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Professional Counseling's Alignment with the Core Competencies for Interprofessional Collaborative Practice

Kaprea F. Johnson[1], Miranda MJ Parries[2]

[1]Counseling & Human Service Department, Old Dominion University, Norfolk, VA United States of America
[2]Department of Counselor Education, University of North Alabama, Florence, AL United States of America

Email address:

Kfjohnso@odu.edu (K. F. Johnson), mparries@una.edu (Miranda M.J. Parries)

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Abstract: Previous findings show that there is a misconception of the counseling profession and a lack of awareness of their role in interprofessional collaboration; which may lead to underutilization of counselors for team based care. As an example, in 2009 six professional health related associations developed core competencies for interprofessional collaborative practice and counseling associations were not involved in the development. This manuscript introduces the profession of counseling to others in medical health professions in hopes that similarities will bridge the gap between knowledge and future collaborative practice. The manuscript shows how the profession aligns with the core competencies for interprofessional collaborative practice (CCIPC), ethical codes, accreditation bodies, and existing counseling literature. It concludes with implications for practice, system level support, and policy.

Keywords: IPEC, Counseling, Interprofessional Education, Interprofessional Collaboration

1. Introduction

Counselors are amongst the youngest profession in healthcare with the national association being founded in 1952, ethical code established in 1961, first licensure law passed in 1976, and accreditation beginning in 1978 through the Council for Accreditation of Counseling and Related Educational Programs (Remily & Herlihy, 2007). Counselors have struggled to define their identity (Myers, 1995) and many other healthcare professionals do not understand the roles and scope of practice among counselors (Johnson, Fowler, Kott, & Lemaster, 2014). This lack of knowledge can lead to counselors being absent in policy conversations or discussions (Eriksen, 1997), competency creation [IPEC, 2009 competencies are an example], and minimal or no involvement in collaborative interprofessional health care teams. In the 70's the World Health Organization (WHO) began to promote interprofessionalism. During this time, counselors were fighting to establish their professional identities with some calling the profession a 'semi-profession' (Etzionio, 1969) or 'emerging profession' (Friedson, 1983). Moving forward into the 80's and 90's, the professional identity of counselors became stable and was both nationally and internationally recognized during a time when countries were establishing organizations dedicated to interprofessional collaboration and education (Pecukonis, Doyle & Bliss, 2008). In 2009, the Core Competencies for Interprofessional Collaborative Practice were developed through collaborative efforts of several allied health organizations and no behavioral health representatives were on the committee. After the development of the competencies the willingness to collaborate across disciplines became increasingly important and sought after (Davidson & Waddell, 2005).

While there is some research available on social workers and psychologists collaborating interprofessionally with health science disciplines (Cubic, Mance, Turgesen, & Lamana, 2012; Kvarnstrom, 2008; Priest, Roberts, Dent, Blincoe, Lawton, & Armstronf, 2008; Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013; Rozensky, 2012) there exists no empirical studies specifically integrating and showing outcomes of counselors as members of interprofessional health care teams. Interestingly, there was a conceptual article published in the *Journal of Counseling and*

Development in 1990 entitled "Counselor Credentialing and Interprofessional Collaboration;" the article precipitated the importance of interprofessional collaboration to enhance mental health care access and treatment for clients however it only included what it termed *nonmedical provider disciplines* in its model for future collaboration (Brooks & Gerstein, 1990). The article, while paving the way for discussions on interprofessional collaboration, is limited in scope because it does not invite or introduce counselors to the idea of collaborating interprofessionally with members of medical provisions of services (Brookset al., 1990).

Similarly, Myers, Sweeney, and White (2002) also precipitated the importance of collaboration, making collaborating an advocacy effort on behalf of the client and the profession; unfortunately their article focused on intra-professional collaboration and omitted collaboration amongst medical health professionals. The gap in the counseling literature is the lack of information on collaborative efforts either clinically or educationally between counselors and medical health professionals. This manuscript hopes to address the gap through introducing counselors and the counseling profession to the Core Competencies for Interprofessional Collaborative Practice (CCIPC). The CCIPC is the language used by medical health professionals who engage in interprofessional collaboration; if counselors know the language then they can engage in conversations that will lead to interprofessional collaborations. Secondly, the manuscript seeks to help medical related professions understand how counselors and the profession of counseling could be of benefit to interprofessional clinical collaborative efforts through showing alignment between counseling and the competencies.

1.1. Historical Developments in Collaboration

The World Health Organization (WHO), established in 1948 as the United Nations' authority for health, is tasked with being a premier leader on international health issues, guiding health research, defining and creating standards, endorsing evidence-based practices, providing technical support and monitoring and evaluating health trends and needs. Within this role, WHO has endorsed the practice of interprofessional education, defined as effective collaboration of students from two or more professions learning from and with each other to improve health outcomes and interprofessional collaboration, defined as multiple professional health care workers from different backgrounds working in cohesion with patients, clients, families, care takers, and communities to deliver the highest quality of care. The WHO in the mid 2000's developed committees focused on interprofessionalism and later the Interprofessional Education collaborative (IPEC) was established.

1.2. IPEC Membership

IPEC, membership is comprised of (1) American Association of Colleges of Nursing, (2) American Association of Colleges of Osteopathic Medicine, (3) American Association of Colleges of Pharmacy, (4) American Dental Education Association, (5) Association of American Medical Colleges, and (6) Association of Schools of Public Health. This group of associations collaborated to create a working group May 2011that resulted in the Core Competencies for Interprofessional Collaborative Practice, referred to as the IPEC competencies (CCIPC, 2011). The competencies were created to enable effective collaboration to meet patient, family and community needs in a cooperative manner. Although, only six helping professions developed the competencies they are not specific or limited by professions (CCIPC, 2009). The competencies were purposefully created to transcend disciplines and be accessible to all helping professionals.

While, the medical health field responded to changes in healthcare by emphasizing interprofessional collaboration, developing and defining core competencies for interprofessional collaboration; missing is any major association from counseling contributing to the competencies. In addition, absent from the literature are contributions showing clinical collaborative efforts between counselors and medical health professionals. While the information is not available in the literature, the counseling profession can contribute significantly to interprofessional collaboration (Johnson & Freeman, 2014) and it aligns well with the Core Competencies for Interprofessional Collaborative Practice.

2. Rationale

Numerous reports and policy documents over the past decade have emphasized the importance of collaboration in healthcare (Casimiro et al., 2009; Luke et al., 2009; McClelland & Kleinke, 2013). Healthcare collaboration has improved quality and decreased costs for patients and healthcare systems (Casimiro et al., 2009; Levett-Jones, Gilligan, Lapkin & Hoffman, 2012; McClelland & Kleinke, 2013). A shared language, guided by the core competencies for interprofessional collaborative practice are important and help assist teams provide care to patients with decreased distractions from poor collaboration. A shared language has been noted for improving overall health care for patients, better communication amongst professionals, creating more jobs within human services, and improving the experience for patients (Berwick, Nolan, & Whitting, 2008). Language, more specifically, a shared healthcare language for interprofessional health care providers must be taught (IPEC, 2009). It is suggested that interprofessional education in the form of workshops, training, and formal education is vital to developing a shared language and leading to increased clinical collaborations (Johnson, & Freeman, 2014), and improving collaboration efforts by healthcare teams (Mellin, 2011; IPEC, 2009; Quealy-Berge & Caldwell, 2004). Increased interaction in the form of collaborative education will increase knowledge of other health-related disciplines and break down barriers and misconceptions others may have of counselors, leading to more opportunities (Johnson,

Fowler, Kott, & Lemaster, 2014; Myers, Sweeney& White, 2002; Reiner, Dobmeier, & Hernandez, 2013). IPEC can be the key and the entrance for counselors into collaborative practice and education opportunities with other, medical-related disciplines.

3. Linking Theory to Practice

This section focuses on explaining the IPEC competencies (theory) in relation to the counseling ethical codes (practice), accreditation standards (practice), and current literature (practice & theory). These connections are important in making the profession of counseling visual to medical related professions and for counselors to understand their potential role on an interprofessional team.

The IPEC competencies were developed to create a shared purpose and common good in health care that would enhance patient/community/population care across the health care continuum (IPEC, 2009). The IPEC competencies build upon or complement existing counseling ethical codes, accreditation standards, and current counseling research literature. Each competency has a general competency statement, followed by more specific statements. The entire document can be found at: http://www.aacn.nche.edu/education-resources/IPECReport.pdf.

3.1. IPEC Competency 1: Values / Ethics

The competency statement is "Work with individuals of other professions to maintain a climate of mutual respect and shared values" (IPEC, 2009; p.19). The competency is a call to action for health professionals to respect others, in terms of others voice, range of skills, scope of practice, and as a human being engaged in the care process. There were a total of ten specific values/ethics competencies that were outlined by IPEC. Counselors and the counseling profession have long valued patient-centered care and culturally responsive care (Betancourt, 2005; Tucker, Herman, Ferdinand, Bailey, Lopex, Beato, Adams, & Cooper, 2007). Counseling ethical codes, counseling literature, and accreditation standards mirror these values. Counseling ethical codes ask for the same level of competency in section A, the counseling relationship, along with section D relationships with other professionals. Specifically, section A calls for us counselors to be knowledgeable, aware, and skilled in the area of cultural sensitivity and patient care.. Section D, calls for counselors to respect other approaches and this relates directly to interprofessionalism. Accreditation standards could be strengthened in this area, and mention specific statements that relate to values and ethics when involved in interprofessional collaboration. The counseling literature was limited in this area based on searches that were conducted.

For IPEC competency one (i.e., values/ethics of interprofessional collaboration), the search engines GoogleScholar, APA PsychNet, and PsychInfo were used. For GoogleScholar, the following search terms were used: (1) *interprofessional collaboration counselor* and (2) *collaboration with mental health counselors*; this search revealed two relevant articles (Aitken & Curtis, 2004; Mellin, Hunt, & Nichols, 2011). For APA PsychNet, the following search terms were used: (1) *Interprofessional and Collaboration and Counselor* and (2) *Interprofessional and Collaboration and Values*; three relevant articles were found using this search (Arthur, 2010; Cooper, 2013; Johnson & Freeman, 2014). For PsychInfo, the following search terms were used: (1) *Interprofessional and Collaboration and Counselor* and (2) *Interdisciplinary and Collaboration and Counselor*; two relevant articles were also found using this search (Miller, Hall, & Hunley 2004; Quealy-Berge & Cadwell, 2004). Furthermore, limited published research is available on the counseling profession and interprofessional collaboration.

3.2. IPEC Competency 2: Roles / Responsibilities

The competency statement is "Work with individuals of other professions to maintain a climate of mutual respect and shared values" (IPEC, 2009). The competency seeks for health professionals to understand their limitations and their strengths appropriately when serving clients. This individual competency urge not only skill in collaboration, but also the continued practice of it. The ACA ethical code requires the same level of competency in Section D- Roles with other professionals. This section addresses the need for counselors to adhere to quality interactions with other professionals because of the direct impact on client care. Along similar lines, related literature in the counseling field has focused on this topic and has found that it is important for counselors to maintain their professional identity while understanding their limitations (Mellin, Hunt, & Nichols, 2011). Accreditation standards could be strengthened in this area, but as it stands, programs must prepare counselors to understand and work within their scope of competency as well as learn about and understand the roles of other professionals associated with their setting and client population (CACREP, 2009). The counseling literature in this area was diverse, addressing school counseling, rehabilitation counseling, and career initiatives that involve some form of collaboration from counselors but mostly intra-professional collaboration and not collaborations across disciplines.

Specifically, for IPEC competency two (i.e., roles and responsibilities of counselors during interprofessional collaboration), the search engines GoogleScholar, EBSCOhost, and PsychInfo were used. Using EBSCOhost, using the terms *Counselors and Roles and Interprofessional teams* found six articles. Of six articles, three were duplicates (Arthur & Russell, 2010), two focused on school counselors teaming with mental health counselors and that is considered intraprofessionalism, and the final article (Brooks & Gerstein, 1990) focused on counseling credentialing and interprofessional collaboration. For GoogleScholar, the following search terms were used: *Counselors and responsibility roles and interprofessional collaboration and interdisciplinary* elicited 3,700 and pages one through four were reviewed with the fourth and fifth page not having relevant articles. Five relevant articles were found (Mellin,

Hunt, & Nichols, 2011; O'Connor & Fisher, 2011; Shoffner & Briggs, 2001; Shoffner & Williamson, 2000; Waskett, 1996). Lastly Psychinfo was used with the search terms, *Counselors and Interprofessional and Roles,* which populated ten results, with two relevant articles (Myers, Sweeney, & White, 2002; Quealy & Cadwell, 2004).

3.3. IPEC Competency 3: Interprofessional Communication

The competency statement is "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" (IPEC, 2009; p.23). Effective communication indicates a willingness to work with professionals in other fields. The competency is calling for health professionals to use effective communication skills to maintain a sense of collaboration and care with colleagues and those in need of care. Counseling ethical codes ask for the same level of competency in code D.1.b, in which it calls for counselors to form and maintain strong interdisciplinary relationships so clients will be best served. Related literature in the counseling field has found that since counselors are trained in communication, they are in a position to lend their unique skills to any interprofessional collaboration in clinical and educational settings (Arthur & Russell-Mayhew, 2010). Accreditation standards could be strengthened in this area, but as it stands, it says that programs should provide an understanding of a counselor's role as a member of an interdisciplinary team, including strategies for collaboration and communication (CACREP, 2009).

For Competency three, (i.e., interprofessional communication), the search engines Google Scholar and APA PsychNet were utilized. Unfortunately, no articles mentioned counselors directly in articles related to interprofessional communication. There were no articles found written by counselors or by persons from counseling departments or deliberately addressed the counseling profession. However, articles listed and discovered were highly related to the counseling profession. Google Scholar, using search terms *counseling and communication and technology* found three relevant results (Balas, Jaffrey, Kuperman, Boren, Brown, Pinciroli & Mitchell, 1997; Maheu & Gordon, 2000; Mallen, Vogel &Rochlen, 2005). Google Scholar and APA PsychNet, using search terms *collaboration and interprofessional communication and counseling* found four relevant articles (Lingard et al., 2006; Rice et al., 2010; Sheehan, Robertson, & Ormond, 2007;Suter, Arndt, Arthur, Parboosingh, Taylor, & Deutschlander, 2009).

3.4. IPEC Competency 4: Teamwork and Team-Based Care

The competency statement is "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" (IPEC, 2009; p. 25). The competency is essentially recommending professionals apply counseling skills, such as active listening and reflecting, to build team cohesion and effectively deliver appropriate care to patients. Overall, the competency is requesting that health care professionals work together to create efficient and effective practices for their patients based on teamwork. Counseling ethical codes ask for the same level of competency in code D. 2. D, in which, it calls for counselors to be open and communicate with patients, families and other professionals to establish and maintain a team approach to treatment and diagnosis. Along similar lines related literature in the counseling field has focused on the topic of team based care in all aspects of counseling and many different counseling settings (i.e. schools, rehabilitation, and clinical mental health). The need for IPEC across health related disciplines is essential as well as socially progressive; however, its primary use within the health care system, including human services, is rare (Pecukonis, Doyle &Bliss, 2008). Accreditation standards could be strengthened in this area, but as it stands it says the availability of information is for learning purposes as well as research among faculty and students (CACREP, 2009).

For competency four (i.e. teamwork and team-based care) Using ebscho host two relevant articles were found (Knapp, Bennett, Plumb, & Robinson, 2000; McPherson, Headrick, & Moss, 2001) using the search terms, *teamwork and Interprofessionalism.* Using PsycInfo and googlescholar four relevant articles appeared however these do not focus on counselors specifically nor are they written by counselors. The (1) *IPEC and Team-based Care*, (2) *IPEC AND Collaboration,* (3) *IPEC AND Interdisciplinary* teamwork were used (Barnsteiner et al., 2007; Goldberg, mosack, & Brickell, 2011; Reeves, 2012; Sueter et al., 2009).

4. Discussion

This project has identified several key concepts related to ethics, accreditation and interprofessional collaboration. Ethical standards urge counselors to be collaborative, however this should be a stronger theme; perhaps an actual section on *interprofessional collaboration* would clearly show the counseling profession and other professions that counselors value interprofessional collaboration. It was discovered that CACREP standards rarely mention interprofessional collaboration. However, we recommend that there be a requirement that all "specialty" areas have a focus on interprofessionalism because the current and continuing direction of healthcare is moving in the direction of collaborative care models. If the counseling profession refuses to get on board, it will be left behind and continued to be excluded from the inclusion and leadership in healthcare teams. Lastly, though counseling literature does not reflect interprofessionalism across disciplines, there were many articles found with school counselors practicing interprofessionalism with stakeholders in education, such as the principal or teachers. We are suggesting expanding the

scope of practice to consulting, and team collaboration with medical related disciplines. It can be as simple as school counselors making referrals to nurse practitioners and nurse practitioners telling their clients who are in k-12 schools the benefit of speaking with the school counselor. Interprofessional collaboration does not have to mean everyone working together in a hospital, but it does mean everyone knowing about each other, feeling comfortable consulting and feeling comfortable referring (Knowledge and awareness).

5. Implications for Counseling

This manuscript has introduced others to counselors, and explained the connection between the core competencies for interprofessional collaborative practice to the field of counseling. Along with the benefit of having a shared language amongst health care professionals, like the IPEC competencies, there are several discussion points related to collaborative practice, system level support, and policy/advocacy for counselors.

5.1. Collaborative Practice and Training

Interprofessional education and collaboration competencies should be taught to a range of counseling and health care stakeholders including community leaders, government agencies, counseling programs, in community centers, and other places where the impact of training relates directly to the provision of services and eventually to better care of clients. Future direction of this training should focus on innovative ways to develop and include IPEC across the learning continuum (Cerra & Brandt, 2011). For counseling, IPEC can begin to be introduced in the classroom and in clinical settings. Proper training in IPEC and with the competencies lead to better collaborative practices and more opportunities for collaboration (Sueter, Arndt, Arthur, Paboosingh, Taylor, & Deutschlander, 2009). Collaborative practices of the future with the help of IPEC and counselor buy-in would increase referrals to counselors from medically related professions, specific medical related terms will be recognizable and become a common language to counselors and counselor jargon would be understandable by other health providers; through these initiations and collaborations, patient care and inclusion of all health providers will improve (Wood, Flavell, Vanstolk, Bainbridge & Nasmith, 2009). With all change, there maybe some barriers including some resistance to change, especially among those that are more invested in the system and have been in the old system for a while [silo model of practice and education]. However, with the recent changes, interprofessional collaboration is key to keeping counselors moving forward with the transformation of healthcare as important, viable members.

5.2. System-Level Support Structure

Three key components required to support interprofessional teams are the characteristics of team members and their level of commitment, communication methods within the team itself and the development of creative methods of teamwork (Molyneux, 2001). Included among the original IPEC participants were nursing, medicine, dental, pharmacy, and public health; but, the inclusion of counseling and related departments, such as human services, social work and psychology will speak to the psychological and social aspects of heath care to include mental health, access and a social component.

Another major system level support that can be employed to facilitate interprofessional collaboration clinical and educational collaborations is the inclusion and use of technology. In order to support and sustain interprofessional teams despite scheduling conflicts related to professional differences and client locations, technology is being utilized to bring teams together. Videoconferencing has been seen as the standard, thus far, allowing for interprofessional teams ability to meet and address client/patient care (Jarvis-Selinger, Chan, Payne, Plohman & Ho, 2008). However, many other forms of technology including emails, secured discussion boards, and instant messenger sites can also be used. Tele-health methods, the utilization of technologies to deliver healthcare in the forms of remote transmission of test results or diagnostic information or real time communication via audiovisual means, e.g. telephone, webcam or other communication method, are also used in healthcare to facilitate treatment for client/patients who cannot easily access medical services due to injury or location (Bogen, Aarsæther, Augestad, Lindsetmo, Hiten & Patel, 2013). It will be important for counselors to be a part of these interprofessional tele-health teams to address mental, social, or environmental concerns these distance clients may have.

With most changes there may be some barriers. Despite the general aim to benefit the clients/patients, differentiated cultures introduced in training, and reinforced through training and specialization, produces a unique demonstration of each profession's values, beliefs, customs and attitudes (Hall, 2005; Pecukonis, Doyle, & Bliss, 2008; Robinson & Cottrell, 2005). In order to facilitate teams, departments need to come together to foster opportunities to practice interprofessional teamwork during training, both in the classroom, as part of a professional philosophy, and in practical settings (Johnson, & Freeman, 2014; McNair, 2005). In addition, program standards set by CACREP pose a significant challenge because interprofessional standards do not exist meaning interprofessional collaboration would have to be added as an additional course or module to existing courses.

5.3. Policy and Advocacy

Based on the changing scope of health care, counselors must be ready to work in a variety of settings with an assortment of health professionals. New third party reimbursement policies are starting to transition from reimbursing solely clinical psychologists, to recognizing and reimbursing counselors (Virginia Association of Clinical Counselors, n.d.). However, these propositions and policies

include rigorous expectations and guidelines that must be followed precisely in order to be reimbursed. This positively impacts counselors by expanding their scope, making advancement towards increased recognition, and providing common ground between the field of counseling and other medically related health professionals. However, there are still some third party reimbursement companies who aren't willing to work with counselors directly but perhaps leave room for counselor reimbursement on a team during team-based care. Medicare still does not reimburse the services of Licensed Professional Counselors. Since 1989, Medicare has covered psychologists and social workers, but they are still reluctant to cover counselors, however all medical related professions (i.e. dentist, physical therapy, specialty doctors, etc.) are covered. The "Seniors Mental Health Access Improvement Act of 2013" (S. 562) has been introduced into the Senate to establish reimbursement from Medicare for counselors (American Counseling Association, n.d.) therefore this is a step in the right direction.

Along with political and third party reimbursement changes, there is a need for ethical and accreditation standard updates to reflect the changing scope of healthcare. With all other professional organizations involved in the development of the IPEC competencies there are statements within their ethical codes and accreditation standards that relate directly to interprofessional collaboration. It is important that the counseling profession make the necessary updates to reflect health care in this decade, which calls for interprofessional collaboration, team based care, and interprofessional team based treatment groups. The reflection of this new content shows that counselors and the profession are on the cutting-edge of what's happening in healthcare.

6. Conclusions

If counselors increase their level of understanding of interprofessionalism, become knowledgeable of the core competencies for interprofessional collaborative practice, and begin to broach relationships with health and medical related professions these actions can result in a greater understating of others and more enhanced collaborative clinical relationships. Simultaneously, it is important for medical health professions to increase their knowledge on the scope of practice of counselors. Overall, interprofessional collaboration leads to cost-effective and optimal patient care (IOM, 2003; WHO, 2010). The changing scope of health care is moving towards the most cost-effective way to provide healthcare to all citizens. Training, knowledge, and awareness of IPEC competencies push counselors and the profession ahead of the curve in terms of timely enhancements to our current state of training. Counselors and the profession have to broach medical related professions and engage in relationships that will be beneficial to clients and the population in your area. There has been a call for more inclusion of behavioral scientists on interprofessional teams (Dacey et al., 2010) and now it's time for counselors to take the next step to answer the call.

Research in this area can take many different pathways because it is under-researched in the counseling field. As a starting place it would be important to examine existing interprofessional relationships between counselors and medical related professions. While it is known that these collaborations exist little is known about how these collaborations were formed, their guiding principles for shared language, and benefits and challenges. In addition it will be important moving forward in this direction to survey practicing counselors and counselor educators on their perceptions of interprofessionalism specifically if they would be willing to engage in the practice, what they foresee as challenges at their place of employment and their beliefs on the benefits. In terms of their willingness to engage in interprofessional collaboration there are several scales that are available that focus on students' readiness for interprofessional collaboration and education and there are existing faculty and staff readiness scales. After the research is established it would be important to monitor the success of these interprofessional relationships through standardized scales evaluating successful.

Table 1. *Alignment.*

IPEC Competencies	Aca Ethical Codes	Cacrep Standards	Counseling Literature
IPEC COMPTENCY 1: VALUES/ETHICS **Work with individuals of other professions to maintain a climate of mutual respect and shared values** 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 care professions. VE5. Work in cooperation with those who receive care, those who provide care, and others who contribute to or 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.	A.1.a (p. 4) A.1.b (p. 4) A.2.c (p. 4) A.2.d (p. 4) A.4.b (p. 4) A.5.a (p. 5) A.5.b (p. 5) A.5.c (p. 5) A.5.d (p. 5) A.5.e (p. 5) A.12.g (p. 6) A.8.b (p. 5) B.1.a (p. 7) B.3.a (pg. 7) B.3.c (pg. 8) B.3.e (pg. 8) B.5.b (pg. 8) B.6.a (pg. 8)	S.II.B.1. (p.9) S.II.B.2 (p.9) S.IIG.1.b (p.10) S.II.G.1.c (p.10) S.II.G.1.i (p.10) S.II.G.1.j (p.10) S.II.2.a (p.10) S.II.2.b (p.11) S.II.2.d (p.11) S.II.2.e (p.11) S.II.2.f (p.11) S.II.3.a (p.11) S.II.3.b (p.11) S.II.3.c (p.11) S.II.3.d (p.11) S.II.3.f (p.11) S.II.3.g (p.11) S.II.3.h (p.11)	1. Mellin, Hunt, & Nichols, 2011 2. Aitken & Curtis, 2004 3. Quealy-Berge & Caldwell, 2004 4. Miller, Hall, &Hunley, 2004 5. Arthur, 2010 6. Cooper, 2013

IPEC Competencies	Aca Ethical Codes	Cacrep Standards	Counseling Literature
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.	B.6.c (pg. 8) B.6.f (pg. 8) B.8.a (pg. 9) B.8.b (pg. 9) B.8.c (pg. 9) C.5 (pg. 10) D.1.a (pg. 11) E.4 (pg. 12) E.5.b (pg. 12) E.8 (pg. 13) E.1.c (pg.13) F.6.h (pg. 15)	S.II.4.d (p.12) S.II.5.a (p.12) S.II.5.b (p.12) S.II.5.c (p.12) S.II.5.d (p.12) S.II.5.e (p.12) S.II.5.g (p.12)	
IPEC COMPTENCY 2: ROLES/RESPONSIBILITY **Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of the patients and populations served** 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.	A.1.d (pg. 4) A.2.a (pg. 4) A.2.b (pg. 4) A.7 (pg. 5) A.9.b (pg. 5) A.11.a (pg. 6) A.11.b (pg. 6) A.11.c (pg. 6) A.11.d (pg. 6) B.3.b (pg. 8) C.2.a (pg. 9) C.2.c (pg. 9) C.2.g (pg. 9) C.3.a (pg. 10) C.4.a (pg. 10) C.4.b (pg. 10) D.1.d (pg. 11) D.1.f (pg. 11) D.2.a (pg. 11) E.6.b (pg. 12) F.8.a (pg. 15)	S.IIG.1.c (p.10) S.III.L.2 (p.23) S.II.7.f (p.14) S.III.A.1 (p.15) S.III.A.2 (p.15) S.III.A.3 (p.15) S.III.D (p.16) S.III.C.3 (p.15) S.III.C.4 (p.15) S.III.D.1 (p.16)	1. Arthur & Russell, 2010 2. Brooks & Gerstein, 1990 3. Shoffner& Briggs, 2001 4. Shoffner& Williamson, 2000 5. Mellin, Hunt, & Nichols, 2011 6. O'Connor &Fisher, 2011 7. Waskett, 1996 8. Myers, Sweeney, & White, 2002 9. Quealy&Cadwell, 2004
IPEC COMPTENCY 3: INTERPROFESSIONAL COMMUNICATION **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** 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.	A.3 (p. 4) D.2.d (p. 11)	S.III.D.3 (p.19) S.III.D.5 (p.20) S.III.D.9 (p.20) S.III.E.2 (p.20) S.III.F.2 (p.26)	1. Arthur & Russell-Mayhew, 2010 2. Balas, 1997 3. Gordon, 2000 4. Mallen, 2005 5. Adkinson-Bradley, 2005 6. Bedi, 2006 7. Courtland, 1997 8. Cates, 2006 9. Edwards 2008 10. Brown, 2009 11. Blevins, 2008 12. Kawahara, 2011 13. Tummala-Narra, 2010
IPEC COMPTENCY 4: TEAMWORK AND TEAM-BASED CARE **Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver**	D.1.b (p. 11) D.1.c (p. 11) D.1.e (p. 11)	S.IIG.1.b (p. 10) S.CC.K.1 (p. 28) S.CC.K.3 (p. 28)	1. Knapp, Bennett, Plumb, & Robinson, 2000 2. Suter, Arndt, Arthur,

IPEC Competencies	Aca Ethical Codes	Cacrep Standards	Counseling Literature
patient-/population-centered care that is safe, timely, efficient, effective, and equitable 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 teamwork. 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.		S.CC.I.3 (p.27) S.CC.L.4 (p.28) S.CC.M.1 (p.28) S.CC.N.1 (p.29) S.CMHC.A.3 (p.30)	Parboosingh, Taylor, &Deutschlander, 2009 3. Reeves, 2012 4. Barnsteiner, Disch, Hall, Mayer, & Moore, 2007 5. McPherson, Headrick, & Moss, 2001 6. Goldbrg, Mosack, &Brickell, 2011 7. Johnson & Freeman, 2014

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