
Build Your Competency Map

The AT Residency Program Director's Next Step

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INTRODUCTION

You Finished the First Guide. Now What?

If you read *Where Do I Start?*, you walked away with a mental model of the five foundations every AT residency program needs before you touch a form. At the very end of that guide, I told you something specific: if you have your foundations and you're ready to build, the next thing you should do is build your competency map.

This guide is about exactly that. What a competency map actually is, why it matters more than most people realize, and how to build one, step by step, regardless of your specialty area.

I've seen program directors skip this step. They jump straight to scheduling clinical rotations or drafting didactic curriculum items. It's usually around six months later they start rearranging everything because they built a program without a spine. The competency map is the spine. Everything else, your rotations, your assessments, your didactic plan, connects to it.

If you haven't read the first guide, that's fine. This one stands on its own. But the two are meant to work together, foundations first, then structure.

SECTION ONE

What Is a Competency Map?

A competency map is a structured document that identifies every clinical competency your residents are expected to achieve by the time they complete the program. **THEN** connect each competency to the experiences, instruction, and assessments that will get them there.

Think of it like a trail map. You know where the trailhead is, that's your resident walking in the door on day one. You know where the summit is, that's a clinician who's ready for autonomous, specialized practice. The competency map shows every path between those two points. It tells you which skills the resident will develop, where they'll develop them, how you'll know they've developed them, and what happens if they haven't.

Without a competency map, you're essentially telling a resident: "Hike this mountain. I'm sure there's a trail somewhere." You might both get to the top, but you won't be able to explain to anyone, **including the CAATE**, how you got there.

What a Competency Map Is Not

It is not a syllabus. It is not a rotation schedule. It is not a checklist of skills your resident needs to perform once and sign off on. A competency map is a living framework that ties everything in your program together. The syllabus, the schedule, and the checklists all emerge from it, not the other way around.

This is the mistake I mentioned in the first guide: building the curriculum before the clinical model. Your competency map prevents that mistake because it forces you to answer the right questions in the right order.

PAUSE AND REFLECT

→ *If someone asked you right now, "What will your residents be able to do when they finish your program?"*

Could you answer in specific, measurable terms?

SECTION TWO

Why It Matters More Than You Think

The competency map does three things for you simultaneously, and understanding all three is what separates program directors who are building something sustainable from those who are assembling parts and hoping they fit.

It gives your program direction.

Every decision you make as a program director, which clinical sites to use, which preceptors to invest in, what didactic content to teach, when to assess, all should trace back to a competency. If you can't connect an activity to a competency, you have to ask yourself why it's in the program. The map keeps you honest.

It makes accreditation manageable.

CAATE doesn't just want to see that your residents rotated through a clinic for twelve weeks. They want to see what competencies that rotation was designed to develop, how you assessed whether the resident achieved them, and what you did when they didn't. The competency map organizes all of that information in one place. When it's time for your self-study, you're not reconstructing, you're reporting.

It protects your residents.

A clear competency map tells your residents exactly what's expected of them. It removes the ambiguity that breeds anxiety. Your residents should never be guessing at what "good" looks like. The map defines it. And when a resident is struggling, the map shows you exactly where to focus your support, not a vague sense that "they're behind," but a specific competency that needs attention.

PAUSE AND REFLECT

→ *Think about a resident who struggled in your program (or one you've observed). Could you point to a specific competency gap, or was it more of a feeling?*

→ *If it was a feeling, what would it take to turn that into something measurable?*

SECTION THREE

The Four Layers of a Competency Map

A competency map has four layers. Each one answers a different question, and together they form the complete picture of how your program turns a licensed AT into a specialized clinician.

01 Competency Domains

These are the broad categories of clinical practice your residency is designed to develop. Think of them as the major trail systems on your map. Your specialty area and the CAATE Standards will guide these, but they should also reflect the clinical reality of your program. For example, a program might define domains like patient evaluation, clinical intervention, diagnostic imaging interpretation, interprofessional collaboration, and evidence-based practice. The exact domains depend on your program's focus and your clinical environment.

02 Specific Competencies

Within each domain, identify the specific competencies a resident must achieve. These need to be observable and measurable, not aspirational statements, but concrete skills and knowledge. "Demonstrate proficiency in performing a comprehensive shoulder evaluation" is a competency. "Understand shoulder pathology" is not. The difference matters because you're going to assess these. If you can't watch someone do it or evaluate their work product, it's not specific enough.

03 Learning Experiences

For each competency, map where and how the resident will develop it. This is where your clinical sites, didactic curriculum, and mentorship model come in. A single competency might be addressed across multiple experiences: a clinical rotation, a case-based discussion, an independent literature review, and direct preceptor observation. The key is intentionality. Every experience in your program should connect to at least one competency. If it doesn't, question whether it belongs.

04 Assessment Methods

For each competency, define how you'll know the resident has achieved it. This is the layer most programs build last when really, it should be built alongside everything else. Assessments can be direct observation, practical examinations, case presentations, portfolio submissions, preceptor evaluations, patient encounters, case logs, or standardized assessments. The best programs use multiple methods for each competency because a single snapshot rarely tells the whole story.

"The competency map is not a document you create once and file away. It's a living framework that evolves as your program learns what works."

SECTION FOUR

How to Build It: A Step-by-Step Process

You don't need special software to start this. A whiteboard, a spreadsheet, or a blank document will work. What you need is the discipline to go through these steps in order and resist the urge to skip ahead.

Step 1: Start with the End

Describe the clinician your program is designed to produce. Not in generic terms, specifically. What can this person do on day one of independent, specialized practice that they couldn't do when they walked in? Write it down. Be honest about what your clinical environment can actually develop, not what sounds good on a website. This description becomes your North Star. Everything in your competency map should point toward it.

Step 2: Define Your Domains

Using your end-state description and the CAATE Standards as guides, identify the broad domains of clinical practice your program will address. Most programs land on four to eight domains. Fewer than that and you're probably too broad. More than that and you're likely splitting hairs. Each domain should represent a distinct category of professional competence.

Step 3: List the Competencies Within Each Domain

This is where the real work happens. For each domain, write out every specific competency your resident needs to achieve. Use action verbs: perform, interpret, apply, demonstrate, analyze, communicate. Avoid verbs that hide behind vagueness: understand, appreciate, be aware of. Each competency should be something you can observe, measure, or evaluate through a work product.

A helpful test: if you handed this list to a preceptor and said "tell me if the resident can do this," could they answer clearly? If the answer is "it depends on what you mean," the competency needs to be sharper.

Step 4: Map Competencies to Learning Experiences

Take each competency and identify where in your program the resident will have the opportunity to develop it. Walk through your clinical rotations, your didactic sessions, your mentorship touchpoints, and your independent learning requirements. Some competencies will map cleanly to a single rotation. Others will span the entire program. That's fine and expected. The goal is to ensure that no competency is on an island by itself. If a competency doesn't have a corresponding learning experience, either create one or question whether the competency belongs in your program.

Step 5: Assign Assessment Methods

For each competency, decide how you'll evaluate whether the resident has achieved it. Be specific about the method, the timing, and the standard. "Preceptor evaluates resident's shoulder examination using a structured rubric during the upper extremity rotation" is an assessment plan. "We'll evaluate them at some point" is not. Build in multiple assessment touchpoints where you can. A resident who demonstrates competency in month three and is never assessed again is a documentation risk for accreditation and a development risk for the resident.

Step 6: Look for Gaps

When your map is drafted, read it as an outsider. Are there competencies with no clear learning experience? Are there rotations that don't connect to any competency? Are there assessment methods that only capture a single moment in time? If there are, understand that these gaps are not failures, they're the whole point of doing this exercise before you start building. Find the gaps now, not when a site visitor asks about them.

PAUSE AND REFLECT

- *Which of these steps feels most natural to you? Which one feels like it will take the most time?*
- *Who on your team could help with Step 3?*

Your preceptors know what competencies matter in practice, bring them in early.

SECTION FIVE

The Mistakes I've Seen in Competency Mapping

These are patterns I've watched play out across programs. None of them are fatal. All of them are fixable but they're a lot easier to prevent than to repair after the fact.

01 Writing competencies that sound good but can't be measured

If a competency includes the word "understand" or "appreciate," pause. Those words describe internal states that you can't observe. Rewrite them as observable behaviors. "Understand hip anatomy" becomes "identify and describe relevant hip anatomy during patient evaluation." The shift is subtle but it changes everything downstream, especially when you get to assessment. Keep this objective!

02 Making the map too granular too early

There's a temptation to list every possible sub-skill within a domain. Resist it. Start with the competencies that represent meaningful milestones. You can always add specificity later as your program matures. A map with 200 micro-competencies will overwhelm your preceptors, your residents, and you.

03 Building the map alone

Your preceptors need to be part of this process. They're the ones who will be teaching to these competencies and assessing whether residents achieve them. If they don't have input into what the competencies are, they won't have ownership of them. And ownership is what turns a document into a culture.

04 Treating it as a one-time project

The first version of your competency map will not be perfect. That's by design. A good map gets revised after your first cohort completes the program, after preceptor feedback comes in, after you realize a rotation doesn't develop what you thought it would. Continuous quality improvement isn't just a CAATE requirement, it's how programs actually get better.

05 Disconnecting competencies from assessment

A competency without an assessment method is a hope, not a standard. If you can't tell an accreditor exactly how you know whether a resident achieved a given competency, that competency is unfinished. Map the assessment at the same time you map the competency.

SECTION SIX

What to Do This Week

Same as last time, I want to leave you with something you can actually act on. Not someday. This week.

If you haven't defined your competency domains yet:

Open the CAATE Standards. Read them through the lens of your clinical environment. As you read, start a list of the broad categories of practice your residents will need to develop. Don't worry about getting them perfect, just get them started. Four to eight domains. Write them on a whiteboard if that helps. Just get them out of your head and into a place where someone else can react to them.

If you have domains but no specific competencies:

Pick your strongest domain, the one you know best clinically, and list every competency a resident should achieve within it. Use action verbs. Be specific enough that a preceptor could assess it. Then take that list to one of your preceptors and ask: "Does this match what you see in practice? What's missing?" That conversation will teach you more than another week of solo drafting.

If you have competencies but they're not connected to anything:

Build the connections. Take your competency list and, for each one, write down where the resident will develop it and how you'll assess it. If you hit a competency that has no clear home, no rotation, no didactic session, no mentorship touchpoint, time to flag it. That's a gap. And gaps found now are gifts, not problems.

"Progress, even slow progress, is progress. The program directors who build something lasting are the ones who took the time to map the trail before they started hiking."

◆ BUILT FOR THIS EXACT STEP

Cairns: Competency Mapping That Connects to Everything

Cairns was designed around the competency map as the central structure of a residency program. Define your domains and competencies, and Cairns automatically connects them to clinical rotations, assessment schedules, preceptor assignments, and accreditation standards. When a competency is underdeveloped or unassessed, you see it immediately, not six months later during self-study prep. One framework. Everything connected.

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The competency map is the spine of your program. Build it with intention, revise it with humility, and share it with your team. Everything else connects to it.

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