Continuing Competence in Physical Therapy: An Ongoing Discussion

Background

This paper is a joint effort of the American Physical Therapy Association (APTA) and the Federation of State Boards of Physical Therapy (FSBPT). Representatives of the two Boards of Directors generated the idea for this paper when they met in May 2009 to discuss continuing competence. The paper is watermarked "draft" to communicate that it is a product of ongoing discussions among the stakeholders of APTA and FSBPT and that it will continue to be informed by these discussions. The recommended plan to move forward includes:

- Sharing this paper with the Boards of Directors of APTA and FSBPT,
- Scheduling a joint dialogue with staff and Board members of the two organizations,
- Sharing the paper with the stakeholders of both organizations,
- Generating discussion among the stakeholders (preferably in groups that include APTA members and licensing board members), and
- Collecting feedback on the issues generated in the discussions.

The information generated from the discussions will inform the direction and decisions about continuing competence for the profession of physical therapy.

NOTE: The figures on pages 19-21 are best viewed in color.

Part 1—Introduction

Continuing competence of health care professionals is of the utmost importance to a diverse range of stakeholders including the public, health care providers, regulatory bodies, employers, insurers, and professional associations. Health care professions play a critical role in ensuring the physical and mental well-being of society. That responsibility comes with an obligation to demonstrate that the public's trust is well guarded by competent providers.

Context

APTA and FSBPT have independently and jointly discussed the topic of continuing competence for many years. Within these discussions, the organizations have both agreed and disagreed over their respective roles and how to move the concept of continuing competence forward within the profession. Recently, leaders within the 2 organizations recognized some opportunities for collaboration, including the potential for creating a mutually agreed-upon definition of continuing competence, and continued dialogue about the issues surrounding continuing competence.

In an effort to move the collaboration forward, leaders representing each organization met to share each organization's strategic initiatives pertaining to continuing competence and to start a discussion of the issues. One of the conclusions of this meeting was that a written document was needed to help frame the discussions within each organization, between the 2 organizations, and among other stakeholder groups.

Purpose

The purpose of this paper is to provide factual information from a variety of sources, to encourage exploration of the issues and to promote the sharing of opinions related to continuing competence. This paper poses questions for consideration. And, finally, it provides a common foundation for further discussions among physical therapy stakeholders and eventually could be the basis for interdisciplinary dialogue.

The purpose of this paper is **not** to answer all possible questions about continuing competence. Nor is the purpose to solve problems or suggest best practices. At this point, there are many more questions about continuing competence than there are answers. Highlighting the questions and reviewing the literature are the first steps toward developing those answers.

Importance of Continuing Competence

Anecdotally the importance of continuing competence is clear. Ask consumers if they think the ongoing competence of their health care providers is important, and undoubtedly they will respond with a vehement "yes." Looking beyond the anecdotal and personal points of view, there are several reputable and influential organizations that have commented on the importance of continuing competence in health care.

The April 2004 report *Road Map to Continuing Competency Assurance*, [1] by the Citizens Advocacy Center (CAC), made a powerful statement about the importance of continuing competence:

> Patients have every right to assume that a health care provider's license to practice is the government's assurance of his or her current professional competence, and clinicians themselves would like assurance that those with whom they practice are current and fully competent. Unfortunately, this is not the case.[1 (p i)]

"Unfortunately, this is not the case" is a clear challenge to regulators and professionals to work toward additional measures of competence and to keep the public informed on progress.

In the third report of the Pew Health Professions Commission, titled *Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century*, [2] another powerful statement was made about the need for professions to embrace continuing competence:

> The skills, competencies and values for a successful lifetime of professional practice cannot be learned in a single educational encounter. Rather, the health professions must recapture the tradition of a continuing commitment to learning. The rate of change in the health care system makes this commitment imperative for the practitioner and society alike. This commitment must transcend passive, continuing professional education and move towards clear standards of continuing competence.[2 (p xv)]

A 2007 study conducted by AARP and CAC[3] provided insight into the public's mindset about the continuing competence requirements for health care professionals. More than 95% of respondents believed that health care professionals should be required to show they have the up-to-date knowledge and skills needed to provide quality care as a condition of retaining their licenses. Ninety percent of the respondents indicated that it is very important, at the least, for health care professionals to periodically be re-evaluated to show they are currently competent to practice safely.

The importance of continuing competence in health care in general seems clear. The next step is to consider the specific factors that are evolving in physical therapy that influence the need for continuing competence. As physical therapists are able to perform differential diagnosis, continue to move toward unlimited direct access, and transform physical therapy into a doctoring profession, do they play an increasing role in public health and therefore have an increased responsibility to demonstrate their competence?

Assumptions and Agreements

Individuals reading this paper will have a variety of perspectives about continuing competence. These perspectives are shaped by individual experiences, education, and work experience, to name just a few factors. It is reasonable to expect that people may draw different conclusions even when presented with the same set of data.

It also is reasonable to assume that different stakeholder groups will have a variety of perspectives and may draw different conclusions. Employers may look at the demonstration of competence differently from employees. Insurers and employers may have differing points of view. Regulatory boards and professional associations may see some elements of continuing competence, including the roles of each group, in different ways, which is to be expected when considering their unique missions. What is most important is to discuss the conclusions and understand how each organization will move forward.

FSBPT's mission is representative of its regulatory boards' missions: "to protect the public by providing service and leadership that promote safe and competent physical therapy practice." The mission of APTA, the principal membership organization representing and promoting the profession of physical therapy, is "to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public."

While many factors may lead to disagreement or divergent opinions about specific elements of continuing competence, there is general agreement that continuing competence is an important topic that needs to be better understood and that efforts should be made to advance the concept of continuing competence among professionals. General agreement on these broad but important ideas is a good starting point, but only a starting point. The issue of continuing competence is complex and there are a number of topics already identified that need to be explored.

Contents of This Paper

Part 2 of this paper covers definitions of continuing competence—both citing those that have been developed specific to physical therapy and exploring definitions from other health care professions. The definition section is followed by Part 3, a discussion of current continuing competence models, including a discussion of continuing education. Part 4 addresses issues that have come to the forefront as requiring additional consideration and dialogue:

1. Who is responsible for continuing competence? What are the roles of the various constituents in continuing competence? What is the purview of regulation regarding continuing competence?
2. In what portion of the scope of practice should a licensee be responsible for maintaining competence? What is in a licensing board's authority to regulate? In what part of the scope of practice should a licensing board require demonstration of continuing competence? Is there a set of knowledge, skills, and abilities that represent contemporary practice that all physical therapists should be able to demonstrate?

3. Does continuing competence relate to ensuring safe practice, effective practice, or both? If it includes effective practice, what is the minimum standard for effectiveness?
4. What are the economic and legal implications of implementing continuing competence requirements?
5. What are stakeholder fears and concerns about continuing competence requirements?

Part 2—Defining Continuing Competence

One of the significant challenges to meaningful discussion of the issues surrounding continuing competence is the lack of definitions that are comprehensive and relevant to all health care professions. The July 2006 report from AARP, titled *Implementing Continuing Competency Requirements for Health Care Practitioners*,[4] addressed this challenge:

> Recommendation #4: Professions should endeavor to codify standards and definitions of clinical competence that are relevant to them and incorporate those cross-cutting competencies identified by the IOM as being relevant to all health care professions: patient-centered care, interdisciplinary teams, evidence-based practice, quality improvement, and informatics.[4 (p IX)]

However, establishing common definitions, by itself, is not enough to promote a common understanding of what continuing competence means. Delineating working models that further explain the purpose, responsibility, and approach to continuing competence is also essential for laying the foundation for collaboration, appreciation of multiple perspectives, and a fuller description of the issues surrounding continuing competence.

Although a variety of definitions of *continuing competence* exist, few of the definitions address the 3 key elements of purpose, responsibility, and approach as described by the National Organization for Competency Assurance (NOCA) and as outlined by the American Nurses Association (ANA) Expert Panel on Continuing Competence in its definition and assumptions provided below.

> Continuing professional nursing competence is ongoing professional nursing competence according to level of expertise, responsibility, and domains of practice as evidenced by behavior based on beliefs, attitudes, and knowledge matched to and in the context of a set of expected outcomes as defined by nursing scope (of) practice, policy, Code for Nurses, standards, guidelines, and benchmarks that assure safe performance of professional activities.[5 (p4)]

The ANA panel also spelled out its assumptions regarding continuing competence:

> 1. The purpose of ensuring continuing competence is the protection of the public and advancement of the profession through the professional development of nurses.
> 2. The public has a right to expect competence throughout nurses' careers.
> 3. Any process of competency assurance must be shaped and guided by the profession of nursing.
> 4. Assurance of continuing competence is the shared responsibility of the profession, regulatory bodies, organizations/workplaces, and individual nurses.
> 5. Nurses are individually responsible for maintaining continuing competence.
> 6. The employer's responsibility is to provide an environment conducive to competent practice.
> 7. Continuing competence is definable, measurable, and can be evaluated.
> 8. Competence is considered in the context of level of expertise, responsibility, and domains of practice.[5 (p4)]

The elements of purpose, responsibility, and approach are further explained below:

1. **Purpose**
    a. Why is continuing competence important?
    b. Who should be evaluated?
    c. How do you address continuing competence for individuals on different career paths?
2. **Responsibility**
    a. Who is responsible for ensuring continuing competence?
    b. Who should pay for ensuring continuing competence?
    c. What happens to individual professionals who do not meet continuing competence requirements?
3. **Approach**
    a. How do you evaluate and measure continuing competence effectively and feasibly?
    b. Should a variety of methods be used or is one particular approach preferable?
    c. What standard(s) should be used to evaluate continuing competence?
    d. How frequently should continuing competence be assessed?

The addition of the assumptions regarding continuing competence further clarifies the definition and promotes collaboration. Each of the definitions presented in this section "addresses a complex mix of academic learning, mental and physical acuity, the application of knowledge in clinical situations, and adherence to standards related to professional values, such as public health, ethics, or professional roles."[4(p12)]

Current Definitions From FSBPT and APTA

FSBPT

FSBPT recently adopted the following definitions of *continuing competence* and *competence.*[6] These definitions were generated in collaboration with APTA.

> *Competence* is the application of knowledge, skills, and behaviors required to function effectively, safely, ethically, and legally within the context of the individual's role and environment.
>
> *Continuing competence* is the lifelong process of maintaining and documenting competence through ongoing self-assessment, development, and implementation of a personal learning plan, and subsequent reassessment.

APTA

The APTA House of Delegates adopted the following position in 2007 delineating definitions and some key assumptions related to professional development and continuing competence:[7]

PROFESSIONAL DEVELOPMENT, LIFELONG LEARNING, AND CONTINUING COMPETENCE IN PHYSICAL THERAPY (**HOD P05-07-14-14).** Excerpts are provided below. (See the Appendix for the full position.)

> **Competence**: The possession and application of contemporary knowledge, skills, and abilities commensurate with an individual's (physical therapist or physical therapist assistant) role within the context of public health, welfare, and safety.

> **Continuing Competence**: The ongoing possession and application of contemporary knowledge, skills, and abilities commensurate with an individual's (physical therapist or physical therapist assistant) role within the context of public health, welfare, and safety and defined by a scope of practice and practice setting.

The Board of Directors of APTA provided the 2009 House of Delegates with a motion for adoption of the definitions developed this past year in collaboration with FSBPT. This motion, along with several other versions developed by APTA's delegates, was withdrawn with the understanding that APTA would seek additional collaboration and clarification with stakeholders.

Continuing competence is an increasingly important issue to all health care providers and the public they serve. Establishing common definitions and the delineation of working assumptions are the essential foundation for collaboration, appreciation of multiple perspectives, and a fuller description of the issues surrounding continuing competence.

Historical Perspective: Previous Definitions of Competence and Continuing Competence

FSBPT and APTA have collaborated on issues related to continuing competence for more than 10 years. In 1998, FSBPT, through its Task Force on Continuing Competence, generated several definitions: [8]

> **Competence:** The application of professional knowledge, skill and abilities which relate to performance objectives of an individual's (PT) role within the context of public health, welfare and safety (adapted from Parry, 1996).
>
> **Continued Competence:** The ongoing application of professional knowledge, skills and abilities which relate to the occupational performance objectives in a range of possible encounters that is defined by the individual scope of practice and practice setting.

In 2001, APTA's Board of Directors approved a publication, *Assessing Competence: A Resource Manual,* produced by a Task Force on Continued Clinical Competence. The manual included a glossary of working definitions "to ensure consistent assessment of that competence": [9]

> **Competence**: Possessing the requisite knowledge, abilities, and qualities to be a physical therapist.
>
> **Professional Development**: The ongoing acquisition, application, and evaluation of contemporary knowledge, skills, and abilities to meet or exceed performance standards based on the physical therapist's roles and responsibilities, within the context of public health, welfare, and safety.

Other Definitions in the Literature

The literature is rife with definitions of terms related to professional development and continuing competence. Below are examples from sources in health care.

Competence

- A competent physician is one who demonstrates the requisite knowledge, technical skills, judgment, and interpersonal and communication skills to provide safe, effective patient care within the scope of professional medical practice while engaging in ongoing, practice-based learning and improvement.[10(p17)]

- Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection on daily practice for the benefit of the individual and community being served.[11]

- The defining attributes of competency are the application of skills in all domains for the practice role, instruction that focuses on specific outcomes or competencies, allowance for increasing levels of competency, accountability of the learner, practice-based learning, self-assessment, and individualized learning experiences. The learning environment for competency assurance involves the learner in assessment and accountability, provides practice-based learning opportunities, and individualizes learning experiences.[12(p58)]

Continuing competence

- The American Occupational Therapy Association's (AOTA) *Standards for Continuing Competence*[13] define continuing competence as a process involving the examination of current competence and the development of capacity for the future. It is a component of ongoing professional development and lifelong learning. Continuing competence is a dynamic, multidimensional process in which the occupational therapist and occupational therapy assistant develop and maintain the knowledge, performance skills, interpersonal abilities, critical reasoning, and ethical reasoning skills necessary to perform current and future roles and responsibilities within the profession.

- Continuing competence is the ongoing ability of a registered nurse to integrate and apply the knowledge, skills, judgment, and personal attributes to practice safely and ethically in a designated role and setting. Personal attributes include but are not limited to attitudes, values and beliefs.[14]

Professional development and lifelong learning

- **Professional Development:** The ongoing self-assessment, acquisition, and application of knowledge, skills, and abilities that meet or exceed contemporary performance standards described by continued competence and are commensurate with an individual's (physical therapist or physical therapist assistant) role and responsibilities within the context of public health, welfare, and safety.[7]

- **Lifelong Learning:** The systematic maintenance and improvement of knowledge, skills, and abilities through one's professional career or working life. Lifelong learning is the ongoing process by which the quality and relevance of professional services are maintained.[7]

- Professional development is more consistent with evaluation on a continuous scale ranging from novice to expert. Professional development connotes a process of continuous improvement, lifelong learning, and growth, which allow professionals to improve their practice so as to better serve patients, clients, and organizations, the profession, and society.[15(p194)]

- The American Speech-Language-Hearing Association (ASHA) Clinical Certification Standards[16] define professional development as an instructional activity:
    - where the certificate holder is the learner;
    - that is related to the science or contemporary practice of speech-language pathology, audiology, or the speech/language/hearing sciences;

    - that results in the acquisition of new knowledge and skills, or the enhancement of current knowledge and skills necessary for independent practice in any practice setting and area of practice;
    - where the certificate holder is responsible for determining that the professional development activity is appropriate, relevant, and meaningful to any practice setting and area of practice; and
    - in which the certificate holder's attendance can be documented by a third party, such as an employer, educational institution, or sponsoring organization.

- The "process by which [professionals] acquire knowledge, skills and values which will improve the service they provide to clients … which can be used to embrace initial training, in-service training, and a variety of [workplace] experiences."[17(p17)]

Minimal competence

- Standard of Minimal Competence for the National Physical Therapy Exam - PT
  The minimal
    - knowledge,
    - judgment,
    - technical skills, and
    - interpersonal skills

  required to safely and effectively practice physical therapy, considering current best evidence from clinically relevant research regarding the safety and efficacy of therapeutic, rehabilitative, and preventive physical therapy services[18] (See Appendix C).

Summary of Defining Continuing Competence

In summary, there is significant overlap among the definitions of competence, continuing competence, professional development, and lifelong learning. Variations of these terms are used, further complicating the differentiation of their meanings. An important goal in defining common terms as recommended by the Citizen's Advocacy Center[1] would be to codify the standards and definitions of continuing competence and professional development. A common language shared within physical therapy and among all health care providers would greatly serve our ability to optimally address the issues surrounding continuing competence.

Part 3—Current Continuing Competence Models

This section presents an overview of the prevalent models for determining continuing competence currently in use by regulatory and certification bodies. Most regulated professions have had some requirement for re-licensure to ensure competence, and many certification bodies have long had requirements for recertification. While definitions of continuing competence have been variable among professions, models used for determining ongoing competence have historically been similar. By far the majority of professions have used continuing education requirements as the standard for re-licensure, allowing the completion of educational courses to suffice for continuing competence to practice.

Continuing Education

Dentistry, nursing, social work, architecture, and law are all examples of regulated professions that have relied on continuing education almost exclusively to fulfill continuing competence requirements. Models that use continuing education typically require a set number of continuing medical education (CME) credits or continuing education units (CEUs) for each re-licensure cycle. A CEU is a measure of the time involved in participation in a continuing education activity. At present, many professions use CEUs/CME to establish requirements for licensure renewal and have standards and mechanisms for approving continuing education activities and/or providers.

Continuing education and physical therapy

Physical therapy boards have been slow to add continuing education requirements for re-licensure and have only recently begun to consider expanding the concept to continuing competence requirements. In 1996, only 21 of the physical therapy licensing boards required continuing education.[19] Currently, 40 jurisdictions require continuing education or continuing competence units in some form. In addition, a few states require a specific number of hours of active practice. Most recently, a few jurisdictions, including California and North Carolina, have started accepting activities such as passage of a specialty exam or completion of a residency as evidence of meeting continuing competence requirements in addition to traditional continuing education courses.

Limitations of continuing education

The use of continuing education as the sole measure of continuing competence has come under increasing scrutiny over the last 20 years. In part, the scrutiny is a result of the significant limitations to using continuing education as the sole determinant of continuing competence. First, there is limited evidence in the literature that mandating continuing education ensures competence. Licensees may select continuing education based on the ease of meeting the requirement rather than on their specific competence needs. Second, a competency-based needs assessment is currently not required prior to the selection of a continuing education program. Third, most continuing education programs currently have limited, if any, ways to assess that individual learning has occurred or that the program made any difference in the individual's competence. The reports of the Pew Health Professions Commission often criticize continuing education as a determinant of competence, stating, "Continuing education requirements, however laudable, do not demand demonstration that a licensed professional is still competent to perform everything in his or her scope of practice anytime after initial licensing."[2(p19)]

Additional limitations are found within the mechanisms by which a continuing education program is approved. The standards used to approve a continuing education program are variable and sometimes ill-defined and/or difficult to measure. As a result, programs are assigned credit based on time rather than a determination of learning or competence gained. In this model, a 6-hour course is worth more credit than a 4-hour course, regardless of the learning outcomes.

Finally, most continuing education courses are not designed to be competency-based. They most often focus on increasing knowledge or application of knowledge, which are important for the health care provider to learn, but should not be equated to a change or improvement in hands-on clinical skills. The 2009 publication *Redesigning Continuing Education in the Health Professions*[20] illustrated a more comprehensive approach to continuing professional development and proposed a framework to develop a new, more effective system.

If continuing education has so many limitations, why is it so prevalent? The answer to this question is probably related to the fact that continuing education requirements are easy to administer, and approval of continuing education courses has been a revenue source for approving organizations. That said, continuing education can add value related to continuing competence. In fact, the Citizen's Advocacy Center [1(p iv)] also recommended reforming continuing education programs "to ensure that courses are evidence-based and require enrollees to demonstrate that the course has improved their knowledge base, skills, and/or practice management."

Examination

Probably the *next* most prevalent model for ensuring competence for re-licensure or recertification is examination. Since this tool is used by the majority of regulated professions to ensure entry-level competence, it is easy to understand why this model is also used for continuing competence. Examination effectively deals with the major limitation identified for continuing education—it truly provides the missing assessment component and can potentially identify the individual's knowledge, strengths, and weaknesses. If the assessment is designed well, it can even provide feedback within specific content areas in order to direct further competence development.

As with continuing education, examinations are relatively easy to administer. The physician assistant profession is an example of a group that uses examination for re-licensure. However, the group uses it in conjunction with continuing education, requiring both continuing education as well as the passage of a high-stakes examination. Other professions, such as medical specialties, also use examination for recertification.

Examination and physical therapy

Currently no jurisdictions require passage of an examination related to the practice of physical therapy for re-licensure of physical therapists. One jurisdiction requires all of its licensees to pass a jurisprudence examination on a one-time basis. A few additional jurisdictions require passage of a "take-home" or "open-book" jurisprudence exam for re-licensure. The American Board of Physical Therapy Specialties (ABPTS) requires either re-examination or completion of a portfolio for maintenance of specialty certification.

Limitations of examination

As with continuing education, examination as a form of ensuring competence has limitations. Probably the biggest limitation is the acceptance of this requirement by the individual professionals. The fear of failure on the part of the licensee or the certificate holder makes this model very unpopular. In particular, this fear relates to the consequences of the failure on one's licensure status, ability to practice, and ultimately one's livelihood. And, there is the embarrassment of "failing" that is also cited by licensees as a concern. The physician assistant profession has dealt with this issue by providing licensees with choices. In lieu of the high-stakes examination, the licensee may choose to take a Web-based multiple-choice examination from home. If the practitioner chooses this option, he or she must also obtain an additional number of units of continuing education or participate in other approved activities.

Another related limitation to using the examination model is the challenge a regulatory board has in dealing with failure. Does the board immediately revoke the license or require remediation? Can the licensee continue to practice while remediation is undertaken? It would be a challenge to argue that someone should continue to practice while remediating when an exam demonstrates a limitation in competence. Must the licensee discontinue practice until such time as he or she can pass the exam, which may take months? The difficulty addressing these questions has deterred licensing boards from using an examination model in the demonstration of continuing competence.

Finally, a knowledge-based examination may not be the best indicator of an individual's ability to perform safely and competently in a clinical situation. Some professions are attempting to deal with this limitation by creating scenario-based examinations or simulations. The cost of developing high-quality simulation examinations has made this option impractical. Using clinical skills examinations with patient actors is another approach that might deal with this limitation but, again, the cost of implementation makes this model impractical.

Self Assessment

Within the last 10 years, a unique model that promotes self-reflection has been used by various professions and has gained popularity. The self-assessment model is often called a *portfolio* and comprises a 5-step process. The first step requires the clinician to review past educational and clinical experiences. Based on this historical reference, the clinician then engages in a self-reflection process to identify strengths and weaknesses and, in particular, learning needs. Third, the professional identifies activities that can address these needs. The planning is followed by implementation and documentation and an evaluation of how well the plan met the individual's particular needs. The cycle is then repeated with the concept that continuing competence and professional development are ongoing, continuous processes.

The Commission on Dietetic Registration was one of the first groups to institute a version of self-assessment, called the Professional Development Portfolio (PDP). Other groups, such as the North Carolina Board of Nursing, have developed similar programs. In Canada, where continuing competence requirements are mandated by the federal government, many professions have developed self-assessment/portfolio models.

The popularity of the portfolio model is based on the ease of administration and the fact that it addresses the element of licensee fear posed by high-stakes examinations. It also includes an assessment component that continuing education alone does not provide.

Self assessment in physical therapy

No physical therapy licensing board currently uses a self-assessment/portfolio model. However, within the profession, the maintenance of portfolios has been identified as a component of professionalism. A number of entry-level physical therapy education programs require students to develop a portfolio and encourage them to maintain the portfolio throughout their careers. FSBPT developed and piloted a self-assessment/portfolio model but postponed its full implementation based on the need to develop a framework for continuing competence as well as some of the limitations described below.

Limitations of self assessment

Self-assessment/portfolio models require a fair amount of paperwork for both the licensee and anyone assessing or administering the activity. In an era in which clinicians are already faced with extensive documentation requirements related to patient care, additional paperwork requirements to document

continuing competence activities may be viewed negatively. Professions have attempted to deal with this limitation by creating online systems that minimize the paperwork burden.

Probably the biggest limitation of self-assessment models it that there is no evidence that practitioners are able to accurately self-assess. In fact, the literature strongly suggests that practitioners are not proficient at self-assessment:

> Extensive reviews of the literature reveal three consistent patterns. First, there is little or no relationship between actual performance or ability and self-rated performance or ability (correlations between objectively assessed performance and self-assessed performance usually lie in the 0.3 range). Second, the vast majority of individuals rate themselves to be above average in performance, with all but the highest performers overestimating their level of performance. Third, and perhaps most critical for this discussion, the worst offenders are those in the lowest quartile of performance, those most in need of remediation.[21]

The validity of self assessment is contingent on practitioners accurately self-assessing. It is particularly problematic that the lowest performers, the very group who may have competence issues, are the poorest self-evaluators.

Peer Assessment/Chart Review

Peer review is often suggested as the model for assessing continuing competence that bridges the gap between assessment of knowledge and the relevance to actual clinical practice. There are several forms of this model ranging from chart review to actual clinical site visit. The American Academy of Family Practice has used chart review along with continuing medical education requirements for the demonstration of continuing competence. The chart review aspect is called METRIC (Measuring, Evaluating and Translating Research Into Care). In this model, family practice physicians review 10 charts and enter specific pieces of data into an online system. They receive a report providing information about how they are performing compared with other practitioners with similar patients. The METRIC program then provides an opportunity to develop a plan for improvement and a follow-up chart review can be conducted to see if improvement has been demonstrated. The American Institute of Certified Public Accountants uses an actual site-visit model for accounting practices. However, this program is strictly optional. In Canada, several professions, including the Ontario pharmacy and physical therapy regulatory agencies, use peer review as a measure of continuing competence.

Peer assessment/chart review in physical therapy

There are no US jurisdictions that currently use this model for assessing continuing competence of licensees. Four jurisdictions require hours of active practice, which is an attempt to verify that the licensee is continuing to practice and therefore continuing to maintain skills and potentially experiencing some sort of peer review through engagement in the profession. These jurisdictions often define *practice* broadly to include teaching, research, and administration functions. The Minnesota Chapter of the American Physical Therapy Association currently provides peer-review services to clinicians and clinics that may want such an assessment. The Minnesota Board of Physical Therapy has used the chapter's services as a disciplinary requirement and is considering using peer review as part of its continuing competence program at some time in the future.

Peer review/chart review limitations

Chart review has the obvious limitation of being just that, a chart review. While outcomes can be assessed to some extent via chart review, there is no ability to measure competencies such as patient interaction, cultural competence, etc.

The biggest limitation of onsite peer review as well as chart review is the ability to administer such a program. In its fullest sense, it requires one-on-one visits and review using trained impartial reviewers. With a large number of licensees or certificants the administration process becomes infeasible. The American Academy of Family Practice has overcome this limitation by creating an online system that does not require one-on-one review. However, this system relies on the ability of the independent physician reviewer to interpret the results and assess the licensee's capabilities based on the results. Another limitation of any kind of peer review that relies on a pool of reviewers is interrater reliability. Ensuring that all raters are being uniform and accurate in their assessments is difficult at best.

Combination Model

The combination approach to a continuing competence model suggests that there is no one activity or model that ensures all aspects of continuing competence. Since each model has its strengths as well as its limitations, a multi-activity model providing a menu of options may get closer to truly assessing and ensuring continuing competence. As described previously, many professions have moved to a combination model and no longer require continuing education solely. The National Board of Certification in Occupational Therapy allows certified occupational therapists to meet standards using many different activities including, among other things, continuing education, publishing, presenting, fieldwork supervision, and mentorship. The American Board of Medical Specialties maintenance of certification program uses a 4-part framework that includes licensure, self-assessment and education, a secure knowledge-based examination, and an assessment of performance in practice. This assessment examines best practice as well as the quality of care compared with peers and national benchmarks.

Combination model in physical therapy

As mentioned previously, physical therapy regulators have been slow to implement continuing competence requirements for re-licensure. When a jurisdiction has implemented continuing competence requirements, it has more often than not implemented continuing education requirements. Even within the past year, several states that had no requirements previously have added continuing education requirements versus implementing continuing competence requirements that would allow for a combination approach. That being said, several states such as North Carolina, California, and Texas are moving toward the combination model.

Limitations of the combination model

While addressing many of the limitations of a single-activity model, the combination model also raises additional feasibility issues. With a variety of activities allowed, resources are required to monitor all of the activities including the approval process. It also can be fairly complex for the licensee or certificant as well as the organization that administers the program. Determining what is accepted and what is not and identifying the limitations of the accepted activities can be complex and cumbersome.

Best Practices in Continuing Competence Models

According to NOCA,[5] 3 traits of best practices emerge in the literature in continuing competence. Continuing competence should take (1) a multi-step approach that (2) uses a triangulation of tools in (3) an iterative process.

Multi-step approach

Four or 5 steps are typically identified as critical for ensuring continuing competence. While the actual number of steps and their descriptions may vary, they typically include the following elements:

assessment/planning, development, implementation, documentation/review, and reassessment. Swankin et al described this 5-step model as "most promising."[4(p19)]

Triangulation

Vandewater[22 (p1)] suggested "triangulation," a mix of various approaches to continuing competence. As suggested earlier in the overview of the various models, each model has limitations. The use of multiple tools, the model described as the combination model, addresses many of these limitations and allows for a mixed approach. This approach also addresses many of the various feasibility issues related to any one model used in isolation. The CAC, in its 2004 *Road Map for Continuing Competency Assurance*, supported a mixed model.[1]

Iterative process

NOCA[5] further proposed that because the pace of change in the world today is fast, professions must look beyond initial licensure, certification, and competence, and assess workers' abilities throughout their careers. Continuing competence is not something that occurs once every renewal cycle but should be ongoing and reflect a commitment to the consumer, the individual, and the profession.[23]

Roles Related to Continuing Competence

As with lack of agreement on definitions and an ideal model for continuing competence, there also has been lack of agreement on the responsibilities and roles related to continuing competence. Some have argued that inherent within the definition of a *professional* is the responsibility of the individual professional to maintain competence and, therefore, no additional requirements for licensure are needed. NOCA, [5] however, argued that reports such as the Institute of Medicine's (IOM) 1999 report, *To Err is Human: Building a Safer Health System*, [24] make it clear that other parties need to be involved. The work by Regehr and Eva[21] examining the ability of professionals to self-assess also supports the concept that professionals, by themselves, will not effectively ensure continuing competence.

There has been increasing demand for licensing boards to require continuing competence measures for re-licensure. The IOM's 1999 report[24] recommended that licensing boards should implement periodic reexamination and relicensing based on both competence and knowledge of safety practices. This was re-emphasized in the IOM's 2003 report, *Health Professions Education—A Bridge to Quality*: [25]

> Recommendation 4: All health professions' boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care—as defined by the five competencies identified by the committee—through direct measures of technical competence, patient assessment, evaluation of patient outcomes, and other evidence-based assessment methods.[25(p9)]

The Federation of State Medical Boards (FSMB) has adopted a "Maintenance of Licensure" policy that states, "State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking re-licensure."[10]

The FSMB, as well as the CAC, in conjunction with AARP, have separately conducted studies about consumer expectations related to licensing boards. These studies find that an overwhelming majority of the public believes that physicians should be reevaluated on a regular basis to ensure they are maintaining their competence.[1,10]

The CAC[1] posited that licensing boards are the only entities that have the ability, provided they have been given the authority by the legislature, to require continuing competence. The CAC goes on to

suggest that mandating continuing competence is the key to the implementation of a successful continuing competence program.

However, there also has been a recognition within the literature that many stakeholders need to be involved in the process of ensuring continuing competence, not only licensing boards. The CAC wrote that licensing boards should look to some of the certifying bodies and other groups to develop tools. The CAC went on to state that collaboration between stakeholders is essential and that "there is virtually universal agreement that no one stakeholder group can drive through a successful program on its own."[1(p7)]

According to the 2003 Institute of Medicine report:

> Ultimately, accreditation, certification and licensure are collectively but one leverage point for ensuring that health professionals maintain up-to-date skills and competencies. Educational institutions have an essential part to play in instilling a sense of importance of being a lifelong learner, and employers also have a major role in shaping the ongoing professional development of health professionals.[25(p113)]

While membership in professional associations is typically voluntary, these organizations play a key role in promoting professional development and lifelong learning and therefore play a key role in promoting continuing competence. Professional associations focus on their role to foster and advance their given profession for the good of the public it serves. APTA accomplishes its mission by:

1. describing the scope of practice of the profession;
2. establishing standards of safe and effective practice;
3. advocating for fair, reasonable, and consistent laws, regulations, and processes;
4. providing professional development offerings; and
5. providing tools that assist its professionals to assess their knowledge and skills based on the standards of practice, to manage their lifelong learning, and to critically evaluate their options and opportunities.

APTA state chapters play an active role in the formulation of and advocacy for continuing competence requirements. For example, chapters may advocate for continuing competence requirements that are comprehensive and ensure public protection, while at the same time are fair and not overly burdensome for licensees. Consistent with best practice, chapters can also strive to ensure that licensees are provided broad options from a variety of sources to meet their continuing competence requirements, rather than a specific and single requirement. Finally, chapters have a role in advocating for the appointment of physical therapists to state licensing boards that are well-informed and cognizant of the many issues related to continuing competence.

While there are both shared and unique interests in the roles of the various stakeholders, collaboration among the professional association, the regulatory bodies, employers, educational programs and accreditors, and others would be extremely powerful in moving continuing competence forward, as suggested by the CAC and the IOM.

Summary of Continuing Competence Models

A variety of continuing competence models are in practice, with continuing education the dominant model among regulated professions and within physical therapy. Groups external to the regulated professions with an interest in public protection and best practices, such as the CAC and NOCA, have

recommended that a multi-step approach be developed that involves ongoing assessment/planning, development, implementation, documentation/review, and reassessment over the course of a licensee's career, using a variety of methods for triangulation of the information generated. There are roles for numerous stakeholders in the continuing competence conversation, and collaboration among the stakeholders is recommended to create a system that can ensure provider competence and protect the public.

Part 4—Continuing Competence Issues for Discussion

1. Who is responsible for continuing competence? What are the roles of the various constituents in continuing competence? What is the purview of regulation regarding continuing competence?

A number of stakeholders identified in this paper have a vested interest in the continuing competence of physical therapists. These stakeholders and their potential interest and/or role in continuing competence are listed below.

Stakeholder	Interest/Role
Accrediting agencies (eg, JCAHO)	Improved health care quality
Employers	Competent employees; providing an environment that is conducive to competent practice and allows time to pursue continuing competence activities
Licensee	Demonstration to the public and profession a commitment to maintaining high standards of practice
Profession/professional association	Advancement of the profession
Providers of education and training (vendors)	Provision of high-quality offerings that further the competence of members of the profession
Public/consumer	The right to expect competence through the practitioner's career ("up-to-date knowledge and skills" from the AARP [2007] study in Virginia)
Regulators/licensing boards	Public protection

It is important and worthwhile for the various stakeholder groups to recognize the multiple interests and roles of the other stakeholders and to generate buy-in around those interests and roles. Further, those who develop definitions, assumptions, and models of continuing competence should seek to understand and meet the needs of the various stakeholders: "Clearly, a stronger system will result if all stakeholders are willing to participate in the development and implementation of mechanisms for competency assessment and demonstration."[4(p6)]

2. In what portion of the scope of practice should a licensee be responsible for maintaining competence? What is in a licensing board's authority to regulate? In what part of the scope of practice should a licensing board require demonstration of continuing competence? Is there a set of knowledge, skills, and abilities that represent contemporary practice that all physical therapists should be able to demonstrate?

In order to answer the first question regarding the portion of an individual's scope of practice included in continuing competence, there must be agreement on both the definition of continuing competence and the roles of the stakeholders involved. Discussion of the scope of continuing competence may lead to clarity about the definitions and roles. The second question, the authority of a licensing board to regulate the practice of an occupation, is fundamental to this discussion. There may be a perception that a board's authority is limited to the regulation of minimal entry-level practice versus the entire scope of a profession. This perception may stem from the fact that requirements for entry into a profession are typically very clear and licensing boards have historically focused on assuring that incompetent practitioners do not enter the profession. A board's authority to regulate physical therapy comes from the legislature as recorded through the practice act. None of the physical therapy practice acts restrict the authority of the board to the regulation of minimal entry-level practice. For example, the Arizona

Physical Therapy Practice Act, in describing the powers and duties of the board, states that the Board shall "regulate the practice of physical therapy by interpreting and enforcing this chapter."[26(p3)]

Similarly, the Oregon licensing board states:

> The Physical Therapist Licensing Board was created in 1971 to regulate the practice of physical therapy in Oregon. The Board's purpose is public protection and to establish professional standards of practice which assure that physical therapists and physical therapist assistants are properly educated, hold valid/current licenses, practice within their scope of practice and continue to receive ongoing training throughout their careers.[27]

Through the licensure process, a licensee is responsible to the board for the services and care that he or she provides, whether advanced skills or entry-level skills are performed. Several states have additional requirements and standards for licensees who perform, what the jurisdiction considers, advanced practice skills that pose particular potential for harm to the public. For example, in California, to perform needle electromyography (EMG), a skill that most would consider "advanced practice," physical therapists are required to maintain board certification, demonstrating the authority the California Board of Physical Therapy has to regulate this advanced practice skill.

Swankin et al[4] maintained that the use of voluntary continuing competence or professional development programs is not sufficient as they do not impact all members of a profession, among other things. They argued that a mandate for continuing competence is required and that the mandate would best be enforced by state licensing boards, the only stakeholder that has legal authority over all members of a profession and the only stakeholder with the power to remove the privilege to practice. The authority of licensing boards comes from the state legislature and is delineated in the practice act. While a licensing board's purpose is to protect the public from incompetent practitioners, such protection is not intended to create unnecessary barriers to access by consumers.

If boards, therefore, have the authority to regulate the entire practice of physical therapy, what portion of the scope of practice should they include to assure continuing competence? If state licensing boards require continuing competence, which some do, what exactly would or should they require? And, is there a common set of knowledge, skills and abilities consistent with contemporary practice that all physical therapists should be able to demonstrate as a part of continuing competence? Four possible options (and there may be others) are shown below.

Figure 1. Introduction to Diagrams

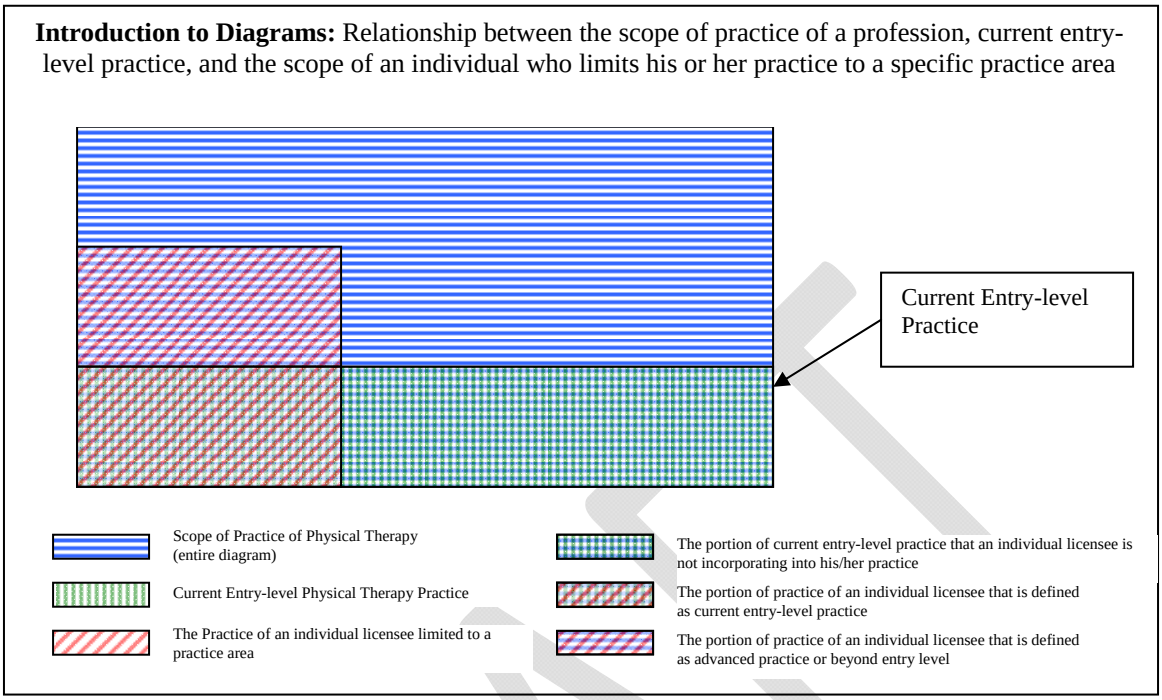


Figure 2. All of Entry-level Practice

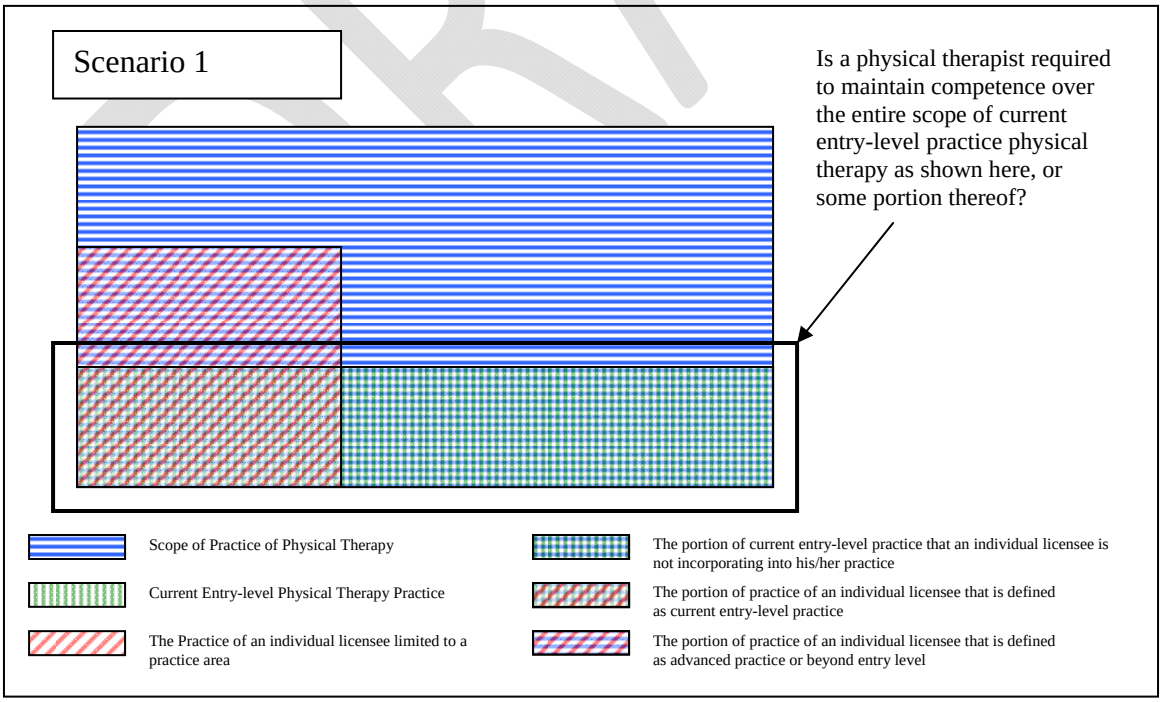


Figure 3. Entry Level Within Individual Scope of Practice

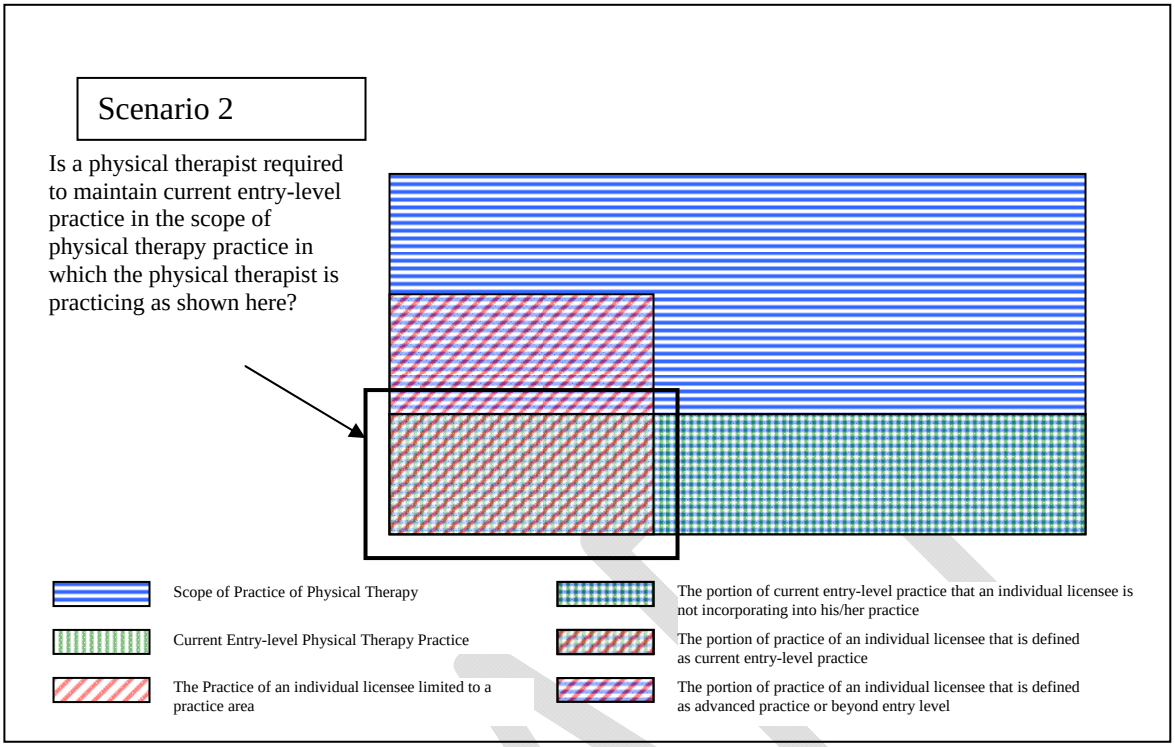


Figure 4. Individual Scope of Practice

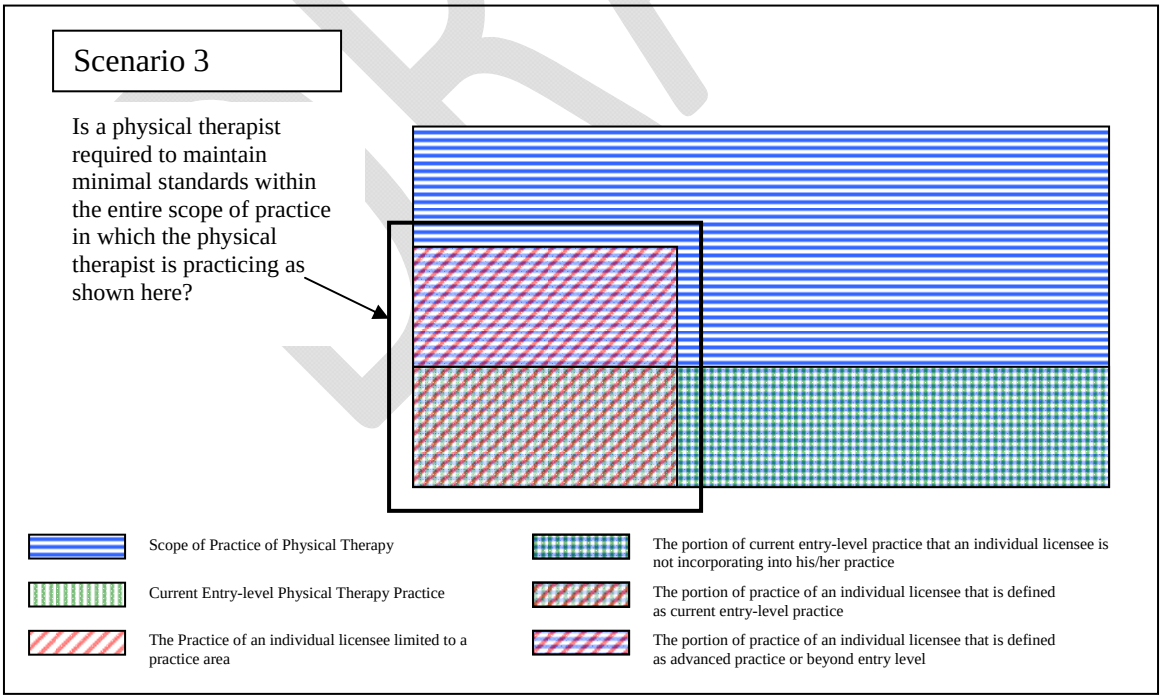
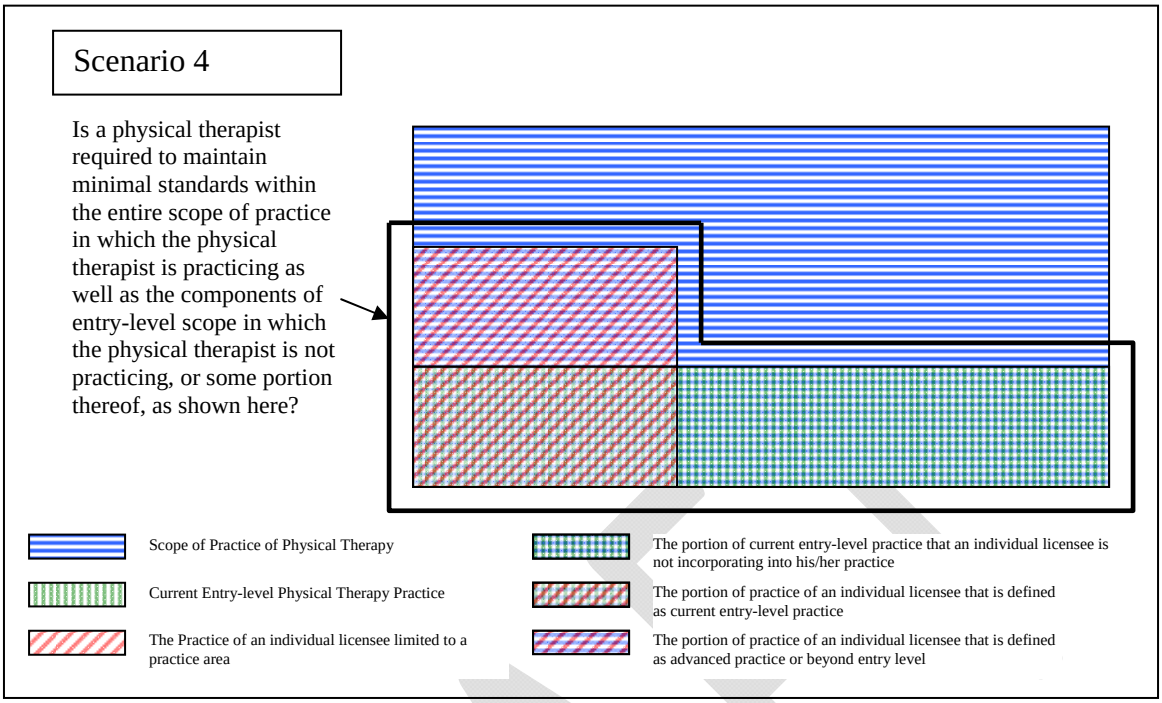


Figure 5. Individual Scope of Practice and Entire Entry-level Scope



Little information exists in the literature to assist in the determination of the scope of continuing competence. The FSMB[10] suggested that requiring physicians to maintain competence in the general undifferentiated practice of medicine (GUMP) (the green checkered pattern in the diagrams, also identified by the area below the line indicating entry-level practice in Figure 1) may have a low level of relevance to patient care, since physician practice narrows over time. As a result, if remediation is required in the GUMP, it may not result in improved practice. FSMB further claimed that tailoring continuing competence "to reflect at least in part what the physician does in his or her practice will be perceived by the physician as more relevant and credible than a GUMP-level assessment."[10(p11)] Further, Swankin et al[4] indicated that there is growing consensus that assessment of continuing competence should include *current* practice and cognitive knowledge and clinical skills. Thus, there is some support for focusing continuing competence on the current practice of the licensee (Scenarios 2 and 3 above, Figures 3 and 4). The question of whether continuing competence should be limited to the minimal skills in the practice of the licensee (the lower left rectangle in the scenarios) or to all of the licensee's skills, seems less certain.

Regarding the question of whether there is a common set of knowledge, skills, and abilities consistent with contemporary practice that all physical therapists should be able to demonstrate as a part of continuing competence, there is information from other health professions and organizations that may provide guidance.

The Institute of Medicine has indicated that educators and accreditation, licensing and certification organizations should ensure that students and working professionals develop and maintain proficiency in 5 core areas:

- delivering patient-centered care,
- working as part of interdisciplinary teams,

- practicing evidence-based medicine,
- focusing on quality improvement and
- using information technology.[20]

In 2003, the organizations for physician assistant certification, accreditation, and education, and physician assistant membership organizations collaborated in the development of a list of core competencies that "all physician assistants regardless of specialty or setting are expected to acquire and maintain throughout their careers":[28(p1)]

- Medical knowledge
- Interpersonal and communication skills
- Patient care
- Professionalism
- Practice-based learning and improvement
- Systems-based practice
- As well as an unwavering commitment to continual learning, professional growth, and the physician-PA team.

For physical therapists, does a core set of knowledge, skills, and abilities (KSAs) exist that all physical therapists apply regardless of practice setting or area of practice? And, should all physical therapists be required to demonstrate this set of KSAs as a part of continuing competence? This core set of KSAs might include such things as:

- Foundational sciences that provide the framework for the knowledge within the profession.
- Components of screening that every physical therapist who encounters a patient should be able to perform in order to identify signs and symptoms that would indicate a patient should be referred on or is appropriate to be treated.
- Professionalism, cultural competence, and communication skills.

Developing a set of KSAs is consistent with the FSMB recommendation above "to reflect at least in part what the physician does in his or her practice."[10(p11)]

A review of several jurisdiction practice acts, regulations, and policies related to continuing competence may help address how some jurisdictions view the questions related to scope of continuing competence. At this point, only 8 jurisdictions have continuing competence requirements. The rest either require continuing education or have no requirement.

North Carolina defines continuing competence as "the licensee's ongoing activities to augment knowledge, skills, behaviors, and abilities related to the practice of physical therapy."[29(p1)]

Texas, as of this writing, is proposing a regulation defining continuing competence as: "the lifelong process of maintaining and documenting competence through ongoing self-assessment, development and implementation of a personal learning plan, and subsequent reassessment."[30(p21)]

Arizona states that the board shall "establish the mechanisms for assessing continuing professional competence of physical therapists to engage in the practice of physical therapy and the competence of physical therapist assistants to work in the field of physical therapy."[26(p3)]

The Georgia Physical Therapy Board has defined, in policy, the requirements for continuing competence as "planned learning experiences which have content beyond the licensee's present level of knowledge and competence which may be subject to audit by the board. Content of the experience must relate to patient care in physical therapy whether the subject is research, treatment, documentation, education, management, or some other content area. The purpose of this requirement is to assist in assuring safe and effective practices in the provision of physical therapy services to the citizens of Georgia."[31(p8)]

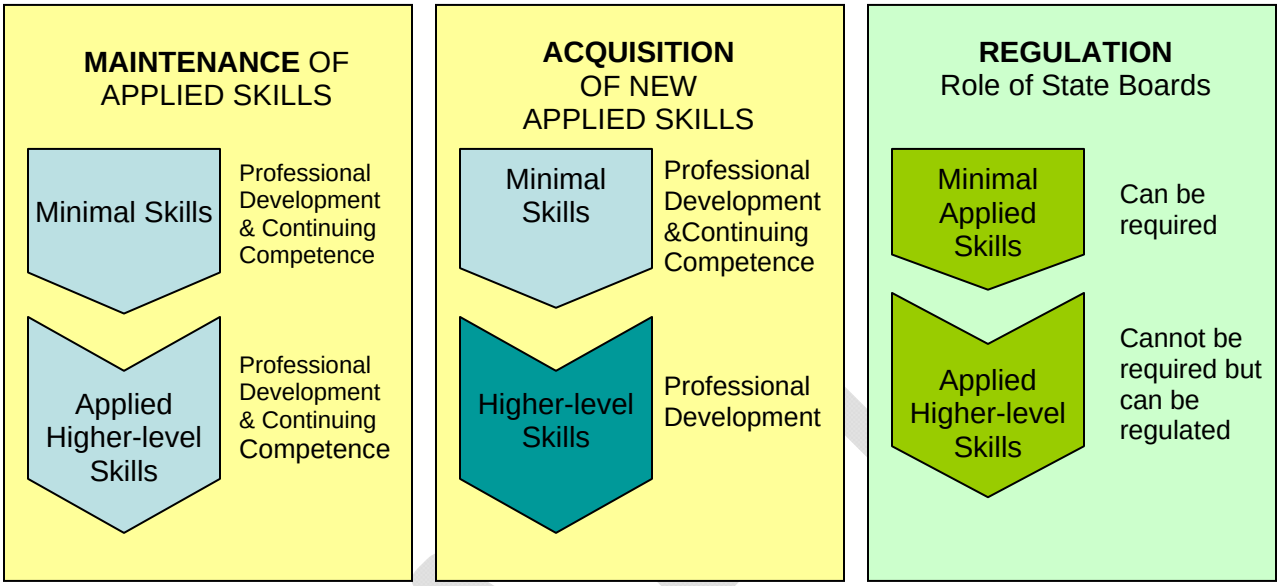
Kentucky defines continuing competence in statute in 201 KAR 22:045, Section 1: "'Continued competency' means a planned learning experience relating to the scope of physical therapy practice, whether the subject is intervention, examination, research, documentation, education, or management of health care delivery systems."[32(p10)]

Each of the jurisdictions identified above uses language that addresses an ongoing process of learning related to the scope of physical therapy practice.

The following diagram presents a model that may be helpful in discussing the various scenarios and differentiating between professional development and continuing competence. This diagram suggests that professional development is both the acquisition and maintenance of entry level and advanced knowledge and skills. It suggests that the scope of continuing competence is a subset of professional development and includes the maintenance of all applied skills including current entry-level and higher-level skills, as well as the acquisition of applied current minimal skills. The diagram further suggests that the acquisition of applied higher-level skills is not continuing competence, but remains solely within the purview of professional development.

Consistent with the discussion earlier in this section, the column on the right side of the diagram labeled "Regulation: Role of State Boards" suggests that a board has the authority to regulate the entire scope of physical therapist practice, including advanced practice, and has a responsibility to ensure safe, competent practice of the advanced skill. However, the board cannot require the licensee to become competent in advanced skills that he or she is not applying. A licensing board can require a licensee to have minimal entry-level applied skills within his or her practice; however, a board cannot require the licensee to acquire advanced practice skills.

Figure 6. Model Depicting the Relationship Between Continuing Competence and Professional Development



1. Does continuing competence relate to ensuring safe practice, effective practice, or both? If it includes effective practice, what is the minimal bar for effectiveness?

Entry-level practice is defined as the level of practice assessed on the National Physical Therapy Examination (NPTE). The current minimal level of practice for the purpose of creating the NPTE is based on the results of a practice analysis conducted at least every 5 years. For purposes of assessing continuing competence, all licensees are held to the current minimal standard, regardless of what the standard was when the licensee entered the profession.

As indicated above in issue #1 in this section, the role of regulation is to ensure *public protection*, which is further defined as safe and effective practice. In terms of its inclusion in continuing competence, the term "safe" is typically not questioned, as safety is clearly a public protection issue and should be guaranteed and assessed as a part of continuing competence. The issue of "effectiveness" is not as clear cut and raises questions. What is effective practice? How is effective practice measured? What is the minimal bar for effectiveness? Should the word "effectiveness" or "effective" be included in a definition of continuing competence? The ANA Expert Panel on Continuing Competence definition and assumptions included in the second section of this paper do not include the word "effective"—possibly on purpose to avoid the issues raised by it.[5(p4)] The definition includes the wording "and in the context of a set of expected outcomes as defined by nursing scope (of) practice, policy, Code for Nurses, standards, guidelines, and benchmarks that assure safe performance of professional activities," in fact skirting the issue of effectiveness. The National Board for Certification in Occupational Therapy includes the phrase "safe and effective" in its definition of continuing competence.[23(p2)] The FSMB states "A competent physician is one who demonstrates the requisite knowledge, technical skills, judgment, and interpersonal and communication skills to provide safe, effective patient care within the scope of professional medical practice…"[10(p17)] In a document from the Council on Licensure, Enforcement and Regulation, Schmitt and Shimberg[33] stated that:

Regulation is intended to:

- Ensure that the public is protected from unscrupulous, incompetent, and unethical practitioners;
- Offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner; and
- Provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses.

> The lack of any systematic procedure for assuring that licensees have kept abreast of technical or research developments and can still provide quality services to the public has led to demands for board instituted programs to monitor the competency of those licensed.[33(p1)]

Another way to consider the term "effective" is in relation to quality of care, as Swankin et al[4] suggested. The motivation for requiring continuing competence includes ensuring patient safety and improving the quality of care.[4] Substituting "quality care" for "effectiveness," however, does not answer the question of how much quality or how effective is the domain of continuing competence. If the outcomes of treatment are in a general positive direction, is that effective or quality care? If the treatment plan is formulated and delivered using evidence-based practice, is that effective or quality care? If the patient/client fails to improve, is that considered lack of effectiveness or quality? If the licensee engages in a process of clinical decision-making and/or applies clinical guidelines when they exist, is that effective practice? Given the lack of guidance in the literature from other health professions, the default "do no harm" measuring stick may apply in this instance and *any* positive outcome or the application of a sound, contemporary process may be the best measuring sticks to indicate that effective care was delivered.

Even though the terms "effective" and "quality care" are not defined, they are commonly used in physical therapy state practice acts. Below is a sample of state laws containing these terms.

Arizona 32-2043. Supervision; patient care management

> H. For each patient on each date of service, a physical therapist must provide and document all of the therapeutic intervention that requires the expertise of a physical therapist and must determine the use of physical therapist assistants and other assistive personnel to ensure the delivery of care that is safe, effective and efficient. Documentation for each date of service must be as prescribed by the board by rule.[26(p10-11)]

North Dakota

> 4. For each patient on each date of service, a physical therapist shall provide all of the therapeutic intervention that requires the expertise of a physical therapist and shall determine the use of physical therapist assistants or physical therapy aides that provide for the delivery of care that is safe, effective, and efficient.[34 (p6)]

Massachusetts

> Physical therapists must exercise their professional judgment when determining the number of supportive personnel they can safely and effectively supervise to ensure that quality care is provided at all times.[35]

New Hampshire

> For each date of service, a physical therapist shall provide all therapeutic interventions that require the expertise of a physical therapist and shall determine the use of assistive personnel that provides delivery of service that is safe, effective, and efficient for each patient.[36]

4. What are the economic and legal implications of implementing continuing competence requirements?

There are costs associated with ensuring continuing competence, yet, as NOCA[5] argued, there are also costs associated with *not* ensuring continuing competence, the difference being the specific stakeholder or stakeholders who bear the cost. Swankin et al[4] categorized the costs in 2 ways: the costs to the health care professional to assess, maintain, and demonstrate his or her competence over the course of his or her career; and the cost to the licensing boards to establish and administer continuing competence requirements. If the licensure boards fund the development of rules and regulations and the monitoring of compliance through licensure fees, then both categories of costs will be borne by the licensee. The CAC[1] and AARP[4] recommended that the licensee should bear the costs of assessing and demonstrating his or her competence. Historically, most of the cost of professional development in physical therapy has been borne by the individual or by employers. FSBPT and APTA both have made significant investments in assessment tools and education to maintain competence and develop individuals professionally.

Several legal implications should be considered related to continuing competence. First, methods used to demonstrate continuing competence should be legally defensible. Second, public protection and the promotion of public health and safety are the legal basis for licensing boards' ability to ensure the competence of their licensees, and assurance of competence fits under the board's licensing role rather than its disciplinary role. As a result, licensing boards have the right to restrict the ability to practice if a licensee fails to demonstrate minimal competence. However, different from the disciplinary function, the details of competence demonstration are not revealed to the public and are confidential between the licensee and the board. The public does have the right to know whether or not a licensee is competent (eg, through publication of a list of licensees, for example), but not the related details.[4]

5. What are stakeholders' fears and concerns about continuing competence requirements?

Stakeholder	Fears/Concerns
Employer	• Burdensome systems and methods to demonstrate competence • The time and cost required of employees to engage in continuing competence activities
Licensee	• Taking a test and failing • The competence of other providers

	• Burdensome and/or expensive procedures to fulfill re-licensure requirements
Profession/professional Association	• Creation of valid, reliable, and legally defensible tools to assess and gain competence • Licensing boards limiting or dictating the methodology required to demonstrate competence • The definitions of "minimal" and "safe and effective"
Providers of education and training (vendors)	• The time and resources required to demonstrate that education and training meet established standards to satisfy continuing competence requirements
Public/consumer	• The competence of all licensees and requirements for them to periodically demonstrate competence
Regulators/licensing boards	• Failure to protect the public • Onerous and expensive systems to assess competence that are difficult to administer

Overall Conclusion

It is clear that continuing competence is a complex topic that includes many issues and involves multiple stakeholders. It is, therefore, not surprising that many definitions of the same terms exist. While there is no one universally accepted definition of continuing competence, many of the definitions used by various organizations include common elements. These common elements provide an opportunity for collaboration among professions and stakeholders to develop common definitions as recommended by the Citizen's Advocacy Center.[1] However, definitions alone often leave unanswered questions, and it is helpful also to identify common assumptions and models to address the elements of purpose, responsibility, and approach to continuing competence.

Historically, most professions have used continuing education as the sole indicator of a practitioner's continuing competence. However, continuing education used alone has come under increasing criticism due to lack of evidence that it indeed ensures competence. The literature is beginning to identify some best practices for continuing competence models including a multi-step approach that uses a triangulation of tools and an iterative process.

Determining how best to move forward to define and describe a model for physical therapy requires input and ongoing discussion from the multiple stakeholders. In addition, opportunities exist to collaborate interprofessionally, given that other health care professions are actively engaged in this discussion, and conceptually the issues are similar.

Some of the issues that warrant further discussion among professions and professionals include:

1. Who is responsible for continuing competence?
2. What is the scope of continuing competence?
3. Does continuing competence relate to ensuring safe practice, effective practice, or both?
4. What are the economic and legal implications of implementing continuing competence requirements and what are stakeholders' fears and concerns and how can they be addressed?

5. What are the next steps in moving the discussion of continuing competence within a profession and among professions forward?

Given the lack of evidence that currently exists, the profession would be best served by applying the evidence that currently exists, encouraging and supporting research to create additional evidence, educating stakeholders about current practices, and promoting discussion around the issues identified in this paper.

Staff Authors

Janet Bezner, PT, PhD, deputy executive director, APTA
Marilyn Phillips, PT, MS, CAE, director of professional development, APTA
Mark Lane, PT, vice president, FSBPT
Susan Layton, vice president, FSBPT

References

1. Citizen Advocacy Center. *Maintaining and Improving Health Professional Competence: The Citizen Advocacy Center Road Map to Continuing Competency Assurance*. Washington, DC: Citizen Advocacy Center; April 2004. http://www.cacenter.org/files/MaintainingImprovingCompetence.pdf. Accessed February 8, 2010.

2. Pew Health Professions Commission. *Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century*. San Francisco, CA: Pew Health Professions Commission, Center for the Health Professions, Univ of California, San Francisco; 1995.

3. Woelfel Research Inc, Stowell-Ritter A; for AARP. *Strategies to Improve Health Care Quality in Virginia: Survey of Residents Age 50+.* Washington, DC: AARP; 2007. http://assets.aarp.org/rgcenter/health/va_care_07.pdf. Accessed February 8, 2010.

4. Swankin D (Citizen Advocacy Center), LeBuhn RA (Citizen Advocacy Center), Morrison R; for AARP. *Implementing Continuing Competency Requirements for Health Care Practitioners.* Washington, DC: AARP; 2006. http://assets.aarp.org/rgcenter/health/2006_16_competency.pdf. Accessed February 8, 2010.

5. Henderson JP. *Practices and Requirements for Renewal Programs in Professional Licensure and Certification*. Washington, DC: National Organization for Competency Assurance; 2009.

6. Federation of State Boards of Physical Therapy, FSBPT Continuing Competence Model. https://www.fsbpt.org/ForCandidatesAndLicensees/ContinuingCompetence/Model. Accessed February 15, 2010.

7. American Physical Therapy Association. Professional Development, Lifelong Learning, and Continuing Competence in Physical Therapy. (HOD P05-07-14-14). http://www.apta.org/AM/TemplateRedirect.cfm?template=/CM/ContentDisplay.cfm&ContentID=63994. Accessed February 12, 2010.

8. Lane M (Federation of State Boards of Physical Therapy), The Continuing Competence Initiative, 2006. https://www.fsbpt.org/ForCandidatesAndLicensees/ContinuingCompetence/ContinuingCompetenceInitiative/. Accessed February 15, 2010.

9. American Physical Therapy Association. *Assessing Competence: A Resource Manual.* Alexandria, VA: American Physical Therapy Association; 2001.

10. Federation of State Medical Boards Special Committee on Maintenance of Licensure. *Draft Report on Maintenance of Licensure*. Dallas, TX: Federation of State Medical Boards; February 2008. http://www.fsmb.org/pdf/Special_Committee_MOL_Draft_Report_February2008.pdf. Accessed February 8, 2010.

11. Quality management framework [online brochure]. Toronto, Ontario, Canada: College of Physiotherapists of Ontario; November 2007. http://www.collegept.org/LiteratureRetrieve.aspx?ID=25279. Accessed February 8, 2010.

12. Tilley S. Competency in nursing: a concept analysis. *J Contin Educ Nurs*. 2008;39(2):58-64.

13. American Occupational Therapy Association. AOTA fact sheet: continuing competence in the OT profession. Report of the President to the Representative Assembly. http://www.aota.org/Practitioners/Advocacy/State/Resources/ContComp/36433.aspx. March 2006. Accessed February 8, 2010.

14. SRNA Continuing Competence Program: Frequently Asked Questions. Saskatchewan Registered Nurses' Association (SRNA) Web site. http://www.srna.org/images/stories/pdfs/registration/ccp_faq.pdf. Accessed February 5, 2010.

15. Swisher LL, Page CG. *Professionalism in Physical Therapy. History, Practice, and Development*. St Louis, MO: Elsevier; 2005.

16. 2005 Standards and Implementation Procedures for the Certificate of Clinical Competence in Speech-Language Pathology. American Speech-Language-Hearing Association Web site. http://www.asha.org/certification/slp_standards.htm#Std_VIIImpl. Rev 2009. Accessed February 8, 2009.

17. Hoyle E, John P. *Professional Knowledge and Professional Practice*. London: Cassel; 2005.

18. Pitoniak MJ. *Technical Report on the Standard Setting Process for the National Physical Therapy Examination—Physical Therapist Exam*. Alexandra, VA: Federation of State Boards of Physical Therapy; 2007.

19. American Physical Therapy Association. *State Licensure Reference Guide*. Alexandria, VA: American Physical Therapy Association; 1996.

20. Committee on Planning a Continuing Health Professional Education Institute; Institute of Medicine. *Redesigning Continuing Education in the Health Professions.* Washington, DC: National Academies Press; 2009.

21. Regehr G, Eva K. Self-assessment, self-direction, and the self-regulating professional. *Clin Orthop Relat Res*. 2006;229:34-38.

22. Vandewater DA. *Best Practices in Competence Assessment of Health Professionals. Background Policy Paper*. Halifax, Nova Scotia, Canada: College of Registered Nurses of Nova Scotia; March 2004. http://www.crnns.ca/documents/competenceassessmentpaper2004.pdf. Accessed February 8, 2010.

23. Byrne M, Waters L; for the CCI Think Tank. *Continued Competence Leadership Forum: From Pieces to Policy*. *Post-event White Paper*. Denver, CO: Competency & Credentialing Institute; 2008. http://www.cc-institute.org/docs_upload/TT07_white_paper.pdf. Accessed February 8, 2010.

24. Kohn LT, Corrigan JM, Donaldson MS, eds; for the Committee on Quality of Health Care in America, Institute of Medicine. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academies Press; 2000.

25. Greiner AC, Knebel E, eds; for Committee on the Health Professions Education Summit. *Health Professions Education: A Bridge to Quality*. Washington, DC: National Academies Press; 2003.

26. AZ Rev. Stat. Title 32, Chapter 19. Board of Physical Therapy. Arizona State Board of Physical Therapy Web site. http://www.ptboard.az.gov/public/ptays/docs/T32C19-040825.pdf. Accessed February 12, 2010.

27. Oregon Physical Therapist Licensing Board Web site. http://www.ptboard.state.or.us/. Accessed February 8, 2010.

28. Competencies for the Physician Assistant Profession. National Commission on Certification of Physician Assistants Web site. http://www.nccpa.net/pdfs/Definition%20of%20PA%20Competencies%203.5%20for%20Publication.pdf. Accessed February 12, 2010.

29. 21 NCAC 48G .0100. Licensure Renewal; Continuing Competence. http://www.ncptboard.org/documents/continuingcompetence/ADOPTED%20-%2021%20NCAC%2048G%20%20CONT%20COMP%20RULES%20COMBINED.pdf. Accessed February 11, 2010.

30. Texas Board of Physical Therapy Examiners Board Meeting [minutes]. August 21, 2009:21. http://www.ecptote.state.tx.us/_private/PTBoard0809.pdf. Accessed February 12, 2010.

31. Georgia State Board of Physical Therapy Board Policies. Policy #7—Continuing Competence Policy. Approved October 31, 2007. Reaffirmed January 2009. http://sos.georgia.gov/plb/pt/pt%20Board%20Policies.pdf. Accessed February 11, 2010.

32. Kentucky Board of Physical Therapy Laws and Regulations. August 1, 2009. http://pt.ky.gov/NR/rdonlyres/FD10A39B-1EDC-4933-A307-C8F845CBF19D/0/kypracact.pdf. Accessed February 12, 2010.

33. Schmitt K, Shimberg B. *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask*. Lexington, KY: Council on Licensure, Enforcement and Regulation; 1996.

34. North Dakota Board of Physical Therapy Practice Act. Grafton, ND: North Dakota Board of Physical Therapy. Page 6. https://secure.ndbpt.org/www/pdf/NDpractice_act.pdf. Accessed February 15, 2010.

35. 259 CMR 5.00: Physical Therapists. http://www.mass.gov/?pageID=ocaterminal&L=6&L0=Home&L1=Licensee&L2=Division+of+Professional+Licensure+Boards&L3=Board+of+Registration+in+Allied+Health+Professionals&L4=Statutes+and+Regulations&L5=Rules+and+Regulations+Governing+Allied+Health+Professionals&sid=Eoca&b=terminalcontent&f=dpl_boards_ah_cmr_259cmr500&csid=Eoca#5.02. Accessed February 11, 2010.

36. N.H. Rev. Stat. § 328-A:11. http://www.gencourt.state.nh.us/rsa/html/XXX/328-A/328-A-11.htm. Accessed February 11, 2010.

Appendix

PROFESSIONAL DEVELOPMENT, LIFELONG LEARNING, AND CONTINUED COMPETENCE IN PHYSICAL THERAPY HOD P05-07-14-14

The American Physical Therapy Association (APTA) supports the concepts of continued competence, lifelong learning, and ongoing professional development as identified in APTA Vision Statement for Physical Therapy 2020 (Vision 2020), the Standards of Practice for Physical Therapy, and the Code of Ethics.

KEY ASSUMPTIONS

Physical therapists recognize their responsibility toward professional development and lifelong learning based on the following key assumptions:

- Physical therapists are health care professionals who are obligated to engage in lifelong learning and are ultimately responsible for meeting or exceeding contemporary performance standards within their area(s) of practice
- Physical therapist practice:
  - Encompasses the six elements of Vision 2020: autonomous practitioner, direct access, doctor of physical therapy, evidence-based-practice, practitioner of choice, and professionalism
  - Includes practicing autonomously in all settings regardless of practice environment or business arrangements
  - Is based on the seven core values of professionalism: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility
  - Is defined by the Guide to Physical Therapist Practice, the Standards of Practice for Physical Therapy, and the Code of Ethics
- Continued competence is a component of professional development that addresses the minimum requirements of contemporary practice

Physical therapists are obligated to participate in professional development:

- To ensure continued competence through the acquisition and maintenance of minimally acceptable standards of practice
- To strive toward the achievement of advanced knowledge, skills, and abilities for excellence in practice
- To support and advance the profession

Physical therapist assistants are health care providers, working under the direction and supervision of the physical therapist, who are obligated to engage in lifelong learning and are responsible for meeting and exceeding contemporary performance standards within their scope of work.

Physical therapist assistants are obligated to:

- Self-assess current levels of competence and areas of growth and development
- Strive toward the achievement of advanced knowledge, skills and abilities for excellence within their scope of work
- Support and advance the profession

DEFINITIONS

Competence: The possession and application of contemporary knowledge, skills, and abilities commensurate with an individual's (physical therapist or physical therapist assistant) role within the context of public health, welfare, and safety.

Continued Competence: The ongoing possession and application of contemporary knowledge, skills, and abilities commensurate with an individual's (physical therapist or physical therapist assistant) role within the context of public health, welfare, and safety and defined by a scope of practice and practice setting.

Lifelong Learning: The systematic maintenance and improvement of knowledge, skills, and abilities through one's professional career or working life. Lifelong learning is the ongoing process by which the quality and relevance of professional services are maintained.

Professional Development: The ongoing self-assessment, acquisition, and application of knowledge, skills, and abilities that meet or exceed contemporary performance standards described by continued competence and are commensurate with an individual's (physical therapist or physical therapist assistant) role and responsibilities within the context of public health, welfare, and safety.

DESCRIPTION OF PROFESSIONAL DEVELOPMENT

Professional development encompasses the entire scope of one's career beginning with professional education and continuing through one's professional life span. Professional development is an ongoing process of assessment and planned actions that provide the opportunity for:

- Maintaining and expanding knowledge and skills based on evidence
- Self-reflection about and facilitation of professional core values
- Autonomous practice within the context of one's practice setting
- Creating, anticipating, and actively responding to changes in an evolving health care system
- Induction into new responsibilities

- Acquisition of contemporary clinical and practice management knowledge, skills, and abilities

Professional development should include the use of a wide variety of methods for attaining new knowledge, skills, and abilities including participation in continuing education courses, academic courses, independent study, journal clubs, Association committees, advocacy events and training, volunteer experiences, 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. A variety of methods, settings, and types of experiences should be employed to best meet the acquisition of new knowledge, skills, and abilities.

ROLE OF THE ASSOCIATION

The Association has the responsibility to interpret the concepts and scope of physical therapist practice in a manner consistent with APTA's positions, standards, guidelines, policies, and procedures. Further, the Association has a responsibility to develop or encourage the development of policies, products, and services that address the current and future needs of members, the organization, and the profession in relation to career and professional development.