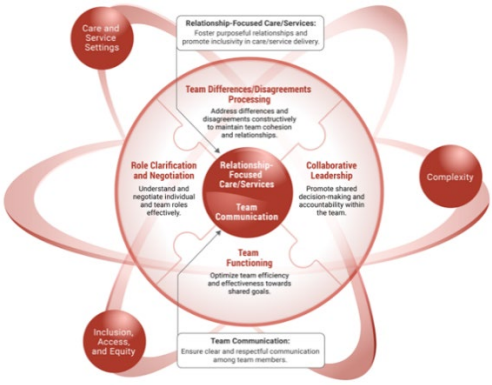
Ehpic IPE Case: Weaving the CIHC Competencies Together

Developed by: Ivy Oandasan and Lynne Sinclair and adapted for EHPIC 2025 by Lynne Sinclair/Stella Ng

The 2024 CIHC Competency Framework integrates the competencies required for collaboration in healthcare and services. The six competency domains are interdependent and highlight the knowledge, skills, attitudes, and values that together shape the judgments and behaviours that are essential for collaborative practice.

The six domains are:

Role Clarification and Negotiation
Team Communication
Team Differences/Disagreements Processing
Relationship-Focused Care/ Services
Team Functioning
Collaborative Leadership



You are creating a client story that will optimize opportunities for interprofessional learning and weave each of the competency domains together. This *ehpic IPE Case* is a six-part activity that will create an IPE case that could be used for curriculum and simulations.

STEM: You are each supervising a learner from a specific profession/discipline. You have been asked to develop a patient-centred story-based learning scenario to use with your learners in your discipline. The person is Dora Chung, a 56 year old woman who is living with Type 2 Diabetes and with knee pain.

ACTIVITY 1: The Professions and Weaving in Role Clarification and Negotiation

Articulate the profession/discipline you are representing. Discuss with the rest of your small group and list the health disciplines represented in your group:

a) dietician	e) diabetes educator
b) physiotherapist	f)
c) family physician	g)
d) endocrinologist	h)

Start to create a collective scenario that brings together multiple health care professionals interacting with Dora. Now identify one critical piece of information that *each* profession must exchange, discuss and negotiate with one other health care professional on the team to ensure quality patient care is provided.

The family physician needs to communicate new lab results within a referral to Dora's endocrinologist so that Dora's **worsening fatigue** can be investigated in relation to her Type 2 Diabetes.

The physiotherapist needs to communicate assessment findings and recommendations with Dora, Dora's family physician and dietician.

Ask students: ***Why does the physiotherapist need to loop in the family physician and dietician?***

Possible responses (facilitator can probe and add as needed):

Family physician's role is to have a view of the "whole" situation.

Dietician may be able to support dietary guidance given knee pain is impacting Dora's activity levels, and physiotherapist is unsure about the directionality of the relationship between knee pain, activity levels, and diet. They feel that a conversation with the team, including Dora, may help with untangling the situation.

Ask students: ***What other roles may become involved?***

Possible responses (facilitator can probe and add as needed):

Endocrinologist, diabetes educator (there could be others—but we know we'll be adding these 2 to the case)

Activity 2: Building Team Communication and Learning into the Case

What is Dora's main healthcare issue(s) identified by the team?

Initially, Dora's knee pain and Type 2 Diabetes were noted. We introduced worsening fatigue as a new concern.

For each of the health professionals involved in the case, articulate what their priority goal for Dora's health care would be using her/his health professional lens.

a) dietician – consider diet given activity levels & fatigue
b) physiotherapist – Ax and provide exercises
c) family physician – overall care management
d) endocrinologist – r/o any new concerns
e) diabetes educator – on standby as needed
f)
g)
h)

Now using team communication with Dora and her caregiver, create a shared team goal:

We're now adding context that the family physician, dietician, and physiotherapist are co-located as members of Dora's primary care team. The endocrinologist and diabetes educator are elsewhere, co-located with each other at a local hospital's diabetes care clinic.

While Dora's fatigue has increased recently, the primary care team is unsure if this is related to Dora's diabetes or her reduced activity levels due to her knee pain, or both. Dora is also unsure and expresses complete trust in the team to present a possible plan to sort things out. Experiencing a high volume of patients, the team has a quick, informal team huddle to consider next steps.

Ask students: ***What do you think would be important in terms of the process of communicating in this huddle, to ensure Dora's concerns are addressed?***

Possible responses (facilitator can probe and add as needed):
Ensuring the perspectives of all three health professionals, and Dora, are all considered and heard. Prioritizing goals could be challenging, so clear and respectful communication will be important. Given how busy the team is, it can be challenging to communicate comprehensively so a tool like the SBAR could be useful (facilitator could share this). It could also be challenging to include Dora in the conversation given time pressure; however, the team is relationship-focused (**tying in additional competency**) so they work thoughtfully to ensure Dora heard and supported, that she is part of the conversation and understands what the plan is.

The team, including Dora, decide there is no harm in working with Dora on her knee pain while she awaits her upcoming visit with the endocrinology team. She will do what she can with physiotherapy exercises and she will wait for her endocrinology appointment.

Ask students: ***What do you think would be important in terms of communication between the primary care team and the endocrinology team?***

Possible responses (facilitator can probe and add as needed):
Sharing not only lab results and new concerns but also the primary care team's existing plan. Ensuring the whole team, including Dora, is kept apprised.

Possible tool to share: SBAR

Activity 3: Processing Team Differences/Disagreements

Collaborative healthcare is strongly needed when the patient's care is complex. Examine your case and see if you have built in some complexity into the patient's care. (For example – the patient is unable to pay for her medications or the patient's husband is ill and she is suffering caregiver distress – or you find out the patient does not speak the language.) This "IP catalyst" provides the critical lever that must be addressed by the team if best care is to be provided. It ensures that the team can process any team differences/disagreements. Identify at least one critical IP catalyst for this case:

You have learned that after the endocrinology visit, the diabetes educator was called in by the endocrinologist (who has no concerns and makes no changes to Dora's diabetes management plan) to advise Dora on self-management strategies. However, the diabetes educator was apparently not aware of Dora's knee pain.

Dora has now been given differing advice by members of her overall care team. The physiotherapist in Dora's primary care setting and the diabetes educator at the local hospital have given conflicting information.

However, the endocrinologist's written communication back to the family physician does not include the details of the diabetes educator's conversation with Dora. So, only Dora is aware of the team difference.

Ask students:
Without assigning blame to anyone, what do you think are some of the systems issues that could have led to this gap in communication (tying in additional competency), which led to a team difference?

How could you foresee this going? Might it become a team disagreement? What would you do if it did?

What might you do in your future practice to mitigate this common occurrence?

Possible responses (facilitator can probe and add as needed):
When patients venture from one care context to another, sometimes some information can be missed, especially when electronic health/patient records are not shared across contexts.

Depending on Dora's capability and confidence in interpreting and coordinating her own care advice, this could go in many different directions. If a disagreement arises, it could be helpful to consider some tools for moving toward clarification (thinking back to team communication—**tying in additional competency**) and collaboration (e.g. Thomas-Kilmann instrument) rather than escalating to conflict.
In future practice, could aim to provide very clear background, perhaps using SBAR to avoid missing information.

Activity 4: Relationship-Focused Care/Services

All members of a team will dynamically collaborate, fostering purposeful relationships among and between care/service partners and persons participating in or receiving care/services. To support relationship-focused care/ services, teams grow and maintain purposeful relationships among the person(s) participating in or receiving care/service, care partners, and others involved with care/services. How will you build learning about this competency into your developing case?

Dora is confident in navigating her own care. She shares the conflicting advice she received with her family physician at her next appointment. The family physician then works with the dietician and physiotherapist to easily clear up the confusion.

Ask students: ***What aspects of relationship-focused care/services would enable this quick remediation of the preceding confusion?***

Refer students to Relationship-Focused Care/Services competency points from CIHC framework.

Possible further discussion point: Will there be any closing of the loop with the diabetes educator? Does this matter? Or is the onus only on the primary care team?

Activity 5: Team Functioning

Team members work interdependently and bring their shared perspectives to collaborate towards shared goals through shared decision-making. Team functioning requires optimizing the efficiency and effectiveness of all members' time and expertise. How will you build learning about this competency into your developing case?:

Ask students: ***What do you think the primary care team in this case has done to cultivate the collaborative approach they seem to have?***

What factors have helped you feel like you can share your perspective and feel heard and respected when working on a team? (this does not need to be a healthcare team)

Refer students to Team Functioning competency points from CIHC framework.

Activity 6: Collaborative Leadership

All members of a team will value each other's knowledge, skills, and expertise, and acknowledge that everyone contributes different strengths and perspectives. They value and support each other and are accountable in sharing decision-making and responsibilities to reach common goals and achievable or desirable health outcomes. How will you build learning about this competency into your developing case?:

Ask students: ***How might you create opportunities to share the strengths and perspectives of those involved in Dora's healthcare (including Dora and her family)?***

What are the common goals and achievable/desirable health outcomes for Dora? How might you create opportunities to have this conversation over time?

What is the process for decision-making and does it seem to be collaborative and shared? What does collaboration look like when everyone feels that they are right?

Refer students to Collaborative Leadership competency points from CIHC framework.

Pulling It All Together:

The 2024 CIHC Competency Framework integrates the competencies required for collaboration in healthcare and services. Please review the above six competency domains in your case and see if any other elements should be considered to ensure that the interdependency of the domains are addressed. Suggest anything else that might support learners to understand and enact the knowledge, skills, attitudes, and values that together shape the judgments and behaviours that are essential for collaborative practice.