbal handoff processes. • Excludes key information about patient status and medical and rehab management. • Does not share records or results with receiving provider. • Does not document handoff or update electronic handoff information.	• Verifies preferred method of communication (ensure access to that method (ie, EMR, Zoom/Teams, long-distance phone call. • Adheres to jurisdictional/institutional rules and laws in handoff procedures. • Conducts handoff communication that minimizes known threats to transitions of care (eg, by ensuring that you engage the listener, avoiding distractions). • Follows a structured handoff template for verbal communication. • Provides succinct verbal communication that conveys, at a minimum, medical condition and management to date, illness severity, functional status, patient goals, potential barriers, and medical team contact information in the situation a question, concern, or adverse event arises with equipment use. • Has the receiver of the handoff repeat back the instructions/information to demonstrate understanding. • Documents—and updates—an electronic handoff tool.
Receiver of communication	**Receiver of communication**
• Does not share preferred method of communication. • Does not follow jurisdictional/institutional rules and laws related to patient information. • Does not ask questions if there is confusion. • Does not repeat information to ensure understanding.	• Provides feedback to transmitter regarding one's preferred method of communication to ensure that informational needs are met. • Adheres to jurisdictional/institutional rules and laws. • Asks clarifying questions.

• Does not inform others (health care team, patient/family) that a transition of care has occurred. • Does not accept responsibility for care provided to patient during care encounter. • Does not keep records of handoff communication.	• Repeats back to ensure closed-loop communication. • Ensures that the health care team, including patient/family, knows that the transition of responsibility has occurred. • Assumes full responsibility for required care during one's entire care encounter. • Documents the handoff conversation.

Clinical Sample Scenario
As the clinical instructor in an inpatient acute setting, you have been asked to observe and assess a physical therapy student, Erin, perform a physical therapist handoff about a patient, Jake, to a therapist in an outpatient setting, Morgan. Jake is a 66-year-old male who is discharged home from the acute care hospital today, where he has been seen to manage weakness and initiate mobility training following treatment for a new transtibial amputation.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not identify preferred method of communication for initiating the handoff. • Performs handoff using personal phone while in a crowded elevator. • Unprepared (lacking information) for handoff. • Handoff takes a long period of time as the student must look for documents with relevant information. • Excludes noteworthy information about the patient during the call and does not share important rehab information and documentation with transition health care team. • Does not complete documentation and close the communication loop.	• Determines date and time of handoff and preferred method. • Performs handoff in a private room using a work phone, ensuring privacy when discussing patient information. • Compiles information for the handoff in advance using a structured template to ensure that key information is shared. • Facilitates a short conversation sharing key information about the patient and their medical and rehab course since hospitalization and rehab goals. • Asks the health care team members, including patient/family, to repeat the information back to ensure understanding. • Ensures that the health care team has access to records related to the patient's rehab care during hospitalization, following regulatory guidelines.

	• Documents that this handoff has occurred and communicates this with the health care team and patient/family.

Entrustable Professional Activity 19:

Recognize and respond to an urgent or emergent change in status.

Description of the Activity (Specification)

Physical therapists often are the first health care providers to initiate physical activity, assess patient response to movement, move with a patient, stress the cardiac system, and may witness a patient decompensate or have a significant change in status. The ability to promptly recognize a patient who requires urgent or emergent care, initiate evaluation and management, and seek help is essential. Physical therapists may be the initial health care provider to recognize a change in a patient's status during these events in any setting. Early recognition and intervention provide the greatest chance for optimal outcomes in patient care. This EPA calls for simultaneously recognizing the need and initiating a call for assistance. Examples of conditions for which therapists are expected to recognize, initiate evaluation and management, and seek help may include the following:

- Chest pain
- Mental status changes
- Shortness of breath and hypoxemia
- Fever
- Hypotension and hypertension
- Tachycardia and arrhythmias
- Signs and symptoms of hypoglycemia and hyperglycemia
- Falls

Component steps:

- Recognize the severity of a patient's illness and indications for escalating care, including examination and laboratory findings that might be expected based on patient- and disease-specific factors and expected response to physical activity and/or strenuous exercise.
- Identify potential underlying etiologies of the patient's emergent change in status.
- Apply basic cardiac life support as indicated.
- Engage team members required for immediate response, continued decision-making, and necessary follow-up to optimize patient outcomes.
- Activate the emergency response system when indicated and participate as a team member.
- Communicate the situation to the responding emergency response team members.

	• Document patient assessments and necessary interventions in the medical record. • Report any information regarding a patient or client incident separately from the medical record, using the proper incident report form(s). Identify the appropriate timing that day for the provision of physical therapist services for patients on that list (if not scheduled, eg, a patient concluding the episode of care, pain management, provide physical therapist services around optimal medication dosing). • Communicate the physical therapist's schedule to the appropriate stakeholders (patient, family, other health care providers).
Limitations	None
Most Relevant Domains of Competence and Critical Competencies	**Patient and Client Care and Services** **PC 6** Interprets laboratory data, imaging studies, and other tests required for the area of practice. **PC 7** Evaluates examination[G] findings and available evidence to establish a diagnosis and prognosis. **PC 10** Synthesizes ongoing evaluation findings to modify interventions to meet patient and client needs according to the individual's presentation, goals, and resources. **PC 11** Uses a continual process of patient or client assessment that includes appropriate outcome data to direct the progression of the plan of care. **PC 12** Recognizes urgent and evolving situations and determines appropriate responses. **PC 17** Identifies the need for interprofessional and intraprofessional collaboration, consultations, or referrals. **Reflective Practice and Improvement** **RP 2** Uses internal and external sources of information to develop expertise that promotes the ability to adapt to unknown or evolving situations.
Most Relevant Experiences	See page 34
Information Sources to Assess Progress	See page 35
Entrustment Supervision Scale	See page 35
Expiration Date	There is an expectation that a clinician would practice and use these skills on a regular basis to maintain competence. If there is a lapse in use (expiration date), the recommendation would be that the clinician be reassessed to determine competence.

Sample Behaviors for Entrustable Professional Activity 19:

Recognize and respond to an urgent or emergent change in status.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not consistently assess baseline vitals. • Needs reminders to continue to monitor vitals. • Does not recognize an emergent change in the patient's status. • Does not follow basic cardiac life support guidelines. • Does not follow the steps to activate the emergency response system. • Does not recognize the need for additional help or does not ask for it when needed. • Does not remain calm throughout the event. • Provides incomplete information when speaking with the responding emergency response team.	• Assesses baseline vitals and continues to monitor vitals as needed. • Recognizes an emergent change in a patient's status that warrants action. • Applies basic life support as indicated. • Activates the emergency response system as indicated by the location. • Recruits additional supports as needed. • Remains calm throughout the event, maintaining professionalism and steadfast communication with the patient. • Communicates the details of the event to the responding emergency response team. • Provides comprehensive documentation of the event.

Clinical Sample Scenario

You are a clinical instructor in a hospital on the medical-surgical floor, and your physical therapist student, Andi, is gait training a patient who is status post left total knee arthroplasty 2 days prior. The patient is using a standard walker, weight-bearing as tolerated on the left lower extremity with contact guard assistance for safety. While ambulating, the patient became diaphoretic, began having difficulty breathing, and subsequently lost consciousness and was lowered to the floor.

Behaviors that do not merit entrustment	Behaviors that merit entrustment
• Does not do a chart review to verify that the patient is appropriate for participation in physical therapy. • Does not assess baseline vitals and determine that they were appropriate to treat. • Does not recognize changes in the patient's status during intervention, including that the	• Prior to getting out of bed to ambulate, assessed baseline vitals: HR, BP, RR, and determined that they were appropriate to treat. • Recognizes patient's speech became slowed, and they were diaphoretic and short of breath. • Communicates with the patient to assess tolerance for activity.

patient's speech became slowed, they were diaphoretic, and they were short of breath. • Does not communicate with the patient about their status. • Required prompting to activate the emergency response system. • Needed prompting to reassess vitals and initiate basic life support until the emergency response team arrives. • Communicates limited details of the event when the responding emergency response team arrives. • Does not complete facility incident report as per policy.	• When the patient starts to lose consciousness, slowly lowers them to the floor and calls for help/activates the emergency response system. • Reassesses vitals and initiates basic life support until the emergency response team arrives, remaining calm throughout. • Documents the necessary details within the EMR as per the facility guidelines (eg, incident report)

Map of EPAs and Competencies

Competency	EPA1	EPA2	EPA3	EPA4	EPA5	EPA6	EPA7	EPA8	EPA9	EPA10	EPA11	EPA12	EPA13	EPA14	EPA15	EPA16	EPA17	EPA18	EPA19	Total
KP 1		X		X																2
KP 2									X									X		2
KP 3			X	X									X				X			4
KP 4						X														1
PC 1														X						1
PC 2												X								1
PC 3	X						X						X							3
PC 4		X	X		X	X						X								5
PC 5		X													X					2
PC 6		X																	X	2
PC 7			X																X	2
PC 8				X				X	X											3
PC 9				X											X					2
PC 10					X	X						X					X		X	5
PC 11					X		X					X	X				X		X	6
PC 12		X				X			X					X					X	5
PC 13								X			X									2
PC 14	X							X								X				3
PC 15									X			X	X					X		4
PC 16																		X		1
PC 17		X	X	X	X				X						X			X	X	8
CO 1				X	X		X			X										4
CO 2	X				X						X						X	X		5
PM 1	X		X			X					X					X				5
PM 2																	X			1
PM 3													X			X	X			3
PM 4														X						1
PM 5						X								X						2
PM 6											X									1

Competency	EPA1	EPA2	EPA3	EPA4	EPA5	EPA6	EPA7	EPA8	EPA9	EPA10	EPA11	EPA12	EPA13	EPA14	EPA15	EPA16	EPA17	EPA18	EPA19	Total
PM 7											X									1
PM 8								X								X		X		3
PM 9								X								X				2
EL 1			X							X										2
EL 2	X						X			X			X		X					5
EL 3				X						X										2
EL 4					X		X			X										3
EL 5							X			X		X								3
EL 6										X										1
RP 1						X		X												2
RP 2									X										X	2
PR 1	X																			1
PR 2			X					X	X		X		X			X				6
PR 3															X					1
PR 4																				0
PR 5	X																			1
PR 6																				0
PR 7														X		X				2
PR 8																				0
SB 1		X										X								2
SB 2															X					1
SB 3							X								X					2
SB 4														X			X			2
SB 5														X						1
SB 6																		X		1

As noted in the table above there were three essential competencies (PR 4, PR 6, PR 8) that were not mapped to a particular Entrustable Professional Activity. That does not mean that the competency is not important, it just means that it would need to be assessed via an alternate method other than an EPA.

Considerations

Curriculum Development and Organization

The defined performance outcomes provided in this report, the first component of Van Melle's core components of a CBE program, can be used by programs to guide curriculum development, implementation, and learner assessment.[4] All aspects of the curriculum and assessment processes are directly linked to one or more of the essential outcomes (competencies, domains, EPAs).[12,105] Components 2-4 are focused on the curriculum: (2) sequenced progression, (3) tailored learning experiences, and (4) competency-focused instruction.[4]

The developmental sequence progression starts in the classroom with foundational knowledge and can then include case-based learning, laboratory practice, practice with standardized patients, and frequent exposure to authentic patient or client environments. This sequence is not new to physical therapy, but having national outcomes that all DPT students would work on can provide an opportunity for a more focused clinical curriculum—the specific activities students need to practice and receive feedback on that will be used to improve performance. In reviewing a program's curriculum, programs may find that there are gaps in the specific knowledge, skills, and behaviors currently provided or modeled within their curriculum that are needed to achieve the necessary outcomes. Some programs may find that while they do not have gaps in the specific knowledge, skills, and behaviors currently provided or modeled, there may possibly be a need to reorganize learning experiences to support the developmental progression better.

Instructional methods would leverage deliberate practice, reflection, and feedback, with a stronger emphasis on how knowledge is applied in a clinical context rather than simply acquired. Early clinical immersion, integration across classroom and clinical learning, and authentic formative assessment strategies can create powerful learning environments that foster readiness for independent practice.

Assessment of Learner Performance in a Competency-Based Education Model

In a CBE model, a comprehensive program of assessment is essential to provide an overview of learner performance on defined outcomes.[4] This multifaceted assessment integrates various sources of information and methods to ensure a thorough evaluation of the learner. Each source contributes unique insights into the learner's competence, ensuring that assessments are not solely based on isolated incidents but reflect a broader spectrum of consistent performance over time.[12] This data includes information on knowledge and skills assessed in the classroom (eg, written and practical exams) and workplace-based assessments in authentic patient or client settings.

While assessment within a CBE model is necessary to ensure that learners achieve the defined outcomes (assessment of learning), the primary purpose of assessment is to provide feedback to improve learner performance (assessment for learning).[106,107] Assessment of EPAs in the workplace occurs frequently and are low-stakes assessments that provide feedback to the learner soon after the activity is observed, helping to improve performance of that activity the next time it occurs in the clinic.[12] This feedback helps the learner understand what went well when they performed the activity and what they need to work on (gaps) for the next time so that the level of supervision may be reduced. Progress (reduced supervision needed) on these low-stakes assessments can help guide learners to seek out additional learning opportunities to practice and be reassessed. This same information can help faculty collaborate with learners to facilitate finding those learning opportunities.[4]

Entrustment

Entrustment is the process of granting learners the responsibility to perform specific tasks with varying levels of supervision. It is a forward-looking decision, based on the learner's demonstrated competence and the supervisor's trust in their ability to manage future tasks independently. Entrustment decisions are informed by the learner's performance, reliability, integrity, capability, and humility.[12]

Entrustment Supervision Scales

Typically, proficiency scales are used in physical therapy to assess learners in the workplace (eg, Clinical Internship Evaluation Tool (CIET),[108] Clinical Performance Instrument (CPI),[109] Physical Therapist Manual for the Assessment of Clinical Skills (PT MACS)),[110] which focus on the performance of the individual learner. These high-stakes assessments usually occur twice, at the midterm and final, and are commonly administered by one person. Proficiency-based scales have some challenges, including poor reliability and the inability to differentiate performance between learners. Utilizing an entrustment supervision scale (ESS) to assess learners helps improve reliability and reduce bias and has been shown to differentiate performance between learners better. The ESS scale would be used every time a learner requests to be assessed. Therefore, these are low-stakes assessments by multiple people when possible, helping learners focus on assessment for learning.

Entrustment supervision scales assess the level of support or supervision a learner needs to perform a particular activity safely and efficiently, ranging from cotreatment and direct supervision to unsupervised practice, and are a key component of workplace-based assessment.

This approach shifts the focus from proficiency ratings to the level of supervision required for specific tasks. A supervisor can use this scale to indicate how much supervision was needed while observing a learner performing the activity, and it can also be used to make a judgment about how much supervision that same learner would need in the future for that activity with a patient of similar complexity. This type of scale helps supervisors make informed decisions about the learner's readiness on a defined continuum of progressive autonomy and responsibility.[12]

Sample entrustment supervision scale for use in physical therapy: TRUST PT

Level 1 Ready to observe

Level 2 Ready to co-perform

Level 3 ready for direct supervision

Level 4 Ready for indirect supervision

Level 5 Ready for unsupervised practice

Level 6 Ready to supervise others

Ad Hoc Entrustment Decisions

Ad hoc entrustment decisions are those decisions made by an individual supervisor in real-time during clinical practice. These decisions are crucial for patient safety and learner development, allowing supervisors to adjust the level of supervision dynamically.[12] Ad hoc entrustment decisions consider the learner's competence and the complexity of the task at hand to determine the required amount of supervision.

Summative Entrustment Decisions

Summative entrustment decisions are high-stakes evaluations that determine whether a learner is ready for unsupervised practice. This is a more formal qualification developed by a team, typically a Clinical Competence Committee (CCC). CCCs review multisource information, including ESS ratings, ad hoc entrustment decisions, and other assessment data, to make informed judgments about the learner's readiness. These decisions are critical for ensuring that graduates are competent and prepared for independent practice.[12]

The Role of Clinical Competence Committees in Making Summative Entrustment Decisions

CCCs play a central role in assessing learner performance in CBE. These committees are responsible for reviewing aggregated evidence of learner performance and making summative decisions regarding entrustment. A CCC typically comprises experienced educators, clinicians, and other stakeholders who bring diverse perspectives to the assessment process. The committee's structure ensures that decisions are made collaboratively, drawing on the collective expertise of its members.[12]

Summary

The assessment of learner performance in a competency-based education model is a comprehensive and dynamic process. It integrates multisource information, workplace-based assessments using entrustment supervision scales, ad hoc entrustment decisions, and the collaborative efforts of clinical competence committees. This approach ensures that learners are evaluated holistically, supporting their development toward unsupervised practice and ultimately enhancing the quality of patient care.[12]

Opportunities for the Future

The publication of Competency-Based Education in Physical Therapy: Essential Outcomes for Entrance Into Practice—anchored by EPAs, domains of competence, and associated competencies—represents a pivotal moment for the physical therapy community. This framework offers a standard set of performance outcomes expected of all DPT graduates at entrance into practice, a shared language, and a vision that can unify and advance learner development, performance assessment, and accountability across the continuum of education and practice. Beyond initial education, this foundational work creates multiple opportunities for academic and clinical partners, educational researchers, physical therapy-related organizations, and interest groups (ie, ABPTRFE, ABPTS, CAPTE, FSBPT) to build capacity and expand the relevance and reach of CBE in physical therapy throughout the learner continuum.

Faculty Development and Support for Implementation

Academic and clinical faculty are central to the success of any CBE model. This CBEPT framework invites a shift from time-based curricula and traditional grading systems to one that prioritizes coaching, direct observation, and developmental feedback across authentic contexts.[4] Again, the physical therapy profession's long-standing practice of facilitating learning in authentic clinical environments through direct observation and providing developmental feedback is well established. To prepare faculty for this role, institutions and organizations would benefit from longitudinal faculty development, which will take time. This includes training on core concepts of a CBE educational program; shared language on concepts such as competencies, domains of competence, and EPAs; the use of workplace-based assessment tools (eg, entrustment-supervision scales); how to provide effective feedback to improve learner performance (eg, coaching); and designing learning experiences in the classroom and clinical setting.

Extension to Postprofessional and Lifelong Learning

This CBEPT entrance into practice framework also offers a strong foundation upon which to build specialty-specific performance expectations in residency and fellowship education. Postprofessional residency and fellowship education programs are ideally positioned to develop and evaluate more advanced EPAs. Similarly, professional development providers may establish EPAs for learners within the programs they provide to scaffold learning experiences for licensed physical therapists pursuing advanced specialization, leadership roles, or advanced clinical reasoning. Using shared language and progressive outcomes across the learner continuum enhances continuity and supports the profession's need for physical therapists who embrace and value lifelong learning.

Adaptation for Physical Therapist Assistant Education

While this framework was developed specifically for the preparation of physical therapists at the entrance to practice, it provides a model for developing a similar, tailored structure for physical therapist assistant education. The pillars and guiding principles of A Vision for Excellence in Physical Therapy Education[1] apply to physical therapist assistants as well. Developing EPAs and competencies specific to the physical therapist assistant role would address one of the aims of the vision and help clarify expected contributions in patient care, team-based practice, and scope-appropriate decision-making. This would also support clearer alignment between physical therapist and physical therapist assistant educational pathways, promoting efficient supervision models, intraprofessional collaboration, and clearer articulation of professional roles and boundaries.

Education Research and Scholarship

The physical therapy education research community has a unique opportunity to investigate the implementation, effectiveness, and validity of evidence for this CBEPT model. As Jensen et al noted in their 2022 *Journal of Physical Therapy Education* article,[45] advancing CBEPT will require a robust research agenda that explores faculty and learner perceptions, assessment reliability, implementation strategies, and outcomes. Investigating how CBEPT impacts readiness for licensure, clinical practice, and long-term professional success is essential. Moreover, the validation of programmatic assessment tools aligned with EPAs and competencies represents rich areas for scholarly inquiry. Case reports, case series, and multi-institutional studies will be of value as the profession embarks on this opportunity. From the beginning of the work to develop this framework in 2017, there has been recognition that education research should drive the use of this CBEPT framework. There is no doubt that over time, education research will identify opportunities to build on this initial framework to further enhance learning and patient outcomes.

CBE Resources Beyond Physical Therapy

Many resources exist to support the understanding and implementation of CBE across the health professions. These materials offer philosophical foundations, design principles, and practical strategies that are broadly applicable to physical therapist education. In addition to the physical therapy-specific references included in this report, many valuable insights can be found in the broader health professions literature.

Several health profession associations have developed their own CBE frameworks and continue to curate tools and resources to support adoption within their respective disciplines. These organizations offer position statements, research publications, toolkits, faculty development materials, and implementation guidance through their websites:

- Association of American Medical Colleges
- American Association of Veterinary Medical Colleges
- Accreditation Council for Graduate Medical Education
- American Association of Colleges of Nursing
- American Physical Therapy Association

As the field of CBE continues to evolve, new resources are regularly developed in response to emerging needs among educators and learners. While the physical therapy profession is in the process of building its own repository of discipline-specific materials, educators are encouraged to explore resources from other health professions to gain a deeper understanding of CBE principles and practices. These external resources can provide valuable guidance on assessment strategies, program design, faculty development, and learner progression.

Acknowledgments

This report reflects the collaborative spirit and shared commitment of a dynamic and diverse community dedicated to advancing excellence in physical therapy education. We extend our deepest gratitude to the many individuals and colleagues who contributed to this multiyear effort to explore and articulate a framework for competency-based education in physical therapy.

This work would not have been possible without the generous engagement of academic and clinical educators, clinicians, researchers, students, professional leaders, and other interested parties who offered their time, insights, and expertise. This project benefited from the thoughtful perspectives, robust dialogue, and unwavering dedication of these volunteers who shaped every stage of the project—from conceptual development through critical review. Together, these individuals and groups have helped lay a foundation for continued growth and innovation in preparing physical therapists to meet the evolving needs of society.

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Jean Fitzpatrick, PT, PhD, MHS, Entrustable Professional Activities Panel
Gail Jensen, PT, PhD, FAPTA, Research Panel
Sara Knox, PT, DPT, PhD, Domains of Competence and Competencies Panel
Steven Bryce Chesbro, PT, DPT, EdD, staff lead

The Education Leadership Partnership (2016–2022)

Founding Partners

American Physical Therapy Association
APTA Academy of Education
American Council for Academic Physical Therapy

Partners

American Board of Physical Therapy Residency & Fellowship Education
American Board of Physical Therapy Specialties
Commission on Accreditation in Physical Therapy Education
Federation of State Boards of Physical Therapy
APTA Acute Care
APTA Academy of Education, PTA Educators Special Interest Group
APTA Health Systems Council
APTA Private Practice
US Department of Veterans Affairs

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Clinical Education Strategy Meeting (2018)

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ELP Outcomes Strategy Meeting (2019)

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Competency-Based Education in Physical Therapy Development Panels

Domains of Competence and Competencies Panel (2019–2025)

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Peggy Gleeson, PT, PhD
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Entrustable Professional Activities Panel (2019–2025)

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Additional Clinicians Who Assisted With Mapping Competencies to EPAs

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Research Panel (2019–2023)

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Reactor Panel (2020–2025)

We extend our deepest appreciation to the 130 individuals who served on the reactor panel for this project between 2020 and 2025. These contributors—spanning physical therapy education and clinical practice, as well as educators from other health professions—generously offered their time, expertise, and thoughtful perspectives to critically review and respond to the evolving components of this framework.

Engaging in up to 8 rounds of structured feedback aligned with a modified Delphi approach, reactor panel members provided input on proposed titles, content, and conceptual foundations for the domains of competence, associated competencies, EPAs, the mapping of competencies to EPAs, and illustrative vignettes. This iterative process ensured a broad range of perspectives and helped shape the development of Competency-Based Education in Physical Therapy: A Framework for Entrance Into Practice.

The insights and feedback shared by these individuals were invaluable in creating a credible, relevant, and meaningful framework that reflects the complexity and evolving needs of physical therapist professional education.

Consultants

Lead

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Support

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Matthew Lecroix, PharmD, MS,
David R. Brown, MD

Glossary

Ad-hoc entrustment decisions: Happen every day in the clinical teaching environment. This is when a supervisor estimates whether the skills of the learner at that moment match the complexity of the patient or client and the risks involved.[12]

Clinical competence committee: A group of individuals involved in learner education and assessment responsible for making effective and credible judgements of learner performance based on the review and interpretation of multiple aggregated assessments and then deliberately deciding on progression and entrustment of patient care tasks.[12]

Clinical reasoning: The integration of cognitive, psychomotor, and affective skills in the context of patient and client and provider perspectives to provide patient and client care through a biopsychological approach that is adaptive, iterative and collaborative.[111] Critical thinking is inherent to the clinical reasoning process.

Competency: An observable and measurable ability of a physical therapist, integrating multiple components such as knowledge, skills, values, and attitudes.[4,22]

Cultural humility: A lifelong commitment to critically examine one's own beliefs, customs, and values combined with an intention to honor others' beliefs, customs, and values and a willingness to learn from others, acknowledge differences, and accept others for who they are.[81]

Development: All activities that health professionals and education partners pursue to improve their knowledge, skills, and behaviors as teachers and educators, as leaders and managers, and as researchers and scholars in both individual and group settings.[12]

Domain of competence: A defined area encompassing related competencies.[3,22]

Domains of learning: The 3 domains of learning are cognitive (intellectual), affective (emotional responses), and psychomotor (physical tasks).

Educational Leadership Partnership: Includes representatives representation from the: American Physical Therapy Association, APTA Academy of Education, and American Council of Academic Physical Therapy, American Board of Physical Therapy Residency and Fellowship Education, American Board of Physical Therapy Specialties, Commission on Accreditation in Physical Therapy Education, Federation of State Boards of Physical Therapy, and community partners representing APTA Academy of Acute Care Physical Therapy, APTA Private Practice, APTA Health Systems Council, Physical Therapist Assistant Education, and Veterans Affairs.[1] The partnership is intended to be a group with a more global perspective than that of any one organization represented or any other stakeholder.

Emotional intelligence: The capacity to be aware of, control, and express one's emotions, and to handle interpersonal relationships judiciously and empathetically.

Entrustable professional activities: A unit of professional practice that can be fully entrusted to a trainee as soon as they have demonstrated the necessary competence to execute this activity unsupervised.[22,77] An example of an EPA used in medical residencies is "Gather a history and perform a physical exam."

Entrustment Committee: See Clinical Competence Committee.

Entrustment decisions: The decision to transfer the responsibility to a learner.[12]

Entrustment supervision scales: Scales that focus on the amount of supervision, support, or help needed to complete an activity in the workplace. These scales differ from traditional scales in their focus on entrustment with tasks and the level of supervision or support required to safely complete workplace-based activities.[11,12,22]

Evidence-based practice: "The integration of best available evidence, clinical expertise, and patient values and circumstances related to patient and client management, practice management, and health policy decision-making."[112]

Evidence-informed practice: Evidence-informed practice includes a wider scope/set of goals than evidence-based practice. It implies that many different levels of evidence and types of evidence are needed and used to support decisions in clinical practice. Levels of evidence may include but are not limited to clinical best practice guidelines, survey data, and other qualitative data.[113]

Examination: A physical therapist's examination includes history, systems review, and tests and measures.[68] Please refer to the *Guide to Physical Therapist Practice* for more details. [68]

Feedback: Information provided by an agent (teacher, peer, self, etc) regarding aspects of one's performance or understanding with the purpose of reducing the discrepancy between current practices or understandings and desired practices or understandings.[12]

Formative assessment: Involves gathering data for improving student learning.[12]

Mediums of communication: The substance through which a communication is conveyed. An example of mediums for the aural (sound) mode of communication for relaying examination findings might include synchronous in-person communication, asynchronous voicemail, use of an interpreter, etc.

Modes of communication: Means of communication. There are 5 modes of communication: visual, linguistic, spatial, aural, and gestural.

Patient Client Management Model: The Physical Therapist Patient and Client Management Model contains the following elements: examination, evaluation, diagnosis, prognosis, intervention, and outcomes. Patient and client management is an ongoing, iterative process that focuses on the evolving needs of each individual. Physical therapists apply the process of patient and client management to rehabilitate, habilitate, maintain health or function, prevent functional decline, and, in healthy individuals, enhance performance.[68]

Professional education: Entry-level education for which successful completion is required to be eligible to sit for a license.

Postprofessional education: According to APTA, the term "physical therapist postprofessional education" is used to refer to degree and nondegree-based professional development for the physical therapist to enhance professional knowledge, skills, and abilities[114] and includes the use of a wide variety of methods for attaining those aims, including participation in continuing education courses, academic courses, residency or fellowship education, independent study, mentoring experiences, and on-the-job training. All professional development experiences should be based on an assessment of need; generated from outcome objectives; planned for successful, progressive learning; and evaluated for attainment of delineated outcomes.[115]

Resources: Sources of supply, support, or aid that facilitate the delivery of services. Types of resources may include people, information, materials, tools, energy, capital, and time.

Scholarly activities: Activities that systematically advance the teaching, research, and practice of physical therapy. Boyer's model identifies 4 types of scholarship: (1) discovering knowledge, (2) integrating knowledge, (3) applying knowledge, and (4) scholarship of teaching.[116]

Social determinants of health: The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[117]

Summative assessment: Uses data to assess how much a learner knows or has retained and can do at the completion of a learning sequence.[12]

Summative entrustment decisions: Have the nature of a formal qualification for the future responsibility of the learner from that moment on. Within an EPA-based curriculum, summative entrustment decisions constitute permission to carry out an EPA when there is sufficient grounding of trust among the team that the learner can bear this responsibility.[12]

Systems-based practice: The process of understanding and being sensitive to how the interactions and interrelationships of all 4 major levels of the health care delivery system shape the behavior of the system. The 4 major levels of the health care delivery system are (1) the patient and client, (2) the care team (professionals, family members, and others), (3) the organizations in which care is delivered, and (4) the environment (regulatory, market, policy).[83]

System-level: The organizations in which care is delivered.

References

1. Vision for Excellence in Physical Therapy Education. *J Phys Ther Educ*. 2021;35:1-35. https://journals.lww.com/jopte/fulltext/2021/12001/a_vision_for_excellence_in_physical_therapy.1.aspx
2. Gruppen LD, Mangrulkar RS, Kolars JC. The promise of competency-based education in the health professions for improving global health. *Hum Resour Health*. 2012;10:43. doi: 10.1186/1478-4491-10-43
3. Frank JR, Mungroo R, Ahmad Y, Wang M, DeRossi S, Horsley T. Toward a definition of competency-based education in medicine: a systematic review of published definitions. *Med Teach*. 2010;32:631–637. (Central to this approach are EPAs—the fundamental tasks of a physical therapist and a set of domains of competence (DoCs) that organize the knowledge, skills, and attitudes required for professional practice in the form of competencies.)
4. Van Melle E, Frank JR, Holmboe ES, Dagnone JD, Stockley D, Snell L. A core components framework for evaluating implementation of competency-based medical education programs. *Acad Med*. 2019;94(7):1002–1009. doi:10.1097/ACM.0000000000002743
5. Thibault GE. The future of health professions education: emerging trends in the United States. *Faseb Bioadvances*. 2020;*2*(12):685–694. https://doi.org/10.1096/fba.2020-00061
6. Frank JR, Danoff D, Snell LS, et al. The future of health professions education: Emerging trends in the United States and Canada. *FASEB BioAdvances*. 2021;3(8):559–578.
7. Jensen GM, Hack LM, Nordstrom T, Gwyer J, Mostrom E. National study of excellence and innovation in physical therapist education: Part 2—a call to reform. *Phys Ther*. 2017;97:875–888.
8. Hislop HJ. Tenth Mary McMillan Lecture: The Not-So-Impossible Dream. *Phys Ther*. 1975;55(10):1069–1080, https://doi.org/10.1093/ptj/55.10.1069
9. Jette DU. Unflattening. *J Phys Ther Educ*. 2016;30(3):4–10.
10. Timmerberg JF**,** Chesbro SB, Jensen GM, Dole RL, Jette DU. Competency-based education and practice in physical therapy: it's time to act! *Phys Ther*. 2022;102(5);pzac018. doi: 10.1093/ptj/pzac018
11. ten Cate O, Hennus MP. Entrustable professional activities and entrustment decision-making for competency-based education in the health professions: an introduction. In: ten Cate O, Burch VC, Chen HC, Chou FC, Hennus MP, eds. *Entrustable Professional Activities and Entrustment Decision-Making in Health Professions Education*. Ubiquity Press; 2024:3–14. doi: https://doi.org/10.5334/bdc.a
12. Bok HGJ, Jonker G, Hamstra SJ, Boscardin CK, ten Cate O, Hennus MP. Integrating key concepts in workplace-based assessment: entrustable professional activities, programmatic assessment, and milestones. In: ten Cate O, Burch VC, Chen HC, Chou FC, Hennus MP, eds. *Entrustable Professional Activities and Entrustment Decision-Making in Health Professions Education*. Ubiquity Press. 2024:65–73. doi: https://doi.org/10.5334/bdc.f
13. ten Cate O. Entrustability of professional activities and competency-based training. *Med Educ*. 2005;39(12):1176–1177. doi: 10.1111/j.1365-2929.2005.02341.x.

14. Ten Cate O, Taylor DR. The recommended description of entrustable professional activities: AMEE Guide No. 140. *Med Teach*. 2021;43(11):1261–1272.
15. Frank JR, Snell LS, Cate OT, et al. Competency-based medical education: theory to practice. *Med Teach*. 2010;32(8):638–645. doi:10.3109/0142159X.2010.501190
16. Frank JR, Danoff D. The CanMEDS initiative: implementing an outcomes-based framework of physician competencies. *Med Teach*. 2007;29(7):642–647. doi:10.1080/01421590701746983
17. Accreditation Council for Graduate Medical Education. Common program requirements. Published 2007. Accessed May 10, 2025. https://www.acgme.org
18. Association of American Medical Colleges. *Core Entrustable Professional Activities for Entering Residency: Curriculum Developers' Guide*. AAMC; 2014. https://www.aamc.org/media/20151/download
19. AAMC, AACOM, ACGME. *Foundational Competencies for Undergraduate Medical Education*. Washington, DC: Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Accreditation Council for Graduate Medical Education; 2024.
20. Chaney KP, Hodgson JL, Banse HE, et al.; AAVMC Council on Outcomes-Based Veterinary Education. *CBVE 2.0 Model*. Washington, DC: American Association of Veterinary Medical Colleges; 2024. doi:10.17605/OSF.IO/9NTV5
21. American Association of Colleges of Nursing. *The Essentials: Core Competencies for Professional Nursing Education*. Washington, DC: AACN; 2021.
22. Englander R, Cameron T, Ballard AJ, Dodge J, Bull J, Aschenbrener CA. Toward a common taxonomy of competency domains for the health professions and competencies for physicians. *Acad Med*. 2013;88(8):1088–1094. doi:10.1097/ACM.0b013e31829a3b2b
23. ten Cate O, Scheele F. Competency-based postgraduate training: can we bridge the gap between theory and clinical practice? *Acad Med*. 2007;82(6):542–547. doi:10.1097/ACM.0b013e31805559c7
24. Royal Australasian College of Physicians. Curriculum standards. https://www.racp.edu.au/trainees/advanced-training/curricula-renewal/curriculum-standards. Accessed May 13, 2025.
25. Jensen G. *Educating Physical Therapists*. Routledge; 2024. https://doi.org/10.4324/9781003523949
26. Hislop HJ. Where do we go from here? *Phys Ther*. 1968;48(1):5.
27. Davis CM, Anderson MJ, Jagger D. Competency: the what, why, and how of it. *Phys Ther*. 1979;59(1):1088–1094.
28. American Physical Therapy Association. Position paper on competency testing. *Phys Ther*. 1973;53(8):889–892.
29. May BJ. Evaluation in a competency-based educational system. *Phys Ther*. 1977;57(1):28-33.
30. Jensen GM, Gwyer J, Hack LM, Shepard KF. *Expertise in Physical Therapy Practice*. 2nd ed. Elsevier; 2007.
31. Worthingham C. The clinical environment for basic physical therapy education—1965-1966. *Phys Ther*. 1968;48:1195–1216. https://doi.org/10.1093/ptj/48.11.1195.
32. Worthingham CA. The clinical environment for basic physical therapy education 1965-1966. *Phys Ther*. 1968;48:1353–1382. https://doi.org/10.1093/ptj/48.12.1353.
33. Worthingham CA. Complementary functions and responsibilities in an emerging profession. *Phys Ther*. 1965;45:935–939. https://doi.org/10.1093/ptj/45.10.935.

34. Worthingham CA. Study of basic physical therapy education: II. The environment for basic physical therapy education—1965-1966: the academic or theoretical phase. *Phys Ther*. 1968;48: 935–962. https://doi.org/10.1093/ptj/48.9.935.
35. Worthingham CA. Study of basic physical therapy education: V. Request (prescription or referral) for physical therapy. *Phys Ther*. 1970;50:989–1031. https://doi.org/10.1093/ptj/50.
36. Worthingham CA. Study of basic physical therapy education: VI. Findings of the study in relation to trends in patient care and education. *Phys Ther*. 1970;50:1315–1332. https://doi.org/10.1093/ptj/50.9.1315.
37. American Physical Therapy Association Board of Directors Minutes. November 20–21, 2015. 2015:7–13.
38. American Physical Therapy Association House of Delegates. 2017 Reports to the House of Delegates. American Physical Therapy Association; 2017.
39. Queen's Health Sciences. Queen's Physical Therapy program first in Canada to use competency-based education. *Queen's University Faculty of Health Sciences News & Announcements*. Published May 15, 2023. Accessed May 30, 2025. https://healthsci.queensu.ca/stories/news-announcements/queens-physical-therapy-program-first-canada-use-competency-based
40. Australian Physiotherapy Association. *Physiotherapy Competence Framework*. Published 2023. Accessed May 30, 2025. https://australian.physio/sites/default/files/APA_COMPETENCE_FRAMEWORK_v7.1_FINAL.pdf
41. Physiotherapy Board of Australia, Physiotherapy Board of New Zealand. Physiotherapy Practice Thresholds in Australia and Aotearoa New Zealand. Accessed May 30, 2025. https://physioboard.org.nz/standards/physiotherapy-thresholds
42. Zainuldin R, Tan HY. Development of entrustable professional activities for a physiotherapy undergraduate programme in Singapore. *Physiotherapy*. 2021;112:64–71. doi: 10.1016/j.physio.2021.03.017
43. KNGF. *KNGF Physical Therapist Professional Profile*. 2021. Accessed July 30, 2025. https://www.kngf.nl/app/uploads/2024/07/kngf-physical-therapist-professional-profile_2021.pdf
44. Harrington KL, Teramoto M, Black L, et al. Physical therapist residency competency-based education: development of an assessment instrument. *Phys Ther*. 2022;102(5):pzac019. https://doi.org/10.1093/ptj/pzac019
45. Jensen G, Jette D, Timmerberg J, Chesbro S, Dole R, Kapasi Z, Lotshaw A. Competency-based education in physical therapy: developing a framework for education research. *J Phys Ther Educ*. 2022;36(4):334–340. doi: 10.1097/JTE.0000000000000254
46. KnoXS, Bridges P, Chesbro S, et al. Development of domains of competence and core entrance-to-practice competencies for physical therapy: a national consensus approach. *J Phys Ther Educ*. (Forthcoming.)
47. Fitzpatrick J, Chesbro SB, Jensen GM, et al. Development of entrustable professional activities for entrance into physical therapist clinical practice: applying a national consensus approach. (Forthcoming.)
48. Chesbro S, Jensen GM, Boissonnault W. Entrustable professional activities as a framework for continued professional competence: is now the time? *Phys Ther*. 2018;98:3–7. https://doi.org/10.1093/ptj/pzx100

49. Timmerberg J, Chesbro S, Jensen G, Dole R, Jette D. Competency-based education and practice in physical therapy: the time to act is now. *Phys Ther*. 2022;102:1–9. https://doi.org/10.1093/ptj/pzac018
50. Timmerberg JF, O'Sullivan PS, Chen HC, et al. Competency-based education: exploring opportunities for our future. Presented at: APTA Combined Sections Meeting; January 2019; Washington, DC.
51. Timmerberg JF, Jensen GM, Chesbro SB, Ambler SB. Competency-based education in physical therapy: 101. Presented at: APTA Combined Sections Meeting; February 5, 2022; San Antonio, TX.
52. KnoXS, Timmerberg JF, Chesbro SB, Norris TL. Competency-based education in physical therapy 201: domains of competence. Presented at: APTA Combined Sections Meeting; February 25, 2023; San Diego, CA.
53. Fitzpatrick JF [Timmerberg], KnoXS, Langerwerf L, Jensen GM, Chesbro SB. Entrance into practice performance outcomes in physical therapy: connecting the dots. Presented at: APTA Combined Sections Meeting; February 2024; Boston, MA.
54. Fitzpatrick JA, Jensen G, Norris T. Entrance into practice performance outcomes in physical therapy: the full framework. Presented at: APTA Combined Sections Meeting; February 2025; Houston, TX.
55. Timmerberg JF, Chesbro SB, Jensen G, Brown D, LaCroiXM. Competency-based education in medicine and pharmacy: learning from others. Presented at: Education Leadership Conference; October 2018; Jacksonville, FL.
56. Timmerberg JF, Chesbro SB, Jensen G, Taylor D. Exploring approaches to defining and assessing performance standards for physical therapists entering clinical practice. Presented at: Education Leadership Conference; October 2019; Bellevue, WA.
57. Timmerberg JF, Rowe R, Norris T, Chesbro SB. Outcomes for professional PT education: update on competencies for physical therapy entrance into practice. Presented at: Education Leadership Conference; October 2020; Milwaukee, WI. Virtual presentation.
58. Chesbro SB, McCallum C, Norris T, Langerwerf L, Brooks S. A vision for excellence in physical therapy education: a 2022 action update. Presented at: Education Leadership Conference; October 29, 2022; Milwaukee, WI.
59. KnoXS, Rowe R, Norris T, Chesbro SB, Gleeson P, Bridges P. Competency-based education: domains of competence history and application to the physical therapy profession. Presented at: Education Leadership Conference; October 28, 2022; Milwaukee, WI.
60. Peterson JA, Ambler SB, Jernigan SD, Black L, Jensen GM, Chesbro SB. Beginning the journey: reflections on integrating competency-based education in PT. Presented at: Education Leadership Conference; October 2023; Philadelphia, PA.
61. Fitzpatrick JA, Ambler SA, Englander R. Propelling PT education forward through competency-based education: why, what, and how. Presented at: Education Leadership Conference; October 2023; Philadelphia, PA.
62. KnoXS, Fitzpatrick JF, Norris TL, et al. Domains of competence for physical therapy: the full framework. Presented at: Education Leadership Conference; October 2023; Philadelphia, PA.
63. Ambler SB, Fitzpatrick J, Jensen GM, et al. Intended and unintended consequences of competency-based education: time for a reflective look. Presented at: Education Leadership Conference; October 2024; Oakland, CA.

64. Jensen G, Chesbro S, Timmerberg J, et al. Competency-based education in physical therapy: working to transform physical therapist education and learner assessment in the United States. Presented at: AMEE Annual Conference; September 2023; Glasgow, Scotland. Virtual presentation. Abstract ID: A23SCODA18/6215.
65. Fitzpatrick JA. Entrustable professional activities as an assessment framework for physiotherapy. Keynote presented at: European Network of Physiotherapy in Higher Education Conference; September 2022; Vila Nova, Portugal.
66. O'Sullivan PS, Chesbro SB, Chen HC, et al. Competency-based education in the health professions: using applied research to improve learner and societal outcomes. Symposium accepted for presentation at: American Educational Research Association Annual Meeting; April 2020; San Francisco, CA. https://convention2.allacademic.com/one/aera/aera20/. (Conference canceled.)
67. American Physical Therapy Association. *Guide to Physical Therapist Practice 4.0.* American Physical Therapy Association; 2023.
68. Grignon TP, Henley E, Lee KM, Abentroth MJ, Jette DU. Expected graduate outcomes in US physical therapist education programs: a qualitative study. *J Phys Ther Educ.* 2014;28(1):48–57.
69. Furze JA, Tichenor CJ, Fisher BE, Jensen GM, Rapport MJ. Physical therapy residency and fellowship education: reflections on the past, present, and future. *Phys Ther.* 2016;96(7):949–960.
70. Wagner LM, Dolansky MA, Englander R. Entrustable professional activities for quality and patient safety. *Nurs Outlook.* 2018;66(3):237–243.
71. Haines S, Pittenger A, Plaza C. Describing entrustable professional activities is merely the first step. *Am J Pharm Educ.* 2017;81(1):18.
72. National Physiotherapy Advisory Group. Competency profile for physiotherapists in Canada. Published 2017. https://www.peac-aepc.ca/pdfs/Resources/Competency%20Profiles/Competency%20Profile%20for%20PTs%202017%20EN.pdf
73. Gruppen LD, Burkhardt JC, Fitzgerald JT, et al. Competency-based education: programme design and challenges to implementation. *Med Educ.* 2016;50(5):532–539.
74. Englander R, Flynn T, Call S, et al. Toward defining the foundation of the MD degree: core entrustable professional activities for entering residency. *Acad Med.* 2016;10:1352–1358.
75. ten Cate O, Billett S. Competency-based medical education: origins, perspectives and potentialities. *Med Educ.* 2014(48):325–332.
76. ten Cate O, Chen H, Hoff R, Peters H, Bok H, van der Schaff M. Curriculum development for the workplace using entrustable professional activities (EPAs): AMEE guide No. 99. *Med Teach.* 2015;37:983–1002.
77. Teherani A, Chen C. The next steps in competency-based medical education: milestones, entrustable professional activities and observable practice activites. *J Gen Intern Med.* 2014;29(8):1090–1092.
78. Kopf RS, Watts PI, Meyer ES, Moss JA. A competency-based curriculum for critical care nurse practicioners' transition to practice. *Am J Crit Care.* 2018;27(5):398–406.

79. Association of American Medical College. Core entrustable professional activities for entering residency: faculty and learners guide. https://www.aamc.org/media/20211/download. Published 2014.
80. American Physical Therapy Association. Core competencies of a physical therapist resident. Published 2020. Accessed 2022. https://www.apta.org/contentassets/89db00a8ab01418c844ced87e401563e/core-competencies-pt-resident.pdf.
81. Yeager KA, Bauer-Wu S. Cultural humility: essential foundation for clinical researchers. *Appl Nurs Res*. 2013;26(4):251-256. doi:10.1016/j.apnr.2013.06.008
82. American Physical Therapy Association. *Guide to Physical Therapist Practice*. American Physical Therapy Association. 2013; chap Principles of Physical Therapist Patient and Client Management.
83. Plack MM, Goldman EF, Scott AR, et al. Systems thinking and systems-based practice across the health professions: an inquiry into definitions, teaching practices, and assessment. *Teach Learn Med*. 2018;30(3):242–254. doi:10.1080/10401334.2017.1398654
84. American Physical Therapy Association. Informed consent: What PTs need to know: Understand your legal obligations to your patients. *APTA Magazine*. 2021;13(3):12–16. Accessed June 30, 2025. https://www.apta.org/apta-magazine/2021/04/01/apta-magazine-april-2021/informed-consent-what-pts-need-to-know.
85. World Physiotherapy. Glossary: Informed consent. https://world.physio/resources/glossary.
86. American Physical Therapy Association. Ethics in Practice: How informed is your patient's consent? *APTA Magazine*. 2022;14(10):12-16. https://www.apta.org/apta-magazine/2022/11/01/ethics-in-practice.
87. American Physical Therapy Association. Code of Ethics for the Physical Therapist. https://www.apta.org/apta-and-you/leadership-and-governance/policies/code-of-ethics-for-the-physical-therapist.
88. Harding E, Montes J, Uher D, Zreibe K, Chen HC, Timmerberg J. An alternate scale for assessing learners in the workplace: a pilot study. Presented at: Education Leadership Conference; October 28, 2022; Milwaukee, WI.
89. American Physical Therapy Association. Standards of Practice. Updated August 12, 2020. Accessed. June 23, 2023. https://www.apta.org/siteassets/pdfs/policies/standards-of-practice-pt.pdf
90. American Physical Therapy Association. Diagnosis by Physical Therapists. Diagnosis By Physical Therapists | APTA
91. American Physical Therapy Association. *Guide to Physical Therapist Practice 4.0*: Interventions. https://guide.apta.org/interventions
92. American Physical Therapy Association. Scope of Practice. https://www.apta.org/your-practice/scope-of-practice
93. American Physical Therapy Association. *Guide to Physical Therapy Practice 4.0*: Procedural Interventions. https://guide.apta.org/interventions#ProceduralInterventions
94. American Physical Therapy Association, Documentation: Documentation of a visit. https://www.apta.org/your-practice/documentation/defensible-documentation/elements-within-the-patientclient-management-model/documentation-of-a-visit

95. American Physical Therapy Association. Setting-Specific Considerations in Documentation. https://www.apta.org/your-practice/documentation/defensible-documentation/setting-specific-considerations
96. American Physical Therapy Association. Elements of Documentation within the Patient/Client Management Model. https://www.apta.org/your-practice/documentation/defensible-documentation/elements-within-the-patientclient-management-model
97. Health Care Education Association. Patient education practice guidelines for health care professionals. https://www.hcea-info.org/patient-education-practice-guidelines-for-health-care-professionals#:~:text=Overarching%20Elements&text=Effective%20patient%20education%20focuses%20on,combines%20all%20of%20these%20elements.
98. Direction and Supervision of the Physical Therapist Assistant. American Physical Therapy Association. Published October 2022. Accessed June 9, 2023. https://www.apta.org/apta-and-you/leadership-and-governance/policies/direction-supervision-pta.
99. Levels of Supervision. American Physical Therapy Association. Published September 2019. Accessed June 9, 2023. https://www.apta.org/apta-and-you/leadership-and-governance/policies/levels-supervision.
100. Student PT and PTA Provision of Services. American Physical Therapy Association. Published September 2019. Accessed June 9, 2023. https://www.apta.org/apta-and-you/leadership-and-governance/policies/student-pt-provision-services.
101. Struessel TS, Rodriguez JW, Van Zytveld CR. Advocating for a Systems Approach to Enhance Patient Safety in Physical Therapy Practice: A Clinical Commentary. *HPA Resource*. 2017;17(1):J22–J31.
102. Gheihman G, Forester BP, Sharma N, So-Armah C, Wittels KA, Milligan TA. Identifying and analyzing systems failures: an interactive, experiential learning approach to quality improvement for clerkship-level medical students. *MedEdPORTAL*. 2021;17:11151. doi: 10.15766/mep_2374-8265.11151.
103. Ryder HF, Huntington JT, West A, Ogrinc G. What do I do when something goes wrong? Teaching medical students to identify, understand, and engage in reporting medical errors. *Acad Med*. 2019;94(12):1910–1915. doi: 10.1097/ACM.0000000000002872.
104. American Physical Therapy Association. *Guide to Physical Therapist Practice 4.0*. Roles in Prevention and in the Promotion of Health, Wellness, and Fitness. https://guide.apta.org/chapters/chapter-1#RoleHealth
105. Englander R, Amiel J, Jarrett JB, Chen HC. Considerations in building a curriculum using entrustable professional activities. In: ten Cate O, Burch VC, Chen HC, Chou FC, Hennus MP, eds. *Entrustable Professional Activities and Entrustment Decision-Making in Health Professions Education*. Ubiquity Press. 2024;133–144. doi: https://doi.org/10.5334/bdc.l
106. ten Cate O, Jonker G, Park YS, Holmboe ES, Burch VC. Workplace-based assessment to support entrustment decision-making: four sources of information. In: ten Cate O, Burch VC, Chen HC, Chou FC, Hennus MP, eds. *Entrustable Professional Activities and Entrustment Decision-Making in Health Professions Education*. Ubiquity Press. 2024:197–211. doi: https://doi.org/10.5334/bdc.q

107. Holmboe ES, Yamazaki K, Hamstra SJ. The evolution of assessment: thinking longitudinally and developmentally. *Acad Med*. 2020;95(11S):S7-S9. DOI: https://doi.org/10.1097/ACM.0000000000003649
108. Fitzgerald LM, Delitto A, Irrgang JJ. Validation of the Clinical Internship Evaluation Tool. *Phys Ther*. 2007;87(7):844–860. https://doi.org/10.2522/ptj.20060054
109. Campbell DF, Alameri M, Macahilig-Rice F, Witkin SE, Hellman NG. Validation of the revised American Physical Therapy Association Physical Therapist Clinical Performance Instrument 3.0. *Phys Ther*. 2025;105(4):pzaf015. https://doi.org/10.1093/ptj/pzaf015
110. Texas Consortium for Physical Therapy Education and Research Foundation. *Physical Therapist Manual for the Assessment of Clinical Skills*. 2nd ed. Texas Consortium for Physical Therapy Education and Research Foundation; 2015. http://www.texasconsortium.org/pt-macs.html
111. Huhn K, Gilliland SJ, Black LL, Wainwright SF, Christensen N. Clinical reasoning in physical therapy: a concept analysis. *Phys Ther*. 2019;99(4):440–456.
112. American Physical Therapy Association. Components of Evidence-Based Practice. Published 2020. Accessed February 14, 2022. https://www.apta.org/patient-care/evidence-based-practice-resources/components-of-evidence-based-practice.
113. Woodbury G, Kuhnke J. Evidence-based practice vs. evidence-informed practice: what's the difference? *Wound Care Canada*. 2014;12:18–21.
114. American Physical Therapy Association. Educational degree qualifications and nomenclature for physical therapists and physical therapist assistants. American Physical Therapy Association. Published 2018. Accessed February 14, 2022. Published 2018. https://www.apta.org/siteassets/pdfs/policies/educational-degree-qualifications-pt.pdf.
115. American Physical Therapy Association. Professional development, lifelong learning, and continuing competence in physical therapy; HOD P05-07-14-14. Published 2012. Accessed February 14, 2022. https://www.apta.org/siteassets/pdfs/policies/professional-development-lifelong-learning.pdf.
116. Boyer EL. *Scholarship Reconsidered: Priorities of the Professoriate*. Carnegie Foundation for the Advancement of Teaching; 1990.
117. Office of Disease Prevention and Health Promotion. Healthy people 2030: Social determinants of health. US Department of Health and Human Services. Accessed September 26, 2023. https://health.gov/healthypeople.