Developing a framework for interprofessional collaborative practice, cultural fluency, and ecological approaches to health

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ABSTRACT
This paper describes the development of a framework for reducing health disparities inclusive of interprofessional collaborative practice, cultural humility, and ecological approaches to health; the identification of common core competencies for students from various disciplines; and relevant assessment instruments to measure attainment of those competencies. The framework, associated logic model and initiatives, and core competencies were created through an iterative process involving multiple stakeholders. Using the framework as the outcome, a logic model was created to identify short, medium, and long-term activities and outcomes. Faculty were involved in the identification of core competencies and relevant validated assessment instruments. Future work will include mapping competencies across the curricula in a school of health at a liberal arts university and longitudinal assessment of students to evaluate attainment of competencies.

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Introduction
The persistence of health disparities worldwide requires a dramatic shift in the way health profession students are educated and subsequently approach their work in the United States. The National Institutes of Health defines health disparities as “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups” (Health Disparities, NHLBI, NIH, n.d.). These health differences are preventable, systemic, adversely affect vulnerable and socially disadvantaged groups, and arise from unintentional or intentional discrimination and marginalization (Braveman et al., 2011; Milburn et al., 2019). Eighty percent of individual health is related to factors other than access to care, care quality, genetics, or biology (Hood et al., 2016). Ecological factors such as income, community connections, housing quality, education and food insecurity are also closely linked to systemic and structural social injustices. As Milburn et al. (2019) note, in order to address health disparities and the ecological factors that impact health, “it is critical to build, support, and sustain a health workforce of well-informed, competent leaders, researchers, and practitioners committed to this complex and challenging work.” (p. 2). Given this context, it is imperative that healthcare education focus greater effort on provider racism, cultural fluency, and the skills required to address and dismantle unjust societal structures (Bailey et al., 2017; Brown et al., 2019; Plamondon, 2020).

Frameworks for interprofessional education and practice differ slightly between the US, Canada, UK, and Australia but all address competencies in the areas of communication, role clarity, and teamwork (Brewer, 2013; Interprofessional Education Collaborative, 2016; Orchard et al., 2010; Walsh et al., 2005). While these competencies are important for collaborative practice, they do not sufficiently address critical cultural competencies or the role that health care providers have in advancing social justice. Oelke et al. (2013) assert that cultural competence is linked to interprofessional collaborative practice through interactions with patients, among providers, and within organizations. While attention to cultural competence in healthcare education is not new, many approaches omit the connection to social justice and the impact of societal structures on health and healthcare (Kumagai & Lypson, 2009; Neff et al., 2020).

This paper will describe the process for developing a framework for health equity inclusive of interprofessional collaborative practice, cultural fluency, and ecological approaches to health to be used for education of health profession students enrolled at St. Catherine University in the Henrietta Schmoll School of Health (HSSH) which encompasses 27 distinct programs. The development of this framework, and subsequent initiatives, were funded through a nine-year financial grant from a private foundation. This paper describes the process used to identify core competencies and associated...
assessment instruments. This phased project began with a grounded theory approach to create a framework and logic model which guided the prioritization of initiatives, development of competencies, and identification of assessment instruments.

**Phase 1 – Develop a framework and logic model**

Our framework was developed through a series of facilitated retreats with a steering committee of 11 staff, faculty, and administrators from multiple programs and departments across the HSSH and was intended to apply to health disciplines at our institution (Table 1). Sinek’s (Start with why – How great leaders inspire action | Simon Sinek | TEDxPugetSound, 2009) “Golden Circle” model of “why, how, what” was used as a framework for this effort. The steering committee consisted of the principal investigator of this project, staff from the office of institutional research, and the co-chairs of three subcommittees organized around our project aims.

**Why**

The first task of the steering committee was to define the desired common attributes of graduates across our health care programs. During a half day retreat, the steering committee was divided into two teams of mixed representation in order to focus on our purpose, or the “why.” Each group was tasked with answering the following three questions: 1) What are the primary outcomes of the grant? 2) What is the unique contribution of focus areas? 3) What contributions are possible in concert with each focus area? Each group created a visual representation and shared it with the full group followed by discussion and brainstorming. At the meeting conclusion, draft statements were shared with attendees and a second half-day retreat was scheduled. At the second retreat, consensus was reached on a draft goal (“why”) for the HSSH to “improve societal health and wellbeing by preparing high quality providers capable of practicing in emerging health-related environments focused on interprofessional collaborative practice, cultural fluency, and ecological approaches to health across the lifespan.” The three areas of focus were defined as follows:

- **Interprofessional Collaborative Practice (ICP)** – when multiple health workers from different backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care (WHO | Framework for action on interprofessional education and collaborative practice, n.d.)
- **Cultural Fluency** – ability to navigate the many dimensions of culture needed to build shared meaning and understanding with people from other cultures. It is comprised of several skills such as working with ambiguity, flexibility, respect, empathy and adaptability (Inoue, 2007)
- **Ecological Approach** – grounded in the understanding that the conditions that result in individual health or illness arise out of the interaction between an individual’s traits and their physical and sociocultural environment, and are influenced on multiple levels (e.g., intrapersonal, interpersonal, organizational, community and policy (Sallis & Owen, 2015).

**How**

The steering committee next worked with external evaluation consultants over a period of nine months to develop our approach (“how”) and organize our activities into a framework and logic model (Online Supplement). Using grounded theory, three areas of focus – faculty development, curriculum and co-curriculum, and research and scholarship – were identified. These areas of ‘how’ were operationalized by subcommittees charged to engage faculty and create action plans for implementation and assessment.

**What**

Following a similar process, the “what,” or outcomes we hope to achieve, include improving societal health, addressing workforce needs, providing an unparalleled academic experience and advancing visibility and recognition of the HSSH as a leader in health professions education. The logic model describes the activities designed to achieve the HSSH’s goal and identifies short-term, intermediate, and long-term outcomes.

Idealistically, each aspect of the model was well articulated and consensus easy to reach, but containing it into a logic model with clear definitions, outcomes and indicators was challenging. In addition, many HSSH programs are accredited and mandated to ensure specific competencies according to discipline-specific definitions. There were many questions about implementation of the ‘how’ and assessment of the ‘what’ as both have implications for HSSH program efficiency and curriculum. Because this is a framework, implementation strategy was at this point not fully developed. Conflict was
abated by engaging faculty broadly in both feedback and developing strategies to meet the overarching goal of the grant as part of the subcommittee structure.

**Phase 2 – Identify initiatives and priorities**

Following completion of the logic model, the steering committee held a retreat to identify potential grant related initiatives. Using World Café methodology, the 11-member steering committee participated in round robin conversations to address questions related to barriers to moving forward, faculty development needs regarding the framework, and identification of gaps in training necessary to prepare students for practice (The World Café Community Foundation, 2015).

The ideas generated from this retreat were sent by e-mail as a Qualtrics survey to 339 school of health faculty (full time, part time, and adjunct) for input and prioritization. Faculty were asked to rank their top five choices from a list of sixteen initiatives. The survey was open for nine days and a reminder e-mail was sent to all faculty on day seven. Sixty-two faculty completed the survey, for a response rate of 18%. Data were analyzed using measures of frequency and the six initiatives that received the greatest support (Table 2) were reviewed by the steering committee, mapped to the framework, and sent to appropriate subcommittees for consideration.

Many of these initiatives, such as providing workload support for curriculum development and the creation of alternative contract types, provide necessary operational and structural support for the framework and its related goals and objectives.

Subsequently, each subcommittee recruited membership from across the HSSH, established goals and action steps based on faculty feedback for how faculty development, curriculum and co-curriculum, and research and scholarship will be supported, enhanced, and assessed. The action plans were brought to grant leadership for approval.

**Phase 3 – Establish competencies**

The identification of common attributes across programs is intended to provide a universal base which can be coupled with each student’s disciplinary expertise in order to optimally prepare students to work in teams and meet the challenge of improving societal health and wellbeing. The process to ascertain core competencies related to interprofessional collaborative practice, cultural fluency, and ecological approaches to health started with a review of accreditation standards of health disciplines represented in the HSSH and mapping existing standards to our framework. The list of potential competencies was sent to all members of the steering committee for review, requesting that they share the competencies with their subcommittees. Subcommittee members were asked to review the competencies for relevancy to their discipline and to add others that might be missing. The revised competency list was returned to all subcommittees for a second review to narrow the list to those they considered essential for all students, regardless of their program of study. The list was also presented to the program directors and department chairs of 27 programs and the HSSH Advisory Council, which represented external stakeholders such as clinicians and alumni, for input. The final competency list was sent to the steering committee for review and final approval.

We recognize and acknowledge that a competency-based assessment approach is beset with inherent bias. It is well-argued that the term ‘cultural competence’ preserves the white supremacy culture (Beagan, 2018; DiAngelo, 2011; McIntosh, 1989). It was intentional that this project chose ‘cultural fluency’ to represent shared meaning and understanding rather than achieving a particular goal. Additionally, literature on power and oppression emphasize the patterns of

| Initiative                                                                 | First choice votes n (%) | First, second, third choice votes n (%) |
|----------------------------------------------------------------------------|--------------------------|----------------------------------------|
| Reevaluate faculty workloads to provide support for curriculum development and other initiatives | 20 (32) | 38 (61) |
| Re-envision clinical education                                               | 8 (13) | 22 (35) |
| Create alternative faculty contract types to account for clinical work       | 8 (13) | 22 (35) |
| Improve recognition and appreciation of unique needs across degree levels    | 8 (13) | 18 (29) |
| Create a center for teaching excellence                                      | 5 (8) | 13 (21) |
| Re-envision IPE                                                              | 4 (6) | 13 (21) |

**Table 3. Core competencies for Henrietta Schmoll School of Health framework for health.**

| Framework area                                      | Definition                                                                 | Competency                                                                 |
|-----------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
| Interprofessional collaborative practice             | Students have the ability to work effectively with multiple health workers from different backgrounds. | Identify the full scope of knowledge, skills, and abilities of professionals from health and other fields. Collaborate with other professionals, patients and communities to promote beneficial outcomes relevant to prevention, health improvement and healing. Apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies. Demonstrate cultural humility in respecting individual and/or community values and priorities/preferences for care in decisions making and planning. |
| Cultural fluency                                     | Students are aware of and have the ability to navigate dimensions of culture to build shared meaning and understanding of others. | Recognize the dynamic nature of the relationship between people/communities and their environment and the impact on health and well-being. Analyze health within the context of systemic injustice and disparities. Propose interventions to improve health equity and address social determinants of health. |
| Ecological approaches to health                     | Students are grounded in the understanding of the conditions that result in individual health or illness. |                                                                                                                                 |


imbalance that exist in educational environments, specifically in the way that ideologies of the dominant group are constructed and maintained (Freire, 2000; Palmer et al., 2019). Knowing the implicit bias in educational structures, we have initiated interprofessional competency-based assessment, with no consequences attached, and will learn from the results to inform future iterations through a lens of equity and inclusion.

Table 3 displays the final set of core competencies for all students in the HSSH. Curricular and co-curricular activities will be mapped to the competencies and independently assessed. Students will also be evaluated on their self-rated and observed proficiency of these skills, as described in the following section, and data from these assessments will be used to inform progress toward attainment of the goals of our framework.

**Phase 4 – Identify assessment instruments**

The final phase involved the identification of assessment instruments to measure student attainment of the core competencies. An ad-hoc committee including nine faculty, staff, and students from across the HSSH met over the course of three months to identify instruments that would measure the framework competencies. The goals of the committee were to find instruments that were both valid and reliable and that would, ideally, focus on behaviors versus self-ratings of competency. Literature searches for available instruments in the three areas of interprofessional education, cultural fluency, and ecological approaches to health revealed few tools that met our criteria and none that would address all three components of our framework.

Three instruments were ultimately selected for initial implementation across the HSSH. Two validated surveys were selected for use at entry into a school of health program and prior to graduation: one to measure interprofessional competencies, the IPEC Competency Self-Assessment Tool; and the other to measure cultural fluency, the CQ Instrument (https://culturalq.com/products-services/assessments/cqselfassessments/).

The IPEC Competency Self-Assessment Tool is a 16-item self-assessment that measures interprofessional values and interprofessional interaction. Lockeman et al. (2019) found the instrument to have high internal consistency, reporting McDonald’s omega of 0.92 (95% CI = 0.91, 0.93) for interprofessional interaction and 0.93 (95% CI = 0.92, 0.94) for interprofessional values. In addition, they found scores from the IPEC Competency Self-Assessment Tool to be highly correlated with the Interprofessional Socialization and Valuing Scale (ISVS-9A), an instrument intended to measure change in interprofessional socialization as a result of IPE, interprofessional interaction ($r = .68, p < .001$) and interprofessional values ($r = .66, p < .001$).

The 37-item Expanded Cultural Intelligence Scale (E-CQS) instrument was chosen to assess the cultural fluency of our students. This instrument measures four domains: drive (interest, persistence, and confidence during multicultural interactions); knowledge (knowledge of other cultures); strategy (awareness and ability to plan for multicultural interactions); and action (ability to adapt in multicultural contexts) (https://culturalq.com/about-cultural-intelligence/).

The instrument demonstrates acceptable reliability, with Cronbach’s alpha scores exceeding 0.70 for all scales (drive = 0.77, knowledge = 0.84, strategy = 0.77, and action = 0.84) (Griffith et al., 2016; Matsumoto & Hwang, 2013). Internal validity was established through confirmatory factor analysis, and convergent/discriminant validity was established through comparison with conceptually congruent instruments (Griffith et al., 2016).

The third assessment tool, the Interprofessional Collaborator Assessment Rubric (ICAR) was selected to evaluate interprofessional behaviors of students in clinical programs (Curran et al., n.d.). This instrument was chosen as it is one of the few instruments that relies on observation by supervising faculty or preceptors rather than student self-ratings. Content validity was established using an interprofessional Delphi committee and focus groups involving faculty and students during instrument development (Curran et al., 2011). Because the ICAR measures knowledge, skills, and behaviors, it will only be used by faculty supervisors as students near completion of their clinical training. Faculty will be calibrated on use of the instrument to establish interrater reliability. At this point, we have not identified an instrument to assess recognition of ecological approaches to health.

Some program directors and department chairs expressed concern that the IPEC Competency Self-Assessment Tool contained language specific for patient care, making it difficult for students in the social work and public health programs to complete. One of the public health faculty members piloted the instrument with her class ($n = 30$ undergraduate public health students), providing them with an introduction to replace the word “patient” with “community” or “client” when completing the survey. No students expressed confusion or concern with the language and were able to complete the survey. Ongoing process evaluation will provide input during implementation if the language needs to be altered to reflect client/patient.

**Discussion and key learnings**

The work of developing a common framework for use across a school of health inclusive of 27 disciplines requires patience, perseverance, and resilience. Our framework does not replace established IPE frameworks, but rather adds the essential components of cultural fluency and ecological approaches to health to address individual and structural racism inherent in healthcare and healthcare education. It is unique in that it identifies those core competencies expected of our graduates across associate, undergraduate, and graduate level programs, recognizing that individual programs will likely have additional requirements in each of the competency areas.

Communication, flexibility and resiliency are key to sustainability. Any long-term effort for widespread change is at risk for distraction by unanticipated challenges and competing priorities. We have been largely successful in navigating any disruptions by maintaining a nimble mind-set and strong channels of communication among and between the leadership team and working groups.
A commitment from leadership and across programs is vital for implementation and evaluation. Strategies to build consensus and uniformity of approach require collaborative development of core learning opportunities and faculty support. Interprofessional team development of activities and learning outcomes related to interprofessional practice, cultural fluency, and ecological approaches to health will facilitate the establishment of requirements for all students to engage in a certain number of activities by type. These activities may be embedded in the curriculum or co-curricular in nature. For example, a successful co-curricular approach was a weekly colloquium scheduled during a common open hour, allowing for all students and faculty across the school of health to participate.

Agreement across leadership and across programs also allows for common indicators to track progress toward aims. Process indicators include the number and type of core learning opportunities in which students participate. Outcome indicators include the change in knowledge, attitudes and skills related to interprofessional collaboration, cultural fluency and ecologic approaches to health. Assessing students upon matriculation into programs and upon completion of their degree provides a pre-post measure of change that can be partially attributed to the core learning opportunities.

Limitations
There are several limitations associated with this discussion article. The focus of this paper was to describe the development of a framework for health and its associated competencies and assessment. As this framework has not yet been fully implemented, including curricular mapping and longitudinal assessment of outcomes, we are limited in our capacity to address the ultimate impact of this project. Incomplete implementation also restricts the ability of others to replicate our work. In addition, the size of our school of health, with 27 distinct programs, and the fact that we benefited from generous financial support may limit the generalizability of this work to institutions with fewer health care programs and resources. Future plans involve the creation of an implementation plan for use across the HSSH, as well as evaluation at both the program and student level.

Conclusion
This paper described the process of developing a framework for health inclusive of interprofessional collaborative practice, cultural fluency, and ecological approaches to health. Through an iterative process that engaged constituents at all levels and across all programs in our school of health, we were able to create a common set of core competencies for all students, regardless of discipline, a logic model to guide our curricular/co-curricular, faculty development, and research/scholarship efforts, and to identify assessment instruments to track student progress.

Declaration of interest
The authors report no conflicts of interest. The authors alone are responsible for the writing and content of this paper.

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