

Developing IPEC Core Competencies for an Evolving Professional Landscape: Q&A with Jeffery Stewart, DDS

Interview conducted by Meg Zomorodi

Jeffery Stewart, DDS, MS, currently serves as a consultant to the American Dental Education Association (ADEA), having until recently served as Senior Vice President for Interprofessional and Global Collaboration at ADEA. In his past and current roles with ADEA, Jeff is the ADEA liaison to the Interprofessional Education Collaborative (IPEC) Planning and Advisory Committee. He met with **Meg Zomorodi, PhD, RN, ANEF, FAAN**, of UNC-Chapel Hill, to discuss the latest revisions to the IPEC Core Competencies for Interprofessional Collaborative Practice. Released in November 2023, these updated competencies build on previous versions from 2011 and 2016 to incorporate the perspectives of seven new IPEC member organizations and reflect the continuously evolving research, policy, education, and practice landscape.

"We wanted to engage and empower the IPE and collaborative practice community, and be sure that the core competencies reflected current research, policy, and practice," said Stewart. "This was quite an involved and comprehensive process, which we feel good about."

An overview of changes and the process can be found at <https://www.ipecollaborative.org> [1].

The following interview has been edited for length and clarity.

Zomorodi: Can you expand on some of the changes that were made to the IPEC core competencies, and the rationale behind them?

Jeffery Stewart: *The original four core competencies (values and ethics; roles and responsibilities for collaborative practice; interprofessional communication; and teamwork and team-based care) remain the same, though the number of sub-competencies decreased by 15%, from 39 to 33. This was the result*

of the IPEC hearing quite clearly that many of our members felt like there were too many sub-competencies. During our process of soliciting feedback and input from a wide array of stakeholders, we found that constructs such as diversity, equity, and inclusion; interprofessional leadership; the concept of "One Health;" the importance of well-being and resilience; and the practice of team science all emerged quite clearly as important but were not found in the previous iteration. These are all concepts that we have now infused into the new set of core competencies. I would highlight that the overall domain of interprofessional collaboration is unchanged.

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In values and ethics, competency number one, we introduced the concept of "one health." During our process of soliciting feedback, we found that either not everybody understood a term or there were conflicting opinions as to what a particular term meant. So, we spent a lot of time going to the literature and other respected organizations to come up with definitions for a new glossary. "One health" is one example of that. We define one health as: "A collaborative, multisectoral,

and transdisciplinary approach—working at the local, regional, national, and global levels—with the goal of achieving optimal health outcomes recognizing the interconnection between people, animals, plants, and their shared environment [2]."

Social determinants of health were not included in the previous set of competencies. Now they are mentioned in the communication sub-competency, with the concept of being able

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to practice cultural humility and in communicating. You'll see we've defined that much more broadly, to include all the determinants of health, not only those considered social.

And then well-being was infused in a couple of places, with one example being teams and teamwork in the final sub-competency.

Zomorodi: This was a very transparent process, and you did a lot to try to engage individuals. How did that come to be, and how helpful was that to the process?

Stewart: That's part of the reason that it took almost two years to accomplish, because we did concentrate on being very inclusive, very transparent, very iterative about it. We engaged the wider community through webinars and town halls and at a couple of IPE conferences, during which time we asked people to give us their feedback in person. We also had ways for people to submit written comments through our website, which we collected and reviewed. We also recruited and organized a group of IPE experts around the country: one representative from each of the IPEC member organizations as well as a couple of students that were also nominated for this. They did a whole lot of work and spent a whole lot of time on this, and we're very grateful for their contributions.

The working group was divided into four different work streams: one was charged with gathering feedback and experiences, another was involved in reviewing the literature, then there was one group that really took on the task of leading the competency revision, and the final work stream was actually writing the report.

The transparency and inclusivity of the process was really very important to us. It was a project that was near and dear to everyone's heart. All the people involved are passionate about interprofessional education, and I think that passion was demonstrated in the amount of time and effort that everyone put into this. I think the best thing about this was that it involved so many people and was so collaborative.

Zomorodi: Clinicians are working to try to advance team-based care in their own clinical settings, and they might not be as familiar with the IPEC and the competencies as, say, an academic. What advice would you give them when they begin to think about implementing collaborative practice?

Stewart: That is where we are still facing difficulties, right? We need to be able to create practice settings where students are learning about this and are able to actually experience it and see others model these competencies around collaborative practice.

There are a number of assessment tools. I was involved in developing one when I was at Oregon Health & Science University, for clinical teams to use to assess their level of collaboration. Our provost said she would not send any of her students into a clinical setting where team-based care was not important. The idea was that these clinical settings would take this assessment, and then some of us who were very involved

with interprofessional education would help them understand and then provide some development for them where the assessment tool thought it might be needed. There are teams that are truly interested in improving their function and tools they can use to assess their status.

At the IPEC Faculty Development Institutes, a national program focused on interprofessional faculty development, we have for several years strongly urged faculty members to include a clinical partner as a member of the team that comes to the Institute. We do very much want a member of a clinical site to attend along with the faculty members.

Zomorodi: I am hearing that there is a gap that still exists in practice. As we look at the workforce that we need right now, do you agree this is only going to work if we have practice partners who engage in true partnership with the academic sites?

Stewart: Before the pandemic started, I was at a conference, and I was sitting next to the former director of the National Center for Interprofessional Practice and Education, and we both came to the same conclusion: This is wonderful, and we need to be educating our learners around this, but what really needs to happen is a re-education of the existing clinicians. We need to look for opportunities to educate some of them for the first time about this.

Zomorodi: How do you see these IPEC core competencies aligning with the new movement for competency-based education? What advice would you have for professions that are thinking about competency-based education?

Stewart: Most, if not all, of the accrediting agencies now have some type of a standard around competency in interprofessional or collaborative care. It's important to have competencies that educators can look to in order to be able to demonstrate that their students are competent in these areas.

One of the intents of competency-based education is to shift the focus to desired outcomes for learners rather than the typical structure and process that we see in an educational system. Competencies are important because they translate a set of expectations. When taken together, they demonstrate what a learner can actually do with what they know. The real advantage here is that we'll look for ways that we're already teaching some of these things anyway, but we're doing it separately, and bring it together. That is what interprofessional education is. So much of it is just about finding champions in schools that want to partner, because it is much easier when there's alignment. NCMJ

References

1. IPEC Core Competencies Revision: Version 3 (2021-2023). IPE Collaborative. Updated November 20, 2023. Accessed March 2024. <https://www.ipecollaborative.org/2021-2023-core-competencies-revision>
2. IPEC Core Competencies Draft Glossary of Terms (2023). In: Core Competencies for Interprofessional Collaborative Practice. IPEC; 2023. Accessed March 11, 2024. [https://www.ipecollaborative.org/assets/core-competencies/IPEC_Core_Competencies_2023_Draft_Glossary%20\(2023-04-12\).pdf](https://www.ipecollaborative.org/assets/core-competencies/IPEC_Core_Competencies_2023_Draft_Glossary%20(2023-04-12).pdf)