

# Core Competencies for Interprofessional Collaborative Practice

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Report of an Expert Panel  
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# Core Competencies for Interprofessional Collaborative Practice

## Report of an Expert Panel

This report is inspired by a vision of interprofessional collaborative practice as key to the safe, high quality, accessible, patient-centered care desired by all. Achieving that vision for the future requires the continuous development of interprofessional competencies by health professions students as part of the learning process, so that they enter the workforce ready to practice effective teamwork and team-based care. Our intent was to build on each profession's expected disciplinary competencies in defining competencies for interprofessional collaborative practice. These disciplinary competencies are taught within the professions. The development of interprofessional collaborative competencies (interprofessional education), however, requires moving beyond these profession-specific educational efforts to engage students of different professions in interactive learning with each other. Being able to work effectively as members of clinical teams while students is a fundamental part of that learning.



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## Organization of Report

This report is organized in the following fashion: first, we provide key definitions and principles that guided us in identifying core interprofessional competencies. Then, we describe the timeliness of interprofessional learning now, along with separate efforts by the six professional education organizations to move in this direction. We identify eight reasons why it is important to agree on a core set of competencies across the professions. A concept- interprofessionality- is introduced as the idea that is foundational to the identification of core interprofessional competency domains and the associated specific competencies. Interprofessional education has a dynamic relationship to practice needs and practice improvements. In the concluding background section, we describe three recently developed frameworks that identify interprofessional education as fundamental to practice improvement.

Then, the competency approach to learning is discussed, followed by what distinguishes *interprofessional* competencies. We link our efforts to the five Institute of Medicine (IOM) core competencies for all health professionals (IOM, 2003). The introduction and discussion of the four competency domains and the specific competencies within each form the core of the report. We describe how these competencies can be formulated into learning objectives and learning activities at the pre-licensure/pre-certifying level, and name several factors influencing choice of learning activities. Educators are now beginning to develop more systematic curricular approaches for developing interprofessional competencies. We provide several examples. We conclude the report with discussion of key challenges to interprofessional competency development and acknowledge several limitations to the scope of the report. An appendix describes the goals of the IPEC group that prompted the development of this report, the panel's charge, process and participants.

## Setting the Parameters

Preliminary work to review previously identified interprofessional competencies and related frameworks, along with core background reading on competency development, preceded our face-to-face, initial meeting. Consensus working definitions of interprofessional education and interprofessional collaborative practice were agreed to at that meeting. The need to define the difference between teamwork and team-based care as different aspects of interprofessional collaborative practice, and agreement on competency definitions came later in our work. The definitions we chose for interprofessional education and interprofessional collaborative practice are broad, current, and consistent with language used widely in the international community. Teamwork and team-based care definitions distinguish between core processes and a form of interprofessional care delivery. Competency definitions are consistent with the charge given to the expert panel by the Interprofessional Education Collaborative.

## Operational Definitions

### **Interprofessional education:**

“When students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes” (WHO, 2010)

### **Interprofessional collaborative**

**practice:** “When multiple health workers from different professional backgrounds work together with patients, families, carers [sic], and communities to deliver the highest quality of care” (WHO, 2010)

**Interprofessional teamwork:** The levels of cooperation, coordination and collaboration characterizing the relationships between professions in delivering patient-centered care

### **Interprofessional team-based care:**

Care delivered by intentionally created, usually relatively small work groups in health care, who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or group of patients, e.g., rapid response team, palliative care team, primary care team, operating room team

### **Professional competencies in health**

**care:** Integrated enactment of knowledge, skills, and values/attitudes that define the domains of work of a particular health profession applied in specific care contexts

### **Interprofessional competencies in**

**health care:** Integrated enactment of knowledge, skills, and values/attitudes that define working together across the professions, with other health care workers, and with patients, along with families and communities, as appropriate to improve health outcomes in specific care contexts

### **Interprofessional competency domain:**

A generally identified cluster of more specific interprofessional competencies that are conceptually linked, and serve as theoretical constructs (ten Cate & Scheele, 2007)

We agreed that the competency domains and specific competencies should remain general in nature and function as guidelines, allowing flexibility within the professions and at the institutional level. Faculty and administrators could access, share, and build on overall guidelines to strategize and develop a program of study for their profession or institution that is aligned with the general interprofessional competency statements but contextualized to individual professional, clinical, or institutional circumstances. We identified desired principles of the interprofessional competencies:

- ▶ Patient/family centered (hereafter termed “patient centered”)
- ▶ Community/population oriented
- ▶ Relationship focused
- ▶ Process oriented
- ▶ Linked to learning activities, educational strategies, and behavioral assessments that are developmentally appropriate for the learner
- ▶ Able to be integrated across the learning continuum
- ▶ Sensitive to the systems context/applicable across practice settings
- ▶ Applicable across professions
- ▶ Stated in language common and meaningful across the professions
- ▶ Outcome driven



## Why Interprofessional Competency Development Now?

“Why do we need to educate teams for the delivery of health care? Who should be educated to serve on health delivery teams? How should we educate students of health professions in order that they might work in teams (emphasis on classroom and basic behavioral and biological sciences curriculum)? How should we educate students and health professionals in order that they might work in teams (emphasis on clinical training)? What are the requirements for educating health professionals to practice in health care delivery teams? What are the obstacles to educating health professionals to practice in health care delivery teams?”

(IOM, 1972, pp. 1-2)

Currently, the transformation of health professions education is attracting widespread interest. The transformation envisioned would enable opportunities for health professions students to engage in interactive learning with those outside their profession as a routine part of their education. The goal of this interprofessional learning is to prepare all health professions students for **deliberatively working together** with the common goal of building a safer and better patient-centered and community/population oriented U.S. health care system.

Interest in promoting more team-based education for U.S. health professions is not new. At the first IOM Conference, “Interrelationships of Educational Programs for Health Professionals,” and in the related report “Educating for the Health Team” (IOM, 1972), 120 leaders from allied health, dentistry, medicine, nursing, and pharmacy considered key questions at the forefront of contemporary national discussions about interprofessional education.

The move to encourage team-based education at that time grew out of several assumptions made by that IOM Committee: that there were serious questions about how to use the existing health workforce optimally and cost-effectively to meet patient, family, and community health care needs; that educational institutions had a responsibility not only to produce a healthcare workforce that was responsive to health care needs but also to ensure that they could practice to their full scope of expertise; that optimal use of the health professions workforce required a cooperative effort in the form of teams sharing common goals and incorporating the patient, family, and/or community as a member; that this cooperation would improve care; and that the existing educational system was not preparing health professionals for team work. Almost 40 years later, these issues are still compelling.

The 1972 Conference Steering Committee recommendations were multilevel: organizational, administrative, instructional, and national. At the organizational and instructional levels, they cited the obligation of academic health centers to conduct interdisciplinary education and patient care; to develop methods to link that education with the “practical requirements” of health care; to use clinical settings, especially ambulatory settings, as sites for this education; to integrate classroom instruction in the humanities and the social and behavioral sciences; and to develop new faculty skills in instruction that would present role models of cooperation across the health professions. At the national level, the recommendations called for developing a national “clearinghouse” to share instructional and practice models; providing government agency support for innovative instructional and practice models, as well as examining obstacles to such efforts; and initiating a process in the IOM to foster interdisciplinary education in the health professions. These recommendations have currency today.

The IOM report encouraged funding for educational demonstrations of interdisciplinary professional education in the Health Resources and Services Administration (HRSA), and the effort garnered substantial foundation support. However, such programs remained largely elective, dependent on this external support, and targeted small numbers of students. Several intra- and interprofessional factors limited “mainstreaming” of interprofessional education during this time (Schmitt, Baldwin, & Reeves, forthcoming).

Reports between then and now (e.g., O’Neil & the Pew Health Professions Commission, 1998) have made similar recommendations, and interprofessional care has found traction in numerous specialized areas of health care. However, with the isolation of health professions education from the practice of health care, practice realities have not been sufficient to motivate fundamental health professions’ educational changes. Compelling larger-scale practice issues that emerged in the past decade have prompted broad-based support for changes in health professions education, including interactive learning to develop competencies for teamwork and team-based care.

Widespread patient error in U.S. hospitals associated with substantial preventable mortality and morbidity, as well as major quality issues, has revealed the inadequacies in costly systems of care delivery (IOM, 2000, 2001). It is clear that **how** care is delivered is as important as **what** care is delivered. Developing effective teams and redesigned systems is critical to achieving care that is patient-centered, safer, timelier, and more effective, efficient, and equitable (IOM, 2001). Equipping a workforce with new skills and “new ways of relating to patients and each other” (IOM, 2001, p. 19) demands both retraining of the current health professions workforce and interprofessional learning approaches for preparing future health care practitioners.

The focus on workforce retraining to build interprofessional teamwork and team-based care continues, particularly in the context of improving institutional quality (effectiveness) and safety (Agency for Healthcare Research and Quality, 2008; Baker et al., 2005a, 2005b; King et al., 2008). Growing evidence supports the importance of better teamwork and team-based care delivery and the competencies needed to provide that kind of care.

The passage of the Recovery and Reinvestment Act of 2009 (Steinbrook, 2009) and the Patient Protection and Affordable Care Act of 2010 (Kaiser Family Foundation, 2010) has stimulated new approaches, such as the “medical home” concept, to achieving better outcomes in primary care, especially for high-risk chronically ill and other at-risk populations. Improved interprofessional teamwork and team-based care play core roles in many of the new primary care approaches.

The idea of primary care and its relationship to the broader context of health is itself being reconsidered. First, in primary care there is a focus on expanded

accountability for population management of chronic diseases that links to a community context. Second, health care delivery professionals jointly with public health professionals share roles and responsibilities for addressing health promotion and primary prevention needs related to behavioral change. Third, health care professionals and public health professionals work in collaboration with others on behalf of persons, families and communities in maintaining healthy environments, including responding to public health emergencies. All of these elements link direct health care professionals more closely with their public health colleagues. Therefore, the principles from which we worked included both patient-centeredness and a community/population orientation.

Teamwork training for interprofessional collaborative practice in health professions education has lagged dramatically behind these changes in practice, continually widening the gap between current health professions training and actual practice needs and realities. To spur educational change, after releasing the two reports on safety and quality (IOM, 2000, 2001), the IOM sponsored a second summit on health professions education. Attendees at the summit identified five competencies central to the education of all health professions for the future: provide patient-centered care, apply quality improvement, employ evidence-based practice, utilize informatics, and work in interdisciplinary teams (IOM, 2003). It was noted that many successful examples of interprofessional education exist but that “interdisciplinary education has yet to become the norm in health professions education” (IOM, 2003, p. 79).

Recognizing that health professions schools bear the primary responsibility for developing these core competencies, considerable emphasis also was placed on better coordinated oversight processes (accreditation, licensure, and certification) and continuing education to ensure the development, demonstration, and maintenance of the core competencies. The report indicated that although the *accrediting* standards of most professions reviewed contained content about interdisciplinary teams, few of these were outcomes-based competency expectations.

### **Interprofessional education, by profession**

Policy, curricular, and/or accreditation changes to strengthen teamwork preparation are at various stages of development among the six professions represented in this report. The American Association of Colleges of Nursing, for example, has integrated interprofessional collaboration behavioral expectations into its “Essentials” for baccalaureate (2008) master’s (2011) and doctoral education for advanced practice (2006). Leaders within nursing have drawn from the IOM framework of the five core competencies for all health professionals to compose pre-licensure and graduate-level competency statements geared toward quality and safety outcomes, which integrate teamwork and team-based competencies (Cronenwett et al., 2007, 2009).

The Association of American Medical Colleges (AAMC) formally identified interprofessional education as one of two “horizon” issues for action in 2008, although calls for attention to interprofessional education can be traced back through a series of AAMC reports, including its landmark 1965 Coggeshall Report. An initial survey was conducted of interprofessional education in U.S. medical schools in 2008 and serves as a current benchmark (Blue, Zoller, Stratton, Elam, & Gilbert, 2010). The Accreditation Council on Graduate Medical Education (ACGME) Outcomes Project is being used as a competency guide by many undergraduate programs in medicine. It incorporates general competencies of professionalism, interpersonal and communication skills, and systems-based practice, along with an expectation that residents are able to work effectively as members or leaders of health care teams or other professional groups, and to work in interprofessional teams to enhance patient safety and care quality (ACGME, 2011). Analysis of data from a 2009 ACGME multispecialty resident survey showed that formal team training experiences with non-physicians was significantly related to greater resident satisfaction with learning and overall training experiences, as well as to less depression, anxiety, and sleepiness, and to fewer reports by residents of having made a serious medical error (Baldwin, 2010). Pilot work is ongoing by the American Board of Internal Medicine to evaluate hospitalist teamwork skills (Chesluk, 2010).

“*Enhancing the public’s access to oral health care and the connection of oral health to general health form a nexus that links oral health providers to colleagues in other health professions.*”

(Commission on Dental Accreditation, 2010, p. 12)

Dentistry has been developing competencies for the new general dentist. Among those competencies is “participate with dental team members and other health care professionals in the management and health promotion for all patients” (American Dental Education Association, 2008). Interprofessional education has been identified as a critical issue in dental education. Authors of a position paper have explored the rationale for interprofessional education in general dentistry and the leadership role of academic dentistry and organized dentistry in this area (Wilder et al., 2008). Accreditation standards for dental education programs adopted in August 2010 for implementation in 2013 contain language promoting collaboration with other health professionals (Commission on Dental Accreditation, 2010).

National pharmacy education leaders completed intensive study of interprofessional education and its relevance to pharmacy education (Buring et al., 2009). Curricular guidance documents (American Association of Colleges of Pharmacy, 2004), a vision statement for pharmacy practice in 2015 (Maine, 2005), and accreditation requirements (Accreditation Council for Pharmacy Education, 2011) now incorporate consistent language. Phrases such as “provide patient care in cooperation with patients, prescribers, and other members of an interprofessional health care team,” “manage and use resources in cooperation with patients, prescribers, other health care providers, and administrative and supportive personnel,” and “promote health improvement, wellness, and disease prevention in cooperation with patients, communities, at-risk populations, and other members of an interprofessional team of health care providers” appear throughout those documents.

The Association of Schools of Public Health (ASPH) recently released draft undergraduate learning outcomes relevant to all two- and four-year institutions. The most explicit of the four learning outcomes relevant to interprofessional education is: “Engage in collaborative and interdisciplinary approaches and teamwork for improving population health” (Association of Schools of Public Health, 2011, p. 5-6). At the master’s level, 10 competencies create opportunities related to interprofessional education (Association of Schools of Public Health, 2006).

Interprofessional education has received some attention in the osteopathic medical literature (e.g., Singla, G. MacKinnon, K. MacKinnon, Younis, & Field, 2004). An exploratory analysis of the relationship between the principles of osteopathic medicine and interprofessional education is in press, as part of a description of a three-phase interprofessional education program underway involving one osteopathic medical school and eight other health professions (Macintosh, Adams, Singer-Chang, & Hruby, forthcoming, 2011). Interprofessional competencies developed for this program at Western University of Health Sciences anticipated the development of the expert panel’s work.

““ Many of our [osteopathic medical] colleges are moving into IPE with major initiatives, taking advantage of the environments offered by their colleagues in the other health professions within their universities or affiliates...” ”

(Shannon, 2011)

These educational changes suggest individual health professions’ movement toward incorporating competency expectations for interprofessional collaborative practice. However, the need remains to identify, agree on, and strengthen core competencies for interprofessional collaborative practice across the professions.

Core competencies are needed in order to:

- 1) create a coordinated effort across the health professions to embed essential content in all health professions education curricula,
- 2) guide professional and institutional curricular development of learning approaches and assessment strategies to achieve productive outcomes,
- 3) provide the foundation for a learning continuum in interprofessional competency development across the professions and the lifelong learning trajectory,
- 4) acknowledge that evaluation and research work will strengthen the scholarship in this area,
- 5) prompt dialogue to evaluate the “fit” between educationally identified core competencies for interprofessional collaborative practice and practice needs/ demands,

- 6) find opportunities to integrate essential interprofessional education content consistent with current accreditation expectations for each health professions education program (see University of Minnesota, Academic Health Center, Office of Education, 2009),
- 7) offer information to accreditors of educational programs across the health professions that they can use to set common accreditation standards for interprofessional education, and to know where to look in institutional settings for examples of implementation of those standards (see Accreditation of Interprofessional Health Education: Principles and practices, 2009; and Accreditation of Interprofessional Health Education: National Forum, 2009), and
- 8) inform professional licensing and credentialing bodies in defining potential testing content for interprofessional collaborative practice.

## The Concept of Interprofessionalism

Clear development of core competencies for interprofessional collaborative practice requires a unifying concept. D'Amour and Oandasan (2005) delineated the concept of interprofessionalism as part of the background work for initiatives by Health Canada to foster interprofessional education and interprofessional collaborative practice. They defined **interprofessionalism** as

“the process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population... [I]t involves continuous interaction and knowledge sharing between professionals, organized to solve or explore a variety of education and care issues all while seeking to optimize the patient's participation... Interprofessionalism requires a paradigm shift, since interprofessional practice has unique characteristics in terms of values, codes of conduct, and ways of working. These characteristics must be elucidated” (p. 9).

The competency domains and specific competencies associated with them identified in this report represent our efforts to define those characteristics.

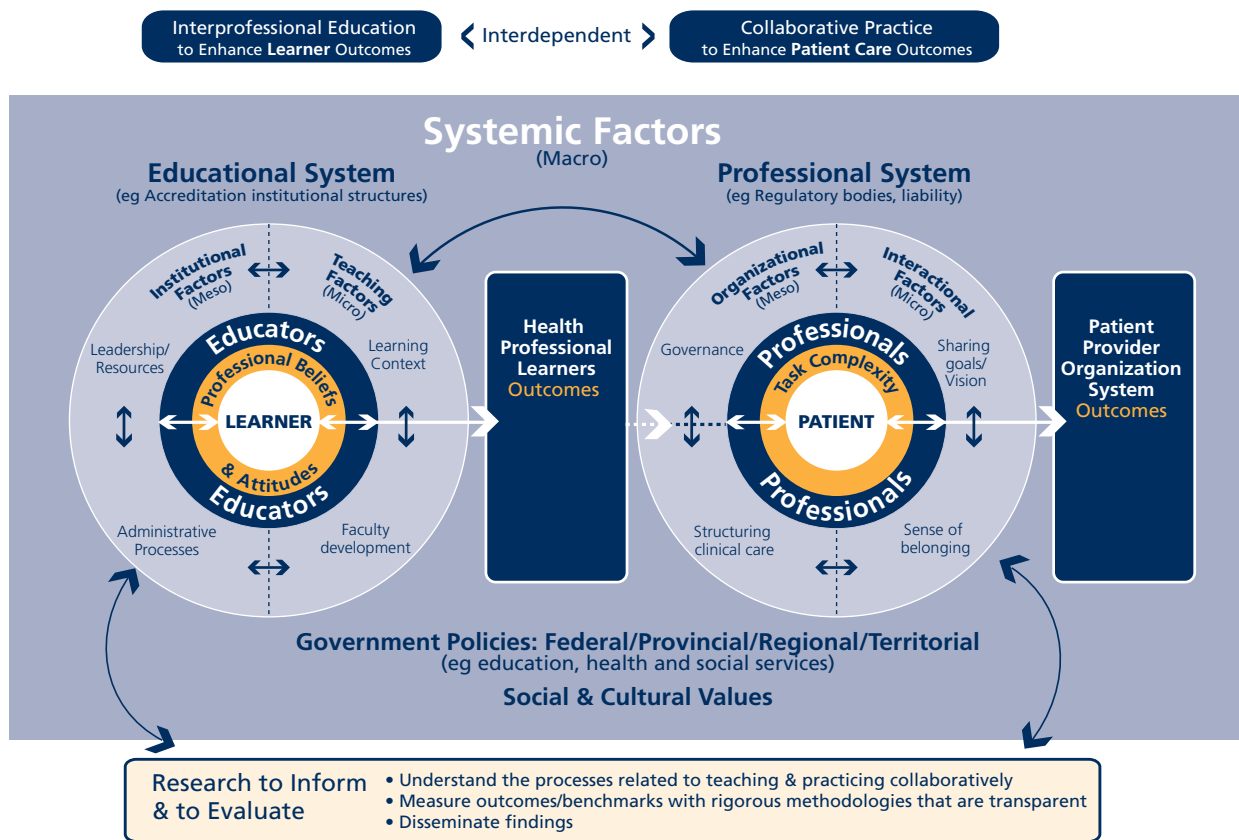
## Frameworks Reflective of the Interdependence between Health Professions' Education and Practice Needs

“Change professional training to meet the demands of the new health care system.”

(O'Neil & the Pew Health Professions Commission, 1998, p. 25)

Until recently, no framework captured the interdependence between health professions' education competency development for collaborative practice and practice needs. Three frameworks now capture this interdependency, two of which arose specifically from an interprofessional context. D'Amour and Oandasan (2005) constructed a detailed graphic to illustrate interdependencies between health professional education and interprofessional collaborative practice, in the service of patient needs and community-oriented care [see figure 1].

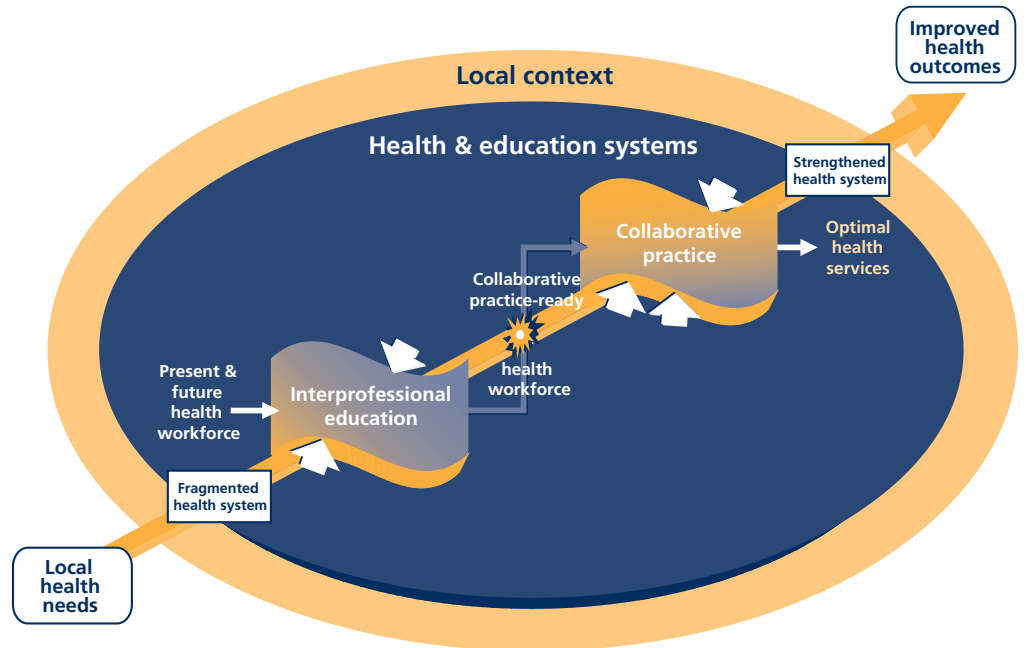
**FIGURE 1: Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept.**



Reprinted with permission from D'Amour, D. & Oandasan, I. (2005). *Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. Journal of Interprofessional Care, Supplement 1, 8-20.*

The WHO Study Group on Interprofessional Education and Collaborative Practice developed a global Framework for Action on Interprofessional Education and Collaborative Practice (WHO, 2010) and a graphic that shows the goal of interprofessional education as preparation of a “collaborative practice-ready” work force, driven by local health needs and local health systems designed to respond to those needs [see figure 2].

**FIGURE 2: Framework for Action on Interprofessional Education & Collaborative Practice**



Reprinted with permission from: *World Health Organization (WHO). (2010). Framework for Action on Interprofessional Education & Collaborative Practice. Geneva: World Health Organization.*

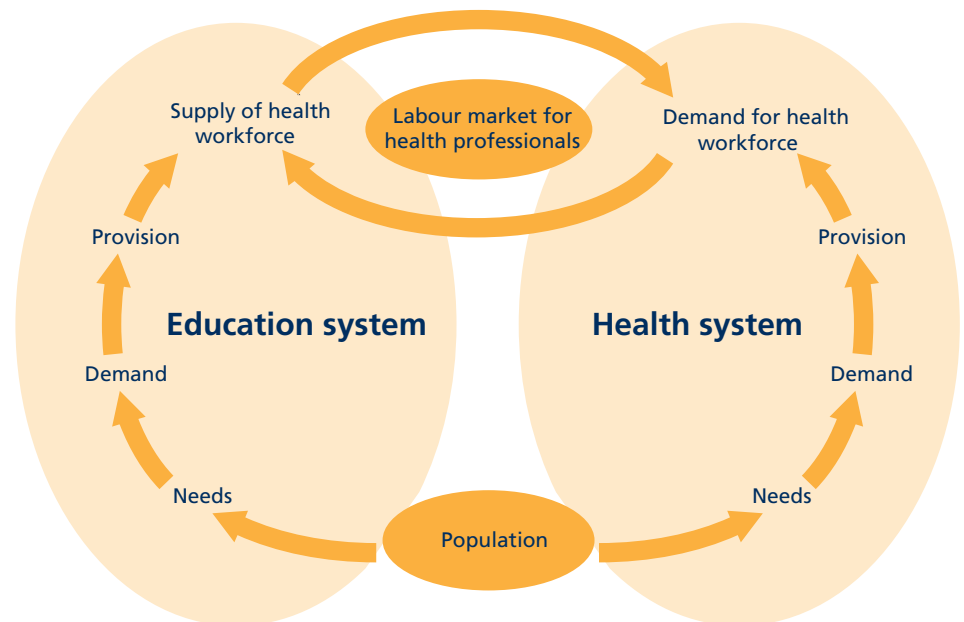
The WHO Framework highlights curricular and educator mechanisms that help interprofessional education succeed, as well as institutional support, working culture, and environmental elements that drive collaborative practice. The framework incorporates actions that leaders and policymakers can take to bolster interprofessional education and interprofessional collaborative practice for the improvement of health care. At the national level, positive health professions education and health systems actions are pointed to that could synergistically drive more integrated health workforce planning and policymaking.

Recently, the Commission on Education of Health Professionals for the 21st Century (Frenk et al., 2010) published an analysis of the disjunctions between traditional health professions education and global health and health workforce



needs. Working from ideas of global social accountability and social equity, the commission proposed a series of recommendations to reform health professions education to prepare a global health workforce that is more responsive to actual population and personal health needs adapted to local contexts. A graphic depicts these interrelationships [see figure 3]. An important aspect of this report is the strong integration of public health preparation in the education of future health care professionals. The “promotion of interprofessional and transprofessional education that breaks down professional silos while enhancing collaborative and non-hierarchical relationships in effective teams” (Frenk et al., p. 1,951) is one of 10 recommendations by the commission for preparing future health professionals to more adequately address global health needs and strengthen health systems.

**FIGURE 3: Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world**



Reprinted with permission from Frenk, J., Chen, L., Bhutta, Z.A., Cohen, J., Crisp, N., Evans, T. et al. (2010). *Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. The Lancet, 376 (9756), 1923-1958.*

Developers of these three frameworks target interprofessional education as a means of improving patient-centered and community-/population-oriented care. They situate interprofessional education and health professions education, in general, in a dynamic relationship with health care systems that are more responsive to the health needs of the populations they are designed to serve.

## The Competency Approach to Health Professions Education and Interprofessional Learning

Competency-based approaches to interprofessional education have developed in parallel to competency-based approaches within the health professions. These have emerged in response to the limitations of learning outcomes related to knowledge- and attitude-based methods (Barr, 1998).

Appendix 1 of the National Interprofessional Competency Framework for Canada provides an excellent summary of four different competency-based approaches, applied to interprofessional education competencies (Canadian Interprofessional Health Collaborative [CIHC], 2010), drawing on the work of Roegiers (2007). The CIHC adopted the integrated framework advocated by Peyser, Gerard, and Roegiers (2006), which emphasizes not only the competency outcomes themselves but also the educational processes that integrate knowledge, skills, attitudes, and values in the demonstration of competencies. The dual charge from IPEC to the expert panel to “recommend a common core set of competencies relevant across the professions to address the essential preparation of clinicians for interprofessional collaborative practice” and to “recommend learning experiences and educational strategies for achieving the competencies and related objectives” is consistent with an integrated approach to interprofessional education competency development and assessment. From a pre-licensure perspective, a core interprofessional competency approach emphasizes essential behavioral combinations of knowledge, skills, attitudes, and values that make up a “collaborative practice-ready” graduate (WHO, 2010).

## Interprofessional Competencies

“ It is no longer enough for health workers to be professional. In the current global climate, health workers also need to be interprofessional. ”

(WHO, 2010, p. 36)

Barr (1998) distinguished between types of competence from an interprofessional perspective [see figure 4]. According to Barr, “common” or overlapping competencies are those expected of all health professionals. It may be more helpful to think in terms of competencies that are common or overlapping **more than one health profession** but not necessarily **all** health professions. This can be the source of interprofessional tensions, such as in the debate about overlapping competencies between primary care physicians and nurse practitioners. The overlap may be a strategy to extend the reach of a health profession whose practitioners are inaccessible for various reasons. For example, a policy statement has called attention to the preventive oral health care role of pediatricians in primary care (American Academy of Pediatrics, 2008); and dental programs recognize that a dentist may be the “first line of defense” for not only oral but also some systemic diseases (Wilder et al., 2008). “Complementary” competencies enhance the qualities of other professions in providing care. Thus, while in this example dentists and pediatricians identify useful overlap in their roles consistent with their scope of practice, dentists and pediatricians mostly have complementary expertise. “Collaborative” competencies are those that each profession needs to work together with others, such as other specialties within a profession, between professions, with patients and families, with non-professionals and volunteers, within and between organizations, within communities, and at a broader policy level. Interprofessional collaborative competencies are the focus of this report.

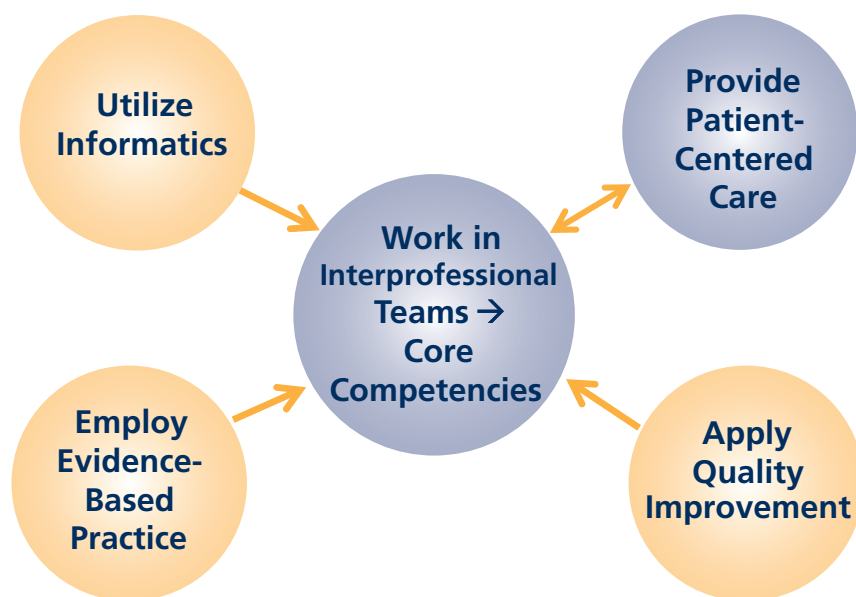
**FIGURE 4: Barr’s (1998) three types of professional competencies**



## Developing Interprofessional Education Competencies for Interprofessional Collaborative Practice in the U.S.

Our report examines the further development of the core competency—work in interdisciplinary teams—identified in the 2003 IOM report. Although the IOM report named the key processes of communication, cooperation, coordination, and collaboration in teamwork, the interprofessional competencies that underpin these processes were not defined. Also important to the elaboration of teamwork competencies are the interrelationships with the other four IOM core competencies (see Figure 5). Provision of *patient-centered care* is the goal of interprofessional teamwork. The nature of the relationship between the patient and the team of health professionals is central to competency development for interprofessional collaborative practice. Without this kind of centeredness, interprofessional teamwork has little rationale. The other three core competencies, *in the context of interprofessional teamwork*, identify 21st-century technologies for teamwork communication and coordination (i.e., informatics), rely on the evidence base to inform teamwork processes and team-based care, and highlight the importance of continuous improvement efforts related to teamwork and team-based health care.

**FIGURE 5: Interprofessional Teamwork and IOM CORE COMPETENCIES**

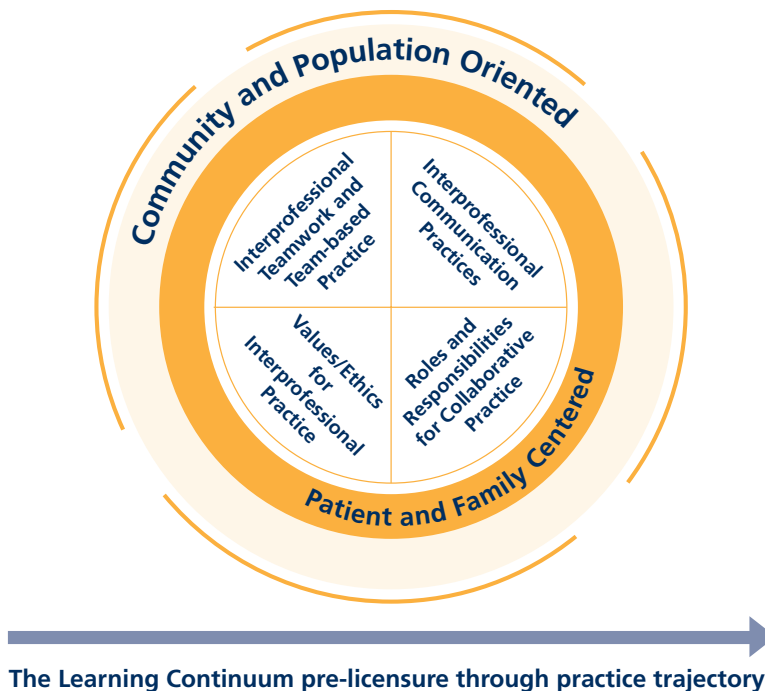


## Core Competencies for Interprofessional Collaborative Practice

National and international efforts prior to this one have informed the identification of interprofessional competency domains in this report (Buring et al., 2009; CIHC, 2010; Cronenwett et al., 2007, 2009; Health Resources and Services Administration/Bureau of Health Professions, 2010; Interprofessional Education Team, 2010; O'Halloran, Hean, Humphris, & McLeod-Clark, 2006; Thistlethwaite & Moran, 2010; University of British Columbia College of Health Disciplines, 2008; University of Toronto, 2008; Walsh et al., 2005). A number of U.S. universities who had begun to define core interprofessional competencies shared information on their efforts to define competency domains. [A list of universities is included at the end of the report.]

Although the number of competency domains and their categorization vary, we found convergence in interprofessional competency content between the national literature and global literature, among health professions organizations in the United States, and across American educational institutions. Interprofessional competency domains we identified are consistent with this content. In this report, we identify four interprofessional competency domains, each containing a set of more specific competency statements, which are summarized in the following graphic [see figure 6].

**FIGURE 6: Interprofessional Collaborative Practice Domains**



## Interprofessional Collaborative Practice Competency Domains

<b>Competency Domain 1:</b>	<b>Values/Ethics for Interprofessional Practice</b>
<b>Competency Domain 2:</b>	<b>Roles/Responsibilities</b>
<b>Competency Domain 3:</b>	<b>Interprofessional Communication</b>
<b>Competency Domain 4:</b>	<b>Teams and Teamwork</b>

## Competency Domain 1: Values/Ethics for Interprofessional Practice

**Background and Rationale:** Interprofessional values and related ethics are an important, new part of crafting a professional identity, one that is both professional and interprofessional in nature. These values and ethics are patient centered with a community/population orientation, grounded in a sense of shared purpose to support the common good in health care, and reflect a shared commitment to creating safer, more efficient, and more effective systems of care. They build on a separate, profession-specific, core competency in patient-centeredness. Without persons who are sometimes patients and their families as partners in the team effort, the best interprofessional teamwork is without rationale. Teamwork adds value by bringing about patient/family and community/population outcomes that promote overall health and wellness, prevent illness, provide comprehensive care for disease, rehabilitate patients, and facilitate effective care during the last stages of life, at an affordable cost.

Health professions educators typically consider values and ethics content an element of professionalism, which has significant overlap with constructs of humanism and morality (Baldwin, 2006). “Old” approaches to professionalism have been criticized as being self-serving and are seen as creating barriers between the professions and impeding the improvement of health care (Berwick, Davidoff, Hiatt & Smith, 2001; IOM, 2001; McNair, 2005). “New” approaches are oriented toward helping health professions students develop and express values that are the hallmark of public trust, meaning the “other side” of professionalism (Blank, Kimball, McDonald & Merino, 2003; McNair, 2005). These values become a core part of one’s professional identity, and Dombeck (1997) has labeled the moral agency associated with that identity as “professional personhood.” However, the “new” professionalism in health professions education needs further development in the context of interprofessional collaborative practice, leading to several different approaches.

The **first** is a “virtues in common” approach (McNair, 2005) that draws on the work of Stern (2006) and others and is represented by the Interprofessional Professionalism Collaborative. The group defines “interprofessional professionalism” as

“Consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of altruism, excellence, caring, ethics, respect, communication, [and] accountability to achieve optimal health and wellness in individuals and communities” (Interprofessional Professionalism Collaborative, 2010).

A **second** approach suggests ethical principles for everybody in health care to hold in common, recognizing the multidisciplinary nature of health delivery systems. This approach has been developed by the Tavistock group (Berwick et al., 2001), which noted that the problems of health systems are fundamentally ethical. The principles consider health and health care a right. They support

balance in the distribution of resources for health to both individuals and populations; comprehensiveness of care; responsibility for continuous efforts to improve care; safety of care; openness in care delivery; and cooperation with those who receive care, among those who deliver care, and with others outside direct health care delivery. Cooperation is seen as the central principle.

A **third** approach, and the one adopted for this expert panel report, focuses on the values that should undergird *relationships* among the professions, joint relationships with patients, the quality of cross-professional exchanges, and interprofessional ethical considerations in delivering health care and in formulating public health policies, programs, and services.

Mutual respect and trust are foundational to effective interprofessional working relationships for collaborative care delivery across the health professions. At the same time, collaborative care honors the diversity that is reflected in the individual expertise each profession brings to care delivery. Gittel captured this link between interprofessional values and effective care coordination when she described the nature of relational coordination in health care: “Even timely, accurate information may not be heard or acted upon if the recipient does not respect the source” ((2009, p. 16).

Interprofessional ethics is an emerging aspect of this domain. This literature explores the extent to which traditional professional values, ethics, and codes need to be rethought and re-imagined as part of interprofessional collaborative practice. A common example has to do with the confidentiality of the practitioner-patient relationship in team-based care delivery. Important discussions are emerging in this area (Banks et al., 2010; Clark, Cott & Drinka, 2007; Schmitt & Stewart, 2011).

This competency domain is variously represented in other interprofessional competency frameworks. A key difference is whether values are integrated into other competencies as the attitude/value dimension of those competencies (e.g., QSEN competencies in nursing, Cronenwett et al., 2007, 2009 and A National Interprofessional Competency Framework-CIHC, 2010) or represented as a separate competency (e.g., University of Toronto IPE Curriculum, University of Toronto, 2008). The fact that each health profession has educational and accreditation requirements around professionalism creates an opportunity for curricular integration of interprofessional competencies related to values and ethics (University of Minnesota, Academic Health Center, Office of Education, 2009), as well as the opportunity for accreditors to evaluate their presence and update requirements around professionalism to explicitly incorporate interprofessional values and ethics.



**General Competency Statement-VE. Work with individuals of other professions to maintain a climate of mutual respect and shared values.**

**Specific Values/Ethics Competencies:**

- VE1. Place the interests of patients and populations at the center of interprofessional health care delivery.**
- VE2. Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care.**
- VE3. Embrace the cultural diversity and individual differences that characterize patients, populations, and the health care team.**
- VE4. Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions.**
- VE5. Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services.**
- VE6. Develop a trusting relationship with patients, families, and other team members (CIHC, 2010).**
- VE7. Demonstrate high standards of ethical conduct and quality of care in one's contributions to team-based care.**
- VE8. Manage ethical dilemmas specific to interprofessional patient/population centered care situations.**
- VE9. Act with honesty and integrity in relationships with patients, families, and other team members.**
- VE10. Maintain competence in one's own profession appropriate to scope of practice.**

“ “ We all have a moral obligation to work together to improve care for patients. ” ”

(Pronovost & Vohr, 2010, p. 137)

## Competency Domain 2: Roles/Responsibilities

**Background and Rationale:** Learning to be interprofessional requires an understanding of how professional roles and responsibilities complement each other in patient-centered and community/population oriented care. “Front line” health professionals (Suter et al., 2009) have identified being able to clearly describe one’s own professional role and responsibilities to team members of other professions and understand others’ roles and responsibilities in relation to one’s own role as a core competency domain for collaborative practice. This domain is an explicit feature in most interprofessional competency frameworks (Thistlethwaite & Moran, 2010; WHO, 2010; CIHC, 2010; Cronenwett et al., 2007; University of Toronto, 2010).

“Variety diversity”—or categorical differences among team members—presents both a resource and a problem for teamwork in health care (Edmondson & Roloff, 2009). Diversity of expertise underpins the idea of effective teams. Diversity of background or cultural characteristics also adds to teamwork resources. Yet, stereotyping, both positive and negative, related to professional roles and demographic/cultural differences affect the health professions (Hean, in press). These stereotypes help create ideas about a profession’s worth known as “disparity diversity” (Edmondson & Roloff), eroding mutual respect. Inaccurate perceptions about diversity prevent professions from taking advantage of the full scope of abilities that working together offers to improve health care.

The need to address complex health promotion and illness problems, in the context of complex care delivery systems and community factors, calls for recognizing the limits of professional expertise, and the need for cooperation, coordination, and collaboration across the professions in order to promote health and treat illness. However, effective coordination and collaboration can occur only when each profession knows and uses the others’ expertise and capabilities in a patient-centered way.

Each profession’s roles and responsibilities vary within legal boundaries; actual roles and responsibilities change depending on the specific care situation. Professionals may find it challenging to communicate their own role and responsibilities to others. For example, Lamb et al. (2008) discovered that staff nurses had no language to describe the key care coordination activities they performed in hospitals. Being able to explain what other professionals’ roles and responsibilities are and how they complement one’s own is more difficult when individual roles cannot be clearly articulated. Safe and effective care demands crisply defined roles and responsibilities.

Team members’ individual expertise can limit productive teamwork across the professions. Collaborative practice depends on maintaining expertise through continued learning and through refining and improving the roles and responsibilities of those working together.

**General Competency Statement-RR. Use the knowledge of one's own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served.**

**Specific Roles/Responsibilities Competencies:**

- RR1. Communicate one's roles and responsibilities clearly to patients, families, and other professionals.**
- RR2. Recognize one's limitations in skills, knowledge, and abilities.**
- RR3. Engage diverse healthcare professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs.**
- RR4. Explain the roles and responsibilities of other care providers and how the team works together to provide care.**
- RR5. Use the full scope of knowledge, skills, and abilities of available health professionals and healthcare workers to provide care that is safe, timely, efficient, effective, and equitable.**
- RR6. Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.**
- RR7. Forge interdependent relationships with other professions to improve care and advance learning.**
- RR8. Engage in continuous professional and interprofessional development to enhance team performance.**
- RR9. Use unique and complementary abilities of all members of the team to optimize patient care.**

“...teamwork requires a shared acknowledgement of each participating member's roles and abilities. Without this acknowledgement, adverse outcomes may arise from a series of seemingly trivial errors that effective teamwork could have prevented.”

(Baker et al., 2005b, p. 14)

## Competency Domain 3: *Interprofessional Communication*

“When I was in medical school I spent hundreds of hours looking into a microscope—a skill I never needed to know or ever use. Yet, I didn’t have a single class that taught me communication and teamwork skills—something I need every day I walk into the hospital.”

(Pronovost & Vohr, 2010, p. 46)

**Background and Rationale:** In Suter et al.’s (2009) study, front-line health professionals identified communication as the second core competency domain, and in most competency frameworks communication is considered a core aspect of interprofessional collaborative practice. Developing basic communication skills is a common area for health professions education (e.g., AAMC, 1999), but health professions students often have little knowledge about or experience with interprofessional communication. More than a decade ago, an AAMC report on communication in medicine acknowledged the importance of being able to communicate effectively with “other members of the healthcare team, given the movement toward better integrated care” (AAMC, 1999, p. 6).

Communication competencies help professionals prepare for collaborative practice. Communicating a readiness to work together initiates an effective interprofessional collaboration. In a qualitative study of nurses’ and resident physicians’ definitions of collaboration (Baggs & Schmitt, 1997), respondents cited the ways in which health professionals communicate a readiness to work together. They named being available in place, time, and knowledge, as well as being receptive through displaying interest, engaging in active listening, conveying openness, and being willing to discuss as elements indicating readiness.

Using professional jargon creates a barrier to effective interprofessional care. A common language for team communication is a core aspect of the TeamSTEPPS team training program, which endorses practices such as SBAR, call-out, and check-back, whose aim is communication that is clearly understood (Agency for Healthcare Research and Quality, n.d.).

An important part of language is literacy, both general reading literacy and health literacy. Both play a part in teamwork and patient-centered care. Presenting information that other team members and patients/families can understand contributes to safe and effective interprofessional care.

One of the five IOM core competencies (IOM, 2003) is the ability to use informatics. Teamwork and team-based competency for better patient-centered care requires mastery of numerous new communication technologies.

Professional hierarchies created by demographic and professional differences are common but create dysfunctional communication patterns working against effective interprofessional teamwork. Further, considerable literature related to safe care now focuses on overcoming such communication patterns by placing responsibility on all team members to speak up in a firm but respectful way when they have concerns about the quality or safety of care. However, these communication patterns keep professionals from sharing their expertise across professional lines more generally. Learning to give and receive timely, sensitive, and instructive feedback with confidence helps health professionals improve their teamwork and team-based care.

Learning to work together to communicate and manage emotionally difficult information with patients and families, such as end-of-life information, or error disclosures requires openness, understanding, and an ability to convey messages in a sensitive and respectful manner.

“Communicating refers to aspects of openness, style, and expression of feelings and thoughts. These communications are directed specifically at modifying teamwork aspects. Team-related communications exploit opportunities that influence team interactions, organization, and functioning.”

(Essens et al., 2009)

**General Competency Statement-CC. Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.**

**Specific Interprofessional Communication Competencies:**

- CC1. Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function.**
- CC2. Organize and communicate information with patients, families, and healthcare team members in a form that is understandable, avoiding discipline-specific terminology when possible.**
- CC3. Express one’s knowledge and opinions to team members involved in patient care with confidence, clarity, and respect, working to ensure common understanding of information and treatment and care decisions.**
- CC4. Listen actively, and encourage ideas and opinions of other team members.**
- CC5. Give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.**
- CC6. Use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict.**
- CC7. Recognize how one’s own uniqueness, including experience level, expertise, culture, power, and hierarchy within the healthcare team, contributes to effective communication, conflict resolution, and positive interprofessional working relationships (University of Toronto, 2008).**
- CC8. Communicate consistently the importance of teamwork in patient-centered and community-focused care.**

## Competency Domain 4: Teams and Teamwork

“An essential component of patient-centered primary care practice is interprofessional teamwork. High-functioning teams require collaboration between physicians, nurses, pharmacists, social workers, clinical psychologists, case managers, medical assistants, and clinical administrators...”

(Department of Veterans Affairs, August 26, 2010, p. 2)

**Background and Rationale:** Learning to be interprofessional means learning to be a good team player. Teamwork behaviors apply in any setting where health professionals interact on behalf of shared goals for care with patients or communities. Teamwork behaviors involve cooperating in the patient-centered delivery of care; coordinating one’s care with other health professionals so that gaps, redundancies, and errors are avoided; and collaborating with others through shared problem-solving and shared decision making, especially in circumstances of uncertainty. These processes reflect increasing levels of interdependence among those embedded in teams, in microsystems like hospital units, or in and between organizations and communities.

Learning to work in teams entails becoming a part of a small and complex system that is organized to share the care of a person or a population. Involvement as a team member is based on the value of the professional expertise added that can contribute to the outcomes of care in specific situations. Understanding how team developmental processes can affect team members, overall team functioning, and outcomes of team-based care is an important part of being an effective team member.

A potential source of conflict among team members is the diversity of their expertise areas and professional abilities. Conflicts may arise over leadership, especially when status or power is confused with authority based on professional expertise. Whatever the source, staying focused on patient-centered goals and dealing with the conflict openly and constructively through effective interprofessional communication and shared problem-solving strengthen the ability to work together and create a more effective team.

Strong leaders in team-based care want to satisfy patient and community needs, and they value all team members’ potential contributions in meeting those needs. Leaders interact with team members in ways that draw out potential contributions and build support for working together through an understanding of the dynamics of the team (Zaccaro, Heinen, & Shuffler, 2009).

Working in teams involves sharing one’s expertise and relinquishing some professional autonomy to work closely with others, including patients and communities, to achieve better outcomes. Shared accountability, shared problem-solving, and shared decision are characteristics of collaborative teamwork and working effectively in teams. Valuing working with others to deliver patient-centered care that is community/ population-oriented, being clear about one’s own and others’ roles and responsibilities, and practicing interprofessional communication contribute importantly to teamwork behaviors and effective team functioning.

Quality improvement tools can improve teamwork processes and aid in the design and functioning of team-based care to enhance outcomes for patients and communities. How to improve teamwork behaviors, understanding how teams

“As preparation for collaborative practice, the interprofessional education of teams is seen as a key implementation strategy for certain phases of the Healthy People 2020 Education for Health framework”... interprofessional education with an emphasis on prevention will not only greatly assist with achieving the Healthy People objectives ...but also help prepare the next generation of health professionals to better address preventable health problems.”

(Evans, Cashman, Page, & Garr, 2011)

work, and determining what makes teams effective are rich areas of research (e.g., Salas, Goodwin, & Burke, 2009) that are expanding the evidence base. As this evidence develops it can be used to inform more effective teamwork and team-based care.

**General Competency Statement-TT. Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.**

**Specific Team and Teamwork Competencies:**

- TT1. Describe the process of team development and the roles and practices of effective teams.**
- TT2. Develop consensus on the ethical principles to guide all aspects of patient care and team work.**
- TT3. Engage other health professionals—appropriate to the specific care situation—in shared patient-centered problem-solving.**
- TT4. Integrate the knowledge and experience of other professions—appropriate to the specific care situation—to inform care decisions, while respecting patient and community values and priorities/preferences for care.**
- TT5. Apply leadership practices that support collaborative practice and team effectiveness.**
- TT6. Engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among healthcare professionals and with patients and families.**
- TT7. Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care.**
- TT8. Reflect on individual and team performance for individual, as well as team, performance improvement.**
- TT9. Use process improvement strategies to increase the effectiveness of interprofessional teamwork and team-based care.**
- TT10. Use available evidence to inform effective teamwork and team-based practices.**
- TT11. Perform effectively on teams and in different team roles in a variety of settings.**

## Competencies, Learning Objectives and Learning Activities

“Competencies can be operationalized and assessed by linking them with professional activities.”

(ten Cate, 2005, p. 1176)

The individual competencies we have identified under the four core competency domains can be thought of as behavioral learning objectives to be achieved by the end of pre-licensure or pre-certification education. They are linked to learning activities and assessments of the effectiveness of those activities in achieving the objectives.

For example, the University of Virginia identified five core interprofessional competencies: communication, professionalism, shared problem-solving, shared decision making, and conflict resolution. They have written four learning objectives for each of these competencies that have parallels to our individual competency statements. For their core competency of professionalism, for example, a learning objective is “to display interest, trust, and mutual respect across the professions” (University of Virginia, n.d.). When educators began the development of their interprofessional curriculum, they asked faculty to identify the learning activities they already provided that addressed this and other interprofessional learning objectives, and whether/how they assessed their achievement. They began to build the interprofessional learning program from this identified base of activities.

A similar approach was taken in illustrating example learning objectives for meeting the five IOM core competencies within pharmacy. For the topic of “interprofessional team roles and responsibilities and professionalism” sample learning objectives were: “Describe individual roles and responsibilities” and “demonstrate consensus building within a team” (Buring et al., 2009). Learning objectives can focus on knowledge, skills, and values/attitudes that are thought to lead to competency in a staged way.

A great variety of activities developed explicitly for interprofessional learning are being used, but may not have been linked explicitly to achievement of interprofessional competencies. Other activities, such as international learning experiences, are almost always interprofessional, but typically have not been viewed through this lens. Opportunities to exploit existing learning experiences for learning interprofessional competencies, such as students from different professions being co-located in the same clinical setting at the same time, often have not been pursued.

In many instances, interprofessional learning activities are still aimed primarily at *exposure* to students from other professions. Educators assess interprofessional experiences at the level of learner reactions, attitudes and perceptions, knowledge or skill. Modifying a framework from Kirkpatrick (1967), Barr, Koppel, Reeves, Hammick & Freeth (2005) documented a predominance of positive learning outcomes of these types in the 107 studies that met the team’s quality criteria. Mainly “college-led” activities produced these results, which suggest that some of the elements that make up competency development can be achieved in educational settings. Learner behavior change, the primary goal of competency development, occurred less frequently but followed from both college and service-



led learning. Organizational change and clinical outcomes were more commonly associated with practice-based interprofessional learning by practitioners. These data convey the importance of student learning in the clinical setting for practical learning, practice change, and patient-centered outcomes. They reinforce the value of purposive engagement between education and practice for building competency, as this report emphasizes.

Much remains to be understood about the optimum ways to assist students to learn interprofessional competencies. How particular activities nurture the values, knowledge or skills that undergird one or more of these competencies needs to be made explicit. A critical aspect involves the choice of learning pedagogies. A variety of adult learning characteristics are relevant including active (versus passive) learning, self-directed (versus faculty-directed) learning, and situated (versus classroom) learning. Recommendations for rethinking pedagogies used in undergraduate medical education toward more active, clinically integrated and developmentally progressive learning (Cooke, Irby & O'Brien, 2010) are also key to *interprofessional learning*.

Other factors play a part in design as well. One is appropriateness for the stage of pre-licensure/pre-credentialing professional education: early in education versus late in education, pre or non-clinical versus clinical, for example. Certain activities lend themselves to learning that can incorporate students at different stages simultaneously. Faculty should contemplate some additional questions: Are the activities individually oriented or population-based? Do they contribute to learning in a variety of clinical and community settings? Do they foster engagement with students from other professions? Are they short-term or longitudinal activities? Is the activity required or elective learning? Is the learning provided in separate courses or as “threads” in the curriculum? Are the students given flexibility of learning choices or expected to follow a rigid structure to achieve interprofessional competencies?

The relevance of the learning activities to the real and changing world of interprofessional collaborative practice will ultimately determine how useful the experiences are to students as they move forward in their careers.

New educational technologies such as online learning, distance technologies, networking innovations, and simulation approaches are overcoming traditional barriers to interprofessional learning related to time and space (Weinstein et al., 2010). Use of these learning technologies can help model the real world of practice, especially in communities, where teamwork often happens asynchronously across time and space. For example, Western University of Health Sciences plans to experiment with asynchronous, community-based approaches to interprofessional learning in the third phase of their new interprofessional education program to be piloted in the next academic year (Aston, 2011).

## Learning Activities, Examples

The design and implementation of interprofessional learning activities in the U.S. is exploding and there are many, many excellent examples of these activities that could have been chosen as illustrations. It is also the case that there is a low level of awareness and a lack of a “clearinghouse” at a national level for sharing information on the design, implementation and assessment of these interprofessional learning activities.

**Example A.** The Jefferson Health Mentors Program is a two-year longitudinal interprofessional learning experience required early in the program of study in which student teams from medicine, nursing, pharmacy, physical therapy, occupational therapy, or couples and family therapy are paired with a Health Mentor, usually an older adult with one or more chronic illnesses living in the community, as their teacher. The overarching learning objectives are that 1) students will understand the roles of their colleagues and be prepared to function as members of effective health care teams and 2) students will understand the point of view of individuals with chronic conditions and be prepared to provide patient-and family-centered care. From an interprofessional competency perspective, the program is clearly patient-centered with a community orientation, focuses on the understanding of the unique role of each profession in a team-based approach, and incorporates cultural competency, communication, and team-building exercises, with special emphasis given to working as part of a team.

The eight-module program for over 1,000 students is nested in existing health professions course shells, employs a combination of didactic and active, experiential learning, and uses reflective writing, team-based case studies, and faculty-facilitated team-based debriefings of experiences to solidify learning. The program has a rigorous assessment plan around the two core objectives (Collins et al., 2009).

**Example B.** The University of Washington is developing exportable educational programs to help students learn effective interprofessional communication. One focus of that training is interprofessional error disclosure. The training employs a combination of didactic presentations, role modeling demonstration of a clinical scenario using a standardized patient by an interprofessional group of faculty, and practice learning using simulation methods. Students from medicine, nursing, pharmacy, and dentistry are exposed to evidence-based information concerning the value of openness and honesty with patients and families when an error resulting in harm has occurred in their care, and instructed in the types of communication messages that patients expect to receive, including apologies. Students reflect on the scenario, including attending to the feelings associated with this difficult conversation. Then, interprofessional groups of students practice conducting an error disclosure in a simulation case scenario to immerse them in practical learning. During that scenario they may identify how their professions may be involved in creating safer environments to avoid such an error in the future. This exercise was completed by nearly 500 students in an All Professions Training Day (Gray, 2011).

This example is full of opportunities for evaluating specific behavioral learning objectives/competencies, especially around interprofessional values/ethics and communication. Competency development in the domain of values/ethics stresses placing patients or communities at the center of care; building a trusting relationship with patients, families and other team members; acting with honesty and integrity; managing ethical conflicts specific to interprofessional caregiving; and respecting the diversity of individual and cultural differences among patients, families and team members. Competency development in the domain of interprofessional communication stresses using respectful language, organizing and communicating information with patients, families and health team members in an understandable form, choosing effective communication tools and techniques, and communicating effectively in difficult situations.

**Example C.** Service learning projects are frequently used as values-based educational opportunities to help students develop person and patient-centered knowledge and skills with a community/population-orientation around the health and health care needs of the at risk, vulnerable, and underserved. There is an extensive literature on the service learning approach to education, and this approach is being applied more frequently in interprofessional education.

The extracurricular Urban Service Track at the University of Connecticut offers students from the schools of medicine, nursing, pharmacy and dentistry who are interested in primary care, and are at various points in their training, the opportunity to become Urban Health Scholars (Clark-Dufner, Gould, Dang, Goldblatt & Johnson, 2010). There are plans to add social work students in another cycle. The program was created and is supported by the Connecticut Area Health Education Center Program, located within the University of Connecticut Center for Public Health and Health Policy. Three principles common to all students participating are 1) interest in working with underserved patients, 2) a history of volunteerism, and 3) a commitment to learning and working in interprofessional health care teams. Interprofessional team building and leadership is one of 11 identified competency areas. These competency areas were identified in collaboration with primary care practitioners in the state caring for the urban underserved. Over a two-year period, students who are based at federally qualified community health centers or community health agencies participate in a variety of learning activities chosen to help them develop the 11 identified competencies. These activities incorporate advocacy skills and the delivery of prevention and health promotion activities.

## Stages of Competency Development

The idea of interprofessional learning as continual is consistent with the ACGME Medical Outcomes Project, where a “milestones” framework structures medical residency training. Milestones define more specific levels of performance to be expected in competency domains across three years of residency education (ACGME, March 23, 2010). New U.S. continuing education reports (e.g., American Association of Colleges of Nursing and Association of American Medical Colleges, 2010) indicate that interprofessional learning takes place beyond the pre-licensure, pre-credentialing period, particularly in the workplace. In the three-stage model in place at the University of British Columbia (Charles, Bainbridge, & Gilbert, 2010), the third stage is mastery and encompasses advanced level interprofessional learning experiences for graduate students.

“...[A] capability can be defined as an integrated application of knowledge where the student or practitioner can adapt to change, develop new behaviors and continue to improve performance.”

(Walsh et al. pp. 232-233)

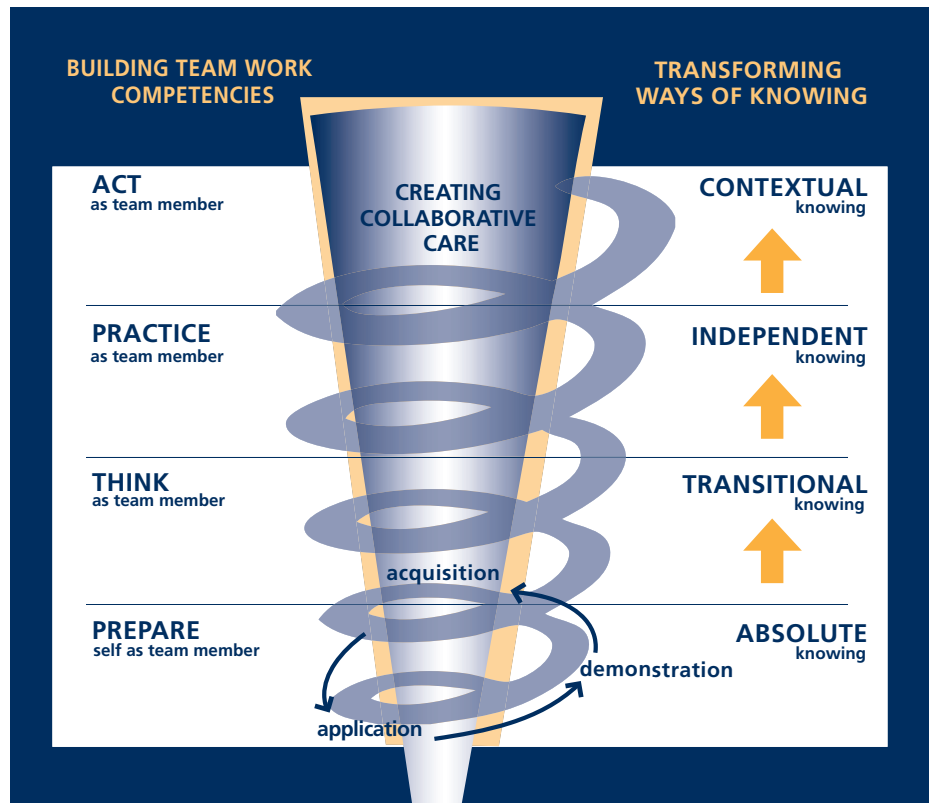
Competency statements described in this report reflect the endpoint of initial health professional education (pre-licensure or pre-credentialing). Within the pre-licensure framework, educators have identified stages of interprofessional learning, and shaped interprofessional learning activities to these stages. A central part of choosing learning activities is a core interprofessional curriculum plan, which integrates required curricular components. For example, the University of Toronto (2008) uses a three-stage curriculum framework [see figure 7] of exposure, immersion, and competence in preparing health professions’ students for collaborative practice. The program culminates in the demonstration of the core competencies in clinical placement.

FIGURE 7: A Framework for the Development of Interprofessional Education Values and Core Competencies



The Medical University of South Carolina has made a commitment to the overall goal of ensuring that all health professions students there acquire interprofessional competencies. Four more specific goals drive a “learning spiral” conceptualized around two dimensions: **building teamwork competencies** through a sequence of “prepare, think, practice, and act” and **transforming ways of knowing** from absolute to transitional, independent, and contextual stages. The framework draws from several carefully selected approaches to adult learning (Blue, Mitcham, Smith, Raymond, & Greenberg, 2010; Medical University of South Carolina, 2007). As they progress through the four stages of the learning cycle, students acquire, apply and demonstrate their interprofessional teamwork competencies in increasingly complex learning settings [see figure 8].

**FIGURE 8: Medical University of South Carolina conceptual framework for advancing interprofessional education.**



Reprinted with permission from Medical University of South Carolina. (2007, February). *Creating Collaborative Care (C3): A Quality Enhancement Plan (QEP)*. Charleston, SC: Author.

The new 1Health program at the University of Minnesota dedicates three learning phases to three core interprofessional competency domains: professionalism/ethics, communication, and teamwork. Learning experiences culminate with students working in an interprofessional team to address a patient care, population health, or community problem. The expectation is that all students will achieve interprofessional competencies defined by the Academic Health Center prior to graduation (University of Minnesota, 2010; Josiah Macy Jr. Foundation, 2010).

A staged program focused on sequential learning approaches—didactic, simulation, and clinical—also is in place at the Western University of Health Sciences, where students from nine professions will cap a series of learning experiences with an interprofessional clinical practice stint in a hospital or community setting in the 2011-2012 academic year (Western University of Health Sciences, 2011).

An important element these programs share is that they use a full range of extracurricular activities to help students reach the competency goals.

As suggested by this sample of frameworks, for pre-licensure/pre-credentialing learning, interprofessional competencies ultimately are demonstrated through teamwork and team-based care in concrete clinical learning situations. Demonstration and honing these competencies require reflection, flexibility, and adaptability to the spectrum of care contexts – from prevention and health maintenance to acute, chronic, long-term and palliative care – and the overall goals of care in specific situations.

## Theories Informing Interprofessional Education

“An array of learning and related theories can contribute to understanding and implementing IPE.”

(Sargeant, 2009, p. 179)

Interprofessional education now suffers from a lack of guidance from appropriate theories. The scope of this report precludes more than brief guidance in that area. Two recent sources are particularly helpful in considering appropriate theories to guide the design and implementation of interprofessional education. The first is a scoping review of theories, which have guided interprofessional learning, that might usefully be considered, or that may help assess what unstated theory informs a particular experience (Reeves et al., 2007). The second is an article by Sargeant (2009), which describes specific social and learning theories that capture the differences in the content and processes of interprofessional learning. Sargeant examines complexity theory, and theories related to social identity, professionalism, and stereotyping, as well as situated learning, communities of practice, reflective and experiential learning, and transformative learning. Cognitive theories, such as cognitive apprenticeship (Brandt, Farmer & Buckmaster, 1993) and the ecological approach to team cognition (Cooke, Gorman, & Rowe, 2009) set forth frameworks useful in interprofessional team-based learning.

## Key Challenges to the Uptake and Implementation of Core Interprofessional Competencies

- **Institutional Level Challenges** – There is a lack of top administrative leadership support for adequate resources to create an interprofessional component to health professions students' education. In institutions that implement systematic programs of interprofessional education top leadership support has been critical.

**Positive Examples:** The Medical University of South Carolina chose the topic of interprofessional education for its 10-year Quality Enhancement Plan required for reaffirmation of accreditation by the Southern Association of Colleges and Schools. The University of Minnesota, Rosalind Franklin University, and Western University of Health Sciences are among the schools implementing institution-level interprofessional education programs with top administrative support.

- **The Lack of Institutional Collaborators** - Some schools interested in launching interprofessional learning have no other or limited professional schools in their institution to partner with, and some potential partners are unwilling to take on an interprofessional agenda.

**Positive Example:** Vanderbilt University has reached out to two other universities to add pharmacy and social work students, enhancing the experience of the medical and nursing students, indeed all students, in the new Program in Interprofessional Learning.

- **Practical Issues** - Scheduling and finding time to bring students together across the professions remains an issue.

**Positive Examples:** The University of California, San Francisco and Rosalind Franklin University have gone to a common calendar across programs.

- **Faculty Development Issues** - Health professions faculty need training to become effective interprofessional educators. The content and process of interprofessional learning differ from other academic content they teach.

**Positive Examples:** The Medical University of South Carolina's Faculty Development Institute is competitive throughout the University; and its promotion and tenure guidelines support involvement in interprofessional education. The University of Toronto has an annual interprofessional education faculty development program and consults with other institutions to assist in faculty development. The Western University of Health Sciences has explicitly trained faculty in interprofessional facilitation skills.



**Institute of Medicine  
Educating for the Health Team  
1972**

“ A major deterrent to our efforts to fashion health care that is efficient, effective, comprehensive, and personalized is our lack of a design for the synergistic interrelationship of all who can contribute to the patient’s well being. We face, in the next decade, a national challenge to redeploy the functions of health professions in new ways, extending the roles of some, perhaps eliminating others, but more closely meshing the functions of each than ever before.

There are organizational, political, ethical, and legal problems to be faced. But it is certain that in the coming process of reexamination the responsibility of the academic health centers and other educational institutions will be central. Can the provision of health care be improved by closer interaction of health professionals in new ways, and can the education of health professionals together facilitate the cooperative endeavors so urgently needed in practice? ”

(IOM, pp. 4-5)

- **Assessment Issues** - The need for assessment instruments to evaluate interprofessional competencies represents a “next step” in the development of competency-based interprofessional education for all stages of interprofessional learning. This work is in early stages of development.

**Positive Example:** One example of work underway is the project described by Curran et al. (2009) in Canada to develop an Assessment Rubric for interprofessional collaborative competencies within the context of an Interprofessional Team Objective Structured Clinical Examination.

- **Lack of Regulatory Expectations** - Recognition by accrediting bodies of interprofessional competencies as vital to health professions educational programs reinforces the imperative to address it by faculty and institutional leaders.

**Positive Examples:** The pharmacy profession at the national level has now integrated interprofessional learning expectations into curricula and accreditation. Eight accrediting organizations participating in the Accreditation of Interprofessional Health Education initiative supported by Health Canada have adopted shared principles and plan to pilot test a common program assessment tool to evaluate interprofessional education activities. (Accreditation of Interprofessional Health Education, 2009a, 2009b)

The challenges to bringing about transformational change in health professions education, which includes much stronger emphasis on “learning together to work together,” are real and will require creativity and commitment to overcome. However, positive changes, such as the examples described, indicate that many of the elements requiring change are “unfreezing”. Further, the support for such changes is coming from many different sectors. We are confident that 40 years from now calls for integrated interprofessional education for collaborative practice will not resonate with healthcare practitioners, as the IOM 1972 report does with today’s health professions educators. Every indication is that the time is now indeed right for transformational changes and, collectively, we are ready for action.

## Scope of This Report

This report focuses on the charge the panel was given to identify individual-level interprofessional competencies for future health professionals in training. We wrote competency statements and identified learning activities relevant for the pre-licensure/pre-credentialing student. The report targets a specific aspect of health professions training focused on relationships among professions and with patients using a community/population-orientation. As such, it makes a specific, limited contribution to the larger arena of health professions education and health improvement. However, we hope that the competencies identified are general enough in language to articulate with and bolster interprofessional learning beyond the student level, as well as to spur needed educational research and evaluation.

Educators have raised challenges to educational approaches that frame outcomes in terms of competencies [Reeves, Fox & Hodges, 2010; ten Cate & Scheele, 2007; Walsh et al., 2005].

These include:

- 1) “parceling out” and reinforcing conventional boundaries of practice across the professions with potentially negative impact on the efforts to encourage more collaboration in practice;
- 2) unwieldy educational and evaluation processes brought about by too much specificity in professional competency expectations by multiple evaluators/regulators;
- 3) a reductionism that works against complex thinking needed for holistic responses to specific practice situations;
- 4) “freezing” competency expectations at a particular point in time, i.e., competency rather than capability, the latter increasing in complexity and sophistication over a lifetime professional learning trajectory in different clinical contexts;
- 5) lack of flexibility in practice contexts where overlapping practice boundaries and innovation can be responsive to shifting patient and population health needs;
- 6) difficulties with assessment of competencies.

In this report, we have made an effort to address, or at least recognize, these current or potential limitations.

By including public health in crafting the interprofessional competencies we acknowledge our increasing acceptance that real health improvement is a function of direct care providers and public health professionals working together to address environmental and social determinants of health, prevention, and early detection

as well as the individualized components of treating illness. We break ground with modest beginnings as we all work out the nature of these relationships in broader approaches to improving health and health care.

The inclusion of systems knowledge is not explicit in the report. However, the recognition that interprofessional competencies are best learned and mastered over time in specific interprofessional learning contexts (clinical and non-clinical) around specific healthcare and health improvement goals is a fundamental message of the report.

The competencies we identified in this report do not address either the unique aspect of each health profession or the common clinical and public health knowledge base that health professionals share. We recognize that greater awareness of shared areas might lead to greater efficiencies in health professions education. The uniqueness of professional expertise is fundamental to teamwork and team-based care. We recognize the dynamic nature of this evolving knowledge base in a climate that increasingly values interdisciplinary/interprofessional translational research, and the ways this type of research will help close the gaps between research and practice going forward.

We recognize that the report is silent about the non-professional workers who have always been there to provide care on the “front lines”, such as home care and nursing home aides, community health workers and others in new roles being created. Their experiential knowledge base is critical to giving individualized care that is safe, efficient, and effective, and, accordingly, models need to be developed to recognize and value their role in teamwork and team-based care.

We also realize that other disciplines, more remote from direct health improvement initiatives, such as architects, engineers, librarians, and those in the humanities contribute in important ways to the overall quality of health and health care.

Finally, this report grew from the commitment of the six participating professional educational organizations to define interprofessional competencies for their professions. Our hope is that other professional education organizations, as well as a broader group of stakeholders in the quality of health professions education, will see the value of these competencies and adopt the recommendations in their own work. The most important stakeholders are persons who are sometimes patients and communities themselves that stand to benefit when health professions work together better to improve health and health care. Engaging other stakeholders will add broader scope and momentum to help transform the interprofessional education of health professionals for the future.



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## APPENDIX

# Interprofessional Education Collaborative, Expert Panel Charge, Process and Panel Participants

The following participating associations convened the expert panel to produce a report on core competencies for interprofessional collaborative practice: the American Association of Colleges of Nursing, the American Association of Colleges of Osteopathic Medicine, the American Association of Colleges of Pharmacy, the American Dental Education Association, the Association of American Medical Colleges, and the Association of Schools of Public Health. These six organizations formed an initial working group—the Interprofessional Education Collaborative (IPEC)—that produced a statement on interprofessional education collaboration in March 2009. This statement committed members to developing a common vision for how the respective professions could combine their unique abilities to deliver patient-centered team-based care, promote efforts to reform health care delivery and financing in line with that vision, and foster meaningful interprofessional learning experiences to support team-based care of the future. A framework of activities to support these goals was drafted in June 2009, including the identification of core competencies for interprofessional collaborative practice, current educational experiences, and curricular models.

### Panel Charge

Each IPEC organization appointed two individuals to the expert panel and charged the panel to:

- ▶ Recommend a common core set of competencies relevant across the six professions to address the essential preparation of clinicians for interprofessional collaborative practice
- ▶ Recommend learning experiences and educational strategies for achieving the competencies and related objectives

The panel was asked to identify consensus working definitions of interprofessional education and interprofessional collaborative practice, as well as a functional meaning of competencies. The educational piece of how to assess interprofessional competencies is an important companion activity that will necessarily follow from the recommended set of core competencies.

### Panel Process described

A core set of materials on interprofessional competencies and related frameworks provided the panel with a common starting point at the panel's initial meeting at

the AAMC headquarters in Washington, D.C. on March 16, 2010. Over time and in step with fast developing educational and practice initiatives, the panel compiled additional resource material. This material came from new literature; expanded documentation of participating associations' own competency development efforts; information about interprofessional competency development work from educational institutions linked to the American Interprofessional Health Collaborative network; Health Resources and Services Administration, Bureau of Health Professions consensus efforts (2010); and the collection of institutional examples of interprofessional education being implemented in universities throughout the U.S. and beyond, including the panelists' own institutions.

Core competency domains were identified at an initial face-to-face meeting, after which the panel worked through conference calls and email exchanges to refine the competency domains, develop individual competency statements related to those domains, and engage in robust content development, the results of which are manifested in this final report. This work also reflects feedback on the draft competencies by invited attendees at a conference- "Interprofessional Team-based Competencies: Building a Shared Foundation for Education and Clinical Practice, held February 16-17, 2011, jointly sponsored by the Health Resources and Services Administration, Josiah Macy Jr. Foundation, Robert Wood Johnson Foundation, and American Board of Internal Medicine Foundation in collaboration with IPEC. Proceedings of that conference are published separately from this report.

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**Core Competencies for Interprofessional Collaborative Practice**  
Report of an Expert Panel

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Staff support was provided by Alexis L. Ruffin, M.S., Director, Medical Education, at the Association of American Medical Colleges.

The Expert Panel would like to thank the following institutions for sharing information about their interprofessional education programs for health professions students:

University of British Columbia  
The University at Buffalo-SUNY  
East Tennessee State University  
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Indiana University  
Jefferson College of Health Sciences  
University of Kentucky  
University of Minnesota  
Medical University of South Carolina  
Rosalind Franklin University of Medicine and Science  
St. Louis University  
University of Toronto  
University of Virginia  
University of Washington  
Vanderbilt University  
Western University of Health Sciences



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# CORE COMPETENCIES FOR INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE



**SAMHSA-HRSA**  
**Center for Integrated Health Solutions**

NATIONAL COUNCIL  
FOR BEHAVIORAL HEALTH  
MENTAL HEALTH FIRST AID  
*Healthy Minds. Strong Communities.*

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JANUARY 2014

[www.integration.samhsa.gov](http://www.integration.samhsa.gov)

## SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is the first “national home” for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care.

Jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration, and run by the National Council for Behavioral Health, CIHS provides training and technical assistance to community behavioral health organizations that received SAMHSA Primary and Behavioral Health Care Integration grants, as well as to community health centers and other primary care and behavioral health organizations.

CIHS’ wide array of training and technical assistance helps improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the health and wellness of individuals living with behavioral health disorders.

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Prepared by the Annapolis Coalition on the Behavioral Health Workforce under contract to the HRSA-SAMHSA Center for Integrated Health Solutions at the National Council for Behavioral Health.

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## PROJECT TEAM

CIHS engaged the Annapolis Coalition on the Behavioral Health Workforce ([www.annapoliscoalition.org](http://www.annapoliscoalition.org)) to lead and manage the competency development project. The Coalition is a non-profit organization dedicated to improving the recruitment, retention, training and performance of the prevention and treatment workforce in the mental health and addictions sectors of the behavioral health field.

The core Annapolis Coalition team managing the project included:

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While we are grateful for the input from the senior content advisors and all of the key informants listed in Appendix I, the final decisions on the content of this report were made by the project team. They alone are responsible for any errors or omissions.

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# INTRODUCTION

Despite the increasing national focus on integrated care, there is no single, widely recognized set of competencies on this service approach for either the behavioral health or primary care workforce. To address this gap, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) charged the Center for Integrated Health Solutions (CIHS; [www.integration.samhsa.gov](http://www.integration.samhsa.gov)) to identify and disseminate core competencies on integrated practice relevant to behavioral health and primary care providers. The development of these competencies was performed by the Annapolis Coalition on the Behavioral Health Workforce ([www.annapoliscoalition.org](http://www.annapoliscoalition.org)) under the auspices of CIHS.

The core competencies developed through this project are intended to serve as a resource for provider organizations as they shape job descriptions, orientation programs, supervision, and performance reviews for workers delivering integrated care. Similarly, the competencies are to be a resource for educators as they shape curricula and training programs on integrated care. The charge was to develop a “core” or “common” set of competencies broadly relevant to working in diverse settings with diverse populations. The competency sets are not intended to be setting or population specific. Their principal relevance is to the integration of behavioral health with primary care as opposed to the integration of behavioral health with specialty medical care.

## Workforce Sectors

Behavioral health encompasses prevention, intervention, and recovery from mental health and substance use conditions. Equally important, it focuses on promoting behaviors that support health and wellness. This workforce, which is described in a previous SAMHSA-funded report ([www.annapoliscoalition.org/download\\_actionplan.aspx](http://www.annapoliscoalition.org/download_actionplan.aspx)), is comprised of graduate trained professionals, direct care staff with on the job training and experience, and persons in recovery from behavioral health conditions. This includes, but is not limited to: psychiatrists, psychologists, social workers, advanced practice psychiatric nurses, marriage and family therapists, addiction counselors, mental health counselors, psychiatric rehabilitation specialists, psychiatric aides and technicians, and peer support specialists and recovery coaches.

Primary care is a complex concept that focuses on the provision of “...comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern...” (American Academy of Family Practitioners, [www.aafp.org](http://www.aafp.org)). It includes health promotion, disease prevention, education, diagnosis and treatment. The primary care workforce includes, but is not limited to, physicians, physician assistants, advanced practice nurses, registered nurses, and a range of allied health professionals.

## Types of “Integrated Care”

While the concept of integration, as used within this document, refers to collaboration between behavioral health and primary care providers, there are many forms and models of integrated care. CIHS developed a framework, which can be accessed online ([www.integration.samhsa.gov/resource/standard-framework-for-levels-of-integrated-healthcare](http://www.integration.samhsa.gov/resource/standard-framework-for-levels-of-integrated-healthcare)). The competencies reported are principally intended to address levels 4, 5, and 6 in that framework, which involve either close or full collaboration and one of three organizational models: some systems integration, integrated practice, or transformed/merged practice.

## Finding Common Language

The competency set requires the use of consistent language to refer to the recipients of healthcare. The terms used by different professions/specialties and in different settings vary widely (i.e. patient, client, or consumer) and it is clear that no single term is preferred by, and perhaps even acceptable to, the many groups and individuals involved in the delivery of integrated care.

For this document, the term *healthcare consumer* or simply *consumer* has been selected as one that is understood, though perhaps not preferred, in primary care, mental health, and the field of addictions. As captured below in the competencies, it is generally recommended that providers adopt the language of the setting in which care is delivered. To the extent to which such language is unacceptable to providers, they are encouraged to educate others within their team and setting about their rationale for using alternative language.



Within this document, the term *behavioral health* is used to refer to mental health and addictions. Behavioral health is distinguished from “general health,” recognizing the imperfections in the distinction and the language used to describe it. Behavioral health is also distinct from healthy or health behavior. Unless otherwise noted, the term *health conditions* refers to all health conditions and is not specific to behavioral health.

## Guiding Assumptions

The development of this core competency set was guided by a series of assumptions that are articulated below.

1. It is crucial to stress that these competencies reinforce or enhance the basic competencies of each discipline and the specialty competencies that each provider must have to practice in his or her field. There is not a bright line between those competencies and many of the competencies that are essential for the provision of integrated care. Some competencies that are generic to most forms of healthcare, such as those related to *interpersonal communication*, are included in this set because they are *absolutely essential* to the effective delivery of integrated care.
2. In order for a core competency set to be practical and useful, it has to have a manageable number of competency categories and individual competencies. Long and detailed competency sets overwhelm the reader, the educator, the interprofessional team leader, and the direct care provider. Clarity and simplicity was the goal.
3. The competencies are optimally skill oriented, focusing on what the provider of integrated care can actually “do.” Knowledge and attitudes make the desired behavior possible, but demonstration of an essential skill is the desired outcome.
4. The focus of integrated care and these workforce competencies is very broadly defined, not narrowly focused on particular diagnosable disorders. Similarly, the competencies are intended to be relevant to healthcare consumers across the lifespan from diverse populations, and are not specific to a particular age or population.
5. The competency set specifies skills such as the use of evidence-based treatments and tools, but generally does not identify specific treatments or tools. These will vary by setting and population and will change over time as the evidence base grows and prevention and treatment approaches evolve. Up-to-date information on evidence-based treatments and tools can be accessed at various websites including [www.samsha.gov](http://www.samsha.gov) and [www.hrsa.gov](http://www.hrsa.gov).
6. The competencies are premised on consumers and family members as partners in the healthcare process whose strengths, goals and preferences should drive healthcare decisions.
7. The issue of culture must be considered in all efforts to understand health, illness, treatment, resilience and recovery.
8. The effective delivery of integrated care requires system modifications to support changed practice. However, system design was outside of the scope of this project. Clearly the financing and organization of care delivery can have a major impact on the ultimate competence of the providers working in those delivery systems.
9. Core competencies are defined as those that apply to the *majority* of providers involved in integrated care. Each competency is not necessarily relevant to *every* provider. For example, more complex, clinically oriented competencies may not be applicable to care managers or navigators. Many of these competencies may be relevant to peer support roles. The employer must designate the competencies applicable to each position.

Long and detailed competency sets overwhelm the reader, the educator, the interprofessional team leader, and the direct care provider. Clarity and simplicity was the goal.

## A Single Integrated Set of Competencies

The initial project goal was to develop two competency sets: one for behavioral health practitioners and the other for primary care practitioners. However, the results of the data gathering process revealed that most competencies required for integrated care were common to behavioral health *and* primary care providers. The initial draft of competencies, which contained some distinctions between behavioral health and primary care skills, met with criticism from a number of key informant reviewers who argued that such separation would promote continued silos between disciplines and professions and foster an unnecessary interprofessional divide. Thus the competencies that appear below are structured as a single integrated set.

## METHOD

The method for arriving at the core set of competencies involved three major activities: (1) structured interviews with the key informants; (2) review of the recent literature on integration, and (3) review and analysis of selected competency sets judged to have relevance to this process. Each of these sources yielded potential content for inclusion in the competency set. Using a qualitative and consensus driven process, the Project Team integrated and distilled the recommendations into a number of competency *categories* and then placed individual competencies within those categories. A draft competency set was reviewed by the Senior Content Advisors and Key Informants and revised based on the feedback received. A more detailed description of the methodology is contained in Appendix II.

## USING THE CORE COMPETENCIES

The identification of core competencies creates an essential foundation for preparing and further developing a workforce to deliver integrated care. These competencies can be used to further that agenda in multiple ways.

### Shaping Workforce Training

Competency sets are a reference point for educators who are designing and delivering a training curriculum. This set of competencies on integrated care can be used to identify the need for training courses and can shape the content of such courses. It can be used to update and expand the focus of existing courses, to design continuing education events, and to select topics for in-service education within healthcare organizations.

### Informing Job Descriptions

The competencies can be used to develop or update job descriptions and duties for positions within settings where integrated care is delivered. Lack of role clarity is a prime driver of dissatisfaction with and turnover in healthcare positions. Greater clarity in job descriptions and job roles can help improve employee satisfaction and retention.

### Employee Recruitment

These competencies in integrated care can be used in the recruitment process to educate prospective employees about the nature of the work, since “realistic job previews” tend to decrease the frequency with which candidates are offered and/or accept jobs for which they are not well suited. Similarly, the competencies can be used to assess the qualifications of job candidates, both during a review of applications and during the interview process.

### A Guide to Orientation

The competencies can be used as a guide to orienting new employees to their role and responsibilities in the delivery of integrated care. Supervisors and employees can jointly review the competencies and discuss the employee’s perspective on areas where additional training and mentoring may be beneficial.

### Performance Assessment

Competencies should be the foundation on which assessments of performance are based. These competencies on integrated care can be incorporated into employee self-assessment tools, 360-degree evaluations, and formal performance reviews used within healthcare organizations.

### Shaping Existing & Future Competency Sets

There are many existing competency sets that have been developed for the health professions, for the direct care workforce, and for peer support workers. The integrated care competencies identified in this document can be used by the developers of existing competency sets as a benchmark for assessing the extent to which those other sets adequately incorporate content regarding integrated care. Those sets can be updated based on such a review and new competency sets under development can draw from the information within this report as well.

# CORE COMPETENCY CATEGORIES

The competencies are organized into nine competency categories. These were not determined in advance, but emerged from the key informant interviews, the literature review, and examination of other competency sets. Some of the competencies could appear in more than one category, but were placed in the category deemed most relevant. The categories that emerged from the process are outlined in Table 1.

TABLE 1. SPECIFIC COMPETENCIES BY CATEGORY

## I. INTERPERSONAL COMMUNICATION

*The ability to establish rapport quickly and to communicate effectively with consumers of healthcare, their family members and other providers.*

Examples include: active listening; conveying information in a jargon-free, non-judgmental manner; using terminology common to the setting in which care is delivered; and adapting to the preferred mode of communication of the consumers and families served.

## II. COLLABORATION & TEAMWORK

*The ability to function effectively as a member of an interprofessional team that includes behavioral health and primary care providers, consumers and family members.*

Examples include: understanding and valuing the roles and responsibilities of other team members, expressing professional opinions and resolving differences of opinion quickly, providing and seeking consultation, and fostering shared decision-making.

## III. SCREENING & ASSESSMENT

*The ability to conduct brief, evidence-based and developmentally appropriate screening and to conduct or arrange for more detailed assessments when indicated.*

Examples include screening and assessment for: risky, harmful or dependent use of substances; cognitive impairment; mental health problems; behaviors that compromise health; harm to self or others; and abuse, neglect, and domestic violence.

## IV. CARE PLANNING & CARE COORDINATION

*The ability to create and implement integrated care plans, ensuring access to an array of linked services, and the exchange of information among consumers, family members, and providers.*

Examples include: assisting in the development of care plans, whole health, and wellness recovery plans; matching the type and intensity of services to consumers' needs; providing patient navigation services; and implementing disease management programs.

## V. INTERVENTION

*The ability to provide a range of brief, focused prevention, treatment and recovery services, as well as longer-term treatment and support for consumers with persistent illnesses.*

Examples include: motivational interventions, health promotion and wellness services, health education, crisis intervention, brief treatments for mental health and substance use problems, and medication assisted treatments.

## VI. CULTURAL COMPETENCE & ADAPTATION

*The ability to provide services that are relevant to the culture of the consumer and their family.*

Examples include: identifying and addressing disparities in healthcare access and quality, adapting services to language preferences and cultural norms, and promoting diversity among the providers working in interprofessional teams.



## VII. SYSTEMS ORIENTED PRACTICE

*The ability to function effectively within the organizational and financial structures of the local system of healthcare.*

Examples include: understanding and educating consumers about healthcare benefits, navigating utilization management processes, and adjusting the delivery of care to emerging healthcare reforms.

## VIII. PRACTICE-BASED LEARNING & QUALITY IMPROVEMENT

*The ability to assess and continually improve the services delivered as an individual provider and as an interprofessional team.*

Examples include: identifying and implementing evidence-based practices, assessing treatment fidelity, measuring consumer satisfaction and healthcare outcomes, recognizing and rapidly addressing errors in care, and collaborating with other team members on service improvement.

## IX. INFORMATICS

*The ability to use information technology to support and improve integrated healthcare.*

Examples include: using electronic health records efficiently and effectively; employing computer and web-based screening, assessment, and intervention tools; utilizing telehealth applications; and safeguarding privacy and confidentiality.

# I. INTERPERSONAL COMMUNICATION

1. Establish rapport, rapidly develop, and maintain effective working relationships with diverse individuals, including healthcare consumers, family members, and other providers.
2. Listen actively and effectively, as demonstrated by the ability to quickly grasp presenting problems, needs, and preferences as communicated by others, and reflect back that information to ensure that others have been accurately understood.
3. Clearly convey relevant information in a non-judgmental manner about behavioral health, general health, and health behaviors using person-centered concepts and terms that are free of jargon and acronyms and are easily understood by the listener.
4. Explain to the healthcare consumer and family the roles and responsibilities of each team member and how they will work together to provide services.
5. In speaking to healthcare consumers or professionals, use the terminology that is common to the setting in which care is delivered or advocate for and educate others about the rationale for using alternative language.
6. Use the primary language and preferred mode of communication of the healthcare consumer and family members or communicate through the use of qualified interpreters.
7. Adapt the style of communication to account for the impact of health conditions on a healthcare consumer's ability to process and understand information.
8. Provide health education materials that are appropriate to the communication style and literacy of the healthcare consumer and family and that reinforce information provided verbally during healthcare visits.
9. Recognize and manage personal biases related to healthcare consumers, families, health conditions and healthcare delivery.



## II. COLLABORATION & TEAMWORK

1. Recognize, respect and value the role and expertise of healthcare consumers, family members, and both behavioral health and primary care providers in the process of healthcare delivery.
2. Develop a shared understanding of the respective roles and responsibilities of team members to ensure that collaboration is efficient.
3. Recognize the limits of one's knowledge and skills and seek assistance from other providers.
4. Serve as an effective member of an interprofessional team, helping other providers on the team to quickly conceptualize a healthcare consumer's strengths, healthcare problems, and an appropriate plan of care.
5. Exhibit leadership by directing, guiding, or influencing the collaboration and service delivery of the healthcare team.
6. Respect and respond to the leadership displayed by other providers in a healthcare setting or team.
7. Assertively represent one's professional opinions, encourage other team members to express opinions, and resolve differences of opinion or conflicts quickly and without acrimony.
8. Advocate within the healthcare setting or team for the role of the healthcare consumer and family member in healthcare decisions.
9. Facilitate collaborative care by actively sharing relevant information with others through communications that are authorized by the healthcare consumer and are permissible under HIPAA and related laws, regulations and policies.
10. Foster shared decision-making with healthcare consumers, family members, and other providers.
11. Respond to the expressed needs of healthcare consumers, family members, and other providers, while minimizing the extent to which provider preconceptions of illness and treatment obscure those expressed needs.
12. Demonstrate practicality, flexibility, and adaptability in the process of working with others, emphasizing the achievement of treatment goals as opposed to rigid adherence to treatment models.
13. Connect healthcare consumers and family members to other members of the healthcare team through face-to-face encounters known as "warm hand-offs."
14. Use behavioral health and general health interventions to support the work of the team and to enhance healthcare consumer outcomes.
15. Respond immediately, if at all possible, to requests for consultation or intervention from other providers.
16. Adapt health interventions to the work flow and pace that typically characterizes the provision of primary care, including rapid assessment, brief treatment, and a high daily volume of healthcare consumer contacts.
17. Advocate for, teach, and support illness and whole health self-management and recovery approaches to health conditions within the healthcare team and setting.
18. Advocate for and foster the use of peer support approaches and peer support providers in the healthcare setting as a component of healthcare delivery.



### III. SCREENING & ASSESSMENT

1. Use strengths-based wellness, resilience, and recovery models in conceptualizing the health and healthcare of consumers.
2. Routinely conduct brief, evidence-based, and developmentally sensitive screens for the risky, harmful, or dependent use of substances, including alcohol, illicit drugs, and prescription medications, and appropriateness for agonist, antagonist, and anti-craving medications.
3. Routinely conduct brief, evidence-based, and developmentally appropriate screens for cognitive impairment, common mental health problems, and behaviors that compromise health.
4. Routinely conduct brief screens for risk related to self-harm, harm to others, impairments in functional self-care, and environmental safety.
5. Detect signs of abuse, neglect, domestic violence, and other trauma in individuals across the lifespan.
6. Conduct or have other team members conduct more detailed, yet efficient, assessments of healthcare consumers who screen positive for mental and substance use conditions, risk to self or others, or potential abuse and neglect.
7. Recognize and diagnose, using established classification criteria, the most common mental health and substance use conditions seen in the healthcare setting.
8. Recognize the signs, symptoms and treatments of the most common health conditions, health crises, and comorbidity seen in the healthcare setting.
9. Understand the symptoms and treatments for the major healthcare conditions of the consumers under the provider's care.
10. Briefly assess the nature of the consumer's family and social support system and other socio-economic resources that have an impact on health and healthcare.
11. Determine collaboratively the feasibility of providing effective treatment to the healthcare consumer and family within the context of the healthcare team and setting.



### IV. CARE PLANNING & CARE COORDINATION

1. Create and periodically update integrated care plans in consultation with healthcare consumers, family members, and other providers, including individuals identified by consumers as part of their healthcare team.
2. Work with healthcare consumers to develop whole health and wellness recovery plans.
3. Match and adjust the type and intensity of services to the needs of the healthcare consumer, ensuring the timely and unduplicated provision of care.
4. Through the care plans, link multiple services, healthcare providers, and community resources to meet the healthcare consumers' needs.
5. Ensure the flow and exchange of information among the healthcare consumer, family members, and linked providers.
6. Work collaboratively to resolve differing perspectives, priorities and schedules among providers.



7. Provide or arrange access to “patient navigation” services that focus on benefits and financial counseling, transportation, home care, and access to social services, peer support, and treatment, including medications.
8. Establish and support systems and procedures within the team and healthcare setting for the use of agonist, antagonist, and anti-craving medications.
9. Coordinate with health plans in identifying and addressing individual consumer and population needs.
10. Implement disease management programs and strategies for selected health conditions, combining the use of engagement tools, health risk assessments, cognitive and behavioral interventions, medications, web-based tools, protocols and guidelines, formularies, monitoring devices, shared decision-making aides, illness and whole health self-management strategies, peer support and empowerment approaches, and call centers.
11. Effectively connect healthcare consumers who cannot be adequately treated by the team or within the setting to other appropriate services.

## V. INTERVENTION

1. Demonstrate a fundamental belief in the value and effectiveness of brief interventions to improve health through practice patterns and communications with healthcare consumers, family members, and other providers.
2. Use focused interventions to engage healthcare consumers and increase their desire to improve health (e.g., motivational interviewing, motivational enhancement therapy).
3. Promote healthcare consumer and family adherence to care plans.
4. Educate healthcare consumers, family members, and other providers about healthcare conditions, prevention, available treatments, illness and whole health self-management, peer support and recovery.
5. Identify evidence-based interventions and best practices for integrated care settings.
6. Provide health promotion, wellness and prevention interventions.
7. Deliver brief, trauma-informed, problem-oriented treatment for mental conditions or problematic health behaviors.
8. Deliver brief, trauma-informed treatment for risky or harmful substance use conditions, including the misuse of prescription drugs.
9. Deliver brief, supportive interventions addressing the consequences of illness and injury.
10. Implement longer-term models of treatment and support for healthcare consumers with persistent illnesses that require follow-up over time.
11. Prescribe and manage medications for mental health and substance use conditions (appropriately licensed providers only), including Medically Assisted Treatments for addictions, with consultation, as needed, from other prescribing professionals.
12. Educate healthcare consumers and family members about the common effects, side effects, potential long-term adverse health effects, and interactions of pharmacological treatments for mental health and substance use conditions.
13. Recognize the primary indications, effects, and side effects of pharmacological agents used in the treatment setting for the most common health conditions.
14. Recognize the potential impact and interaction of over-the-counter medications and other non-prescription remedies on health and healthcare treatments.
15. Manage behavioral health crises through office and home-based interventions and linkage to treatment facilities.



16. Link healthcare consumers and family members with other resources, including but not limited to specialty healthcare, rehabilitation and social services, peer support, financial assistance, and transportation, following up to ensure that effective connections have been made.
17. Support healthcare consumers in considering and accessing complementary and alternative services designed to support health and wellness.
18. Provide information, education, guidance, and support to family members and other caregivers.

## VI. CULTURAL COMPETENCE & ADAPTATION

1. Identify and address disparities in healthcare access and quality for diverse individuals and populations served.
2. Adapt services, including evidence-based interprofessional team approaches, to the language, cultural norms, and individual preferences of healthcare consumers and family members.
3. Develop collaborative relationships with providers of services tailored to the needs of culturally diverse healthcare consumers and family members.
4. Examine the experiences of culturally diverse healthcare consumers and family members with respect to quality of care and adjust the delivery of care as needed.
5. Educate members of the team about the characteristics, healthcare needs, health behaviors, and views toward illness and treatment of diverse populations served in the treatment setting.
6. Foster and value diversity in terms of the composition of the interprofessional team members in all roles, including, but not limited to, community health workers.



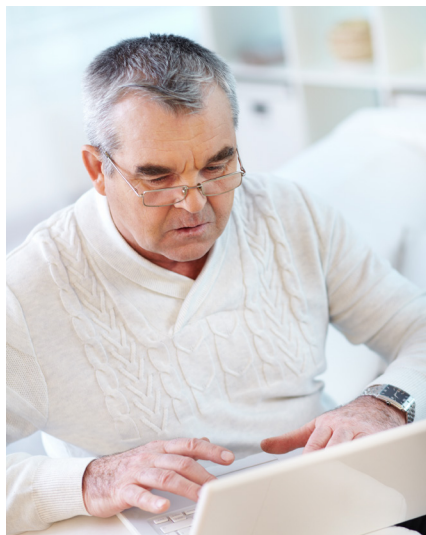
## VII. SYSTEMS ORIENTED PRACTICE

1. Understand and practice effectively within the organization and culture of the interprofessional team, practice setting, and local healthcare system.
2. Provide or arrange assistance to healthcare consumers, family members and other providers in understanding applicable healthcare benefits, coverage limits, and utilization management procedures.
3. Organize and deliver services with an understanding of the impact of team based care on billing, reimbursement, and healthcare coverage.
4. Consider both clinical and cost-effectiveness in decision-making about the organization and delivery of services.
5. Anticipate and adjust the delivery of care to emerging healthcare reforms and structures, such as accountable care organizations, medical homes, and health insurance exchanges.
6. Plan and deliver services with an understanding of the healthcare needs of the population being served.



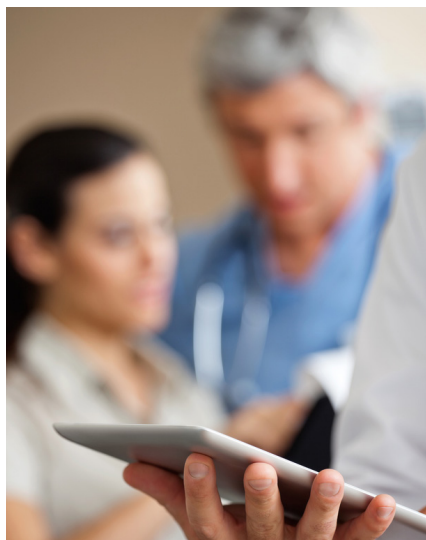
## VIII. PRACTICE-BASED LEARNING & QUALITY IMPROVEMENT

1. Search and evaluate the literature for evidence of the most effective interventions for specific health conditions.
2. Apply relevant practice guidelines to the delivery of care.
3. Deliver evidence-based, integrated approaches to the treatment of health conditions, adapting them to the population, treatment setting, and local system of care.
4. Assess the fidelity of team-based care to evidence-based treatment models.
5. Identify and rapidly address errors in care and assist in implementing policies and procedures to reduce future errors.
6. Measure and monitor individual health outcomes in collaboration with the consumer, adjusting care plans based on outcome data.
7. Monitor healthcare consumer and family satisfaction with care on multiple dimensions and adjust care and practice patterns based on the feedback.
8. Recognize the importance of monitoring client outcomes in the aggregate and demonstrate an ability to read and interpret outcomes monitoring reports.
9. Monitor aggregate consumer health care outcomes and collaborate with the team in improving the process of care based on the data.
10. Collaborate with the healthcare organization and other local healthcare agencies to continuously assess and improve service system design.
11. Establish and pursue individual and team-based learning and improvement goals.



## IX. INFORMATICS

1. Use an electronic health record to retrieve relevant information and to document care concisely.
2. Screen, assess and provide services to healthcare consumers using computer-based and web-based tools.
3. Employ telehealth applications to ensure consumer access to appropriate care and to deliver healthcare.
4. Assist healthcare consumers in using web-based tools as part of their personal healthcare plan.
5. Communicate with healthcare consumers and family members using secure online, mobile, and “smart” technology and devices.
6. Safeguard healthcare consumer privacy and confidentiality with respect to communication, documentation, and data.



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# APPENDIX I: CONTRIBUTORS

## PROJECT TEAM

CIHS engaged the Annapolis Coalition on the Behavioral Health Workforce ([www.annapoliscoalition.org](http://www.annapoliscoalition.org)) to lead and manage the competency development project. The Coalition is a non-profit organization dedicated to improving the recruitment, retention, training and performance of the prevention and treatment workforce in the mental health and addictions sectors of the behavioral health field.

The core Annapolis Coalition team managing the project included:

Michael A. Hoge, PhD, Senior Science and Policy Advisor, The Annapolis Coalition  
 John A. Morris, MSW, Executive Director, The Annapolis Coalition  
 Michele Laraia, PhD, APRN, Project Consultant, The Annapolis Coalition  
 Ann McManis, Director of Operations, The Annapolis Coalition

## Senior Content Experts

Two individuals with nationally recognized expertise in this field were engaged as Senior Content Experts to provide a broad and high-level review of the product.

Andrew Pomerantz, M.D. is the National Mental Health Director for Integrated Services in the Veterans Health Administration and Associate Professor of Psychiatry at Dartmouth Medical School. His “White River” model of primary care – mental health integration, developed over a 15-year period, became a national model for the Veterans Administration in 2004. He is currently engaged in development of the VA’s Patient Centered Medical Home.

Tillman Farley, M.D. is the Medical Services Director of Salud Family Health Centers, a migrant / federally qualified community health center with clinics across north and northeast Colorado. He completed his residency in family medicine in Rochester, New York and now serves as an Associate Professor in the Department of Family Medicine at the University of Colorado School of Medicine. He moved to Colorado from far west Texas where he spent three years directing a federally qualified rural health clinic. Dr. Farley has a strong interest in integrated primary care and health disparities, particularly as these apply to immigrant populations.

## Expert Key Informants

The selection process and expertise of key informants is described in the Detailed Method section below.

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## APPENDIX II: DETAILED METHOD

### Overview

The method for arriving at the core set of competencies involved three major activities: (1) structured interviews with the key informants; (2) review of the recent literature on integration; and (3) review and analysis of selected competency sets judged to have relevance to this process.

### Key Informants

The foundation of the core competencies rests on recommendations from 50 key informants who were selected because of their expertise on integrated care. They were identified in multiple ways, including: authorship of articles and other resources on the topic of integration, nomination by other experts, nomination by the SAMHSA-HRSA Center for Integrated Health Solutions, leadership within a HRSA-supported FQHC, leadership role in a community behavioral health organization that is a grantee within the SAMHSA-sponsored Primary and Behavioral Health Care Integration (PBHCI) program, and national leadership in peer support and recovery.

Special efforts were made to ensure that the key informant pool included individuals whose expertise reflected knowledge of and practice in the following: integration of primary care and behavioral healthcare; development of professional competencies; the unique needs of children, adults, and older adults; urban and rural healthcare; cultural competence, diversity, and disparities; and healthcare financing and managed care. Experts were drawn from varied disciplines and specialties, including: internal medicine and family medicine, public health, addictions, psychiatry, social work, nursing and peer support and recovery. The list of key informants is contained in Appendix I.

Key informants were interviewed by project team members using a semi-structured format. With respect to integration, they were asked to identify published works, other resources, and additional key informants. Their most important task was to recommend specific competencies for inclusion in the competency set. All recommended competencies were distilled into a single set, condensed to eliminate redundancy, and organized into categories in an iterative qualitative process managed by the project team.

### Literature Review

A review of the relevant literature pertaining to workforce factors in integrated health care from 2008 through 2011 was conducted using a dozen databases. In addition, bibliographies in selected articles and reports were reviewed to identify other articles that may not have surfaced in the electronic subject search or that were not catalogued in the bibliographic databases. Titles and abstracts from the various database searches were reviewed and full articles were retrieved for those that met inclusion criteria. A total of 120 resources were retrieved, including: published articles; federal, state, and non-governmental reports; and book chapters. These works were supplemented through the key informant process, which identified new resources recommended by informants that were not covered in the initial search.

The literature on integration is predominantly composed of journal articles that represent opinion papers, literature reviews, and research reports, as well as a number of government and private sector documents, guides, books, and “tool kits.” Most of this literature focuses on the U.S. health care system, although there are significant contributions from several international sources. Regardless of the country of origin of these works, there was agreement within them that, in integrated settings, practitioner roles and responsibilities are often dramatically different from the content of what is currently taught across traditional educational programs or the nature of the roles and responsibilities in traditional clinical settings (see, for example: O’Donohue, Cummings, & Cummings, 2009; Pomerantz, Corson & Detzer, 2009).

The literature reviewed was, by and large, very descriptive and very general about the nature of integration. A very small portion of the literature specifically discussed workforce competencies, which were distilled and added to the list identified through the key informant process.

### Review of Other Competency Sets

While there are no widely recognized competency sets on integrated care, the project team members reviewed general competency sets to gather additional input regarding the structure and content of the set of competencies under development. This review generated information regarding the most common approaches to identifying categories of competencies and yielded suggestions for content related to integration. The competency sets reviewed and analyzed were:

Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: The knowledge, skills, & attitudes of professional practice* (DHHS Publication No. (SMA) 06-4171). Technical Assistance Publication (TAP) Series 21. Rockville, MD.

The original version of this document was authored by the National Addiction Technology Transfer Center (ATTC) and was updated in 2005 through the work of a committee of experts.

Psychiatric, Mental Health and Substance Abuse Essential Competencies Task Force. (2012). Essential psychiatric, mental health and substance use competencies for the registered nurse. *Archives of Psychiatric Nursing*, 26(2), 80-110.

National Panel for Psychiatric-Mental Health NP Competencies, National Organization of Nurse Practitioner Faculties. (2003, September). *Psychiatric-mental health nurse practitioner competencies*. Retrieved from [www.aacn.nche.edu/leading-initiatives/education-resources/PMHNP.pdf](http://www.aacn.nche.edu/leading-initiatives/education-resources/PMHNP.pdf)

This document is currently under revision.

Note that this competency project is distinct from another federally sponsored effort funded by the Agency for Healthcare Research and Quality (AHRQ). The two projects could be viewed as complementary since the competencies described in this report are drawn principally from expert opinion, while the competencies in the AHRQ-funded project are drawn largely from observation of providers delivering integrated care. Both works will contribute useful information to the ongoing effort to define competencies for integration.

## Development of the Competency Set

Three senior project team members, working independently, reviewed the comprehensive list of potential competencies identified through the three sources listed above and identified proposed competency categories. Differences were resolved through a consensus process that produced a working set of competency categories and tentative titles for the categories. A senior project team member placed individual competencies from the comprehensive list into competency categories. Other team members then proposed modifications to the placement and organization of competencies and achieved a complete set through a consensus process. Category titles were modified to fit the content of competencies within the categories.

The resulting competency set was circulated electronically to the senior content experts and all key informants. They were asked to respond to the set and recommend any additions or edits to the proposed competency categories or individual competencies. The competency sets were revised based on the recommendations received, some of which were contradictory in nature. Approximately 80% of recommended changes were incorporated into a revised competency set. The revised competency set was reviewed and approved by the Senior Content Advisors.



## USING THE CORE COMPETENCIES

The identification of core competencies creates an essential foundation for preparing and further developing a workforce to deliver integrated care. These competencies can be used to further that agenda in multiple ways.

### Shaping Workforce Training

Competency sets are a reference point for educators who are designing and delivering a training curriculum. This set of competencies on integrated care can be used to identify the need for training courses and can shape the content of such courses. It can be used to update and expand the focus of existing courses, to design continuing education events, and to select topics for in-service education within healthcare organizations.

### Informing Job Descriptions

The competencies can be used to develop or update job descriptions and duties for positions within settings where integrated care is delivered. Lack of role clarity is a prime driver of dissatisfaction with and turnover in healthcare positions. Greater clarity in job descriptions and job roles can help improve employee satisfaction and retention.

### Employee Recruitment

These competencies in integrated care can be used in the recruitment process to educate prospective employees about the nature of the work, since “realistic job previews” tend to decrease the frequency with which candidates are offered and/or accept jobs for which they are not well suited. Similarly, the competencies can be used to assess the qualifications of job candidates, both during a review of applications and during the interview process.

### A Guide to Orientation

The competencies can be used as a guide to orienting new employees to their role and responsibilities in the delivery of integrated care. Supervisors and employees can jointly review the competencies and discuss the employee’s perspective on areas where additional training and mentoring may be beneficial.

### Performance Assessment

Competencies should be the foundation on which assessments of performance are based. These competencies on integrated care can be incorporated into employee self-assessment tools, 360-degree evaluations, and formal performance reviews used within healthcare organizations.

### Shaping Existing & Future Competency Sets

There are many existing competency sets that have been developed for the health professions, for the direct care workforce, and for peer support workers. The integrated care competencies identified in this document can be used by the developers of existing competency sets as a benchmark for assessing the extent to which those other sets adequately incorporate content regarding integrated care. Those sets can be updated based on such a review and new competency sets under development can draw from the information within the report as well.