AUSTRALIAN COLLEGE OF PHYSIOTHERAPISTS

Pathway to ACP Recognition of Milestone 4 (Expert) Practice Handbook

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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

AUSTRALIAN COLLEGE OF PHYSIOTHERAPISTS

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Glossary

Term	Definition
Candidate	A Titled Physiotherapist undertaking or submitting a role portfolio through Component 1.
Component 1	The first stage of the ACP Clinical Specialisation pathway. Component 1 involves successful completion of the four Milestone 4 role portfolios, enabling titled physiotherapists to demonstrate and gain recognition for Expert-level practice. Satisfactory completion is a prerequisite to apply for Component 2 of the Specialisation pathway.
Cultural responsiveness	Capacity to respond effectively to the healthcare needs of diverse communities.
Evidence artifact	A document, record, or other supporting material submitted to substantiate the evidence presented. Evidence artifacts provide verification of the candidate's claims and may include items such peer review reports, presentations, publications, project outputs, meeting records, certificates, supervisor attestations, or other relevant supporting documentation.
Evidence	Information provided by a candidate to demonstrate achievement of the Milestone 4 (expert) standard of practice and portfolio requirements. Satisfactory evidence describes the breadth and depth of the candidate's professional practice, contributions and impact, explaining how it demonstrates achievement of the relevant role Intended Learning Outcomes (ILOs) at Milestone 4 levels.
Milestone 4	The highest level of practice described within the APA's roles-based career pathway, representing expert-level physiotherapy practice. It includes demonstrating advanced knowledge and skills within your area of practice, influencing others through leadership, education, research and advocacy, managing complexity, and contributing to improvements in healthcare services, systems and outcomes.
Performance Standard	The expected level of performance that must be demonstrated through portfolio evidence to achieve a satisfactory outcome.
Physiotherapy Competence Framework	The APA's Physiotherapy Competence Framework (PCF) Version 7.1 describes the knowledge, skills, behaviours, and performance expectations associated with seven roles of the physiotherapist at four progressive Milestone (M) levels – M1 Foundation, M2 Intermediate, M3 Highly Developed Titled Physiotherapist, M4 Expert Specialist.
Professional Development	Learning activities undertaken to develop or maintain knowledge, skills, behaviours, and expertise relevant to practice.
Recognition	Formal acknowledgement by the ACP that a physiotherapist has demonstrated the required standard of performance within a Role Portfolio.
Reflective Practice	The process of critically examining experiences, decisions, actions, and outcomes to support learning and ongoing professional development.
Reflexivity	An ongoing process of examining how one's own values, assumptions, experiences, and position may influence understanding, decision-making, interactions, and professional practice.
Role Portfolio	A structured collection of evidence demonstrating performance within one of the professional roles at Milestone 4 level Competence framework

Section 1: Introduction

Milestone 4 represents the highest level of physiotherapy practice within the Australian Physiotherapy Association's (APA) Competence Framework (v7.1) and career pathway. The Australian College of Physiotherapists' (ACP) supports titled physiotherapists to develop, demonstrate and gain recognition for this level of practice through its Milestone 4 Recognition Program and Specialist Pathway.

Milestone 4 reflects expert physiotherapy practice. It includes demonstrating advanced knowledge and skills within your area of practice, influencing others through leadership, education, research and advocacy, managing complexity, and contributing to improvements in healthcare services, systems and outcomes.

The ACP Milestone 4 Role Portfolios enable titled physiotherapists to develop, demonstrate, and gain recognition for expert-level practice for four roles of the seven roles described in the APA's Competence Framework (V7.1). The four selected Specialist Physiotherapist roles relevant to a portfolio submission are:

- Collaborator
- Leader
- Health Advocate and
- Scholar.

This handbook guides titled physiotherapists through the process of successfully completing Role Portfolios in each of these four roles, resulting in ACP Professional Certificate(s) of Milestone 4 recognition in the role(s). Successful completion of all four Role Portfolios constitutes Component 1 of the Specialisation Training Program (STP) and is one of the prerequisites for applying to Component 2 of the Specialisation Training pathway.

Where do I start?

- Review Clause 5.1 from section 5. Policy requirements to ensure that you meet the eligibility requirements.
- Review the Milestone 4 (Expert) expectations, as described in the APA Physiotherapy Competence Framework.
- Read Section 3: Intended Learning Outcomes for the Four Roles to select the role(s) you wish to pursue for a Milestone 4 recognition.
- Familiarise yourself with portfolio requirements and assessment criteria described in

- Section 4: Role Portfolio Requirements and sections 7-10 for the requirements for specific role portfolios.
- Curate high-quality evidence demonstrating your practice and impact. Section 2: What is a Portfolio? provides useful information on how to develop a high-quality portfolio.
- Identify gaps and engage with relevant activities to evidence Milestone 4 practice across all role-specific ILOs, drawing upon

- Section 11 Further information and resources (Optional as needed.
- Curate and submit your portfolio. See Section 5: Role Portfolio Submission and Assessment
- for procedural guidelines and Section 6: Relevant Policies.

Pathway to ACP Recognition of Milestone 4 (Expert) Practice

Titled Physiotherapists who satisfactorily complete one or more Role Portfolio will be formally recognised by the ACP through the award of a Professional Certificate at Milestone 4 (named role/s). Each portfolio will be assessed for:

- Quality of evidence (description of evidence and evidence artifacts) and
- Justification of how the evidence meets the relevant Milestone 4 competencies.

Satisfactory completion of Component 1 (all four Role Portfolios) is one of the essential prerequisites for entry into Component 2 of the STP.

What do I need to submit?

For each Role Portfolio, you are required to submit:

- Cover letter
- Current curriculum vitae (CV)
- Role Portfolio and supporting evidence
- Referee verification statement
- Candidate declaration

For further details, see Portfolio requirements in

Section 4:

How is my Role Portfolio assessed?

To achieve a satisfactory outcome:

- Every role-specific Intended Learning Outcome (ILO) must be assessed as **Clearly Met** or **Sufficiently Met**.
- A rating of **Partially Met** or **Not Yet Met** for any ILO will result in an unsatisfactory portfolio outcome.
- All mandatory requirements, including culturally responsive practice report, must be satisfactorily completed.

Further information regarding assessment processes, outcomes and resubmission is provided in Section 5: .

Purpose of the Role Portfolios

Role Portfolios can be used for both professional development and as a formal entry requirement for specialisation training. Titled Physiotherapists can further develop, demonstrate and gain recognition for expert-level competencies in areas that are relevant to their practice and career aspirations on completion of Milestone 3 (Titling).

This model is designed to support titled physiotherapists at different stages of professional growth. Some titled physiotherapists may already be consistently practising at an expert level and have strong evidence of this expertise in one or more of the four roles (Collaborator, Leader, Health Advocate and Scholar), while others may be early in extending and consolidating the competencies recently achieved at Milestone 3. The flexible structure allows candidates to complete and submit Role Portfolios individually or together, enabling them to progress at a pace that reflects their professional and personal priorities and circumstances.

The ILOs for each portfolio provide a practical framework to guide learning and professional development, helping physiotherapists identify, curate, integrate and provide evidence on the competencies expected of expert practice. The portfolio therefore serves both as a tool for learning and professional development and as a means of demonstrating achievement of Milestone 4 (Expert) competencies through peer review.

In summary the Role Portfolios offer:

1. **Choice:** Physiotherapists can engage with one or more roles according to their interests, opportunities and career stage. Completion of an individual Role Portfolio is a valuable professional development achievement, providing recognition of expert level of competency within that role and supporting progression along the APA career pathway. Additional role portfolios may be completed over time as career aspirations and opportunities evolve.

- **Professional Development**: The portfolio process supports physiotherapists to reflect on their practice, identify areas for further development, invest in this learning and build evidence of reaching the competency standard expected. Each role portfolio is aligned with the APA Physiotherapy Competence Framework (v7.1) and provides a structured way to develop and evidence expert practice.

- **Recognition**: Portfolios will be assessed by physiotherapists who are operating at Milestone Level 4 (expert) level, and satisfactory completion of each Role Portfolio will be formally recognised with a Professional Certificate at Milestone 4 (named role) by the ACP. This provides independent validation of expert capability within the role and acknowledges a significant achievement along the APA's physiotherapy career pathway.
- **Progression:** Satisfactory completion of the four portfolios is a prerequisite to apply for Component 2 of Clinical Specialisation. The pathway supports physiotherapists aspiring to specialist practice by offering a clear route to specialisation, while recognising and valuing achievement at every stage of the journey.

As a Titled Physiotherapist, you are encouraged to engage with the Portfolios following completion of Titling. While building on your Milestone 3 clinical practice competencies, you can also engage with the Role Portfolios. For some, this may involve preparing a portfolio to demonstrate existing expert-level practice. For others, the portfolio may serve as a developmental tool to support reflection, identify competency gaps. It may also guide progression towards expert practice through formal learning (such as coursework or professional development training) and self-directed learning applied to clinical practice. Even for those who consider themselves ready for assessment, the process of compiling a portfolio often reveals opportunities for further growth and refinement.

Section 2: What is a Portfolio?

A portfolio is a purposeful curation of evidence that demonstrates your knowledge, skills, experience, and professional development over time. It is much more than a folder of documents. A portfolio tells the story of your professional practice and provides evidence that you are operating at the competencies required for a particular stage of training.

For the Specialisation Training Program (STP), the portfolio provides applicants with an opportunity to demonstrate their capability against the Milestone 4 Intended Learning Outcomes (ILOs), and their related competencies, relevant to specific roles. Rather than relying solely on qualifications, years of experience, or a single assessment, a portfolio allows applicants to showcase evidence from their real-world practice and explain how that evidence demonstrates achievement of the ILOs and competence.

A portfolio is a curated exhibition rather than a storage room. Rather than uploading every piece of evidence you have, make deliberate decisions about which evidence best demonstrates your competence. Through thoughtful selection, organisation and justification of evidence, you create a compelling picture of how your practice meets the required standard.

Why Does the ACP Require the Submission of a Portfolio?

Portfolios are widely used across health professions, including medicine, nursing, allied health, pathology, pharmacy, and specialist training programs. They have become an important assessment method because healthcare professionals work in different contexts and develop competence through a combination of knowledge, practical experience, reflective practice, professional behaviours, and ongoing learning.

Healthcare work is complex and cannot always be assessed adequately through theory and clinical examinations alone. A portfolio enables candidates to demonstrate:

- Knowledge applied in practice
- Clinical and professional judgement
- Leadership and teamwork
- Quality improvement activities
- Communication skills
- Professional development and lifelong learning
- Contribution to patient-centred care and service improvement
- Impact of their work on patients, communities and health services

Portfolios are particularly valuable because they assess performance in authentic workplace settings. They allow candidates to demonstrate not only what they know, but how they apply their knowledge and skills in everyday professional practice.

Another important feature of portfolio assessment is that it encourages reflective practice. Healthcare professionals are expected to continually evaluate their work, identify areas for improvement, and engage in ongoing learning. A well-constructed portfolio demonstrates this professional maturity.

Why Does Curation of a Portfolio Matter?

One of the most common misconceptions is that a strong portfolio is simply a large portfolio. In reality the opposite is often true.

The value of a portfolio lies in the curation of quality evidence, not the quantity of evidence.

Curating evidence involves:

- Selecting the most relevant examples and artifacts
- Demonstrating how each piece of evidence relates to an ILO/competency
- Providing context for the assessor
- Explaining why the evidence is significant
- Showing the depth and quality of your practice

A portfolio should make it easy for the assessor to understand:

1. Which ILO/competency is being addressed
2. What evidence is being presented
3. Why the evidence demonstrates competence

A small number of well-chosen examples and appropriate artifacts, accompanied by clear explanations (justifications), is usually far more persuasive than a large collection of loosely related material.

Every item included in the portfolio should have a purpose.

Using Reflection to Curate Portfolio Evidence

When selecting evidence for a portfolio, reflection should help answer the following questions:

1. Why is this evidence significant?
2. Which competency does it demonstrate?
3. What impact did it have?
4. What did I learn from the experience?
5. How has it changed my practice?
6. What future development has emerged from this learning?

By connecting evidence to critical reflection, the portfolio becomes a narrative of professional growth rather than a repository of accomplishments.

What Does a High-quality Portfolio Look Like?

A high-quality portfolio is curated, focused, organised and evidence-based.

1. It Demonstrates Quality Rather Than Quantity Alone

A good portfolio prioritises strong evidence over extensive evidence.

For example:

- One substantial quality improvement project with a clear explanation of your role may provide stronger evidence than ten certificates from unrelated workshops.

- Two or three well-described leadership activities may demonstrate an ILO more effectively than multiple attendance records at Leadership PD courses.

2. It Provides Context

Assessors often have no prior knowledge of your workplace, role, or projects.

Good portfolios therefore explain:

- The situation or context
- Your specific role
- The actions you took
- The outcomes achieved
- The lessons learned

Without context, even excellent evidence may be difficult to interpret.

3. It Includes Justification

A strong portfolio not only presents evidence but also explains why the evidence demonstrates competence.

For example:

Instead of writing: Attached is a presentation delivered to departmental staff.

A stronger approach would be:

This presentation was developed and delivered to a multidisciplinary audience of 35 staff members. It required synthesis of complex clinical information, stakeholder engagement, and facilitation of discussion. This evidence demonstrates… .

The explanation helps assessors connect the evidence directly to the ILO.

4. It Demonstrates Reflection

Strong portfolios show insight and professional growth.

Reflection may include:

- Challenges encountered
- Lessons learned
- Improvements made
- Future development goals

Reflection demonstrates that learning has occurred and that professional development is ongoing.

What Does a Poor Portfolio Look Like?

Poor portfolios often contain a large amount of information but provide little insight into the candidate's competence.

One useful analogy is the "Shopping Trolley" Portfolio.

This is a portfolio where a lot of information is dropped into a portfolio, without curation and justification. For examples, some portfolios may contain:

- Large numbers of certificates
- Unrelated documents
- Excessive supporting material
- Duplicated evidence
- Minimal explanation

Without purposeful selection and justification of evidence, the responsibility for determining relevance falls largely to the assessor.
This approach creates two problems:

1. Important evidence can become lost amongst less relevant material.
2. The portfolio demonstrates limited professional judgement in selecting and presenting evidence.

A portfolio should not be a repository of everything you have done during your career. It should be a carefully selected collection of evidence that demonstrates that you are consistently operating at a required level of practice.

In conclusion, a successful portfolio is not measured by the number of pages submitted. It is measured by how convincingly it demonstrates that you have met the ILOs/competencies. The strongest portfolios are selective, organised, and purposeful. They provide high-quality evidence, clearly explained relevance, and helps the assessors understand how the applicant is currently operating at the required level of practice.

Section 3: Intended Learning Outcomes for the Four Roles

The Intended Learning Outcomes (ILOs) for each Milestone 4 Role Portfolio were developed using principles of constructive alignment and authentic assessment. The ILOs integrate the Key Competencies, Enabling Competencies and Milestone 4 descriptors of the APA Competence Framework (v7.1) into assessable outcomes that reflect expert professional practice. The ILOs are designed to focus on demonstrable performance, impact, professional judgement, leadership, and sustained achievement over time. They support candidates to present authentic evidence from diverse practice settings while enabling assessors to evaluate achievement of the competencies required for expert-level physiotherapy practice and progression towards specialist recognition.

Collaborator

On successful completion of the **Collaborator Role Portfolio** the candidate will be able to:

1. Lead and optimise interprofessional collaboration to address complex clinical challenges and improve client outcomes.
2. Build and sustain effective collaborative relationships through expert consultation, negotiation, shared decision making and conflict resolution.
3. Lead and optimise referral, delegation and transitions of care for complex presentations to support safe, coordinated management.
4. Develop collaborative capability in others through mentoring, role modelling and facilitation of effective collaborative practice.

Leader

On successful completion of the **Leader Role Portfolio** the candidate will be able to:

1. Lead improvements in quality of care and client safety through the strategic use of health informatics, technology and service-delivery data.
2. Optimise resource stewardship and cost-effective service delivery through the application of evidence, evaluation of service utilisation patterns, and implementation of models of care that enhance client outcomes and system sustainability.
3. Demonstrate leadership that enables complex organisational, system and practice-level change through enhancing team performance, mentoring others to develop leadership capability, and reflecting on the impact of personal leadership.
4. Lead service improvement and sustainable change through developing and communicating a clear vision, using evidence and data to evaluate outcomes, and disseminating learnings to support continuous improvement.

Health Advocate

On successful completion of the **Health Advocate Role Portfolio** the candidate will be able to:

1. Lead and model effective advocacy with and for clients with complex needs to address determinants of health and facilitate timely access to appropriate health services and resources.

2. Lead and model strategies that enable clients with complex needs to adopt healthy behaviours, including influencing organisations to create supportive opportunities and environments for behaviour change.
3. Lead illness and injury prevention, health promotion and health surveillance activities through continuous quality improvement that strengthens practice and health outcomes.
4. Partner with groups, communities and populations to identify health needs and determinants, and lead advocacy for organisational, system and policy change through service design that improves health outcomes.

Scholar

On successful completion of the **Scholar Role Portfolio** the candidate will be able to:

1. Model lifelong learning and continuous professional development through reflective practice, performance evaluation and mentorship that strengthens individual and collective practice.
2. Provide educational leadership through teaching, supervision and evaluation that promotes learner development, client safety and positive learning cultures.
3. Lead evidence-informed practice through the critical appraisal, integration and application of evidence to improve decision-making and professional practice.
4. Advance scholarly inquiry and knowledge translation through ethical research, dissemination of findings and engagement with stakeholders to inform practice, education and policy.

Section 4: Role Portfolio Requirements

A portfolio is a curated collection of evidence, supporting evidence artifacts, and justification that demonstrates achievement of the Milestone 4 (Expert) standard within a role. Portfolios are assessed not only on what you have done, but also on how your practice has influenced others, managed complexity, and contributed to outcomes for clients, teams, services, organisations, or health systems.

For each Intended Learning Outcome (ILO), the candidate needs to:

1. Select evidence from professional practice that demonstrates the relevant ILO and associated key and enabling competencies.

2. Describe the context, role, and contribution, particularly where the situation involved complexity, multiple stakeholders, leadership, collaboration, or system-level considerations.

3. Provide evidence artifacts that support and verify the claims. Evidence artifacts may include documents such as reports, publications, presentation abstracts, project outputs, meeting records, performance data, attestations, or other materials from professional practice.

4. Justify why the evidence represents Milestone 4 performance, making explicit links to the ILOs and relevant competency descriptors.

There is no expectation that evidence will come from a single type of activity. Suitable evidence may include clinical work, service development projects, leadership activities, quality improvement initiatives, education or mentoring activities, committee work, stakeholder engagement, or other professional contributions.

A portfolio that meets the required standard demonstrates:

- **Alignment:** the evidence is clearly related to the relevant ILO and demonstrates Milestone 4 (Expert) performance and complexity in clinical, organisational or system contexts.
- **Authenticity**: the evidence is drawn from the candidate's practice.
- **Verification:** Appropriate evidence artifacts are provided to support and substantiate the claims made within the portfolio.
- **Recency and Consistency:** the evidence demonstrates a sustained pattern of Milestone 4 (Expert) practice over time rather than reliance on a single activity, project or achievement.
- **Impact:** the evidence demonstrates a meaningful contribution to client, team, organisational or system outcomes. Evidence of improved outcomes for patients, teams, services or systems clarifies impact.

Marking Rubric

Attainment of each ILO will be evaluated, against the rubric provided below, by considering a combination of Quality of Evidence and Quality of Justification.

The table below describes the three Quality of Evidence ratings: High, Indirect and Insufficient.

QUALITY OF EVIDENCE		
Rating	**Descriptor**	**Criteria**
High	Direct and relevant evidence	- Evidence is relevant and specific - Provides direct evidence for achievement of the competency
Indirect	Relevant but indirect and/or limited evidence	- Indirect connection with the competency - Achievement of competency needs to be inferred
Insufficient	Marginally relevant, unclear, and/or misaligned evidence	- Little or no alignment with the competency - Does not offer any meaningful evidence for achievement of competency

-

The table below describes the three Quality of Justification ratings: Strong, Limited and Inadequate.

QUALITY OF JUSTIFICATION		
Rating	**Descriptor**	**Criteria**
Strong	Clear and well-reasoned justification	- Justification clearly explains *why* the evidence is appropriate to the ILOs - Clearly demonstrates achievement of the relevant ILO or related competencies - Explanation supported with relevant literature
Limited	Justification relevant but limited	- Justification is relevant but lacks strong reasoning or connection to the ILO - Appraisal requires some inference from the examiner
Inadequate	Justification is inadequate	- Justification is weak, unclear or poorly connected to evidence and/or competency

Direct evidence is evidence and artifacts that clearly and explicitly demonstrates achievement of the competency and can be easily verified by the assessor. Examples include being an author on a publication, presenting at a conference (e.g., published abstract, conference proceedings listing the candidate as a presenter), leading a quality improvement project with an acknowledgement of the candidate's contribution in the report, or providing evidence of teaching with an organisation demonstrating multiple engagements with teaching and response to peer or learner evaluations.

Indirect evidence suggests engagement with the ILO but cannot be readily verified and does not, on its own, demonstrate the related competencies. Examples include attending a conference, completing professional development without assessment, or being a member of a working group without evidence of specific contribution or impact.

The key distinction is that direct evidence shows what was done and achieved that can be verified, whereas indirect evidence indicates exposure to or involvement in relevant activities but requires additional justification to demonstrate how involvement meets the competency.

Note: The same evidence may be used to support multiple ILOs, including across different Role Portfolios. However, candidates must demonstrate consistent performance and show breadth of experience at Milestone Level 4. Repeated use of the same evidence may not adequately demonstrate the breadth of performance required to meet the ILOs.

While evidence may be reused, the justifications must be specific and relevant to each ILO and each role. Curate evidence artifacts to provide objective verification of the evidence claims made within the portfolio. Select artifacts that are directly relevant to the Intended Learning Outcomes (ILOs) being addressed and provide clear evidence of expert-level practice.

Examples of evidence artifacts may include:

- publications, conference presentations, or educational resources.
- project plans, evaluation reports, or implementation outcomes.
- clinical guidelines, protocols, or tools you have collaborated in developing.
- audit and quality improvement reports.
- meeting minutes demonstrating leadership or governance contributions.
- awards, professional recognition, or advanced training achievements.

To support efficient assessment, clearly label artifacts and link to the evidence. For lengthy documents, direct assessors to the most relevant sections. Appropriately de-identify all artifacts before submission. Remove or redact patient, client, staff and confidential organisational information in accordance with privacy legislation, professional obligations and organisational policies. See also Guidelines for writing, referencing and redaction from

Section 11 Further information and resources (Optional.

It is best to focus on the quality and relevance of artifacts rather than the quantity provided. A small number of well-chosen artifacts that clearly demonstrate expertise and impact will generally provide stronger evidence than a large collection of documents with limited relevance or context.

The Quality of Evidence and Quality of Justification ratings are combined into the Portfolio Rubric.

To achieve a satisfactory outcome, all ILOs must be assessed as either 'Clearly Met' or 'Sufficiently Met'.

An ILO assessed as 'Partially Met' or 'Not Yet Met' does not meet the required standard.

Portfolio Rubric

QUALITY OF JUSTIFICATION				
QUALITY OF EVIDENCE		**Strong**	**Limited**	**Inadequate**
	High	Direct and relevant evidence Clear and well-reasoned justification **CLEARLY MET**	Direct and relevant evidence Justification relevant but limited – may lack strong reasoning or connection to the competency **SUFFICIENTLY MET**	Justification is weak, unclear or poorly connected to evidence and/or competency (Evidence quality does not apply) **NOT YET MET**
	Indirect	Relevant but indirect evidence Clear and well-reasoned justification **SUFFICIENTLY MET**	Relevant but indirect evidence Justification relevant but limited – may lack strong reasoning or connection to the competency **PARTIALLY MET**	
	Insufficient	Evidence supplied is marginally relevant, unclear, and/or misaligned with respect to the competency (Quality of justification does not apply) **NOT YET MET**		

Scoring and Portfolio Outcomes

This rubric assesses both the quality of the evidence provided and how well it explains the relevance to the Role ILO. The strongest submissions include direct, relevant evidence and a clear, well-reasoned justification that explicitly links evidence to the ILO being assessed. Where evidence is relevant but more indirect, a strong explanation can still demonstrate that the competency has been sufficiently met.

Clearly Met is awarded when candidates provide direct evidence and convincingly explain how it demonstrates the competency.

Sufficiently Met applies when either the evidence is direct, but the justification is limited, or the evidence is indirect but supported by a strong justification.

Partially Met reflects evidence that is relevant but indirect, combined with a weaker justification.

Not Yet Met is awarded when the justification is unclear or poorly linked to the competency, or when the evidence is insufficient, unclear, or not appropriately aligned with the competency being assessed.

Portfolio requirements

1. **A cover letter** to introduce the application, identify the role portfolio(s) being submitted, and provide a concise overview of key achievements and impact relevant to the application. Recommended length: 1–2 pages.
2. A concise **curriculum vitae (CV)** of no more than three (3) pages. Lists of publications and/or Conference presentations can be added as an attachment to the CV.
3. An **electronic portfolio submission** of one or more role portfolios. Please fill in relevant Role Portfolio Template
4. A **Mandatory requirement** based on a Culturally Responsive practice report.
5. Complete **Applicant Declaration form** that indicates that the information provided is accurate; evidence presented is the candidate's own work unless otherwise acknowledged; and any use of AI, co-authored or collaborative contributions have been clearly identified.
6. **One referee statement** from a suitably qualified individual who can verify the candidate's contributions and confirm their consistent demonstration in the role at an expert standard over an extended period of time. The referee should be familiar with the candidate's practice and be able to comment on the scope, impact and duration of involvement in the role.

A note on use of Artificial Intelligence (AI) in the Portfolio

The use of AI tools to support your writing, organisation of ideas, and review of drafts and critiques of your writing is acceptable in designing your portfolio. However, all examples, reflections, and evidence submitted must be drawn from your own professional practice and experience. Do not use AI to generate, embellish, or invent examples, achievements, roles, or outcomes. Provide authentic, preferably direct evidence that clearly demonstrates your contribution and can be verified where required. AI can help you communicate your experience more clearly, but it should not replace your professional judgement or create content that is not genuinely your own. Submissions that rely on AI and are generic, fabricated, or unsubstantiated examples will not meet the required standard of evidence and may be returned unassessed.

Section 5: Role Portfolio Submission and Assessment

Candidates must submit their completed Role Portfolio(s), together with the required supporting documentation, through the APA-designated submission platform in accordance with the requirements outlined in Section 4.

Candidates will receive written confirmation that their submission has been received.

Following submission, the APA will verify that the candidate has provided the required documentation to demonstrate that they meet the eligibility requirements specified in Clause 5.1.3 of Section 6: Relevant Policies of this Handbook.

Once eligibility and submission requirements have been confirmed, the APA will arrange for assessment by appropriately qualified assessor(s). An assessor may assess more than one Role Portfolio submitted by the same candidate. Each portfolio is assessed by a qualified assessor using the rubric presented in

Section 4: Role Portfolio Requirements. Assessors trained in the use of this rubric will provide written feedback for each portfolio.

Candidates will be advised of the expected assessment timeframe, including any applicable quality assurance review, once their submission has been accepted for assessment.

Following assessment, candidates will receive written notification of the outcome.

Assessment feedback

Candidates will receive written feedback for each Role Portfolio assessed.

The feedback will identify the strengths of the submission and any areas requiring further development, with reference to the relevant Intended Learning Outcomes (ILOs) and the culturally responsive practice report.

Addressing assessment feedback

Candidates who receive an unsatisfactory outcome should review the assessor's feedback alongside the relevant ILOs, assessment rubric and Role Portfolio requirements.

Depending on the feedback, candidates may need to:

- Strengthen the explanation of their professional contribution, achievements or impact.
- Provide a clearer justification linking their evidence to the relevant ILOs and competencies.
- Supplement or replace evidence artifacts where the existing evidence is insufficient or not appropriately aligned.
- Provide additional examples of professional practice to demonstrate the breadth, depth or consistency of performance expected at Milestone 4.

Any revised evidence and justification must continue to meet the applicable requirements for authenticity, relevance and demonstration of expert-level practice.

Resubmission of an unsuccessful Role Portfolio

Candidates may resubmit any Role Portfolio(s) that were assessed as unsatisfactory. Role Portfolios already assessed as satisfactory do not need to be resubmitted.

In preparing a resubmission, candidates should focus on the ILOs and requirements identified in the assessment feedback. Evidence and justifications previously assessed as satisfactory do not need to be revised. Any changes included in the resubmission will be considered during reassessment.

The resubmitted Role Portfolio should include the revised evidence and justifications developed in response to feedback, together with the other required components of the relevant Role Portfolio.

The applicable resubmission fee will apply.

Reassessment

The resubmitted Role Portfolio will be reassessed against the relevant ILOs, assessment rubric and requirements, taking into account any revised evidence and justifications. Candidates will be advised of the expected reassessment timeframe when their revised Role Portfolio is submitted. Candidates will receive written notification of the reassessment outcome, including feedback on any areas that continue to fall below the required standard.

Recognition following reassessment

Successful reassessment of a Role Portfolio results in the award of a Professional Certificate at Milestone 4 for the corresponding role. Each Role Portfolio is recognised independently. An unsuccessful assessment or reassessment of one Role Portfolio does not affect recognition already awarded for another role.

Assessment records and appeals

Assessment feedback, submissions and reassessment outcomes will be retained by the APA for governance and quality assurance purposes. Candidates seeking to appeal an assessment decision should refer to the applicable APA or ACP appeals, complaints and grievances policies and processes.

Fees

Current fees are available on the APA website
The fees cover administration and assessor costs, including feedback and certification for the Portfolio(s).

Appeals, Complaints and Grievances

Information and forms are available under the 'The Australian College of Physiotherapists policies and procedures' of the APA website: https://australian.physio/aboutus/governance

Section 6: Relevant Policies

1. Purpose

The purpose of the following policies is to establish the requirements for Component 1 of the Australian College of Physiotherapists (ACP) Specialisation Training Program (STP), a flexible, portfolio-based pathway for titled physiotherapists to demonstrate and gain recognition for expert-level practice at Milestone 4 of the APA Competence Framework including individual Role Portfolios undertaken for professional development and recognition.

2. Scope

These policies apply to candidates undertaking Component 1 or individual Role Portfolios for professional development and recognition, assessors, and those responsible for the administration and governance of Component 1.

They apply to the four Component 1 roles: Collaborator, Leader, Health Advocate and Scholar.

3. Governing principles

Component 1 is governed by the principles established in the ACP Specialisation Training Program Educational Philosophy and the APA Education Quality Framework. In particular, the following principles guide the delivery and assessment of Component 1:

3.1 Flexibility

Component 1 supports flexible participation that recognises the different professional circumstances, opportunities and career aspirations of titled physiotherapists.

3.2 Fairness, consistency and transparency

Assessment and recognition are based on clear and consistently applied requirements, assessment standards and decision-making processes.

3.3 Valid assessment of Expert practice

Assessment is aligned with the APA Competence Framework and designed to provide a valid basis for recognising achievement at Milestone 4.

3.4 Professional integrity and accountability

Candidates and assessors are expected to uphold ethical conduct, professional integrity and accountability throughout the assessment process.

3.5 Cultural safety and equity

Cultural safety and equity are embedded in the delivery and assessment of Component 1.

4. Definitions

For the purposes of these policies:

Candidate means a titled physiotherapist undertaking or submitting a role portfolio through Component 1.

Component 1 means the portfolio-based component of the Specialisation Training Program through which candidates demonstrate and gain recognition for Milestone 4 practice in the Collaborator, Leader, Health Advocate and Scholar roles.

Role portfolio means the portfolio submitted for assessment against the requirements of a specific Component 1 role.

Milestone 4 (M4) means the Expert level of practice described in the APA Competence Framework.

5. Policy requirements

5.1 Eligibility and participation

Participation

5.1.1 Component 1 of the Specialisation Training Program is aligned to the Collaborator, Leader, Health Advocate and Scholar roles at Milestone 4 of the APA Competence Framework. Each role corresponds to a role portfolio.

5.1.2 Candidates may complete one or more of the four role portfolios, individually or together and in any order. There is no overall timeframe for completion.

Eligibility

5.1.3 A candidate must meet all of the following eligibility requirements each time they submit a role portfolio for assessment:

• current membership of the Australian Physiotherapy Association (APA)

• current membership of the National Group relevant to the field of practice for which the candidate is applying

• current registration with the Australian Health Practitioner Regulation Agency (AHPRA) without any restrictions

• recognition as an APA Titled Physiotherapist in the relevant discipline.

5.2 Learning

5.2.1 Candidates may undertake learning activities to support their professional development towards Milestone 4.

5.2.2 Completion of recommended learning does not, on its own, demonstrate achievement at Milestone 4.

5.2.3 Achievement at Milestone 4 must be demonstrated through the candidate's professional practice.

5.3 Demonstration of achievement

5.3.1 Candidates must demonstrate achievement of the Intended Learning Outcomes for the relevant role at Milestone 4 of the APA Competence Framework.

5.3.2 Achievement must be supported by relevant, authentic and sufficient evidence of the candidate's professional practice.

5.4 Academic integrity and use of AI

5.4.1 Candidates are responsible for the accuracy, authenticity and integrity of all submitted materials.

Examples of professional practice, reflections, evidence, achievements, roles and outcomes in a role portfolio must be based on the candidate's own professional practice and experience.

5.4.2 Artificial intelligence (AI) may be used to support writing, organise ideas, review drafts and provide critique. AI must not be used to generate, embellish or invent examples of professional practice, achievements, roles or outcomes, or to replace the candidate's professional judgement.

5.4.3 Candidates must disclose the use of AI in accordance with the Component 1 submission requirements.

5.4.4 Suspected breaches of academic integrity are managed under the applicable APA or ACP process.

5.4.5 Where a candidate is found to have engaged in unethical conduct in connection with Component 1, the candidate will be removed from the process and will not be entitled to reimbursement of any fees paid.

5.5 Assessment

5.5.1 Each role portfolio is assessed against the Intended Learning Outcomes and approved assessment rubric for the relevant role.

5.5.2 A candidate must satisfactorily demonstrate achievement of all Intended Learning Outcomes to successfully complete a role portfolio.

5.5.3 Component 1 role portfolios are assessed by physiotherapists who have completed the required Component 1 assessor orientation and calibration.

5.5.4 Assessors must declare any actual, potential or perceived conflict of interest in accordance with applicable APA or ACP requirements.

5.5.5 Where a candidate receives an unsatisfactory assessment outcome for one or more Role Portfolios, they must resubmit only those Role Portfolios that were assessed as unsatisfactory and pay the applicable resubmission fee. Candidates are required to address the Intended Learning Outcomes or the Culturally Responsive Practice Report requirements that did not meet the required standard. Evidence and justifications previously assessed as satisfactory do not need to be revised; however, any additional changes made to the Role Portfolio will also be considered during reassessment. Further information on assessment feedback, resubmission and reassessment is provided in Section 5: Role Portfolio Submission and Assessment of this Handbook.

5.6 Recognition and progression

5.6.1 Successful completion of a role portfolio results in the award of a Professional Certificate at Milestone 4 for the corresponding role.

5.6.2 A Professional Certificate is awarded independently for each successfully completed role.

5.6.3 Candidates must successfully complete all four Role Portfolios as one of the requirements to apply for entry into Component 2 of the Specialisation Training Program.

5.7 Currency of recognition

5.7.1 A Professional Certificate awarded through Component 1 does not expire.

5.7.2 Any requirements relating to currency of practice or readiness for Component 2 are determined by the Component 2 entry requirements.

5.8 Withdrawal

5.8.1 A candidate who withdraws a role portfolio after submission is not entitled to reimbursement of the assessment fee.

6. Other applicable APA and ACP policies and processes

6.1 Reasonable adjustments and special consideration

6.1.1 Reasonable adjustments and special consideration are managed in accordance with applicable APA or ACP policies and processes.

6.1.2 A reasonable adjustment must not alter the Milestone 4 standard required to successfully complete a role portfolio.

6.2 Appeals, complaints and grievances

6.2.1 Appeals, complaints and grievances are managed in accordance with applicable APA or ACP policies and processes.

6.3 Fees and refunds

6.3.1 Fees and refunds relating to Component 1 are managed in accordance with applicable APA policies and processes, subject to the specific non-reimbursement requirements in these policies. Current Component 1 fees are published by the APA.

7. Professional Development and Recognition

7.1 Application and participation

7.1.1 The requirements of these policies apply equally to candidates undertaking individual Role Portfolios for professional development and recognition at Milestone 4.

7.1.2 Candidates may undertake individual Role Portfolios for professional development and recognition without intending to progress through the Specialisation Training Program.

7.2 Assessment

7.2.1 An unsuccessful assessment of an individual Role Portfolio does not affect recognition previously awarded for another role.

7.3 Recognition and progression

7.3.1 Professional Certificates awarded for individual Role Portfolios undertaken for professional development are recognised towards Component 1 of the Specialisation Training Program.

7.3.2 Recognition awarded for an individual Role Portfolio does not, on its own, confer Specialist Physiotherapist status.

8. Related documents

- APA Physiotherapy Competence Framework Version 7.1
- ACP Specialisation Training Program Educational Philosophy
- APA Education Quality Framework

Section 7: Milestone 4 Collaborator Role Portfolio

This portfolio submission requires curated evidence to demonstrate that you consistently perform at Milestone Level 4 of the APA Competency Framework (v7.1) for the **Collaborator role**. The purpose of this portfolio is to demonstrate how your everyday practice reflects expert collaborative capability and meets the Intended Learning Outcomes (ILOs) listed in the Table below.

The APA Competence framework defines this role as follows: **"**As Collaborators, physiotherapists work effectively with health care and other professionals to provide safe, high-quality, client-centred management".

It describes the Collaborator role as: "Physiotherapists engage in collaborative practice that is essential for safe, high-quality, client-centred management, and which involves clients and their families, carers, and potentially physiotherapists and other colleagues in the health care professions, community partners, health system stakeholders, agencies and other organisations.

Physiotherapists promote, through collaboration, relationships based in trust, respect, and shared decision making among a variety of individuals with complementary skills in multiple settings across the continuum of care. Effective collaboration involves sharing knowledge, perspectives and responsibilities, and a willingness to learn together. This requires understanding the roles of others, pursuing common client centred goals and outcomes, and managing differences, including resolution of conflict.

Collaboration skills are broadly applicable to activities beyond clinical care, such as work safety, environmental safety, administration, education, advocacy, and scholarship".

ILOs Mapped to Relevant Competencies and Milestone 4 Descriptors

These ILOs are mapped to the Key competencies (KC) and Enabling competencies (EC) and the Milestone 4 Descriptors for the Collaborator role of the Physiotherapy Competence Framework (V7.1). As expert physiotherapy practice is integrated and multifaceted, some competencies are demonstrated across more than one ILO. This intentional overlap reflects how titled physiotherapists enact multiple competencies simultaneously in practice. It also helps them identify authentic workplace evidence that demonstrates the breadth, depth and integration of specialist capability.

Table: ILOs, Key and Enabling Competencies and Descriptors for Milestone 4 Collaborator Role

Intended Learning outcomes	Key Competencies (KC) & Enabling Competencies (EC)	Milestone 4 Descriptors
Lead and optimise interprofessional collaboration to address complex clinical challenges and improve client outcomes.	**KC 3.1** Work effectively with colleagues in the health care and other professions to provide safe, high-quality, client-centred management	
	EC 3.1.1 Establish and maintain positive relationships with colleagues in health care and	**Lead** and **Analyse** interactions among healthcare

	other professions to support collaborative care	professionals to optimise the performance of the team **Demonstrate** exemplary interprofessional collaboration for better health outcomes
Build and sustain effective collaborative relationships through expert consultation, negotiation, shared decision-making and conflict resolution.	**KC 3.1** Work effectively with colleagues in the health care and other professions to provide safe, high-quality, client-centred management	
	EC 3.1.2 Negotiate overlapping and shared responsibilities with colleagues in health care and other professions in episodic and ongoing care	**Lead** discussions with colleagues re: the role of physiotherapy in their practice area in episodic and ongoing management
	EC 3.1.3 Engage in respectful shared decision-making with colleagues involved in client management	**Model** respectful shared decision-making with clients and relevant others and with other professional colleagues **Use** referral and consultation as opportunities to improve quality of care and client safety by sharing expertise
	KC 3.2 Work with physiotherapists and other colleagues in health care and other professions to prevent misunderstandings, manage differences, and resolve conflicts	
	EC 3.2.1 Demonstrate respect toward Collaborators	**Lead** the active development of positive collaborative working relationships
	EC 3.2.2 Implement strategies to promote understanding, manage differences and resolve conflicts in a manner that supports a collaborative culture	**Develop** and **implement** effective strategies to resolve conflicts in a manner that supports a collaborative culture Effectively **facilitate** conflict resolution
Lead and optimise referral, delegation and transitions of care for complex presentations to support safe, coordinated management.	**KC: 3.3** Effectively and safely delegate or transfer management to another professional	
	EC 3.3.1 Determine when management should be transferred to another physiotherapist, healthcare or other professional or allied health assistant	**Demonstrate** expertise in case management, and in optimal referral(s)
	EC 3.3.2 Demonstrate safe transfer of management, using both verbal and written communication, during a client	**Model** effective handover, teaching learners structured communication techniques to facilitate safe and effective

	transition to a different professional, setting, or stage of management	delegation or transfer of management **Analyse** and address gaps in communication between health care professionals during transitions in care, optimising client management
Develop collaborative capability in others through mentoring, role modelling and facilitation of effective collaborative practice.	**KC 3.1** Work effectively with colleagues in the health care and other professions to provide safe, high-quality, client-centred management	
	EC 3.1.1 Establish and maintain positive relationships with colleagues in the health care and other professions to support collaborative care	**Lead** and **Analyse** interactions among healthcare professionals to optimise the performance of the team **Demonstrate** exemplary interprofessional collaboration for better health outcomes
	EC 3.1.3 Engage in respectful shared decision-making with colleagues involved in client management	**Model** respectful shared decision-making with clients and relevant others and with other professional colleagues **Use** referral and consultation as opportunities to improve quality of care and client safety by sharing expertise
	KC 3.2 Work with physiotherapists and other colleagues in health care and other professions to prevent misunderstandings, manage differences, and resolve conflicts	
	EC 3.2.2. Implement strategies to promote understanding, manage differences and resolve conflicts in a manner that supports a collaborative culture	**Develop** and **implement** effective strategies to resolve conflicts in a manner that supports a collaborative culture Effectively **facilitate** conflict resolution
	KC 3.3 Effectively and safely delegate or transfer management to another professional	
	EC 3.3.2 Demonstrate safe transfer of management, using both verbal and written communication, during a client transition to a different professional, setting, or stage of management	**Model** effective handover, teaching learners structured communication techniques to facilitate safe and effective delegation or

		transfer of management **Analyse** and address gaps in communication between health care professionals during transitions in care, optimising client management

Your portfolio submission will be via the Collaborator Role Portfolio Template on Pebble Pad.

Collaborator Role Portfolio Template

Overview (suggested approximately 200 words):

In this section, succinctly describe your work context. If your practice is in a specific discipline, specify the discipline. Outline your scope of practice. Select key information from your CV that highlights your professional activities, years of experience and, if feasible, an overview of the demographic profile of your patients. Include any professional development related to collaborative practice, such as any courses on Interprofessional Practice or Interprofessional Education, or courses in shared collaborative learning spaces.

(Comment box)

Inter-Professional Profile (suggested approximately 200 words)

Provide key details about your Collaborative practice. This can be provided as a narrative, a list, a table, a visual summary or a mix of these. Consider providing information about stakeholders, referral pathways, service partnerships, and organisational interfaces.

(Comment box)

Evidence descriptions and impact statements (approximately 300 words per ILO)
For each ILO, outline your evidence and clarify the impact of your collaborative activity. Consider using case studies where appropriate and list the numbered artifacts that you want reviewers to read as evidence demonstrating achievement of each ILO.

(Comment box x 4)

Attach numbered evidence artifacts: Include a minimum of 3 and a maximum of 5 artifacts to support your evidence descriptions and impact statements (eg, reports, publication abstracts etc)

(Comment box x 4)

Justification (between 150 – 200 words, not including references): Provide your justification on how your collaborative contribution meets the ILO. This is best written as a narrative, including references.

(Comment box x 4)

NB. You may go 10% above or below the suggested word count. Remember that expertise implies skills in reflection and ability to synthesise and select key information from extensive and complex evidence. See also

Section 4: Role Portfolio Requirements and Guidelines for writing, referencing and redaction in

Section 11 Further information and resources (Optional.

Examples of Evidence and Evidence Artifacts

Your goal is to build a clear and convincing case that you **consistently** perform as a collaborator who leads, influences, coordinates and develops collaborative practice across complex healthcare environments. As you are demonstrating consistent achievement of the ILOs and competency standards, you should draw on multiple sources of evidence rather than relying on a single example. The examples below illustrate the types of evidence and related artifacts that may demonstrate that you practice as a Collaborator at Milestone 4. These are examples only, and you are encouraged to reach for evidence that meets your personal circumstances in collating your portfolio evidence. Submit authentic evidence that reflects your professional context and demonstrate achievement of each of the four ILOs.

1. **Collaborative Quality Improvement, Education, or Service Development Projects:** Evidence of involvement in projects that required collaboration across professions, such as developing clinical pathways, patient education resources, service models, or quality improvement initiatives. Artifacts may include project reports, evaluation or outcomes data, implementation plans, or summary of stakeholder feedback.
2. **Participation in Multidisciplinary Teams and Case Conferences:** Records of attendance, leadership, or contributions to multidisciplinary meetings, ward rounds, case reviews, discharge planning meetings, or clinical governance committees. Artifacts may include meeting agendas or minutes, or reflective summaries of multidisciplinary contributions.
3. **Partnerships Across Organisations:** Evidence of collaborating with external agencies such as community health services, private practices, hospitals, aged care providers, sports organisations, schools, WorkCover, TAC, NDIS, or insurers. Artifacts may include MOUs or partnership agreements, joint project reports, correspondence confirming collaborative activities or outcomes.
4. **Statements of Collaborative Practice:** Description of collaborative practice and team-based decision-making, case management, service improvement initiatives, or interprofessional projects beyond standard practice. Artifacts may include statements provided by medical, nursing, allied health, pharmacy, community service, or other professional colleagues who have directly worked with you in the collaborative activity, or letters of support.
5. **Interprofessional Education Activities**: Evidence of designing, delivering, and evaluating education sessions, workshops, in-services, or mentoring programs for multidisciplinary audiences. Artifacts may include education session plans or presentation materials, participant feedback, education impact, and evidence of practice change, service improvement, or enhanced team capability arising from the education.

6. **360-Degree Feedback**: Evidence of collecting and responding to feedback from colleagues. Artifacts may include formal feedback from peers, senior colleagues, other health professionals, support staff, and where appropriate, patients or carers.
7. **Performance Reviews or Supervisor Reports:** Evidence of commitment to and impact of your collaborative practice. Artifacts may include annual reviews, professional development assessments, or workplace evaluations that specifically reference a high standard of teamwork, interprofessional communication, and collaborative practice.
8. **Publications, Presentations, or Research with Interprofessional Teams:** Evidence of collaboration in the production and dissemination of research. Artifacts may include peer-reviewed journal articles, conference presentations, posters, quality improvement projects, or research outputs involving multiple professional disciplines.
9. **Conflict Resolution and Negotiation Examples:** Descriptions of situations where complex team dynamics, competing priorities, or stakeholder disagreements have required a high level of negotiation and management. Artifacts may include reflective accounts, de-identified case studies, or supervisor reports.
10. **PD courses specifically on interprofessional activities:** Overview of PD that indicates specific attention to improving competencies around collaboration. Evidence should demonstrate application of learning to enhance collaboration and coordinated care. Artifacts may include certificates, attendance records, and reflective summaries demonstrating application of learning.

*A reminder that the same piece of evidence can be used to demonstrate achievement of more than one ILO, and also for more than one role. However, Justification **must** be unique to each ILO.*

Examples of justification

Justification explains the rationale for including a selected piece of evidence in the portfolio. It outlines the practice need, strategic alignment, expected benefits, and how the evidence links to the ILOs, competencies and descriptors. A strong justification clearly shows how the proposed activity contributes to organisational goals, delivers value, addresses a specific challenge or opportunity, and has impact on individuals and or the system.

Example of Inadequate Justification

(likely to be rated as Not Yet Met)

The supplied evidence demonstrates that I am thorough and professional in my interactions with patients and other health professional colleagues. The documents included in this portfolio show examples of my work and indicate that I have participated in a range of professional activities. These activities reflect my commitment to maintaining appropriate standards and supporting positive outcomes in clinical practice. The evidence suggests that

I communicate effectively and work well with others as part of a healthcare team. It also shows that I am involved in patient care and undertake responsibilities that are consistent with professional expectations. Through the evidence provided, it can be seen that I apply my knowledge and skills in day-to-day practice. Overall, the portfolio demonstrates my ongoing engagement with professional responsibilities and highlights areas of practice that align with the competency requirements. The evidence generally supports my capability in this area and provides an indication that I perform my role in a professional and appropriate manner. (*This justification makes broad claims, provides little specific reasoning, does not explicitly link evidence to the ILO or related competencies, and remains vague about what the evidence actually demonstrates*.)

Example of Limited Justification

(Likely to be rated as Partially Met or Sufficiently Met if linked with Strong Evidence)

The supplied evidence, including clinical correspondence and patient updates, demonstrates regular communication with referring doctors as part of routine patient care. This shows engagement with other healthcare professionals and the sharing of information that may be relevant to patient management. The evidence indicates that communication occurs in a professional manner and supports the exchange of clinical information between members of the healthcare team. Through these activities, I contributed to collaborative care by providing updates and maintaining contact with referring practitioners. This helps ensure that information is available to those involved in a patient's care and supports continuity of service. Overall, the evidence demonstrates participation in professional communication processes that are consistent with collaborative practice, although the specific outcomes or impact on patient care are not clearly demonstrated. (*The justification is limited because it identifies relevant communication activities but provides only a broad link to collaborative care. It does not clearly demonstrate the candidate's specific contribution or impact, requiring some inference by the examiner.)*

Examples of Strong Justification

Example 1: Development of a Cross-Service Referral Pathway

Evidence artifacts: Clinical pathway document developed between physiotherapy, orthopaedics, pain management and primary care services.

Justification: This evidence demonstrates my leadership in the co-design and implementation of a multidisciplinary, multi-organisational referral pathway (ILO2). The initiative required consultation, negotiation and consensus-building across professional groups to establish shared processes and responsibilities, reflecting expert-level influence on service delivery beyond an individual caseload. This aligns with the Competency Framework Milestone 4 descriptors that expert practitioners foster strategic partnerships and contribute to system-level improvements in care coordination and service integration. The value of this work is supported by the WHO *Framework for Action on Interprofessional Education and Collaborative Practice* (2010), which identifies collaborative practice as a key mechanism for strengthening health systems, improving access to care and enhancing patient outcomes. The resulting pathway improved communication between services, reduced delays in access to appropriate treatment and established a sustainable model for coordinated care, demonstrating measurable impact at both the patient and system level. Evidence of implementation beyond a single service, together with evaluation data

demonstrating improved referral processes and patient access, provides verifiable evidence of impact beyond a single service and supports system-level influence.

(note that the evidence would ideally have presented evidence of process or impact that can be verified).

Refs added.

Example 2: Coordinating Management of a Complex Injury Claim

Evidence artifacts: Letters between health professionals. Patient details deidentified. Integrated care proposal.

Justification: This evidence demonstrates Level 4 collaborative practice through my leadership in resolving a complex injury claim involving the client's GP, rehabilitation physician, psychologist, employer and insurer. I identified barriers to recovery, including differing stakeholder expectations and unclear roles, then facilitated discussions to achieve consensus on treatment priorities, functional goals and return-to-work planning. The enclosed proposal and deidentified email correspondence demonstrate my use of advanced communication, negotiation and coordination skills to align stakeholders, support shared decision-making and establish clear pathways for ongoing collaboration. By leading the development and implementation of a unified rehabilitation strategy, I optimised care coordination and reduced duplication across services. The outcome was improved stakeholder alignment and a more efficient, client-centred approach to achieving agreed goals. This reflects evidence that effective interprofessional collaboration and team leadership enhance communication, care coordination and outcomes in complex healthcare settings (Bouton et al., 2023; Kongkar et al., 2025).
References added.

Example 3: Mentoring Staff in Interprofessional Practice

ILO4 Evidence artifacts: Supervision records and feedback forms from mentored junior physiotherapists and allied health clinicians.

Justification: This evidence demonstrates my commitment to workforce development, mentorship, and collaborative capacity-building, through actively developing collaborative capability within the workforce. Through structured supervision, mentoring and coaching, I supported junior clinicians to strengthen their communication skills, navigate complex professional relationships, and participate more effectively in interdisciplinary care planning. This aligns with the Milestone 4 expectation of modelling collaborative practice, fostering the development of colleagues, and enhancing team effectiveness through influence and guidance. The interprofessional collaboration literature identifies mentorship, reflective practice, role clarity and effective communication as key enablers of high-performing teams and improved patient outcomes (Reeves et al., 2017). The CanMEDS Collaborator Framework, which underpins the APA Competence Framework, also emphasises the responsibility of experienced practitioners to strengthen team functioning, support colleagues' development, and promote collaborative decision-making. Feedback from participants (attached) demonstrated increased confidence in interdisciplinary communication and engagement in team-based care planning, providing evidence of my contribution to building a more collaborative, capable and effective workforce.
Ref list added.

Mandatory Culturally Responsive Practice Report

Mapping local Aboriginal and Torres Strait Islander communities and services to facilitate culturally responsive practice

Purpose

Cultural safety and culturally responsive practice are expectations of contemporary physiotherapy practice under the Physiotherapy Board of Australia and AHPRA's professional standards. These expectations are also reflected in the Australian Physiotherapy Association (APA) Competence Framework (v7.1), the Australian Physiotherapy Council's accreditation standards, and the profession's commitment to providing equitable, culturally safe healthcare.

At Milestone 4, physiotherapists are expected to demonstrate advanced collaboration with patients, communities, healthcare providers, and organisations to optimise health outcomes. Effective collaboration requires an understanding of the communities served, the health priorities within those communities, and the services and partnerships that support culturally responsive care.

This activity is designed to provide evidence of your ability to identify, understand, and utilise local Aboriginal and Torres Strait Islander communities, services, and partnerships in support of culturally responsive practice. Through investigating the local context, mapping relevant services and referral pathways, and considering opportunities for collaboration, you can enhance your capacity to work respectfully and effectively with Aboriginal and Torres Strait Islander peoples, communities, and healthcare partners.

Report Requirement

Investigate and document information about the Aboriginal and Torres Strait Islander communities within your current practice location. The report should demonstrate your understanding of the local community, relevant services and supports, and how this knowledge may influence your practice and collaboration with others.

Present your evidence as a brief report of approximately 1,500 words, including the following sections:

1. Country and Traditional Custodians
Identify:

- The Aboriginal and/or Torres Strait Islander Country on which your health service or practice setting is located.
- The Traditional Owners or Custodians of that Country.
- Relevant cultural, historical, and/or contemporary information about the local Aboriginal and Torres Strait Islander community.

2. Local Aboriginal and Torres Strait Islander Communities
Describe:

- The Aboriginal and Torres Strait Islander communities living within your local government area or health service catchment.
- Demographic information relevant to the local community, including population data where available.
- Any local health priorities, strengths, or factors relevant to healthcare delivery.

3. Aboriginal Community-Controlled Health Organisations (ACCHOs)

Identify local Aboriginal Community Controlled Health Organisations and describe:

- The services they provide.
- The populations they support.
- Opportunities for referral, collaboration, or partnership relevant to your practice.

4. Aboriginal and Torres Strait Islander-Friendly Mainstream Health Services

Identify local mainstream health services that demonstrate a commitment to culturally responsive care for Aboriginal and Torres Strait Islander peoples.

Briefly describe relevant initiatives, programs, partnerships, or supports, such as:

- Aboriginal Liaison Officers, Aboriginal Health Workers, or Aboriginal Health Practitioners
- Reconciliation Action Plans
- Cultural safety initiatives
- Aboriginal and Torres Strait Islander-specific programs or clinics
- Partnerships with local ACCHOs

Explain how these services or initiatives may support culturally responsive and coordinated care within your local context.

5. Application to Practice and Reflection

Reflect on how this learning has influenced your professional practice, collaboration, and service utilisation.

Consider some of the following:

- What have you learned about Aboriginal and Torres Strait Islander communities within your practice area?
- How might this knowledge influence your communication, referral decisions, or care planning?
- What assumptions, knowledge gaps, or opportunities for development were identified through this activity?
- What existing or potential partnerships could support improved outcomes for Aboriginal and Torres Strait Islander patients?
- How will you use the services, supports, and referral pathways identified in this report in your current or future practice?
- What actions will you take to strengthen culturally responsive practice and collaboration within your local setting?

Suggested Resources

- Australian Bureau of Statistics (ABS) Census Data
- AIHW Aboriginal and Torres Strait Islander Health Performance Framework
- Closing the Gap reports
- Australian Indigenous HealthInfoNet
- Local Government Community Profiles
- Primary Health Network Needs Assessments
- NACCHO (National Aboriginal Community Controlled Health Organisation)
- Relevant state and territory Aboriginal community-controlled health peak bodies

Marking Rubric for Culturally Responsive Practice Report

This rubric assesses your ability to identify, understand, and utilise local Aboriginal and Torres Strait Islander communities, services, and partnerships to support culturally responsive practice.

Criterion & Weighting	Exceeds Standard	Meets Standard High	Meets Standard	Does not meet standard
Understanding of Local Aboriginal and Torres Strait Islander Communities (20%)	**20-18** Demonstrates a comprehensive investigation of the local community. Includes well selected demographic information. Clearly articulates the relevance of this information to local healthcare delivery and professional practice.	**17-15** Demonstrates a well-developed investigation of the local community. Includes key demographic information. Explains the relevance of this information to local healthcare delivery.	**14-10** Demonstrates an investigation of the local community. Includes community information. Describes relevance to healthcare delivery or local practice.	**9-0** Evidence of investigation is limited. Key components are omitted, unsupported, or are not clearly linked to the local community or professional practice.
Knowledge of Local Aboriginal and Torres Strait Islander Services and Supports (ACCHOs & Indigenous friendly services) (20%)	**20-18** Identifies a comprehensive range of relevant ACCHOs and mainstream services and clearly explains their role, services, and contribution to culturally responsive care. Demonstrates strong understanding of local service networks.	**17-15** Identifies relevant ACCHOs and mainstream services and describes the services and supports they provide. Demonstrates sound understanding of local service networks.	**14-10** Identifies relevant ACCHOs and mainstream services and provides a basic description of available services and supports.	**9-0** Limited or inaccurate identification of services, or insufficient description of their role and relevance.
Application to Professional Practice and Collaboration (30%)	**30-26** Clearly identifies multiple opportunities to strengthen referrals, collaboration, partnerships, or	**25-20** Identifies practical opportunities for referrals, collaboration, partnerships, or service	**19-15** Identifies examples of relevant referral pathways, partnerships, or service utilisation that	**14-0** Limited or no consideration of how knowledge may be applied to practice, referrals,

	service utilisation. Demonstrates how learning will inform current and future practice.	utilisation and explains how these may influence practice.	may support practice.	collaboration, or patient care.
Reflection on Culturally Responsive Practice (20%)	**20-18** Demonstrates critical reflection on learning, assumptions, knowledge gaps, and professional responsibilities. Identifies specific actions to strengthen culturally responsive practice and collaboration.	**17-15** Demonstrates thoughtful reflection on learning and identifies clear implications for future professional practice.	**14-10** Reflects on learning gained from the activity and identifies implications for professional practice.	**9-0** Reflection is minimal, descriptive only, or demonstrates limited consideration of implications for practice.
Evidence and Professional Communication (10%)	**10-9** Information is consistently supported by current and credible sources. Writing is clear, professional, well organised and accurately referenced throughout.	**8-7** Information is supported by credible sources. Writing is clear and professional with only minor referencing or presentation issues.	**6-5** Information is supported by appropriate sources and generally communicated clearly. Minor issues with organisation, writing or referencing may be present.	**4-0** Limited use of credible sources, significant communication or referencing issues, or poor report organisation.

Section 8: Milestone 4 Health Advocacy Role Portfolio

The APA Competency Framework (v7.1) defines the role of the Health Advocate as: "Physiotherapists contribute their expertise and influence as they work with groups, communities, client populations, government and other agencies and organisations to improve the health of individuals and groups of people. They work with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilisation of resources to effect change".

They further describe the role the Health Advocate as contributing "to efforts to improve the health and well-being of their clients, their communities, and broader populations which they may serve. Improving health is not limited to mitigating illness or trauma but also involves illness and injury prevention and health promotion. Improving health also includes promoting health equity, whereby individuals and populations reach their full health potential without being disadvantaged by, for example, race, ethnicity, religion, gender, sexual orientation, age, disability, social class, economic status, or level of education.

Physiotherapists leverage their position to support clients in navigating the health care system and to advocate with, and for, them to access appropriate resources in a timely manner. Physiotherapists seek to improve the quality and outcomes of health promotion and health care by addressing the health needs of the clients, communities, or populations whom they serve. Physiotherapists promote healthy communities and populations by influencing the system (or by supporting others who influence the system), both within and outside of their work environments.

Physiotherapy advocacy occurs within complex systems and thus requires the development of partnerships with clients, support networks, relevant others or community agencies and organisations to influence health determinants. Advocacy often requires engaging with other health care professionals, community agencies, administrators, and policy-makers" (APA, 2017).

This portfolio submission requires evidence that you consistently perform at Milestone Level 4 of the APA Competency Framework (v7.1) for the **Health Advocate role**. The purpose of this portfolio is to demonstrate how your everyday practice reflects Expert health advocacy capability and meets the following Intended Learning Outcomes.

ILOs mapped to Relevant Competencies and Milestone 4 Descriptors

The Intended Learning Outcomes (ILOs) have been developed from the Key and Enabling Competencies and Milestone 4 descriptors within the Physiotherapy Competence Framework (V7.1). As expert physiotherapy practice is integrated and multifaceted, many competencies are demonstrated across more than one ILO. This intentional overlap reflects how titled physiotherapists enact multiple competencies simultaneously in practice and helps Titled Physiotherapists identify authentic workplace evidence that demonstrates the breadth, depth and integration of specialist capability.

Intended Learning outcomes	Key Competencies (KC) & Enabling Competencies (EC)	Milestone 4 Descriptors
Lead and model effective advocacy with and for clients with complex needs to address determinants of health and facilitate timely access to appropriate health services and resources.	**KC 5.1** Respond to the individual client's health needs by advocating with the client within and beyond the practice setting	**Lead** others in how to work effectively and efficiently with complex clients to address the determinants of health that affect them and their timely access to needed health services or resources **Engage** in advocacy to administrative or governing bodies on behalf of clients in their area of practice
	EC: 5.1.1 Work with clients to identify and address the determinants of health that affect them, and their access to necessary health services or resources	
Lead and model strategies that enable clients with complex needs to adopt healthy behaviours, including influencing organisations to create supportive opportunities and environments for behaviour change.	**KC 5.1** Respond to the individual client's health needs by advocating with the client within and beyond the practice setting	**Model** working with clients with challenging and complex needs to increase opportunities to adopt healthy behaviours **Prepare** and **lead** strategies to influence organisations to support client adoption of healthy behaviours
	EC: 5.1.2 Work with clients and relevant others to increase Opportunities to adopt healthy behaviours	
Lead illness and injury prevention, health promotion and health surveillance activities through continuous quality improvement that strengthens practice and health	**KC 5.1** Respond to the individual client's health needs by advocating with the client within and beyond the practice setting	**Lead** and demonstrate initiative in illness and injury prevention, health promotion, and health surveillance activities in the management of clients in the area of practice
	EC 5.1.3 Incorporate illness and injury prevention, health promotion, and health surveillance activities into practice	

outcomes.	**KC 5.2** Respond to the needs of the groups, communities or populations they serve by advocating with them for organisational or system-level change to achieve improved health outcomes	
	EC 5.2.2 Improve practice by applying a process of continuous quality improvement to illness and injury prevention, health promotion, and health surveillance activities	**Lead** change in practice to achieve process of continuous quality improvement in illness and injury prevention, health promotion, and health surveillance activities in their area of practice
Partner with groups, communities and populations to identify health needs and determinants, and lead advocacy for organisational, system and policy change through service design that improves health outcomes.	**KC 5.2** Respond to the needs of the groups, communities or populations they serve by advocating with them for organisational or system-level change to achieve improved health outcomes	
	EC 5.2.1 Work with a group, community or population to identify and address the social, economic and environmental factors that influence health status	**Advocate** for and **facilitate** system and/or policy changes to impact determinants of health through appropriate service design.
	EC 5.2.3 Contribute to improvement of health in the community or population the practitioner serves	**Actively participate** in organisational processes to improve health in the communities or populations they serve

These ILOs are integrated from the key and enabling competencies and Milestone 4 descriptors of the Health Advocate role. Demonstration of these competencies is one of the requirements for recognition as a Specialist by the Australian College of Physiotherapists.

For further details, see

Section 4: Role Portfolio Requirements and *Section 5: Role Portfolio Submission and Assessment*

.

Your portfolio submission will be via the Health Advocate Role Portfolio Template on Pebble Pad.

Health Advocate Role Portfolio Template

Overview (suggested approximately 200 words):

This section should make clear your work context, and if you practice it in a specific discipline. Outline your scope of practice. Select key information from your CV that highlights your professional activities, years of experience and, if feasible, an overview of the demographic profile of your patients. Include PD related to health advocacy.

(Comment box)

Health Advocacy Profile (suggested approximately 200 words)

Provide key details on your Health Advocacy practice. This can be provided as a narrative, a list of actions, a table or a visual summary or a mix of these. Provide information on stakeholders, formal and informal partnerships, and communities and organisations you have advocated for.

(Comment box)

Evidence descriptions and impact statements for each ILO (suggested approximately 300 words) Outline the evidence that showcases that your health advocacy consistently operates at Milestone Level 4. Consider using case studies where suitable and make clear the numbered artifact/s that you want the reviewers to read as evidence that you meet the ILO.

(Comment box 4)

Attach numbered evidence artifacts: (candidate should be able to attach a number of artifacts here). Include a minimum of 3 and a maximum of 6 artifacts to support your evidence description and impact statement (eg, reports, publication abstracts etc)

(Comment box) (allow up to 5 attachments for each)

Justification (between 150 – 200 words per ILO, not including references): Provide your justification on how your collaborative work meets the ILO. This is best written as a narrative.

(Comment box)

NB. You may go 10% above or below the suggested word count. Remember that expertise implies skills in reflection and ability to synthesise and select key information from extensive and complex evidence. See also

Section 4: Role Portfolio Requirements and Guidelines for writing, referencing and redaction in

Section 11 Further information and resources (Optional.

Examples of Evidence and Evidence Artifacts

Your goal is to build a clear and convincing case that you consistently perform as an Expert Health Advocate who leads, influences, designs and evaluates initiatives that improve health outcomes, reduce inequities and address the determinants of health. At Milestone 4, you are demonstrating practice that extends beyond individual patient care and actively shapes organisations, systems, communities and policy. You are expected to show how you influence decision-making, mobilise resources, advocate for equitable access and lead initiatives that improve health, wellbeing and participation across populations and communities.

Because you are demonstrating consistent achievement of the competency standards, you should move beyond providing a single piece of evidence only. Strong portfolios typically include a range of evidence that demonstrates sustained impact across different contexts, stakeholders and timeframes. Evidence should highlight your leadership, the complexity of the issues you addressed, your advocacy actions, the partnerships you developed and the outcomes that were achieved.

The strongest evidence for Milestone 4 Health Advocate practice will typically demonstrate one or more of the following:

- Leadership beyond individual patient advocacy and into organisational, community or system-level influence.
- A clear focus on addressing determinants of health, health inequities or barriers to access.
- Meaningful partnership with consumers, communities, organisations or other stakeholders.
- Evidence of resource mobilisation, service redesign, advocacy or policy influence.
- Measurable outcomes using evaluation, surveillance, quality improvement or population health measures.
- Sustainable change that extends beyond a single episode of care.
- Impact on populations, communities, services, systems or policy rather than solely individual patients.
- Reflection of strategic, evidence-informed and collaborative leadership.

Assessors will be looking for evidence that shows not only what you did, but also how your advocacy leadership influenced decisions, changed practice, improved equity and contributed to the health and wellbeing beyond individual patients.

Below are examples of direct and indirect types of evidence you can provide to support your case as an expert Health Advocate. These are examples only, and you are encouraged to draw on evidence that best reflects your professional context when curating your portfolio. You are not expected to reference all of the types of evidence listed below to convince the assessors that you are operating at the standard. The assessors will be looking for authentic evidence that demonstrates achievement of the Milestone Level 4 Health Advocate competencies and reflects your role, responsibilities and sphere of influence.

1. Completion of professional development in health advocacy with application to practice: Evidence demonstrating completion of formal professional development in health advocacy, health equity, public health or policy influence, and the application of learning to improve practice, services or health outcomes. Artifacts may include Certification of completion, summary of PD activity and reflective practice summary demonstrating application of learning.

2. Leadership of a service redesign addressing health inequities: Evidence demonstrating your leadership of a project that improved access, equity, participation or health outcomes for a priority population (e.g., First Nations peoples, culturally and linguistically diverse communities, rural populations, people living with disability and/or economically disadvantaged groups). Artifacts may include Project plan or business case, service evaluation or outcomes reports or implementation reports demonstrating impact.

3. Advocacy that influenced organisational policy or practice: Evidence showing your contribution to the development, review or implementation of organisational policies, procedures or strategic priorities that address health inequities or determinants of health. Artifacts may include policy, procedures or guidelines developed or revised, committee minutes documenting your contributions to policy development, submission, briefing or consultation reports.

4. Development of community partnerships to address identified health needs: Evidence demonstrating how you partnered with community organisations, consumers, advocacy groups or health services to identify health needs and coordinate resources to improve outcomes. Artifacts may include MOUs or partnership agreements, joint project reports, letters of support from community partner organisations.

5. Leadership of a health promotion initiative: Evidence showing your role in designing, implementing and evaluating a health promotion program aimed at improving health literacy, wellbeing, participation or disease prevention. Artifacts may include the health promotion program plan, educational resources, campaign materials or program evaluation reports.

6. Prevention initiatives resulting in measurable outcomes: Evidence demonstrating leadership of prevention-focused activities that improved health outcomes or reduced risk factors within a defined population. Artifacts may include the program plan, audit or outcomes report, population health or service outcome data summary.

7. Contribution to local, state or national advocacy activities: Evidence showing your involvement in advocacy efforts that sought to influence healthcare systems, funding models, legislation or public policy. This can include APA committees and/or working parties that have upstream impact on the profession and or the population. Artifacts may include advocacy submissions, position statements or consultation responses, or meeting minutes documenting your advocacy contributions.

8. Health surveillance or population health monitoring activities: Evidence demonstrating your use of health data to identify service gaps, emerging trends or inequities, and to inform service planning or advocacy actions. Artifacts may include population health needs assessment, data analysis or surveillance reports, service planning documents informed by health data.

9. Quality improvement initiatives that improved equitable healthcare access: Evidence showing how you led or influenced continuous quality improvement activities that addressed barriers to care, improved service accessibility or enhanced patient outcomes. Artifacts may include project report, audit report or outcomes and evaluation summaries.

10. Presentations, publications or educational activities advocating for health equity: Evidence demonstrating your influence on professional practice through dissemination of knowledge related to health advocacy, equity, prevention or population health. Artifacts may include Conference presentation or poster, published article, education materials or participant evaluation summary.

Examples of justification

Justification explains the rationale for including a selected piece of evidence in the portfolio. It outlines the practice need, strategic alignment, expected benefits, and how the evidence links to the ILOs. A strong justification clearly shows how the proposed activity contributes to organisational goals, delivers value, addresses a specific challenge or opportunity, and has impact on individuals and or the system.

At Milestone Level 4, strong justifications move beyond describing clinical care delivered to an individual patient. Instead, they demonstrate leadership, advocacy, partnership, health promotion, prevention, service improvement, quality improvement, population health or system-level influence

Example of Inadequate justification

(likely to be judged Not Met on the rubric)

The supplied evidence demonstrates that I am committed to advocating for patients and helping them access appropriate healthcare services. In my role, I regularly identify patient needs and work with other healthcare professionals to ensure patients receive the care they require. This shows that I am able to support people who may experience barriers to healthcare and that I understand the importance of equitable access to services. The evidence also demonstrates my professionalism, communication skills and ability to work within a multidisciplinary team. Through these activities I contribute to positive patient outcomes and help improve the overall healthcare experience. I believe this evidence shows that I have met the Health Advocate milestone because I am actively involved in supporting patients and promoting their wellbeing. My ongoing interactions with patients, families and colleagues demonstrate my commitment to advocacy and improving health outcomes across different settings. (*This justification is inadequate because it is largely descriptive and relies on broad, unsupported statements about advocacy and positive patient outcomes without clearly explaining how the evidence aligns with the ILO. It fails to identify specific determinants of health or inequities, does not demonstrate leadership of an advocacy initiative or influence on organisational, system, or policy-level change, and lacks explicit links to the Milestone 4 Health Advocate expectations.*)

Example of limited justification

(maybe judged Partially Met or Sufficiently Met if linked with High Quality Evidence)

Evidence for ILO 2: Partnerships for improving the health, wellbeing and participation of patients

The supplied evidence demonstrates that I worked with patients, community services and members of the multidisciplinary team to support individuals with identified health, healthcare, and social needs. Through discussions with patients and referral pathways, I helped connect people to appropriate community resources and services, which contributed to their ongoing care and wellbeing. This evidence shows that I recognise the importance of partnership for health advocacy in addressing patient needs and promoting participation in healthcare.

I believe this demonstrates achievement of the Health Advocate role because these activities required communication with a range of stakeholders and consideration of factors affecting patient health. By facilitating access to services and working with others involved in care, I supported improved outcomes for patients and contributed to a more coordinated approach to service delivery. This evidence reflects my commitment to patient-centred care and my ability to build partnerships to address health needs within the community. (see Link to: *While the justification is relevant to the ILO and identifies the value of partnership activities, it provides only general reasoning. The connection between the evidence and Milestone 4 expectations is implied rather than explicit, requiring the examiner to infer the extent of impact, leadership, resource mobilisation, and advocacy demonstrated*.)

Examples of Strong justification

The strongest justifications demonstrate not only what you did, but also why it was needed, how it addressed a health issue or inequity, who benefited, and what outcomes or changes were achieved as a result of your advocacy and leadership.

The examples below illustrate what a stronger justification may look like. They demonstrate how evidence can be explicitly linked to one or more Health Advocate ILOs, describe the need or issue being addressed, articulate the candidate's role and contribution, and draw on relevant contemporary literature to support the rationale. These examples are provided as exemplars to guide your thinking and structure, not as templates to copy. Your justification must be authentic, accurately reflect your own practice and evidence, and clearly explain your individual contribution, the context in which you worked, and the outcomes or impact achieved. Assessors will be looking for evidence of genuine reflection and practice-based reasoning rather than replicated or generic statements.

Example 1: Professional Development Course in Health Advocacy

Evidence: Named course with course outline and ILOs. Certificate of completion, and implementation plan demonstrating application of learning from a Health Advocacy and Health Equity professional development program.

Justification: This evidence demonstrates the development and application of advanced health advocacy capability to address barriers to equitable healthcare access. Through a professional development program, I strengthened my understanding of the social determinants of health and the importance of identifying factors that influence health outcomes beyond the immediate clinical encounter. Following the program, I reviewed local service processes and identified barriers affecting access for patients experiencing socioeconomic disadvantage. Drawing on health equity and advocacy frameworks explored during the course, I developed recommendations to strengthen referral pathways and improve links with community support services. These recommendations were considered alongside other identified service and population health priorities to support local service

planning and quality improvement activities as showcased in the QA report attached. These recommendations were presented to stakeholders and informed service planning decisions.

This evidence aligns with **ILO 1** by demonstrating advocacy that addresses determinants of health and inequities in access to care. It also aligns with **ILO 4** through influencing organisational practice to support more equitable health outcomes. At an advanced practice level, this advocacy extended beyond individual patient care to inform service-level decision-making, strengthen system processes, and support more equitable access across patient populations. The recommendations had implications for broader referral networks and service delivery beyond the immediate clinical setting (see attachment x for Service Plan). Importantly, the evidence demonstrates not only completion of professional development but the application of learning to identify an inequity, advocate for change, and contribute to service improvement. This model has been picked up across our sister service at Y Centre. At an advanced practice level, this advocacy extended beyond individual patient care to inform service-level decision-making, strengthen system processes, and support more equitable access across patient populations. Where relevant, the recommendations had implications for broader referral networks and service delivery beyond the immediate clinical setting. Contemporary literature highlights advocacy and action on the social determinants of health as key strategies for reducing health inequities and improving population health outcomes (Flavel et al., 2024; World Health Organization, n.d.). This evidence therefore demonstrates the practical application of health advocacy principles to improve equity and access within my service.

Example 2: Leadership Contribution to a Professional Organisation

Evidence: Appointment to a State or National APA committee, working group reports, meeting minutes and contributions to advocacy submissions.

Justification: This evidence demonstrates the development and application of advanced health advocacy capability to address barriers to equitable healthcare access. Through a professional development program, I strengthened my understanding of the social determinants of health and the factors that influence health outcomes beyond the immediate clinical encounter. Applying this learning, I reviewed local service processes and identified barriers affecting access for patients experiencing socioeconomic disadvantage. Using health equity and advocacy frameworks, I developed recommendations to strengthen referral pathways and improve links with community support services. These recommendations were presented to stakeholders and contributed to service planning discussions.

This evidence aligns with **ILO 1** by demonstrating advocacy that addresses determinants of health and inequities in access to care. It also aligns with **ILO 4** through influencing organisational practice to support more equitable health outcomes. Importantly, the evidence demonstrates not only professional development, but the translation of learning into action through identifying an inequity, advocating for change, and contributing to service improvement. Contemporary literature identifies advocacy and action on the social determinants of health as essential strategies for reducing inequities and improving health outcomes (Flavel et al., 2024; World Health Organization, n.d.).

Example 3: Health Surveillance and Population Health Monitoring Activity

Evidence: Population health audit, service utilisation analysis, health equity review or needs assessment report used to inform service redesign.

Justification: This evidence demonstrates leadership in applying a population health and health equity lens to identify disparities in healthcare access and outcomes within the service. Consistent with WHO guidance, health advocacy at a systems level requires the collection, analysis and use of health inequity data to identify unmet need and inform service improvement (World Health Organization, n.d.). Contemporary healthcare quality literature similarly emphasises that achieving health equity requires organisations to move beyond individual patient care and adopt data-informed approaches to identifying and addressing disparities in access, experience and outcomes (Baker, 2024).

Drawing on these principles, I undertook analysis of service utilisation data, including referral patterns, attendance rates, waiting times and patient outcomes, to identify inequities affecting specific population groups within our service catchment. The analysis demonstrated that some groups experienced lower service engagement and poorer access to care, prompting further investigation into potential barriers and opportunities for improvement. Based on these findings, I developed and presented recommendations to support service redesign and targeted intervention strategies aimed at improving equity of access and participation.

This evidence aligns with **ILO 3** through leadership and evaluation of health surveillance activities designed to improve outcomes at a population level. It also aligns with **ILO 4** through influencing organisational decision-making and service improvement using population health evidence. Importantly, the evidence demonstrates the use of health surveillance data not simply for reporting purposes, but as a mechanism for advocacy and system improvement, translating evidence into actions intended to reduce inequities and achieve more equitable and sustainable health outcomes.

Useful Resource

The Advocacy in Action Toolkit authored by PHAI - PHAIWA is a practical resource designed to support health professionals in planning, implementing and evaluating advocacy initiatives. It provides a structured framework that guides users through key stages of advocacy, including defining the issue, identifying evidence, developing an advocacy ask, engaging stakeholders and measuring outcomes. The toolkit also includes case studies, tips and practical tools that demonstrate how advocacy strategies can be applied in real-world contexts. As such, it is a valuable reference for physiotherapists seeking to influence policy, systems or practice to improve health outcomes and advance the profession.

Mandatory Culturally Responsive Practice Report

Developing understanding of Aboriginal and Torres Strait Islander allyship (approximately 1,500 words)

Purpose

Cultural safety and culturally responsive practice are expectations of contemporary physiotherapy practice under the Physiotherapy Board of Australia and AHPRA professional standards. These expectations are also reflected in the Australian Physiotherapy Association (APA) Competence Framework (v7.1), the Australian Physiotherapy Council accreditation standards, and the profession's commitment to equitable healthcare.

At Milestone 4, physiotherapists are expected to advocate for equitable health outcomes by recognising and responding to the social, cultural, economic, and systemic factors that influence health and access to care.

This activity is designed to provide evidence of your ability to critically engage with Aboriginal and Torres Strait Islander perspectives on allyship, reflect on your role in promoting culturally responsive and equitable healthcare, and identify actions that support advocacy at the individual, community, and system levels.

It provides an opportunity to deepen understanding of the factors that influence culturally safe healthcare, reflect on personal attitudes, assumptions, and practice, and consider how this learning can support more effective advocacy for Aboriginal and Torres Strait Islander peoples. The reflection demonstrates how key concepts inform the Health Advocate role at Milestone 4, including consideration for how this learning will influence future professional practice.

Completion of this report “Developing understanding of Aboriginal and Torres Strait Islander allyship” is mandatory as part of your Health Advocacy Portfolio.

Report requirements

Select a minimum of two readings (see recommended resources provided) to support your report. Your submission should include a reflective discussion with the following considerations.

- Key concepts and insights gained from the readings. Draw on appropriate quotes to demonstrate your understanding of your readings.
- How the learning has shaped your approach to culturally safe practice.
- How the learning has strengthened your understanding of allyship and its application to the Health Advocate role at Milestone 4, including advocating for equitable health outcomes and culturally safe care at the individual, community, and system levels.
- The impact of this learning on your future health advocacy development and clinical practice.

The reflection should demonstrate critical thinking, self-awareness, and a commitment to culturally safe and respectful healthcare.

1. Introduction (Approximately 150-200 words)

Provide a brief introduction that:

- Explains the importance of Aboriginal and Torres Strait Islander allyship within contemporary health care.
- Introduces Aboriginal and Torres Strait Islander perspectives on allyship, recognising that allyship is granted, not declared.
- Outlines the purpose and structure of the report.

The introduction should establish why the selected concept/s is relevant to professional practice, service delivery, and health equity.

2. Indigenous allyship: Key Concepts and Learning (Approximately 500-600 words)

Drawing on **two allyship papers** written primarily by Aboriginal and/or Torres Strait Islander scholars:

- Discuss key characteristics of how allyship is conceptualised.
- Critically examine expectations, responsibilities, opportunities, and challenges associated with allyship.
- How might concepts of allyship influence your ability to advocate for equitable health outcomes for Aboriginal and Torres Strait Islander peoples at the individual, community, or system level?

3. Reflection on Practice and the Health Advocate Role (Approximately 600-700 words)

Reflect on how the learning from the allyship literature may influence your professional practice and development as a Health Advocate. Areas for reflection may include:

- How has this learning challenged, reinforced, or changed your assumptions, perspectives, or understanding of your professional responsibilities?
- How might this learning influence your approach to advocating for equitable health outcomes for Aboriginal and Torres Strait Islander peoples?
- What opportunities have you identified to strengthen culturally responsive practice, collaboration, or system-level advocacy within your current or future practice context?
- What specific actions will you take to further develop your capability as an ally and advocate?

Reflections should demonstrate critical thinking, self-awareness and practical applications to current or future professional contexts. See Guidelines for writing, referencing and redaction in

Section 11 Further information and resources (Optional of this Handbook.

4. Conclusion (Approximately 100-150 words)

Provide a brief conclusion that:

- Summarises the key insights gained from the literature.
- Highlights the relationship between allyship, your practice, advocacy and culturally responsive practice.
- Identifies priorities for ongoing learning, reflection, and professional development.

Below is a list of recommended readings on Indigenous allyship primarily written by Aboriginal and/or Torres Strait Islander scholars. You are encouraged to draw on these resources when completing your report. Alternatively, you may identify and use your own literature sources, provided they focus on allyship and are primarily written by Aboriginal and/or Torres Strait Islander scholars.

Recommended readings on Allyship

- Toovey, R., Linton, J., Lin, I., Bolton, J., Buhler, M., Bunzli, S., Darlow, B., Hemakumar, D., Dixon, B., Fricke, M., Large, S., O'Sullivan, P., Roach, P., Roots, R., Setchell, J., Tombs, K., White, E., Conley, B. (2026) Moving forward together. Part 5: Championing Physical Therapy Allyship and Advocacy for Indigenous Peoples with Musculoskeletal Pain (editorial), *Journal of Orthopaedic & Sports Physical Therapy*, 56, 6.
- Webinar: Equality, diversity and inclusion in physiotherapy: keeping the conversation going. https://www.csp.org.uk/workplace/equality-diversity/diversity-equality-inclusion-physiotherapy
- Stephanie Nixon - Privilege and critical allyship. (2020) You Tube presentation (1:07:29). IPT-HOPE webinar "The Coin Model of Privilege and Critical Allyship: Implications for Health". https://www.youtube.com/watch?v=3aT3ZiPRTh8; The Coin Model of Privilege and Critical Allyship: Implications for Health: https://bmcpublichealth.biomedcentral...
- Title: Organisational allyship: two views
  URL: https://wellmob.org.au/e-health-topics/training-resources/best-practice-ideas/allyship/52159/?title=Organisational+allyship++two+views

Marking Rubric for Culturally Responsive Practice Report

Criterion & Weighting	Exceeds Standard	Meets Standard High	Meets Standard	Does not meet standard
Understanding of Aboriginal and Torres Strait Islander Allyship (15%)	Demonstrates a nuanced understanding of allyship & critically examines the responsibilities, challenges, & implications of allyship within healthcare.	Demonstrates a well-developed understanding of allyship & explains the responsibilities and expectations associated with allyship within	Identifies & explains key concepts of allyship from the selected literature and demonstrates an understanding of their relevance	Provides a limited or inaccurate discussion of allyship concepts or demonstrates insufficient engagement

	Integrates concepts from multiple sources to develop original insights relevant to physiotherapy practice.	healthcare and professional practice.	to healthcare practice.	with the selected literature.
Engagement with the Literature (10%)	Critically engages with the selected literature, synthesising ideas across sources and considering their implications for healthcare and advocacy practice.	Draws on the selected literature to discuss key concepts and demonstrates thoughtful engagement with the perspectives presented.	Draws on at least two relevant sources and uses them appropriately to support discussion of allyship.	Fails to engage adequately with the required literature or relies primarily on unsupported opinion.
Reflection on Practice and Professional Responsibilities (25%)	Demonstrates critical self-reflection, including examination of assumptions, perspectives, professional responsibilities, & areas for ongoing growth. Clearly articulates how learning has influenced professional thinking & practice.	Demonstrates thoughtful reflection on learning & discusses how it has influenced perspectives, professional responsibilities, or practice.	Reflects on learning gained through engagement with the literature and identifies implications for professional practice.	Reflection is superficial, largely descriptive, or does not demonstrate consideration of implications for professional practice.
Application to the Health Advocate Role (25%)	Demonstrates a sophisticated understanding of the Health Advocate role and clearly articulates opportunities to advocate for equitable & culturally responsive healthcare at individual, community, &/or system levels.	Clearly explains how learning from the allyship literature informs health advocacy & culturally responsive healthcare within professional practice.	Identifies ways in which the learning is relevant to the Health Advocate role & culturally responsive practice.	Provides limited or unclear links between allyship, health advocacy, & professional practice.
Future Development and Action (15%)	Identifies specific, realistic & meaningful actions to strengthen	Identifies practical actions to strengthen	Identifies actions or areas for further development	Provides limited consideration of future learning, development, or

	allyship, advocacy, and culturally responsive practice, & explains how these actions may contribute to improved health outcomes for the community.	allyship, advocacy, or culturally responsive practice & explains their relevance to future professional development.	arising from the learning.	professional action.
Professional Communication and Referencing (10%)	Writing is clear, concise, well-structured, and consistently supported by relevant literature. Referencing is accurate throughout.	Writing is clear and organised with appropriate use of literature and only minor presentation or referencing issues.	Writing communicates key ideas and literature supports discussion. Issues are evident with structure, presentation, or referencing.	Significant issues with communication, structure, use of literature, or referencing detract from the report.

Section 9: Milestone 4 Leader Role Portfolio

The APA Physiotherapy Competence framework (v7.1) defines the Leader role as one in which “physiotherapists engage with others to contribute to a vision of quality services in the health and other sectors and take responsibility for the delivery of excellent client care through their activities as practitioners, administrators, scholars, and/or teachers” (APA, 2023).

It describes the role of the leader as “the engagement of all physiotherapists in shared decision-making for the operation and ongoing evolution of systems in the health and other sectors. Physiotherapists demonstrate collaborative leadership and management within the health and other sectors. At a system level, physiotherapists contribute to the development and delivery of continuously improving health promotion, health care and preventative services, and engage with others in working toward this goal. They function as individual care providers, as members of teams, and as participants in, and leaders of, health and other sectors” (APA, 2023).

At Milestone 4, physiotherapists work beyond their own caseload and influence broader systems. Typical activities include:

- Leading quality improvement initiatives
- Designing and evaluating services
- Managing resources and workforce capability
- Mentoring and developing others
- Leading organisational change
- Influencing policy and strategic directions
- Building partnerships to improve service delivery

ILOs mapped to Competencies and Milestone 4 Descriptors

The Intended Learning Outcomes (ILOs) have been developed from the Key and Enabling Competencies and Milestone 4 descriptors within the Physiotherapy Competence Framework (V7.1). As expert physiotherapy practice is integrated and multifaceted, many competencies are demonstrated across more than one ILO. This intentional overlap reflects how specialist physiotherapists enact multiple competencies simultaneously in practice and helps titled physiotherapists identify authentic workplace evidence that demonstrates the breadth, depth and integration of specialist capability.

Intended Learning outcomes	**Key Competencies (KC) & Enabling Competencies (EC)**	**Milestone 4 Descriptors**
Lead improvements in quality of care and client safety through the strategic use of health informatics, technology and service-delivery data.	**KC 4.1** Contribute to the improvement of health promotion and health care delivery in teams, organisations, and systems	

	EC 4.1.1 Use health informatics and technology to improve health promotion and the safety and quality of care	**Use** health informatics to improve the systems of quality of client care and optimise client safety. **Compare** service delivery data to accepted targets and goals and plan improvements.
Optimise resource stewardship and cost-effective service delivery through the application of evidence, evaluation of service utilisation patterns, and implementation of models of care that enhance client outcomes and system sustainability.	**KC 4.2** Engage in the responsible utilisation and management of available resources	
	EC 4.2.1 Allocate and utilise health care and other resources for optimal client service delivery	**Allocate** health care resources for optimal client care. **Provide** expert opinion to optimise practice patterns for cost-effectiveness and cost control.
	EC 4.2.2 Apply evidence and management processes to achieve cost-appropriate service delivery	**Apply** evidence and facilitate improvement in management processes to achieve cost-appropriate care. **Compare** utilisation data within and outside their institution/practice to revise processes that are inefficient or unnecessary.
Demonstrate leadership that enables complex organisational, system and practice-level change through enhancing team performance, mentoring others to develop leadership capability, and reflecting on the impact of personal leadership.	**KC 4.3** Demonstrate leadership in professional practice	
	EC 4.3.1 Demonstrate leadership skills to enhance quality practice	**Demonstrate** leadership skills to enhance healthcare teams and/or complex organisation/system/practice-level change. **Mentor** others to develop leadership skills. **Reflect** on the impact of their own leadership style on their professional performance and the performance of others.
Lead service improvement and sustainable change through developing and communicating a clear	**KC 4.3** Demonstrate leadership in professional practice	
	EC 4.3.2 Facilitate change in service delivery to	**Share** a clear vision and lead change at

vision, using evidence and data to evaluate outcomes, and disseminating learnings to support continuous improvement.	improve services and outcomes	organisational/ practice level to enhance services and outcomes. **Use** data to inform planning and implement a change strategy to improve services and outcomes in their area of practice. **Disseminate** processes and outcome changes as part of continuous improvement.

Your portfolio submission will be via the Leader Role Portfolio Template on Pebble Pad.

Leader Role Portfolio Template

Overview (200 words):

Outline your scope of practice and your leadership roles. Select key information from your CV that highlights your work context, years of experience and an overview of the demographic profile of your patients.

Leadership Profile (300 words)

Provide key details on your Leadership practice. This can be provided as a narrative, a list, a table or a visual summary or a mix of these. Consider providing information on partnerships, stakeholders, and organisational interfaces.

Evidence description and impact statement (300 words) (comment box) Briefly outline your evidence in a concise narrative clarifying the impact of your leadership activity. Dot points are acceptable. Name the numbered artifacts that you want the reviewers to read as evidence that you meet the ILO. (Repeat for each ILO)

Attach numbered artifacts: (candidate should be able to attach 3-5 artifacts here). Include a minimum of 3 and a maximum of 5 artifacts to support your evidence description and impact statement for each ILO (e.g., reports, publication abstracts etc)

Justification (150 words, not including references): (comment box) Provide your justification on how your collaborative work meets the ILO. This is best written as a narrative. Repeat for each ILO.

NB. You may go 10% above or below the suggested word count. Remember that expertise implies skills in reflection and ability to synthesise and select key information from extensive and complex evidence. See also

Section 4: Role Portfolio Requirements and Guidelines for writing, referencing and redaction in

Section 11 Further information and resources (Optional.

Examples of Evidence and Evidence Artifacts

While there is some overlap between Milestone 4 Leader and Milestone 4 Health Advocate, and similar evidence can be used for both portfolios, it is important to note that the focus of Leader role is on influencing systems, services and people. The Health Advocate role focuses on who (patients, clients, communities, populations) the influencing activity is for, and how it changes their experiences of the system. Leadership focuses on organisational and system performance, whereas health advocacy focuses on patient, population and community outcomes, particularly where inequities or barriers exist.

Note that the same evidence can be used for both portfolios, however the justification for how the evidence meets the ILOs will be different.

For example: Expanding telehealth physiotherapy services can be used as evidence for leadership producing design service model, sourcing funding, leading the implementation and impact of telehealth services i.e. referral and patient numbers. In contrast, evidence for the Health Advocate will focus on providing evidence of how limited access to health services has been improved through advocacy activity; improving access for rural patients and specific populations through the telehealth service; indicators of reduced barriers to care and indicators of increasing access from underserved populations.

The best Milestone 4 practitioners typically demonstrate both leadership and health advocacy, but the evidence they submit should make clear whether the main outcome was organisational improvement (Leader) or equity/access/population impact (Health Advocate).

As you are demonstrating consistent achievement of the ILOs and competency standards, you should draw on multiple sources of evidence rather than relying on a single example. The examples below illustrate the types of evidence and related artifacts that may demonstrate that you consistently practice as a Leader at Milestone 4. These are examples only, and you are encouraged to reach for evidence that meets your personal circumstances in collating your portfolio evidence. You are not expected to provide every type of evidence listed below. Submit authentic evidence that reflects your professional context and demonstrate achievement of each of the four ILOs.

1. Leadership of a service improvement project using data to improve quality and safety: Evidence demonstrating leadership of a quality improvement initiative that used service, outcome, incident or patient experience data to improve quality of care, client outcomes and/or safety. Focus can be on improving waiting times, reducing adverse events, improving discharge outcomes, implementing outcome measurement systems, or redesigning referral pathways. Artifacts may include project plan, audit reports, outcome data, or presentations demonstrating impact.

2. Development and implementation of a new model of care: Evidence demonstrating leadership in the design, implementation and evaluation of a new or revised model of care that improved efficiency, client outcomes or sustainability. Examples may include advanced practice physiotherapy services, group intervention programs, triage pathways, or private practice service innovations. Artifacts may include the business case, model of care, implementation plans, evaluation or outcome reports.

3. Leadership of digital transformation or health technology implementation: Description of leadership in the adoption or implementation of digital systems, health informatics tools or technology-enabled service innovations that improved quality, efficiency or patient safety. Examples may include implementation of electronic outcome measurement systems, telehealth platforms, electronic medical records, decision-support tools or digital patient education resources. Artifacts may include project plans, implementation reports, training resources, evaluation reports, or stakeholder feedback summaries.

4. Resource stewardship resulting in improved service sustainability: Leadership in the efficient and effective use of financial, workforce, equipment or service resources while maintaining or improving quality of care. This can include workforce redesign, optimisation of clinician workloads, reduction of non-value-added activities, equipment utilisation reviews or improvements in service efficiency. Artifacts may include business cases, workforce plans, service utilisation analyses, efficiency evaluations or implementation outcomes reports.

5. Leadership of organisational or system-level change: Evidence demonstrating leadership of significant organisational, service or system change requiring engagement of multiple stakeholders, management of complexity and achievement of sustainable outcomes. Examples may include service amalgamations, implementation of new clinical governance frameworks, statewide service initiatives, organisational restructuring or major practice transformations. Artifacts may include change management plans, stakeholder engagement plans, implementation reports, evaluation reports or evidence of achieved outcomes.

6. Mentoring and development of future leaders demonstrating a sustained contribution to building leadership capability in others through mentoring, coaching, supervision or structured leadership development initiatives. This may include driving leadership development programs, mentoring emerging leaders, or providing formal leadership supervision. Artifacts may include mentoring plans, leadership development program materials, participant feedback reports, supervision records or reflective evaluations of leadership development outcomes.

7. Contribution to professional leadership at organisational, state or national level: Evidence demonstrating leadership influence beyond an immediate workplace through professional associations, advisory groups, governance committees, accreditation activities or sector-wide initiatives. This may include leadership roles within the Australian Physiotherapy Association committees or professional boards. Artifacts may include Committee terms of reference, meeting minutes documenting leadership contributions, project outputs or letters confirming leadership roles.

8. Strategic planning and implementation activities: Evidence demonstrating leadership in the development and implementation of strategic priorities that resulted in measurable improvements to services, workforce capability or organisational performance. Examples may include development of departmental strategic plans, workforce strategies, clinical governance plans or service expansion initiatives. Artifacts may include strategic plans, implementation roadmaps, progress reports, evaluation reports or outcome dashboards.

9. Dissemination of leadership and service improvement outcomes: Evidence demonstrating leadership through sharing innovations, service improvement outcomes or

lessons learned to influence practice beyond the immediate service setting. Examples may include conference presentations, workshops, publications, or professional education activities focused on leadership, quality improvement, innovation or service redesign. Artifacts may include Conference abstracts, published articles, workshop resources, webinar recordings, participant feedback summaries or implementation case studies.

10. Reflective leadership practice demonstrating growth and impact: Evidence demonstrating critical reflection on leadership practice, strengths, challenges, decisions and impact on teams, services or organisational outcomes. Examples should demonstrate insight into leadership behaviours, adaptation of leadership approaches and integration of feedback to improve leadership effectiveness. Artifacts may include structured reflective reports, multisource feedback reports, professional development portfolios or leadership journals.

Examples of Justification

Example of Inadequate Justification

(likely to be rated as Not Yet Met)

The evidence included in this portfolio demonstrates that I have undertaken a variety of leadership activities within my professional practice. The documents show that I have worked with colleagues, participated in meetings, and contributed to different workplace initiatives. These activities indicate that I have experience in leadership and that I am able to support the work of the team. The evidence also suggests that I am involved in decision-making processes and contribute to achieving organisational goals. Through my participation in these activities, I have demonstrated skills that are consistent with leadership expectations and professional practice. The portfolio contains examples of projects and responsibilities that reflect my commitment to quality services and positive outcomes. The evidence generally shows that I can work with others, manage tasks, and contribute to change when required. Overall, the material provided supports my development as a leader and demonstrates capabilities that align with the Leader competency requirements at this level. (*This justification is inadequate because it makes broad assertions about leadership, provides little analysis of the evidence, does not explicitly address the APA Leader key or enabling competencies, fails to link evidence to Milestone 4 descriptors, and does not explain how the evidence demonstrates leadership capability or impact.)*

Example of Limited Justification

(likely to be rated as Partially Met or Sufficiently Met if supported by strong evidence)

The evidence in this portfolio demonstrates my involvement in leadership activities within my workplace, including participation in service development initiatives, team meetings, and quality improvement activities. Through these experiences, I have contributed to discussions about service delivery and supported activities aimed at improving team functioning and organisational processes. The evidence shows that I have taken responsibility for tasks and worked with colleagues to achieve shared goals. These activities align with aspects of the APA Leader role, as they demonstrate engagement in

workplace initiatives and involvement in professional responsibilities beyond direct clinical practice. The evidence also indicates that I contribute to decision-making processes and support changes within the workplace when required. While the documentation demonstrates my participation in leadership-related activities, it provides limited information about my specific influence on outcomes or the impact of my contributions. Overall, the evidence supports my development as a leader and demonstrates participation in activities consistent with Milestone Level 4 expectations. (*This justification is limited because while it identifies leadership activities and makes a general link to the Leader role but does not clearly explain how the evidence demonstrates leadership capability, influence, strategic thinking, or measurable impact. The assessor must infer much of the connection to the competency*.)

Examples of Strong Justification

(Likely to be rated as Met or Partially Met if linked to indirect evidence)

Example 1

The evidence provided, including my business case for implementing a persistent pain service, referral pathway documentation, and service outcome reports, demonstrates achievement of the APA Leader role at Milestone Level 4. Specifically, this evidence shows that I identified a service need, engaged key stakeholders, implemented a practice-level change, and monitored outcomes to support service effectiveness. These activities align with the Milestone 4 expectation of influencing service delivery beyond individual patient encounters and contributing to sustainable improvements in practice. The evidence demonstrates the Leader competency of contributing to strategic planning and service improvement. For example, rather than simply delivering clinical care, I analysed referral patterns, consulted with practice owners and local referrers, and developed a structured program that improved access to evidence-based care. This reflects leadership through influencing others and facilitating change within the organisation. The outcome data included in the evidence demonstrates that my leadership activities resulted in increased service utilisation and improved patient access. Current physiotherapy leadership literature identifies communication, vision, credibility, and the ability to lead change as key leadership characteristics of effective physiotherapists. Ferrando-Margelí et al. (2024) found that leadership in physiotherapy is characterised by influencing practice development and supporting organisational improvement. Similarly, rehabilitation leadership literature emphasises that effective leaders promote collaboration, person-centred care, and system improvement. Collectively, this evidence demonstrates that I am not only participating in workplace activities but actively leading service development consistent with Milestone 4 leadership expectations.

References provided.

Example 2

The evidence provided, including the multidisciplinary falls-prevention project, committee minutes, implementation plan, and audit outcomes, demonstrates my achievement of the APA Leader role at Milestone Level 4. This evidence is appropriate because it shows my leadership of a quality improvement initiative that extended beyond my individual clinical

caseload and influenced practice across the service. The evidence demonstrates several Leader competencies, including leading change, supporting team performance, and contributing to organisational objectives. I identified variations in falls-risk screening practices across the service and led a multidisciplinary working group to develop and implement a standardised screening process. The audit data included in the portfolio shows improved compliance with screening procedures following implementation. This demonstrates not only participation but also influence on service delivery and patient care processes. The leadership literature highlights that contemporary healthcare leadership increasingly involves collaborative and distributed leadership approaches rather than relying solely on positional authority. The physiotherapy leadership scoping review by Ferrando-Margelí et al. (2024) identified communication, professionalism, and the ability to facilitate change as key leadership attributes within the profession. Broader rehabilitation literature also emphasises leadership as a mechanism for improving teamwork, service quality, and patient-centred outcomes. Therefore, the evidence demonstrates my capability to influence practice, support organisational improvement, and lead service change consistent with Milestone Level 4 expectations.

References provided

Mandatory Portfolio Requirement: Learning from Indigenous Leadership

Approximate word limit: 1,500 words

Purpose

Cultural safety and culturally responsive practice are expectations of contemporary physiotherapy practice under the Physiotherapy Board of Australia and AHPRA's professional standards. These expectations are also reflected in the Australian Physiotherapy Association (APA) Competence Framework (v7.1), the Australian Physiotherapy Council's accreditation standards, and the profession's commitment to providing equitable, culturally responsive healthcare.

At Milestone 4, physiotherapists influence individuals, teams, services, and systems to improve healthcare quality and outcomes. Effective leadership includes fostering culturally responsive practice, challenging inequity, supporting culturally safe care, and contributing to environments where Aboriginal and Torres Strait Islander peoples can achieve equitable health outcomes.

This activity is designed to provide evidence of your ability to critically engage with Aboriginal and Torres Strait Islander perspectives on leadership, reflect on your own leadership assumptions and practices, and identify opportunities to influence culturally responsive practice within your sphere of leadership. Through examining Aboriginal and Torres Strait Islander leadership principles, leadership models, and system-level influences, you can strengthen your capacity to lead respectfully, influence others, and contribute to meaningful improvements in healthcare experiences and outcomes for Aboriginal and Torres Strait Islander peoples.

Completion of this report is mandatory as part of the Leader Portfolio.

Report Requirements

Select a minimum of two readings (see recommended resources provided) to complete your report. Your submission should demonstrate how the literature has influenced your understanding of Aboriginal and Torres Strait Islander leadership and how this learning informs your development as a leader and your contribution to culturally responsive healthcare.

When preparing your report, consider:

- Key concepts and insights gained from the literature. Draw on appropriate examples and quotations to demonstrate your understanding.
- How Aboriginal and Torres Strait Islander leadership perspectives compare with other leadership models or assumptions.
- How this learning has influenced your understanding of leadership practice and culturally responsive healthcare.
- How the concepts relate to the Leader role at Milestone 4, including influence at the level of self, others, teams, organisations, and systems.
- The impact of this learning on your future leadership development and professional practice.

The report should demonstrate critical thinking, reflexivity, and a commitment to culturally responsive and respectful healthcare.

1. Introduction (Approximately 150-200 words)
Provide a brief introduction that:

- Explains the role of Aboriginal and Torres Strait Islander leadership within contemporary healthcare.
- Introduces one recognised non-Indigenous leadership model that will be used as a point of comparison within the report.
- Outlines the purpose and structure of the report.

The introduction should establish the relevance of Aboriginal and Torres Strait Islander leadership to professional practice, healthcare delivery, leadership development, and health equity.

2. Indigenous Leadership: Key Concepts and Learning (Approximately 500 words)
Drawing on two leadership papers written predominantly by with Aboriginal and/or Torres Strait Islander scholars:

- Describe key characteristics of leadership identified in the literature.
- Compare these concepts with a recognised non-Indigenous leadership model.
- Critically examine similarities, differences, assumptions, and implications for leadership within healthcare organisations and services.

The discussion should move beyond description and demonstrate engagement with the broader significance of Aboriginal and Torres Strait Islander leadership for contemporary healthcare and culturally responsive practice.

3. Reflection on Practice and the Leader Role (Approximately 600 words)
Reflect on how your learning from the Aboriginal and Torres Strait Islander leadership literature may influence your leadership practice and development. Consider:

- How has this learning challenged, reinforced, or changed your understanding of leadership and your role as a leader?
- How might Aboriginal and Torres Strait Islander leadership principles influence the way you work with colleagues, teams, patients, communities, or other stakeholders?
- What opportunities have you identified to support culturally responsive practice, challenge inequity, or influence change within your team, service, organisation, or broader health system?
- What actions will you take to further develop your leadership capability and contribute to culturally responsive healthcare?

Reflections should demonstrate self-awareness, critical thinking, and application to current or future professional contexts.

4. Conclusion (Approximately 100 words)
Provide a brief conclusion that:

- Summarises the key insights gained from the literature.
- Highlights the relationship between Aboriginal and Torres Strait Islander leadership, culturally responsive practice, and effective healthcare leadership.
- Identifies priorities for ongoing leadership development, learning, and reflection.

Recommended Readings

For this activity, select and critically engage with at least two sources that inform your understanding of Aboriginal and Torres Strait Islander leadership. These sources should form the basis of your report and reflection on leadership and culturally responsive practice. You may draw on the recommended readings listed below or identify your own literature, provided the sources focus on leadership written predominantly by Aboriginal and/or Torres Strait Islander scholars.

- Barnabe, C. (2021) Towards attainment of Indigenous health through empowerment: resetting health systems, services and provider approaches. *BMJ Global Health*. [gh.bmj.com],
- Brearley, L. (2015). Deep listening and leadership: An Indigenous model of leadership and community development in Australia. *Restorying Indigenous leadership: Wise practices in community development*, *2*, 91-127.
- Harfield S, Davy C, Dawson A, Mulholland E, Braunack-Mayer A, Brown A. (2021) Building Indigenous health workforce capacity and capability through leadership – the Miwatj health leadership model. Primary Health Care Research & Development 22(e52):1-9. doi: 10.1017/S1463423621000554
- Panesar, D., Rahiri J-L., & Koea, J. (2021) Indigenous Health Leadership: A Kaupapa Māori Perspective from Aotearoa New Zealand, 5:83–86. [bmjleader.bmj.com]

Marking Rubric for Culturally Responsive Practice Report

Criterion & Weighting	**Exceeds Standard**	**Meets Standard High**	**Meets Standard**	**Does not meet standard**
Understanding of Aboriginal and Torres Strait Islander Leadership Concepts (15%)	Demonstrates a nuanced understanding of leadership concepts and critically examines the assumptions, values, and perspectives underpinning Aboriginal and Torres Strait Islander leadership in healthcare and professional practice.	Demonstrates a well-developed understanding of leadership concepts and discusses their significance within healthcare and professional practice.	Identifies and explains key concepts and characteristics of leadership presented in the selected literature.	Demonstrates limited understanding of leadership concepts or insufficient engagement with the selected literature.
Critical Engagement with Leadership Literature (25%)	Critically examines Aboriginal and Torres Strait Islander and non-Indigenous leadership approaches, synthesising insights across sources and considering implications for healthcare leadership.	Compares Aboriginal and Torres Strait Islander leadership concepts with a non-Indigenous leadership model and discusses similarities, differences, and implications for practice.	Uses the selected literature to describe Aboriginal and Torres Strait Islander leadership concepts and compares them with a non-Indigenous leadership model.	Comparison of leadership approaches is absent, limited, or unsupported by the literature.
Reflection on Leadership Practice (25%)	Demonstrates critical reflection on leadership assumptions, behaviours, and professional responsibilities. Clearly articulates how learning has influenced leadership thinking and practice.	Demonstrates thoughtful reflection on leadership practice and discusses how learning has informed leadership perspectives and professional responsibilities.	Reflects on learning gained from the literature and identifies implications for leadership practice.	Reflection is minimal, descriptive only, or demonstrates limited consideration of implications for leadership practice.
Application of Aboriginal and	Demonstrates a sophisticated	Explains how leadership	Identifies ways leadership	Limited or unclear links

Torres Strait Islander literature to clinical practice (15%)	understanding of how leadership principles can influence individuals, teams, organisations, and/or systems. Clearly identifies opportunities to strengthen culturally responsive leadership and contribute to meaningful impact.	principles may influence leadership practice and support culturally responsive healthcare at the level of self, others, teams, or organisations.	concepts are relevant to the Leader role and professional practice.	between leadership concepts and application to clinical practice.
Future Leadership Development and Action (10%)	Identifies specific, realistic, and meaningful actions to strengthen leadership capability and culturally responsive practice. Explains how these actions may contribute to improved experiences or outcomes for Aboriginal and Torres Strait Islander peoples, teams, organisations, or systems.	Identifies practical actions to strengthen leadership capability and culturally responsive practice and explains their relevance to future professional development.	Identifies actions or areas for further leadership development arising from the learning.	Future leadership actions or development needs are absent or insufficiently developed.
Professional Communication and Referencing (10%)	Writing is clear, concise, well-structured, and consistently supported by relevant literature. Referencing is accurate throughout.	Writing is clear and organised with appropriate use of literature and only minor presentation or referencing issues.	Writing communicates ideas clearly and uses literature to support discussion. Minor issues with structure, presentation, or referencing may be evident.	Significant issues with communication, structure, use of literature, or referencing detract from the report.

Section 10: Milestone 4 Scholar Role Portfolio

The APA competence framework (v7.1) defines the Scholar role as physiotherapists demonstrating their commitment to maintaining and enhancing their professional competence by engaging in critical reflection, continuous learning, teaching others and contributing to scholarship throughout their career.

The framework explicitly describes the scholar role as: Physiotherapists develop scholarly abilities to enhance and advance health and health care. Physiotherapists enhance safety and quality by continually evaluating the processes and outcomes of their daily work, sharing and comparing their work with that of others, and actively seeking feedback. They strive to meet the needs of individual clients and their families and of the health care and other sectors by continuous professional development.

Physiotherapists strive to master their domains of expertise and to share their knowledge. They implement a planned approach to lifelong learning. They recognise the need to continually learn and to model the practice of lifelong learning for others. Through their engagement in evidence-informed and shared decision-making, they recognise uncertainty in practice and formulate questions to address knowledge gaps. Physiotherapists are able to identify relevant evidence, critically evaluate it and apply it in their practice and scholarly activities. They utilise the best available research evidence to arrive at decisions, while taking client values and preferences into account.

As teachers, physiotherapists facilitate individually and through teams, the education of students, colleagues, co-workers, clients, the public and others. Finally, physiotherapists' scholarly abilities allow them to contribute to the application, dissemination, translation, and creation of knowledge and practices applicable to the health and other sectors.

ILOs mapped to Competencies and Milestone 4 Descriptors

On successful completion of the role portfolio: Scholar, the candidate will be able to:

Intended Learning outcomes	**Key Competencies (KC) & Enabling Competencies (EC)**	**Descriptors**
Model lifelong learning and continuous professional development through reflective practice, performance evaluation and mentorship that strengthens individual and collective practice.	**KC 6.1** Engage in ongoing learning to enhance professional activities	
	EC 6.1.1 Develop, implement, monitor and revise a personal learning plan to enhance professional practice	**Model** the development and implementation of a plan to enhance competence across all roles for ongoing professional practice, including mentoring of others
	EC 6.1.2 Identify opportunities for learning and improvement by regularly reflecting on and assessing their performance using various internal and external sources of information	**Access** and **synthesise** multiple sources of performance data applicable to a scope of practice, and utilise to design improvement strategies in their practice

	EC 6.1.3 Engage in collaborative learning to continuously improve personal practice and contribute to collective improvements in practice	**Lead** and **mentor** collaborative learning to continuously improve personal practice and contribute to collective improvements in practice
Provide educational leadership through teaching, supervision and evaluation that promotes learner development, client safety and positive learning cultures.	**KC 6.2** Facilitate the learning of students, clients, the public, and other health care professionals	
	EC 6.2.1 Recognise the influence of role-modelling and the impact of the formal, informal, and hidden curriculum on learners	A**pply** strategies to mitigate the tensions between formal, informal, and hidden curricula
	EC 6.2.2 Promote a safe learning environment	**Lead** change to promote a safe learning environment Facilitate a safe and positive learning organisation culture
	EC 6.2.3 Ensure client safety is maintained when learners are involved	**Model** supervision and graduated responsibility, in an adept manner, ensuring the safety of clients and learners
	EC 6.2.4 Plan and deliver education activities	**Use** relevant learning theories to enhance the learning of others **Teach** at national and/ or international levels relevant to their area of practice.
	EC 6.2.5 Provide contextually appropriate feedback to enhance learning and performance	**Facilitate** learners and teachers to manage the emotional impact of giving and receiving feedback. **Work** with those who give and receive feedback to develop plans for improvement.
	EC 6.2.6 Implement continuous improvement of education based on evaluation	**Apply** systematic approaches to assessment of learners or evaluation of programs.
Lead evidence-informed practice through the critical appraisal,	**KC 6.3** Integrate best available evidence into practice	

integration and application of evidence to improve decision-making and professional practice.	**EC 6.3.1** Recognise practice uncertainty and knowledge gaps and generate focused questions that address them	**Coach** other health professionals to formulate and implement processes to address knowledge gaps
	EC 6.3.2 Identify and select relevant pre-appraised resources and original research	**Lead** the identification and promulgation of current sources of pre-appraised and original research in their area of practice
	EC 6.3.3 Critically evaluate the integrity, reliability, and applicability of health - related research and literature	**Participate** in the development of an evidence synthesis.
	EC 6.3.4 Integrate evidence into decision-making in their practice	**Coach** other health professionals to integrate evidence effectively into decision-making in their practice **Use** implementation science to facilitate evidence informed practice change
Advance scholarly inquiry and knowledge translation through ethical research, dissemination of findings and engagement with stakeholders to inform practice, education and policy.	**KC 6.4** Contribute to the dissemination and/or creation of knowledge and practices applicable to health	
	EC 6.4.1 Demonstrate an understanding of the scientific principles of research and scholarly inquiry and the role of research evidence in health care	**Engage** in scholarly inquiry or research
	EC 6.4.2 Identify ethical principles for research and incorporate them into obtaining informed consent, considering potential harms and benefits, and considering vulnerable populations	**Teach** others the application of ethical principles in research
	6.4.3 Contribute to the work of research programs	**Actively** participate as a research team member, balancing the roles and responsibilities of a researcher with the clinical roles and responsibilities of a physiotherapist

	EC 6.4.4 Pose questions amenable to scholarly inquiry and select appropriate methods to address them	**Coach** others to pose relevant, appropriately constructed questions that are amenable to scholarly investigation **Engage** in the application and implementation of appropriate methods in a scholarly investigation **Develop** resources and capacity to support evidence informed decision making
	EC 6.4.5 Summarise and communicate to professional and lay audiences, including clients, the findings of relevant research and scholarly inquiry	**Present** scholarly work at seminars and conferences Inform and promote communication to organisations and health providers regarding research findings **Engage** stakeholders in collaboration to enhance knowledge translation of research outcomes impacting professional practice

Professional Development Courses on Scholarship

If you **have not** previously completed research relevant PD at Milestone Level 4, you are strongly encouraged to complete some formal training as part of your evidence portfolio. We recommend completion of the Level 4 PEDro training modules (anticipated availability in 2027), as it provides underpinning knowledge and skills in evidence appraisal, evidence-informed practice, and knowledge translation that support achievement of Scholar ILOs. The course intends to develop the capability to critically appraise, interpret, synthesise, and apply research evidence in clinical, educational, and quality improvement contexts.

For the **Scholar** role at **Milestone Level 4**, evidence should demonstrate advanced engagement with scholarship, evidence generation, knowledge translation, educational inquiry, research leadership, and contribution to the profession.

Your portfolio submission will be via the Scholar Role Portfolio Template on Pebble Pad.

Scholar Role Portfolio Template

Overview (200 words):

Outline your scope of practice and scholarship roles. Select key information from your CV that highlights your work context, years of experience and an overview of the demographic profile of your patients or key stakeholders. This should make clear your work context.

(comment box)

Inter-Professional Profile (300 words)

Provide key detail on your Scholarship practice. This can be provided as a narrative, a list, a table or a visual summary or a mix of these. Consider providing information on stakeholders, service partnerships, and organisational interfaces.

(comment Box)

Evidence description and impact statement (300 words) (comment box) Briefly outline your evidence in a concise narrative and make clear the impact of your scholarship activity. Dot points are acceptable. Name the artifacts that you want the reviewers to read as evidence that you meet the ILO.

(comment box x 4)

Attach numbered artifacts: (candidate should be able to attach a number of artifacts here). Include a minimum of 3 and a maximum of 5 artifacts to support your evidence description and impact statement (e.g., reports, publication abstracts etc)

(comment box x 4)

Justification (150 words, not including references): (comment box) Provide your justification on how your scholarship work meets the ILO. This is best written as a narrative.

(comment box x 4)

NB. You may go 10% above or below the suggested word count. Remember that expertise implies skills in reflection and ability to synthesise and select key information from extensive and complex evidence. See also

Section 4: Role Portfolio Requirements and Guidelines for writing, referencing and redaction in

Section 11 Further information and resources (Optional.

Examples of Evidence and Evidence Artifacts

You can provide the following examples of direct and indirect evidence to support your case as a Leader operating at Milestone 4. These are examples only, and you are encouraged to draw on evidence that best reflects your professional context when curating your portfolio. You are not expected to reference all the types of evidence listed below to convince the assessors that you are operating at the standard. Submit authentic evidence that demonstrates achievement of the Milestone Level 4 Leader competencies and reflects your role, responsibilities and sphere of influence as a Scholar.

1. Educational leadership through teaching and supervision: Evidence demonstrating leadership in teaching, supervision, assessment or curriculum development that promotes learner development, capability and safe practice. Artifacts may include Teaching resources, supervision frameworks, curriculum documents, learner evaluations or educational program reports.

2. Completion of the Milestone 4 PEDro Program and application of learning to practice: Evidence demonstrating completion of the Milestone 4 PEDro Scholar program and application of evidence appraisal, evidence synthesis and evidence-informed decision-making within professional practice, education or service delivery. Artifacts may include certificate of completion, completed learning activities, reflective practice summary, examples of changes to practice informed by PEDro learning.

3. Completion of postgraduate study with a significant research or scholarly component: Evidence demonstrating advanced scholarly capability through completion of postgraduate study involving research, evaluation, critical inquiry or knowledge generation. Examples may include a Masters degree in clinical, educational, public health or research disciplines. Artifacts may include your academic transcripts, capstone projects, research reports or scholarly publications arising from the study.

4. Leadership of a research, evaluation or scholarly inquiry project: Evidence demonstrating leadership of research, quality evaluation or educational scholarship activities that generated new knowledge or informed improvements in practice, education or service delivery. Artifacts may include **r**esearch protocols, ethics approvals, project reports, evaluation reports, final study outputs or dissemination materials.

5. Scholarly dissemination through peer-reviewed publication: Evidence demonstrating contribution to the profession's evidence base through publication of research, evaluation findings, clinical innovations or scholarly work. Artifacts may include published articles, accepted manuscripts, DOI records, publication citations or journal correspondence.

6. Presentation of scholarly work at professional conferences or forums: Evidence demonstrating dissemination of research, evaluation findings, innovations or evidence-informed practice to professional audiences. Artifacts may include conference abstracts, presentation slides, posters, invited speaker documentation or participant feedback summaries.

7. Leadership of evidence-informed practice implementation: Evidence demonstrating the critical appraisal, translation and integration of evidence to improve clinical practice,

education, policy or service delivery. Examples may include clinical guideline implementation, knowledge translation projects or evidence-based service redesign. Artifacts may include evidence reviews, implementation plans, guideline contributions, practice recommendations or evaluation reports.

8. Mentoring others in scholarly practice and professional development: Evidence demonstrating support for colleagues, students or emerging leaders to develop skills in evidence-based practice, research, reflective practice or scholarly inquiry. Artifacts may include mentoring plans, supervision records, professional development activities, feedback reports or reflective summaries of mentoring outcomes.

9. Contribution to scholarly peer review, editorial or research leadership activities

Evidence demonstrating leadership in maintaining the quality and integrity of professional knowledge through scholarly review, governance or advisory roles. Examples may include journal peer review, editorial board membership, research committees or guideline development groups. Artifacts may include appointment letters, reviewer acknowledgements, committee records, editorial board listings or guideline authorship documentation.

10. Development and dissemination of evidence-based educational resources: Evidence demonstrating creation of educational resources, programs or learning materials informed by contemporary evidence that influence practice, education or workforce capability. Artifacts may include **e**ducational resources, learning modules, implementation guides, participant evaluation summaries, program reports or evidence summaries underpinning resource development.

Examples of Justification

Example of Inadequate Justification

(likely to be rated as Not Yet Met)

The evidence in this portfolio demonstrates that I am committed to scholarship and ongoing professional development. The documents provided show that I have participated in a range of learning activities, attended professional development opportunities, and engaged with evidence relevant to my practice. These activities indicate that I value lifelong learning and seek to maintain my professional knowledge and skills. The evidence also shows that I have reflected on my experiences and applied learning in my work. Through involvement in various projects and educational activities, I have demonstrated an interest in improving my practice and contributing to positive outcomes. The portfolio contains examples of work that reflect my engagement with research, learning, and professional growth. Overall, the evidence suggests that I possess capabilities that are consistent with the Scholar role. The activities included demonstrate my involvement in learning and development and generally support my progression toward the Scholar competencies expected at this level. (*This justification is inadequate because it relies on broad statements, does not explicitly address the APA Scholar key competency or enabling competencies, fails to reference Milestone 4 descriptors, provides little analysis of what the evidence demonstrates, and does not explain how specific evidence shows scholarly capability, critical appraisal, knowledge translation, reflective practice, or contribution to learning and improvement.)*

Example of Limited Justification for the Scholar Role

(likely to be rated as Partially Met or Sufficiently Met if supported by strong evidence)

The evidence in this portfolio demonstrates my ongoing engagement in professional learning and development. The documents show that I have participated in educational activities, completed professional development opportunities, and reviewed information relevant to my area of practice. These activities have supported my continued learning and helped me maintain my professional knowledge and skills. The evidence also indicates that I reflect on my practice and consider how new knowledge may be applied within my professional role. Through participation in learning activities and professional discussions, I have demonstrated a commitment to ongoing development and evidence-informed practice. These activities align with aspects of the APA Scholar role and support my ability to maintain current knowledge. Overall, the evidence demonstrates participation in scholarly activities and supports my progression towards the Scholar competencies expected at Milestone Level 4. *(This justification is limited as while it describes relevant learning activities and broadly links them to the Scholar role, it provides little critical analysis of how knowledge was appraised, translated into practice, shared with others, or evaluated for impact. The assessor is required to infer achievement of several Milestone 4 expectations.)*

Examples of Strong Justification

(Likely to be rated as Met or Partially Met if linked to indirect evidence)

The evidence provided, including my critical appraisal summary, implementation plan, patient education resources, and clinical outcome audit, demonstrates achievement of the APA Scholar role at Milestone Level 4. This evidence is appropriate because it shows not only engagement with research but also the translation of evidence into clinical practice and evaluation of its impact. The evidence demonstrates the Scholar competency of critically evaluating evidence and applying it to improve practice. After reviewing contemporary evidence regarding exercise and education for knee osteoarthritis, I synthesised key findings and incorporated these into a revised treatment pathway within the practice. I subsequently audited patient outcome measures and patient satisfaction data to evaluate whether implementation achieved the intended outcomes. This process reflects the integration of evidence, clinical reasoning, and outcome evaluation expected at Milestone 4.

The knowledge translation literature emphasises that scholarship involves moving beyond knowledge acquisition to implementation and evaluation of evidence-informed practice. The World Physiotherapy knowledge translation framework highlights the importance of systematically translating research into clinical care (ref). Contemporary evidence also identifies evidence-informed practice as requiring critical appraisal, contextual application, and reflection on outcomes rather than simply reading research. Therefore, the evidence demonstrates my ability to apply scholarly principles to improve practice and patient care, which is consistent with the APA Scholar role at Milestone Level 4.

References added

Mandatory Culturally Responsive Practice Report

Evaluating Research Through Indigenous Perspectives

Purpose

Cultural safety and culturally responsive practice are expectations of contemporary physiotherapy practice under the Physiotherapy Board of Australia and AHPRA's professional standards. These expectations are also reflected in the Australian Physiotherapy Association (APA) Competence Framework (v7.1), the Australian Physiotherapy Council's accreditation standards, and the profession's commitment to equitable, culturally responsive healthcare.

At Milestone 4, physiotherapists are expected to demonstrate professional responsibility through critical reflection, lifelong learning, ethical practice, and the thoughtful application of evidence to practice. Contemporary scholarship requires physiotherapists to critically evaluate not only the methodological quality of research, but also the extent to which research is culturally responsive, ethically conducted, and relevant to the communities it seeks to serve.

This activity is designed to provide evidence of your ability to critically engage with Indigenous approaches to research evaluation and reflect on how these perspectives influence evidence-informed practice. Through examining concepts such as self-determination, Indigenous governance, partnership, reciprocity, data sovereignty, community benefit, and capacity building, you can strengthen your capacity to evaluate, interpret, and apply evidence in ways that support culturally responsive healthcare and equitable outcomes for Aboriginal and Torres Strait Islander peoples.

Completion of this report is mandatory as part of the Scholar Portfolio.

Report Requirements

Prepare a report of approximately **1,500 words** that critically examines an Aboriginal and Torres Strait Islander research evaluation framework and reflects on its implications for scholarship and evidence-informed physiotherapy practice.
The report should demonstrate critical engagement with the selected framework and thoughtful reflection on how Aboriginal and Torres Strait Islander approaches to research evaluation may influence your development as a scholar and evidence-informed practitioner.

1. Introduction (Approximately 150-200 words)
Provide a brief introduction that:

- Explains the purpose of research evaluation.
- Introduces the selected Aboriginal and Torres Strait Islander research evaluation framework.
- Outlines the purpose and structure of the report.

The introduction should establish the relevance of research evaluation to evidence-informed practice, healthcare quality, and culturally responsive care.

2. Understanding Aboriginal and Torres Strait Islander Approaches to Research Evaluation (Approximately 400-500 words)
Drawing on the selected Aboriginal and Torres Strait Islander research evaluation framework:

- Describe the key principles underpinning the framework.
- Discuss key concepts such as:
    - Aboriginal and Torres Strait Islander self-determination
    - Aboriginal and Torres Strait Islander governance
    - Partnership and collaboration
    - Reciprocity
    - Community benefit
    - Data sovereignty
    - Capacity building
- Consider how these principles influence the design, conduct, evaluation, reporting, and translation of research involving Aboriginal and Torres Strait Islander peoples.

This section should demonstrate an understanding of the framework and the perspectives on which it is based.

3. Reflection on Scholarship and Evidence-Informed Practice (Approximately 700-800 words)

Reflect on how this learning may influence your development as a scholar and evidence-informed practitioner. Consider:

- How has this learning challenged, reinforced, or changed your understanding of what constitutes high-quality research?
- How might Aboriginal and Torres Strait Islander research evaluation principles influence the way you evaluate, interpret, or apply evidence in practice?
- What implications does this learning have for stakeholder engagement, research partnerships, knowledge translation, quality improvement activities, or professional decision-making?
- What actions will you take to strengthen culturally responsive scholarship and evidence-informed practice?

Reflections should demonstrate critical thinking, self-awareness, and application to current or future professional contexts.

4. Conclusion (Approximately 100-150 words)

Provide a brief conclusion that:

- Summarises the key insights gained from the selected framework.
- Highlights the implications for evidence-informed physiotherapy practice and scholarship.
- Identifies priorities for ongoing learning and professional development.

Report Expectations

The report should:

- Demonstrate engagement with Aboriginal and Torres Strait Islander perspectives on research evaluation.
- Move beyond description to critical reflection and application.
- Identify implications for evidence-informed physiotherapy practice.
- Demonstrate reflection on assumptions, professional responsibilities, and ongoing development as a scholar.
- Clearly link learning to culturally responsive healthcare and equitable health outcomes.

Recommended Reading

Harfield, S., Pearson, O., Morey, K., Kite, E., Canuto, K., Glover, K., Gomersall, J. S., Carter, D., Davy, C., Aromataris, E., & Braunack-Mayer, A. (2020). Assessing the quality of health research from an Indigenous perspective: The Aboriginal and Torres Strait Islander quality appraisal tool. *BMC Medical Research Methodology, 20*(1), 79. https://doi.org/10.1186/s12874-020-00959-3

Huria, T., Palmer, S. C., Pitama, S., Beckert, L., Lacey, C., Ewen, S., Smith, L. T., Reid, P., & Hughes, C. (2019). Consolidated criteria for strengthening reporting of health research involving Indigenous peoples: The CONSIDER statement. *BMC Medical Research Methodology, 19*(1), 173. https://doi.org/10.1186/s12874-019-0815-8

Kelaher, M., Luke, J., Ferdinand, A., Chamravi, D., Ewen, S., & Paradies, Y. (2018). *An evaluation framework to improve Aboriginal and Torres Strait Islander health*. Centre for Health Policy, Melbourne School of Population and Global Health, The University of Melbourne, prepared for the Lowitja Institute.

Marking Rubric for Culturally Responsive Practice Report

Criterion & Weighting	**Exceeds Standard**	**Meets Standard High**	**Meets Standard**	**Does not meet Standard**
Understanding Aboriginal and Torres Strait Islander Approaches to Research Evaluation (20%)	Demonstrates a nuanced understanding of the selected research evaluation framework and critically examines how its principles influence the conduct, evaluation, and use of research.	Demonstrates a well-developed understanding of the selected research evaluation framework and discusses the significance of its key principles.	Identifies and explains the key principles and concepts underpinning the selected research evaluation framework.	Demonstrates limited understanding of the selected framework or key principles are insufficiently explained.
Critical Engagement with Aboriginal and Torres Strait Islander Evaluation Principles (25%)	Critically examines the assumptions, values, strengths, and implications of the framework and demonstrates sophisticated engagement with these perspectives on research and	Discusses the implications of the framework and demonstrates thoughtful engagement with these perspectives on research and evaluation.	Describes the framework and demonstrates understanding of its relevance to research and evaluation.	Discussion is primarily descriptive, limited in scope, or demonstrates insufficient engagement with the framework.

	knowledge generation.			
Reflection on Scholarship and Evidence-Informed Practice (20%)	Demonstrates critical reflection on assumptions, professional responsibilities, and approaches to evaluating and applying evidence. Clearly articulates how learning has influenced scholarly thinking and practice.	Demonstrates thoughtful reflection on scholarship and evidence-informed practice and discusses how learning may influence professional decision-making.	Reflects on learning gained through engagement with the framework and identifies implications for professional practice.	Reflection is minimal, primarily descriptive, or demonstrates limited consideration of implications for practice.
Application to the Scholar Role at Milestone 4 (15%)	Demonstrates a sophisticated understanding of how Aboriginal and Torres Strait Islander evaluation principles can inform scholarship, knowledge translation, quality improvement, research engagement, and evidence-informed practice.	Explains how Aboriginal and Torres Strait Islander evaluation principles may influence scholarship and evidence-informed practice within professional contexts.	Identifies ways the learning is relevant to the Scholar role and evidence-informed physiotherapy practice.	Limited or unclear links between the learning and the Scholar role.
Future Professional Development and Action (10%)	Identifies specific, realistic, and meaningful actions to strengthen culturally responsive scholarship and evidence-informed practice.	Identifies practical actions to strengthen scholarship, evidence-informed practice, or culturally responsive professional development	Identifies actions or areas for future professional development arising from the learning.	Future actions or development needs are absent or insufficiently developed.

	Clearly explains how these actions may influence future professional practice.	and explains their relevance.		
Professional Communication and Referencing (10%)	Writing is clear, concise, well-structured, and consistently supported by relevant literature. Referencing is accurate throughout.	Writing is clear and organised with appropriate use of literature and only minor presentation or referencing issues.	Writing communicates ideas clearly and uses literature to support discussion. Minor issues with structure, presentation, or referencing may be evident.	Significant issues with communication, structure, use of literature, or referencing detract from the report.

Recognition of Prior Learning: Doctor of Philosophy (PhD) or Masters by Research

A completed PhD demonstrates advanced research capability, critical inquiry, knowledge generation, dissemination of findings, and scholarly leadership. A Masters by Research demonstrates the ability to design, conduct, analyse, and disseminate research relevant to physiotherapy or health professions education.

If seeking RPL for the role of the Scholar, please provide a copy of your Degree Certificate.

Section 11 Further information and resources (Optional)

This optional section provides further information about frameworks and professional development (PD) activities that you might consider for deepening your understanding of the concepts, frameworks and approaches that underpin reflective practice and intended learning outcomes relevant to specific roles at Milestone 4. While completing a course is **not a mandatory requirement** for portfolio submission, it can be a valuable way to strengthen your understanding of areas such as health equity, the social determinants of health, population health, health promotion, advocacy and systems-level change, so that you can meet competency requirements at the Milestone 4 level. This may be particularly beneficial if these concepts are not a significant focus of your current role or previous professional development.

The courses listed below are examples of programs designed for health professionals that can be completed over a relatively short period of time. They are intended as suggestions only and do not represent an exhaustive list. Many of these programs involve enrolment fees or other costs, and candidates are encouraged to undertake their own due diligence regarding the currency, time commitment, and financial implications of any course before enrolling.

Reflection and Portfolio Curation

Reflection is a cornerstone of professional practice and an essential component of developing a meaningful and authentic portfolio. A portfolio should be more than a collection of achievements, certificates, project outputs, or examples of work. Rather, it should demonstrate how an individual's experiences have contributed to their growth, informed their decision-making, strengthened their capabilities, and influenced outcomes for learners, colleagues, organisations, and communities. Reflection transforms evidence into insight, enabling practitioners to articulate not only *what* they have done, but *why* it was important, *how* it was undertaken, and *what* was learned from the experience.

Reflective practice is fundamental to demonstrating capability at Milestone 4 across the domains of Scholar, Leader, Collaborator, and Health Advocate. Through systematic reflection on experiences, outcomes, relationships, and professional decisions, practitioners make visible the reasoning, learning, and growth that underpin their practice. Reflection strengthens self-awareness, supports evidence-informed decision-making, promotes continuous improvement, and enables professionals to articulate their impact on learners, colleagues, organisations, and communities. Within the portfolio, reflective commentary transforms evidence into meaningful demonstrations of competence, illustrating not only what has been achieved, but how learning has been generated and applied to improve future practice.

For practitioners aspiring to or performing at Milestone 4 across the domains of Scholar, Leader, Collaborator, and Health Advocate, reflection provides the mechanism by which professional expertise becomes visible. It allows candidates to demonstrate advanced judgement, critical thinking, self-awareness, and continuous improvement, all of which are hallmarks of specialist professional practice.

Reflective Practice as a Professional Competency

Reflective practice is widely recognised as a core professional competency across education, health professions, and leadership contexts. Schön (1983) described reflective

practitioners as professionals who engage in continuous learning through examination of their actions and experiences. Reflection enables practitioners to move beyond routine performance, critically analyse situations, challenge assumptions, and adapt their practice in response to changing contexts.

At Milestone 4, reflective practice extends beyond personal development to demonstrate insight into the broader impact of practice on clients, teams, services, and health systems, including:

- Critical evaluation of one's professional impact
- Analysis of complex situations and decision-making processes
- Integration of evidence, theory, and experience
- Recognition of strengths, limitations, and areas for growth
- Application of lessons learned to future practice
- Commitment to continuous quality improvement
- Influence on the learning and practice of others
- Consideration of the broader organisational, regional, and health system contexts in which practice occurs

Reflective practitioners actively seek feedback, engage with evidence-informed practice, consider multiple perspectives, and use reflection to guide future actions. Reflection therefore becomes both, a professional capability and evidence of professional maturity.

What Does Good Reflection Look Like

High-quality reflection moves beyond description. Simply recounting what occurred is insufficient. Effective reflection demonstrates critical analysis, self-awareness, learning, and application.

A common progression is:

Descriptive Reflection: "I developed a new orientation program for learners."

Analytical Reflection: "I developed a new orientation program after identifying gaps in learner preparedness. Feedback from previous cohorts highlighted inconsistent understanding of expectations. Drawing on transition-to-practice literature, I redesigned the program to incorporate peer mentoring and structured resources."

Critical Reflection: "The program improved learner confidence scores and reduced requests for additional support. However, feedback from rural learners indicated that certain resources did not adequately address their context. This highlighted assumptions I had made regarding learner needs and reinforced the importance of co-design with stakeholder groups. In future iterations, I will involve learner representatives earlier in the design process."

The final example demonstrates analysis, insight, evidence, self-awareness, learning, and future action, all key characteristics of reflective practice.

Frameworks That Can Support Reflection

There is no single correct framework for reflection in a portfolio. Different models may be appropriate depending on the experience being examined. Some of the commonly used models for reflective practice are provided below.

Gibbs' Reflective Cycle (1988)
A widely used structured model consisting of:

1. Description
2. Feelings
3. Evaluation
4. Analysis
5. Conclusion
6. Action Plan

This framework is particularly useful for systematically examining specific experiences and identifying learning that can be applied to future practice.

Schön's (1983) Reflection-in-Action and Reflection-on-Action
Schön distinguished between:

- Reflection-in-action: thinking critically during practice and adapting in response to unfolding situations.
- Reflection-on-action: reviewing and analysing experiences after they occur to inform future practice.

Together, these forms of reflection support the development of professional judgement, adaptability, and continuous improvement in practice.

Rolfe et al.'s Framework (2001)
This simple model asks:

- What?
- So What?
- Now What?

It is highly effective for concise portfolio reflections and aligns well with competency-based evidence.

De Bono's Six Thinking Hats (1985)
A structured reflection framework that encourages consideration of an issue from multiple perspectives:

1. **White Hat**: facts, information, and evidence.
2. **Red Hat**: feelings, intuition, and emotional responses.
3. **Black Hat**: risks, limitations, and potential problems.
4. **Yellow Hat**: benefits, strengths, and opportunities.
5. **Green Hat**: creativity, alternatives, and new ideas.
6. **Blue Hat**: process management, synthesis, and next steps.

This framework supports comprehensive reflection by encouraging practitioners to explore situations from different viewpoints, promoting balanced decision-making, critical thinking, and problem-solving in practice. *(reference)*

Key References

Gibbs, G. (1988). *Learning by Doing: A Guide to Teaching and Learning Methods*. Oxford Polytechnic.

Rolfe, G., Freshwater, D., & Jasper, M. (2001). *Critical Reflection for Nursing and the Helping Professions: A User's Guide*. Palgrave Macmillan.

Schön, D. A. (1983). *The Reflective Practitioner: How Professionals Think in Action*. Basic Books.

Moon, J. A. (2004). *A Handbook of Reflective and Experiential Learning*. Routledge Falmer.

Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. *Advances in Health Sciences Education*, 14(4), 595-621.

Guidelines for writing, referencing and redaction

Standard of Writing

Writing for Milestone 4 Role Portfolios requires a high standard of rigour, clarity, logical structuring and professionalism. The portfolio should demonstrate expert knowledge, skills, critical thinking and reflective practice, supported by evidence-based practice. It is essential to structure the writing logically. Adherence to academic conventions, including proper referencing (if/where appropriate), precise language and a formal tone, is critical. The writing should also reflect a commitment to ethical standards, particularly when discussing patient cases or clinical scenarios, ensuring confidentiality and respect are maintained.

Submissions must demonstrate:

1. Highly developed clinical knowledge and critical thinking showcasing a deep understanding of physiotherapy concepts, applying evidence-based practice to clinical scenarios. The ability to critically evaluate information, synthesise evidence, and present well-reasoned arguments is essential.

2. Reflective capacity, integrating personal insights, professional learning, and self-assessment. Candidates should analyse their clinical experiences, identify areas for growth, and connect their reflections to evidence-based improvements in practice.

3. Logical structure and clarity, with well-defined sections and smooth transitions. Ideas should be presented cohesively and concisely, ensuring the content flows logically and supports the overall narrative.

4. Adherence to academic conventions using precise, formal language and follow academic conventions, including a recognised referencing style (such as Vancouver or JAMA), where appropriate. All claims must be supported by high-quality evidence from research or clinical guidelines.

5. Professional tone and ethical standards reflecting professionalism and ethical responsibility. When discussing patient cases or clinical scenarios, maintain confidentiality and demonstrate respect for patients and colleagues. Avoid informal language and adhere to ethical standards.

6. Commitment to quality submissions demonstrating attention to detail, including proper grammar, punctuation and spelling.

General Guidelines

- Clear, persuasive communication of ideas supported by evidence
- Engaging and authentic, integrating clinical practice into real-world scenario
- Reflective and professional tone adhering to the standards of the physiotherapy profession

Referencing style

Use a consistent and professional referencing style to ensure clarity and alignment with academic and professional standards.

The following referencing styles are recommended:

1. **Journal of Physiotherapy (preferred)**

The Journal of Physiotherapy uses the Vancouver referencing style, which is widely accepted in the physiotherapy profession. References are numbered in the order they appear in the text using superscript numbers, with the corresponding full citations listed numerically at the end of the document.

o Example for Journal Articles: Smith AB, Johnson CD. Advances in rehabilitation techniques. J Physiother. 2021; 67(4): 300-306

o Example for Books: Brown EF, Green GH. Manual Therapy Essentials. 2nd ed. Elsevier; 2020

2. **JAMA (alternative)**

Candidates may also use the JAMA referencing style, as it is similar to the Journal of Physiotherapy format. JAMA uses superscript numbers for in-text citations, with references listed numerically at the end.

o Example for Journal Articles: Smith AB, Johnson CD. Advances in rehabilitation techniques. JAMA. 2021;325(10):1234-1240

o Example for Books: Brown EF. Fundamentals of Physiotherapy. 3rd ed. Springer; 2020

General Guidelines

• Be consistent: Use the same referencing style throughout the submission

• Abbreviate journal titles according to the National Library of Medicine (NLM) format

• Ensure all sources are accurately cited and include sufficient details for verification

Resources for Assistance

- For guidance on the Journal of Physiotherapy referencing style, refer to the Vancouver Style Manual or consult examples provided in the journal's Instructions for Authors.
- For details on the JAMA referencing style, consult the JAMA Manual of Style.
- Consider using a reference management application that allows you to store, organise, annotate and cite research sources. Applications like Mendeley are available at no cost.

Confidentiality/Redaction of sensitive data

To protect privacy and confidentiality, it is crucial to remove any identifiable information, including names of clients, families, and other health professionals. Ideally, both first and last names should be fully redacted from written documents, and where feasible, from video evidence as well.

Redacting videos

Fully removing names from video can be challenging. If only the first name is mentioned and there are no other identifying details, it is acceptable to leave it as is. However, if other identifying information is present, such as unusual first names or specific health details, redaction is recommended.

Redacting written documents

When redacting sensitive information, the goal is to ensure that any personally identifiable information or confidential details are completely removed or obscured. This includes, but is not limited to, names, contact information, health conditions, and any other details that could identify an individual.

Steps for redacting written documents

1. Names and Identifiers

• **Full Name**: Redact both the first and last names of patients, clients, and healthcare providers unless their name is crucial to the context and they have given consent to its use. Example: *John Doe* becomes **[REDACTED]**

• **Initials**: Sometimes initials are used in place of full names. These should also be redacted if they could be used to identify someone. Example: *J.D.* becomes **[REDACTED]**

• **Other Identifiers**: Redact any other unique identifiers such as: • **Medical Record Numbers**: These should always be redacted to avoid linking a document to an individual

• **Health Insurance Numbers**: These are typically unique to each person and should be removed

• **Identification Numbers**: This can include any form of ID (e.g. government-issued IDs, membership numbers) that could link back to the individual

2. Contact Information

• **Addresses**: Residential and workplace addresses should be redacted. Example: *123 Main St, Melbourne* becomes **[REDACTED]**

• **Phone Numbers**: Any personal phone numbers (e.g., mobile or home numbers) should be removed. Example: *0412 345 678* becomes **[REDACTED]**

• **Email Addresses**: Personal email addresses should also be removed. Example: *johndoe@example.com* becomes **[REDACTED]**

3. Dates and Time-Related Information

• **Dates of Birth**: Any specific birth dates, including the year, month, and day, should be redacted to avoid identifying the individual. Example: *January 1, 1980* becomes **[REDACTED]**

4. Photographs, Videos and Audio

• **Faces and Identifiable Features**: In written documentation, you may reference photographs, video evidence, or audio files. Ensure any visual or auditory features that can identify individuals (e.g., faces, names spoken aloud, personal characteristics) are obscured. If you're unable to redact a face or other identifying feature, it's better to remove the material entirely or gain explicit consent for its use

5. Other Sensitive Information

• **Workplace or School Names**: If a person's workplace, school, or organization is not necessary to the document's purpose, redact it. Example: *St. Joseph's Hospital* becomes **[REDACTED]** Family or Emergency Contact Information: If included, this type of information should also be redacted. Example: Jane Doe (spouse) becomes **[REDACTED]**

Tools and methods for redaction:

1. **Manual Redaction**

• Use tools like a black marker or pen to completely cover the text. Ensure the redacted information is illegible and cannot be recovered

2. **Digital Redaction**

• If working with digital documents, use software tools that are designed for redaction (e.g., Adobe Acrobat, Microsoft Word, or specific redaction software)

• Make sure the redacted text is not just visually hidden (e.g., using white font colour or highlighting), as this could still be extracted or visible in the document properties Redacting tools ensure that the hidden content is permanently deleted or replaced with black bars, making it inaccessible

Best practices for redaction

• **Be consistent:** Ensure all personally identifiable information is consistently redacted across the document

• **Review the document:** After redacting, review the document thoroughly to ensure no sensitive information remains visible or recoverable

• **Secure storage:** Ensure that both the redacted and original (non-de-identified) versions of the document are stored securely in compliance with your organization's privacy policies

Special considerations for educational use

If using medical records or personal data for educational purposes, follow these additional steps:

• **Consent:** Ensure you have explicit consent from individuals for the use of their data if full de-identification is not possible

• **De-identification standard:** Aim for a high standard of de-identification. If possible, remove information that could inadvertently identify a person in combination with other available details (e.g. uncommon names or unique health conditions)

Useful Resource on Cultural Responsiveness

Cultural Responsiveness Framework Guidelines for Victorian health services (2009) is designed to align with health services' strategic planning and clinical governance frameworks, ensuring that culturally diverse populations receive equitable, safe, and high-quality care. The framework is structured along four domains for planning, evaluating and improving organisational effectiveness, risk management, consumer participation and effective workforce.

Professional Development Courses on Health Advocacy

You are encouraged to select learning opportunities that align with your professional context, interests and development needs, and there may be other courses, workshops or programs that are equally relevant to supporting your growth as a Health Advocate. Ultimately, the value lies not in completing a particular course, but in your ability to apply the learning to practice and demonstrate how it has informed your advocacy activities and contributed to improved health outcomes, equity or system improvement.

Monash Driving Change: Harnessing Implementation Science for Healthcare Improvement, Real-World Impact, and Equity

Provider: Monash University (MCHRI)
Duration: Self-paced, (3 hours per week for 3 weeks) – access on demand provided on registration
Mode: Fully Online

Evidence generated: Service improvement projects, implementation plans, evaluation frameworks.
Relevant Role(s): Health Advocate
Excellent for candidates using quality improvement, health surveillance, evaluation and service redesign as Health Advocate evidence.

Graduate Certificate Options (equivalent to 6 months full-time study load) are more substantial commitments.

Graduate Certificate in Health Promotion (UniSC Online)

Duration: 6 months full-time (one semester equivalent)
Mode: Fully online
Key subjects: Community assessment and planning, health promotion implementation and evaluation, healthy public policy and advocacy.
Relevant Role(s): Health Advocate
Strong Graduate Certificate purely from a Health Advocate perspective because healthy public policy and advocacy are explicitly included.

Graduate Certificate in Health Promotion (Flinders Online)

Duration: 6 months full-time (one semester equivalent)
Mode: Fully online
Focus: health professionals looking to extend their influence on patient outcomes.
Relevant Role(s): Health Advocate.
Strong theoretical grounding in health promotion and population health approaches.

Graduate Certificate in Public Health (University of Melbourne)

Duration: 6 months full-time (one semester equivalent)
Mode: Fully online
Focus: Foundation in public health with two electives across epidemiology, biostatistics, qualitative research and public health leadership
Relevant Role(s): Health Advocate and Leader

Professional Development Courses on Leadership

If you **have not** previously completed PD in Leadership in the Health Sector, you are strongly encouraged to complete some formal training as part of your evidence portfolio.

The courses listed below are examples of programs designed for health professionals that can be completed over a relatively short period of time. They are intended as suggestions only and do not represent an exhaustive list. You are encouraged to select learning opportunities that align with your professional context, interests and development needs, and there may be other courses, workshops or programs that are equally relevant to supporting your growth as a Leader. Ultimately, the value lies not in completing a particular

course, but in your ability to apply the learning to practice and demonstrate how it has informed your leadership activities and contributed to system improvement.

Leadership for Clinicians

Provider: Royal Australasian College of Medical Administrators (RACMA)
Duration: Multi-module program delivered across the year
Mode: Fully online or blended delivery
Evidence generated: Professional development plan, adverse event reflection, workforce management analysis, governance and leadership assessments.
Relevant Role(s): Leader
This is one of the most comprehensive health leadership programs available nationally. Topics include healthcare systems, clinical governance, financial governance, workforce leadership, quality and safety, and leading organisational change, making it an excellent fit for all leadership portfolio outcomes.

This program has been reviewed by two senior physiotherapists who have rated it highly and as suitable for Specialists in both the private practice and public health sectors. Physiotherapists currently have a 10% discount to access this program.

Leadership in Healthcare and Aged Care

Provider: Deakin University
Duration: 6 weeks
Mode: 100% online, flexible/self-paced delivery
Evidence generated: Leadership action plan, strategic change project, healthcare systems analysis, reflective leadership activities.
Relevant Role(s): Leader
This course focuses on strategic leadership in healthcare systems, leading organisational change, and developing leadership capability. The assessed leadership action plan provides strong evidence for system-level quality improvement, service innovation, and leading evidence-informed change.

Intensive Clinical Leadership

Provider: University of Melbourne
Duration: 2-day intensive
Mode: Intensive short course
Evidence generated: Leadership development activities, healthcare change initiatives, mentoring and coaching reflections, team leadership projects.
Relevant Role(s): Leader
Designed specifically for healthcare professionals, this course develops practical skills in leading healthcare change, influencing health systems, coaching colleagues, managing challenges, and improving service delivery. It offers strong evidence across all leadership ILOs.

Evolving Health Leadership

Provider: Monash University
Duration: Short online microcredential
Mode: Fully online
Evidence generated: Leadership development activities, organisational culture analysis, team performance improvement plans, strategic leadership reflections.
Relevant Role(s): Leader
This course helps clinicians transition into leadership roles, with a strong emphasis on healthcare transformation, coaching others, building high-performing teams, and leading change in complex healthcare environments.

Effective Leadership in the Healthcare Setting

Provider: Australian Institute of Clinical Governance (AICG)
Duration: 9 hours self-paced learning
Mode: Fully online
Evidence generated: Leadership self-assessment, innovation and change activities, clinical governance reflections, quality improvement exercises.
Relevant Role(s): Leader
This introductory leadership course develops capability in clinical governance, innovation, design thinking, and leading change. It is particularly suitable for demonstrating foundational leadership and quality improvement knowledge.

Foundations of Directorship™ for Healthcare Leaders

Provider: Australian Institute of Company Directors (AICD) and Australian Institute of Health Executives (AIHE)
Duration: 4 days
Mode: Intensive professional development program
Evidence generated: Governance analyses, financial stewardship activities, strategic planning exercises, risk management and clinical governance case studies.
Relevant Role(s): Leader
This program develops governance, financial literacy, risk management, and strategic leadership capabilities. It is particularly valuable for demonstrating resource stewardship, system-level leadership, and organisational decision-making.

Graduate Certificate in Health Leadership

Provider: University of Notre Dame Australia
Duration: 6 months part-time
Mode: Fully online multimode delivery
Evidence generated: Workplace leadership project, peer coaching activities, leadership application project.
Relevant Role(s): Leader
This course includes deliberate inclusion of peer coaching, health industry speakers and

structured networking. The program explicitly aims to build communities of practice across Australia rather than simply delivering academic content.

Health Leadership Programs and Masterclasses

Provider: Australian Institute of Health Executives (AIHE)
Duration: 1-day masterclasses to multi-day programs
Mode: Online and face-to-face national offerings
Evidence generated: Governance activities, strategic planning exercises, clinical governance case studies, leadership development plans.
Relevant Role(s): Leader
AIHE is specifically designed for healthcare leaders and executives. Their programs focus on clinical governance, finance, data-driven decision making, service planning and executive leadership. Participants are typically senior clinicians, directors and executives, creating exceptionally strong networking opportunities.

Governance and document control

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Document owner	Training and Assessment Manager
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