

assess its organizational health. The present moment was chosen for this analysis because, in fact, STFM is quite healthy and thinking about how to best take advantage of this in light of some organizational transitions (eg, losing one CAS representative on the board).

Just as we compare a patient's health to a set of standards and goals, STFM will be comparing its governance structure to a set of standards referred to as "performance requirements." The performance requirements were recently developed by the governance task force and approved by the STFM Board of Directors. They are informed by STFM's mission and values and highlight the need to be responsive to STFM's strategic plan.

The next step for the governance task force will be to compare STFM's current governance structure (what is) with the approved performance requirements (what should be). This will identify problems or gaps: critical differences between what is and what should be. The gaps will be presented to the Board when it meets in May 2013.

After the gaps are identified and agreed upon by the Board, the task force will develop potential solutions to the identified gaps. Those solutions will be shared with the STFM community: elected and appointed leaders and the general membership. By allowing for broad-based input, STFM will increase its chances for developing the best solutions to the identified problems.

STFM is committed to make those changes that will result in the most responsive and effective organization possible. While change for change's sake will not happen, STFM will not shy away from making change where needed. The process will be improved with thoughtful input from STFM's leadership and its members.

If you have any questions or comments please feel free to contact me at vgorksi@montefiore.org or STFM Executive Director Stacey Brungardt, CAE at sbrungardt@stfm.org.

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prepare medical students to function collaboratively on health care teams that include other health professionals. Members of the health care teams from other health professions may be either students or practitioners."

The rationale for this new standard is that interprofessional education (IPE) and practice leads to improved patient outcomes, enhanced safety and quality of care.¹

The broader range of competencies required for interprofessional collaboration (beyond the common competencies for health care professionals and the individual competencies specific for various disciplines) include interprofessional communication and teamwork around patients and populations, specific values and ethics, and roles and responsibilities for collaborative practice.² "Interprofessionalism" has been defined (Amour and Oandasan 2005) as the "...process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population;... [it involves] knowledge sharing...optimiz(ing) the patient's participation...unique characteristics in terms of values, codes of conduct and ways of working."

IPE is not a new concept:

- The Centre for the Advancement of Interprofessional Education (CAIPE), in 1987 defined IPE as occurring "when 2 or more professions learn with, from and about each other to improve collaboration and the quality of care"³
- Two decades later, Health Canada (with the Association of Faculties of Medicine of Canada) developed a method of integrating IPE into professional accreditation, leading to the formation of the Accreditation of Interprofessional Health Education (AIPHE)⁴
- The World Health Organization (WHO) published their "Framework for Action on Interprofessional Education & Collaborative Practice" in 2010.⁵ They explained, utilizing evidence-based research, how IPE and collaborative practice could become a strategy to transform health systems globally⁶

While IPE has achieved broad support, including reinforcement through the patient-centered medical home model and the Affordable Care Act, commitment to this educational model is not universal. In addition to the "silos" that resist the transformation needed for full scale adoption of IPE, barriers to its adoption include communication, conflict resolution, time constraints, attitudes of team members, and presence or absence of resources like electronic health records.⁵ Evaluation of teaching and learning can include instruments measuring degree of collaboration,⁷ as well as ultimately the effectiveness in improv-



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INTERPROFESSIONAL EDUCATION

The proposed Liaison Committee on Medical Education (LCME) Accreditation Standard ED-19-A states: "The core curriculum of a medical education program must

ing patient outcomes including patient experience, the true reason for interprofessional education.

Family medicine traditionally has been well positioned for collaborative practice and can lead in implementing IPE across the educational continuum. Results from a recent informal survey of family medicine chairs reveal that about one-half of the chairs report having much or very much experience with IPE, with several noting integrated learning at their institutions.

Examples of IPE that include metrics for degree of collaboration and effect on patient experience include:

1. Teams of medical, physician assistant, and social work students assess patients collaboratively in simulated community health center settings, addressing multiple conditions placing the individuals at risk for poor outcomes. Major barriers include scheduling the activity within the confines of their various programs' academic schedules. (Eastern Virginia Medical School)
2. A team of medical and nursing students first evaluate and discuss a patient, then present to their attending and involve pharmacy and/or law students when indicated. The team also conducts a population health project collaboratively with supervision from various appropriate interprofessional attendings. (University of Kansas Medical School at Kansas City)
3. Residents, faculty, and medical students join nursing, pharmacy, and physician assistant students and faculty for Morbidity and Mortality rounds, borne of the need to translate root cause analyses into educational opportunities for each involved discipline for inpatients. Major barrier was scheduling key staff, overcome by support from directors from each program. (Hofstra North Shore- LIJ School of Medicine – Southside Hospital Campus)

Lingard outlined the challenges faced when working within the traditionally hierarchical health care system,⁸ and frequently the need for policy change, to achieve allocation of resources for integrating IPE and practice into the fabric of health care delivery. With WHO's

suggestion that IPE can be instrumental in transforming health systems globally; the benefit of optimal patient participation in their care, enhanced by the perspective of multiple disciplines; and success measured by improvement in the health of patients and populations, the potential for IPE is timely and compelling.

From the WHO to the CAIPE to Health Canada to the AAMC and the LCME, the call for IPE is loud and clear and is exemplified by the LCME rationale for the new IPE standard: "Interprofessional education and practice leads to improved patient outcomes, enhanced safety and quality of care."

Tochi Iroku-Malize, Chris Matson, Josh Freeman, Martha McGrew, and Alan David on behalf of the ADFM Education Transformation Committee

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