Core Competencies Needed For Health Care Professionals

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Healthcare professionals need more than discipline-specific technical knowledge. They must communicate with patients, collaborate across professions, use evidence, improve systems, and manage information safely. The original essay identifies four of the five core competencies proposed by the Institute of Medicine: patient-centered care, interdisciplinary teamwork, evidence-based practice, and quality improvement. Informatics should be added as the fifth competency. The Mrs. Linda Jones scenario demonstrates why these abilities must operate together. She receives a new diagnosis of type 2 diabetes, but the encounter focuses narrowly on physical symptoms and leaves her uncertain about treatment, family responsibilities, education, exercise, and long-term risk. The problem is not simply that Dr. Lewis failed to provide more facts. The care system did not elicit her goals, coordinate a team, use structured education, document and retrieve information effectively, or verify that she could act on the plan.

Core Competency 1: Provide Person-Centered Care

Person-centered care respects the patient as a person with values, needs, preferences, culture, responsibilities, and expertise in daily life. It differs from merely being polite. The professional explains the condition and options in understandable language, listens actively, asks what matters most, and shares decisions according to the patient's desired level of involvement. AHRQ defines shared decision-making as collaboration informed by evidence, clinical knowledge, and the patient's goals, preferences, and circumstances (AHRQ, 2026).

The original essay repeatedly uses the word "victim" for patients. That wording should be corrected because illness does not erase personhood or agency. Person-first language such as "person with diabetes" is generally more respectful than defining someone as a diabetic, although individual preferences should be honored. The clinician should also avoid assuming that patient-centered care means agreeing to every request. Recommendations must remain safe and evidence-based, but disagreement should be explored rather than dismissed.

Health Literacy and Understanding

Healthcare organizations are responsible for making information understandable. AHRQ's health-literacy work emphasizes that services should match people's ability to find, understand, and use information. Professionals can use plain language, limit the amount introduced at one time, provide accessible written support, use interpreters, and confirm understanding through teach-back. Health

literacy is not a fixed patient deficit. Even highly educated people can struggle when frightened, in pain, or receiving unfamiliar information.

Respect for Daily Life

A treatment plan must fit the patient's actual life. Mrs. Jones is a graduate student, spouse, and mother of two adolescents. She needs to know how testing, appointments, food planning, medicines, and physical activity can be integrated with those roles. The clinician should ask about schedule, food access, insurance, transport, family support, sleep, and emotional response. A medically correct plan that cannot be implemented is not effective person-centered care.

Core Competency 2: Work in Interprofessional Teams

The Institute of Medicine's competency calls for cooperation, communication, and integration of care across disciplines. Modern healthcare problems rarely fit one profession. A team may include physicians, nurses, pharmacists, registered dietitian nutritionists, diabetes-care and education specialists, behavioral-health professionals, exercise specialists, social workers, dentists, podiatrists, and community workers. The American Diabetes Association recommends coordinated interprofessional care and person-centered, culturally sensitive communication for people with diabetes (ADA Professional Practice Committee, 2026a).

Teamwork requires shared goals, clear roles, timely handoffs, and mutual respect. Simply referring a patient to several professionals can create fragmentation if no one integrates the plan. The patient is also a member of the team. Meetings and records should reflect the goals agreed with that person, not only tasks assigned by professionals.

Communication and Handoffs

Failures often occur at transitions. A laboratory result may be available but not reviewed; a referral may be entered but never scheduled; a pharmacist may identify an interaction without reaching the prescriber. Structured communication tools can reduce omission, but they do not replace accountability. The sender should know who receives the information, and urgent issues require closed-loop confirmation.

Conflict and Psychological Safety

Teams need an environment where members can question a plan without retaliation. A nurse, pharmacist, trainee, or patient may notice a risk overlooked by the senior clinician. Professional

hierarchy should not prevent respectful challenge. Conflict is managed by returning to evidence, the patient's goals, and clearly assigned responsibility rather than defending status.

Core Competency 3: Use Evidence-Based Practice

Evidence-based practice integrates the best available research with clinical expertise and patient preferences. It does not mean applying a guideline mechanically to every person. Research may not include patients with the same age, comorbidities, culture, resources, or treatment history. Professionals must evaluate study quality and applicability, explain benefits and harms, and adjust decisions to the patient's context.

Current diabetes standards are updated regularly because treatments, devices, and evidence change. The ADA states that positive health behavior, psychological wellbeing, diabetes self-management education and support, nutrition therapy, physical activity, sleep, tobacco cessation, and psychosocial care are foundational parts of diabetes management (ADA Professional Practice Committee, 2026b). Dr. Lewis's vague instruction to "watch her diet" does not translate evidence into a usable plan and may reinforce blame.

Asking Clinical Questions

Professionals can structure questions around the patient or problem, intervention, comparison, and outcome. They then search appropriate sources, appraise validity, and apply findings. Evidence hierarchies are useful but not absolute. A systematic review may be strong for treatment effectiveness, while qualitative research may better explain patient experience and barriers. Local data may reveal whether a well-supported intervention is implemented equitably.

Communicating Uncertainty

Evidence rarely eliminates uncertainty. Professionals should avoid exaggerated guarantees and explain what is known, what remains uncertain, and how progress will be monitored. Shared decisions are stronger when patients understand tradeoffs. Uncertainty should not become an excuse for indecision when a serious condition requires timely action.

Core Competency 4: Apply Quality Improvement

Quality improvement examines how the healthcare system performs and tests changes intended to make care safer, more effective, timely, efficient, equitable, and person-centered. It differs from research primarily in its immediate aim and context, although methods can overlap. A quality project may track delayed result notification, missed follow-up, medication errors, or inequitable outcomes

and use iterative cycles to improve the process.

The original essay says professionals should identify errors and hazards, implement safety principles, and continually measure quality. This remains accurate. Measurement should include outcomes, processes, and balancing effects. For example, a clinic might improve rapid result messaging but accidentally increase staff workload or send confusing automated notices. The solution should be evaluated rather than assumed effective.

Learning From Error

When harm or near harm occurs, the organization should examine system conditions as well as individual conduct. Poor interface design, unclear responsibility, workload, interruptions, inadequate training, or missing data can make error more likely. A just culture distinguishes human error, risky shortcuts, and reckless behavior. Punishing every mistake can drive reporting underground, while ignoring deliberate violations also undermines safety.

Equity as a Quality Dimension

Average improvement can conceal disparities. A digital portal may speed communication for some patients while excluding those with limited internet, vision impairment, language differences, or low digital confidence. Quality data should be stratified where appropriate, and alternative access should be designed rather than added only after complaints.

Core Competency 5: Use Informatics

Informatics is the use of information, data, and technology to support decisions, communication, learning, and safe care. It includes electronic health records, patient portals, registries, clinical decision support, telehealth, e-prescribing, and data analysis. The National Academies' five-competency framework explicitly includes informatics alongside patient-centered care, teamwork, evidence-based practice, and quality improvement (Institute of Medicine, 2003).

Technology does not automatically improve care. Poor data, copied notes, alert overload, inaccessible portals, weak security, and fragmented systems can create new harm. Professionals must understand what the system records, what it omits, who can access it, and how errors are corrected. Confidentiality and cybersecurity are clinical responsibilities because loss or misuse of information can harm patients.

Clinical Decision Support

Decision-support tools can present drug interactions, preventive reminders, risk estimates, and

evidence at the point of care. AHRQ notes that clinical decision support can facilitate evidence-based and patient-centered shared decisions. The tool should support rather than replace professional judgment. An alert that fires too often may be ignored; a model trained on unrepresentative data may perform poorly for certain groups. Users should be able to understand the recommendation's basis and report problems.

Patient-Generated and Remote Data

Diabetes technology may include glucose meters, continuous glucose monitoring, applications, and connected devices. Data can support treatment when the patient understands the technology, has access to supplies, and receives appropriate follow-up. More data is not inherently better. Teams must decide which values require action, how quickly they will respond, and who monitors the stream. Otherwise, the patient may believe that information is being watched when no one is responsible.

The Mrs. Jones Scenario

Mrs. Linda Jones is a married first-year graduate student with two children in secondary school. She reports persistent thirst, unintended weight loss, irritability, and fatigue. These symptoms can occur in diabetes but are not diagnostic by themselves. The original scenario states that laboratory results showed type 2 diabetes. A safe account should indicate that Dr. Lewis must explain which test met diagnostic criteria, whether confirmation is required, whether symptoms indicate urgent metabolic risk, and what immediate follow-up is needed. Waiting passively for a mailed letter would be inappropriate for a significant new diagnosis.

Failure of Person-Centered Care

At the follow-up visit, Mrs. Jones has questions about family roles, graduate studies, exercise, and complications. Dr. Lewis concentrates on physical findings and does not explore her emotional response or priorities. This is not patient-centered because the plan is built around disease facts without understanding the person living with the disease. He should acknowledge the diagnosis may feel overwhelming, ask what concerns her most, and agree on a manageable first set of actions.

Failure of Team-Based Care

Mrs. Jones could benefit from diabetes self-management education and support, nutrition counseling, medication review, and evaluation of emotional wellbeing. The ADA recommends developmentally and culturally appropriate diabetes self-management education that supports informed decisions, self-care, problem-solving, and collaboration (ADA Professional Practice Committee, 2026b). A behavioral-health referral may be appropriate if distress, depression, or anxiety is identified, but it

should not be offered simply because she expresses normal concern. The primary clinician remains responsible for coordinating the plan.

Failure to Translate Evidence

“Watch your diet” is vague and potentially stigmatizing. Mrs. Jones needs individualized discussion of eating pattern, medicines if prescribed, physical activity safety, monitoring, sleep, and follow-up. Advice should account for culture, budget, schedule, and preferences. She should know that type 2 diabetes is manageable and that complications are risks to be reduced, not inevitable punishment.

Failure of Informatics

The original scenario describes paper records and uncertain registry data. Without a reliable system, the clinic cannot verify the number of patients served, track results, identify overdue follow-up, or measure outcomes. A functioning registry could flag Mrs. Jones for education, retinal and kidney assessment when appropriate, cardiovascular risk management, and continuing review. The system must use accurate data and clear ownership. Entering a task is not the same as completing it.

Failure of Quality Improvement

The clinic receives monthly reports that staff distrust, suggesting data-quality or workflow problems. A quality-improvement team should map how information is collected, identify missing or duplicated fields, compare reports with source records, and test a corrected process. It should also measure result-notification time, follow-up completion, access to education, patient understanding, and disparities. The aim is not to make the numbers appear higher; it is to ensure they represent actual care.

A Competency-Based Plan for Mrs. Jones

The improved visit would begin with confirmation and explanation of the diagnosis in plain language. Dr. Lewis would assess immediate symptoms and safety, ask what Mrs. Jones understands, and invite her priorities. They would discuss evidence-based options and agree on initial goals rather than attempt to solve everything at once. Teach-back would confirm the plan. Written and digital information would be accessible and consistent.

A coordinated referral would connect her with diabetes education and nutrition support. Medication and monitoring decisions would be individualized. The team would assess emotional distress, financial or schedule barriers, family support, sleep, and activity. Follow-up would be scheduled before she leaves, with clear instructions for urgent symptoms. The electronic record would document responsibilities and support reminders without replacing human contact.

Professionalism and Ethics Across All Competencies

Professionalism includes honesty, confidentiality, respect, boundaries, competence, accountability, and commitment to equity. It connects the five competencies. Patient-centered care without evidence can expose people to ineffective treatment. Evidence without communication can become coercive. Informatics without privacy can cause harm. Teamwork without accountability can allow tasks to be lost between members. Quality improvement without ethics can manipulate metrics or treat patients as data points.

Professionals should recognize the limits of their expertise and seek consultation. Continuing education is necessary because knowledge and technology change. Reflective practice helps identify how assumptions about race, gender, income, disability, body size, or education influence interaction.

Conclusion

All health professionals should be able to provide person-centered care, work in interprofessional teams, use evidence-based practice, apply quality improvement, and use informatics. These competencies are connected rather than independent. The Mrs. Jones case shows what happens when a diagnosis is communicated without exploring the patient's goals, coordinating education, supporting emotional needs, or using reliable information systems. A stronger response explains the diagnosis, confirms understanding, involves Mrs. Jones in decisions, connects her with an appropriate team, and monitors both clinical and quality outcomes. Technical expertise remains essential, but modern healthcare quality depends on how knowledge is communicated, coordinated, measured, and adapted to the life of the person receiving care.

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