Canadian Interprofessional Health Collaborative
Consortium pancanadien pour l'interprofessionnalisme en santé

CIHC Competency Framework
for Advancing Collaboration

APRIL 2024

The Canadian Interprofessional Health Collaborative (CIHC) is made up of health organizations, health educators, researchers, health professionals, and students from across Canada. We believe interprofessional education and collaborative, relationship-focused care and services are key to building effective healthcare teams and improving the experience and health outcomes of persons and their care partners. The CIHC identifies and shares best practices and its extensive and emerging knowledge in interprofessional education and collaborative practice.

SUGGESTED CITATION

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PREFACE

Since its formation in 2006, the Canadian Interprofessional Health Collaborative (CIHC) has served as a hub for interprofessional collaboration in education, practice, and research in Canada. In 2010, the CIHC released the Interprofessional Competency Framework (CIHC-IPCF). Since then, the framework has been widely used as an educational resource. It plays a pivotal role in informing and preparing learners and practitioners for collaborative healthcare and services across Canada and globally.

Recognizing the ongoing evolution of the field and the global need for flexible competency frameworks, in 2023, the CIHC Board of Directors initiated a refresh of the 2010 framework. This refresh aimed to enhance the framework based on insights from a scoping review and consultations with interested parties, ensuring the framework's ongoing relevance to and applicability in collaborative practice.

The scoping review examined who, what, where, and how the CIHC-IPCF was used, shedding light on how educators, researchers and practitioners used the CIHC-IPCF across diverse contexts. Concurrently, the CIHC Working Group engaged Canadian and international experts through group and individual interviews, open-ended questionnaires, and targeted discussions to gather perspectives on the framework's value, use, and potential.

Innovations in team-based collaborative practices in Canada have been propelled by key contextual factors: limited access to care and services, extended wait times, workforce shortages, and the declining well-being of healthcare and social service professionals, amongst others. To optimally address the multifaceted challenges in healthcare and social services, the authors of this framework see a need for relationship-focused care and services that work collaboratively within and across sectors. Such collaborations are crucial for optimizing resources, improving comprehensive care and services, and supporting workforce resiliency. Collaboration is likewise required for advancing health equity toward culturally safe care, in alignment with cross-sector commitments to truth and reconciliation. And collaboration is necessary, too, to meet priorities related to inclusion, equity, and access, including to meet the goals of the Quintuple Aim.

This competency framework is a guide for interprofessional education and collaborative practice. It is primarily designed for educators, researchers, administrators of health organizations, and care/service partners. Its six interdependent domains include many descriptors that apply to the persons participating in or receiving care/services. A supplementary guide will support the engagement of persons and their families in team collaboration. Teams and individuals should be able to integrate and apply these collaborative competencies within complex systems and diverse contexts as is appropriate to their comfort level, capacity, and skill set within their practice settings. This framework focuses less on what learners and care/service partners need to know and more on how they apply their knowledge, skills and attitudes within various real-world environments to make judgments and guide behaviours. The application is at the individual and team level; importantly, it also creates new understandings of collaboration. This conception of competencies aids the adaptability and universality of the CIHC competency framework. There is an imperative to update the competencies to meet the changing needs of populations over time.

The 2024 version of the framework is a testament to the collaborative efforts of the CIHC Working Group, the Board of Directors, and the valuable input of interested parties locally and globally. The 2024 CIHC Competency Framework for Advancing Collaboration is a living document, responsive to the dynamic nature of interprofessional education and collaborative practice. We invite colleagues from local and global health and social services communities to engage with and contribute to this document, recognizing the richness that linguistic and cultural diversity brings to our shared understanding.

A NOTE ON LANGUAGE

Throughout this framework, we use the terms "person" and "persons" instead of "patient," "client," or "community member." As the collaborators of this updated framework, we have elected to use "person(s)" to emphasize that all members of a healthcare team are equal participants with equally valuable contributions to make. In contrast, the term "patient" is accompanied by an implied power dynamic that we seek to no longer perpetuate, and "client" suggests a commodified relationship. Moreover, people who seek wellness and social services don't usually identify as "patients." Because high-quality care and service provision requires collaboration across the health and social sectors, we sought a term that encompasses the full spectrum of person(s) referred to in this framework. We therefore have chosen "person" and "persons" to use throughout the framework, to refer to any individual, group, or population who participates in and benefits from health systems and services, as co-producers of health.

In addition, we use the term "care/service partners" to refer to individuals (including health or social care providers) or institutions pursuing activities for the benefit of an individual, group, or population to promote health, prevent or address health or social challenges. For our definition of "team," we draw on Katzenbach and Smith[1] who describe a team as "A small number of people with complementary skills who are committed to a common purpose, performance goals and approach for which they hold themselves mutually accountable" (p. 45). By "care partners," we refer to the friends, family members, and loved ones who provide informal—often unpaid—care and support to persons participating in or receiving care/service. These care partners are often experts in the health and well-being of the person for whom they provide support.

Finally, we have provided a new name for this framework: the Competency Framework for Advancing Collaboration. The adoption of this new name and these terms reflects our philosophical shift away from exclusionary language and toward the conscientious inclusion of non-regulated care/service partners and of all individuals who are active in care and service provision—including the person(s) receiving those care and services themselves.

1 Katzenbach, J. R., & Smith, D. K. (1994). *The Wisdom of Teams*. New York: Harper Collins. (p. 45)

CANADIAN INTERPROFESSIONAL HEALTH COLLABORATIVE COMPETENCY FRAMEWORK FOR ADVANCING COLLABORATION (2024)

QUICK REFERENCE GUIDE

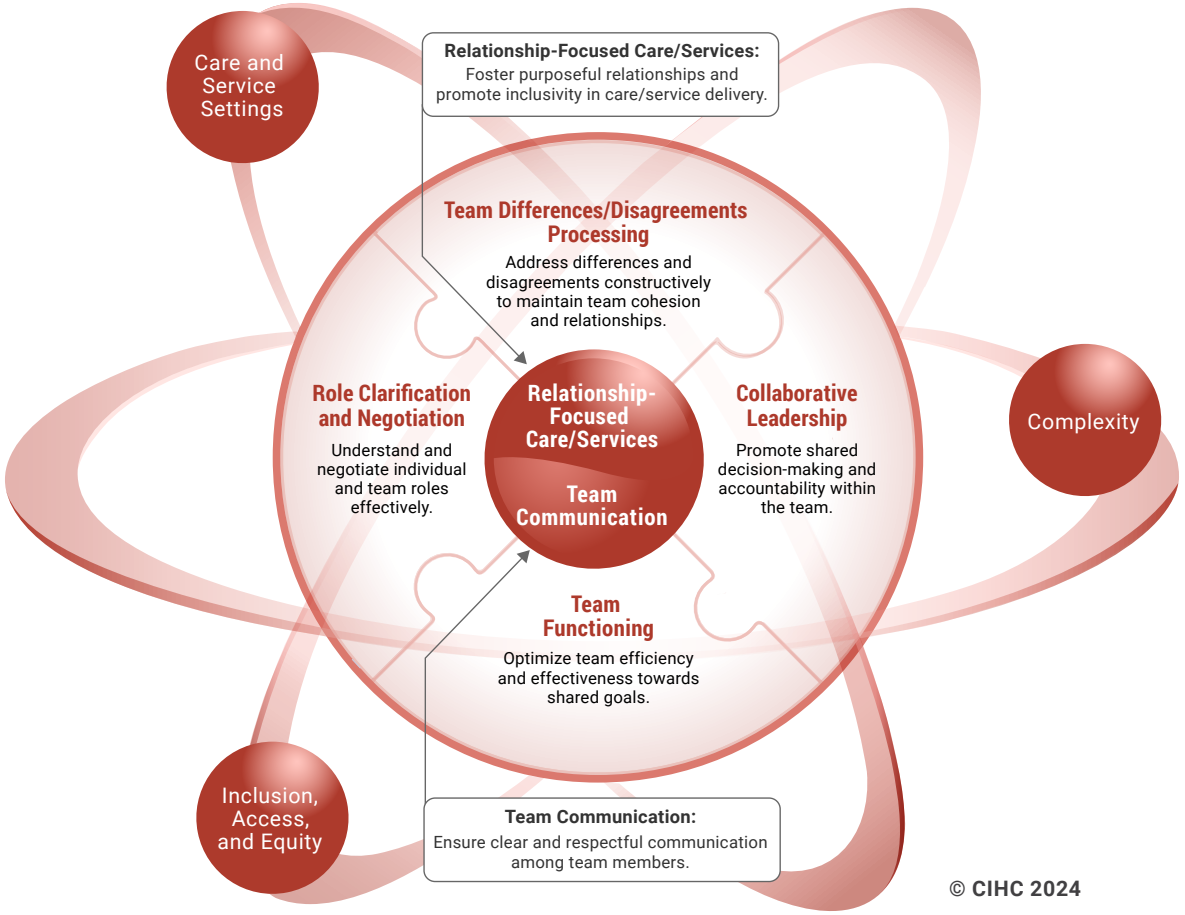
The CIHC Competency Framework integrates the competencies required for collaboration in healthcare and services. The six competency domains listed below highlight the knowledge, skills, attitudes, and values that together shape the judgments and behaviours that are essential for collaborative practice. The first two domains support the four other domains, and all are interdependent.

The six domains are:

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

The following graphic illustrates the configuration of the six domains and highlights the influential factors that impact how the framework may be applied in different situations.

***Goal:** Enhancing healthcare and human services through collaborative, relationship-focused partnerships to shared decision-making around health and social matters.*



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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. All will coordinate and cooperate in shaping person(s)-driven care/services. To support relationship-focused care/services, all will:

- grow and maintain purposeful relationships among the person(s) participating in or receiving care/service, care partners, and others involved with care/services, to support effective partnerships;
- support the participation of person(s) participating in or receiving care/service and their care partners alongside health and human service personnel in all steps of design, planning, implementation, and evaluation of care/services;
- reflect on, value, and embed diversity of thought, beliefs, talents, literacy, and experiences of people and communities into designing, implementing and evaluating care/services;
- share information with all in a culturally safe, respectful manner and in such a way that it is understandable, encourages discussion, and enhances participation in shared decision-making;
- ensure appropriate education and support is provided to persons participating in care and care/service partners to become integral care partners;
- ensure persons receiving care are supported to maximize their partnership potential; and,
- develop—and then continuously, actively cultivate—trusting relationships with all members of the team.

TEAM COMMUNICATION

All members of a team will communicate with each other in a cooperative, responsive, and respectful manner while paying attention to both the content and the relational elements of communication. To support relationship-focused team communication, all will be able to:

- use effective communication strategies, including the use of shared language and the avoidance of jargon, to ensure clear and standardized information exchange;
- listen actively and respectfully, and value all, with emphasis on inclusivity, equity, and diversity;
- foster open and authentic communications that are accessible to all, integrating efforts to address any potential communication barriers such as psychosocial harm, language, culture, or literacy and health literacy;
- effectively use information and communication technologies to improve collaborative relationship-focused care/services, ensuring that all convey the right message along the channel(s) to the right person(s) at the right time;
- implement processes to structure and organize safe information transmission to improve understanding and fidelity of messages; and,
- manage information sharing and documentation for improved understanding and consistency across the team and other teams.

ROLE CLARIFICATION AND NEGOTIATION

All members of a team understand and negotiate their own role and the roles of all, and use their knowledge, skills, expertise, and values appropriately to establish and achieve collaborative relationship-focused care/services. To support role clarification and negotiation, all are able to:

- articulate and share their knowledge, skills, expertise, and values with others, using appropriate language;
- seek to understand the knowledge, skills, expertise, and values of other team members, including person(s) participating in or receiving care/service;
- support person(s) participating in and receiving care/services and their care partner(s) as full members of the team, helping them to express and clarify their role accordingly;
- recognize person(s) participating in and receiving care/services as experts in their lived experience, drivers of their care/service, and active team members;
- clarify their own role and that of others in a specific context;
- recognize and respect the diversity of other health and social care roles, responsibilities, and competencies;
- integrate care partner(s)' and person(s)' competencies or roles seamlessly into models of service delivery;
- recognize the fluidity and overlap of roles; and,
- navigate and adapt to support context-specific operationalization of roles.

TEAM FUNCTIONING

All members of a team understand the nature of interprofessional teams. Team members work interdependently. They bring their shared perspectives to cooperate, coordinate, and collaborate toward shared goals through shared decision-making. Team functioning requires optimizing the efficiency and effectiveness of all members' time, expertise, and contributions. To support team functioning, all are able to:

- facilitate inclusion and participation of all—especially the person(s) participating in or receiving care/service—in the planning, implementation, and evaluation of care and services;
- understand the processes for team development and their interdependence with the other competency domains;
- respect and apply principles of equity, diversity, inclusion, and accessibility;
- understand the impact of strong interdependence among team members in achieving concerted decisions;
- adapt to the evolving needs of person(s) participating in or receiving care/service and the care partners and context;
- identify a shared common purpose that is built on varying perspectives;
- consider influencing factors such as co-location, team composition, team maturity, technologies, and resources;
- uses common purpose and values to continuously negotiate norms regarding team functioning to facilitate or participate in shared decision-making;
- collectively reflect regularly on team functioning;
- enact continuous quality improvement measures; and,
- respect ethical aspects of team function, including confidentiality, resource allocation, and professionalism.

TEAM DIFFERENCES AND DISAGREEMENTS PROCESSING

All members of a team actively engage constructively in addressing disagreements. To support interprofessional team differences and disagreement processing, all are able to:

- acknowledge, recognize, and value the inevitable and potential positive nature of differences in a team (e.g., tensions, disagreement, and conflicts);
- apply good team functioning practices or processes to address disagreements and to prevent their escalation or unresolved conflict;
- know and understand effective strategies, including setting guidelines, for addressing disagreement or conflict;
- establish a safe environment in which to express diverse opinions, developing a level of consensus among those with differing views;
- articulate the tension(s) among team members and facilitate team discussions to prevent escalation;
- implement proactive processes that prevent escalation of disagreements; and,
- effectively work to address and resolve disagreements, including analyzing the causes of disagreement and working to reach an acceptable cooperative solution.

COLLABORATIVE LEADERSHIP

All members of a team 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. To support collaborative leadership, all are able to:

- advance interdependent working relationships among all participants;
- facilitate effective team processes for shared decision-making and to re-evaluate as needed;
- establish and maintain an ongoing sharing of leadership, accountability, and collaborative practice;
- co-create a practice culture that values all members of the team, and supports their physical and mental well-being;
- enact continuous quality improvement applying collaborative decision-making principles; and,
- promote leadership development, including skills and knowledge needed to support effective team dynamics, collaborative practice, and innovation.

CONSIDERATIONS

Underpinning the framework are considerations that influence the way in which the framework is applied.

Inclusion, Access, and Equity

Inclusion, access, and equity are essential considerations in applying the CIHC Competency Framework for Advancing Collaboration. In order to effectively collaborate, teams must be mindful of the diversity of the persons with whom they are working, including differences in culture, ethnicity, race, gender, sexual orientation, ability, and socio-economic positions—all of which can overlap within a single person—as well as the impact that these determinants have on access to health and social care and services. Teams must also be mindful of biases affecting their interactions with persons from different backgrounds and must actively work to both reduce these biases and to create an inclusive and welcoming environment for all. Care/service partners must be aware of potential barriers to accessing care/services, including stigma, language, literacy, health literacy, geography, transportation, and finances. To ensure that care is accessible to all people, teams must work together to identify and remove or lower these barriers, and to provide appropriate resources. Equity, inclusion and access intersect with both the complexity of systems and contextual considerations that influence the way in which the framework is applied.

Complexity

Approaches to team-based collaboration may differ along a continuum, from simple to complex. For example, a recreational runner with a sprained ankle may only need one or two care partners; the impact of the injury on the individual's life may only be minor. However, consider a sprained ankle for a single mother who is the primary caregiver for an infant and a toddler, who also has multiple health concerns and limited social support, and who lives in a third-floor apartment with no elevator—for this person, a sprained ankle is considerably more complex. With such complexities, the team may span sectors to address her transportation, income security, and childcare concerns. By working together across professions and sectors, teams of care partners will more effectively address her needs, especially in complex health and social service systems.

Care and Service Settings

The context in care and service settings includes the person's circumstances, such as food insecurity, home environment, work and leisure conditions, and available supports. Such contexts significantly influence collaboration for optimal care and services. In instances in which teams are not physically co-located and communication occurs virtually or asynchronously, the application of the CIHC Competency Framework for Advancing Collaboration becomes particularly essential.

Healthcare teams operating in such circumstances may need to leverage technology and communication tools (e.g., telehealth, virtual teams, and artificial intelligence) to ensure that information is shared, decisions are made collaboratively, and each team member's expertise is utilized optimally. In specific areas of practice, such as rehabilitation, residential care, and pediatric care, the teams may be more consistent and co-located, while other healthcare settings, like emergency units or high-turnover acute medical units, may see healthcare providers collaborating for only brief periods due to changing shifts and patient discharges. Alternatively, in a community setting where a family cares for a child living with disabilities, the integration of the framework extends beyond traditional healthcare providers to include educators, friends, and community health supports.