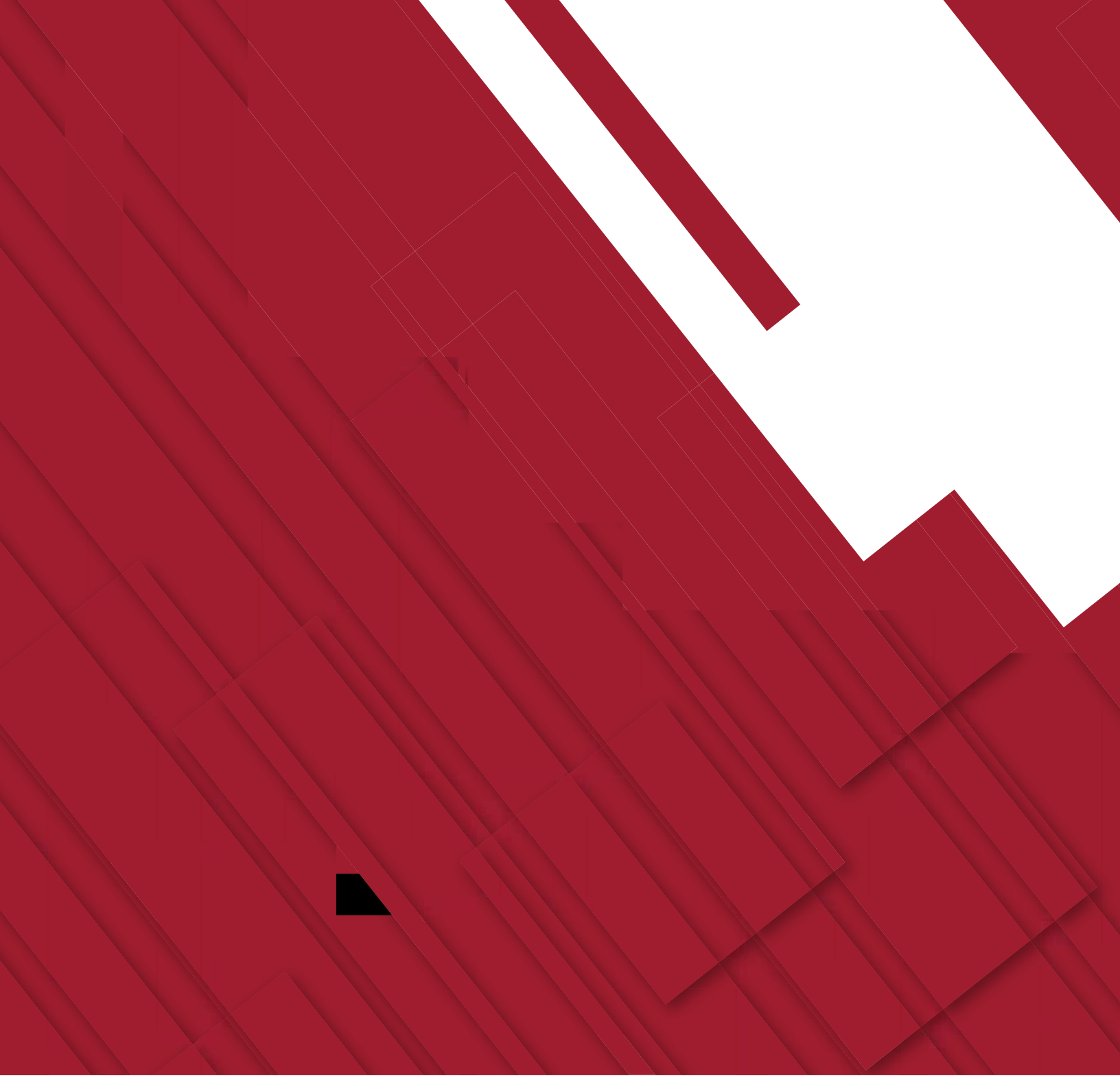

ABSTRACT / ABSTRAIT

The **Canadian Interprofessional Health Leadership Collaborative** (CIHLC) Proposal is a multi-institutional and interprofessional partnership that includes the faculties and schools of medicine, nursing, public health and programs of interprofessional education, representing numerous health care professions. The Collaborative, led by the University of Toronto, consists of five partners: the University of British Columbia, Northern Ontario School of Medicine, Queen's University and Université Laval as regional leads. Each of the regional partners is connected with affiliated networks across multiple sites in Canada, in the United States and globally.

The CIHLC submission is designed to leverage our collective strengths to develop a learner-focused and competency-based educational model focused on ***collaborative leadership for health system change***. The CIHLC is well-positioned to deliver on its proposed initiative. The Canadian national and provincial (state) governments, as well as academic and care institutions in the past ten years, have already demonstrated leadership in interprofessional education and collaborative care at the organizational, practice and policy levels through the development, as well as implementation and evaluation of program initiatives. Many of these initiatives have already been adopted by other countries.

Participating schools within this unique Canadian Collaborative bring diverse areas of expertise and experience in health professional education through learning and innovation within the undergraduate, graduate, postgraduate, continuing education and professional development sectors. Each partner brings exceptional strengths to the Collaborative, such as global networks, regionally-integrated health education and health care systems, cultural translation, interprofessional education, change leadership and training, social accountability, and cultural and clinical competencies.

By exploring and implementing the collaborative leadership competencies, capacities, tools and resources necessary for health systemic change, transformative learning for a new generation of collaborative leaders could result. This would enhance knowledge translation, build capacity for a new health workforce and generate globally-minded leaders guided by social accountability.

La proposition intitulée « **Consortium canadien sur le leadership en matière d'interprofessionnalisme en santé** » (CCLIS) vise un partenariat interprofessionnel entre plusieurs établissements qui inclut des facultés et écoles de médecine, de sciences infirmières, de santé publique et des programmes d'éducation interprofessionnelle dans diverses professions de la santé. Ce consortium, dirigé par l'University of Toronto, est mené par cinq partenaires régionaux : l'University of British Columbia, l'École de médecine du Nord de l'Ontario, la Queen's University et l'Université Laval. Chacun de ces partenaires est à son tour relié à des réseaux affiliés du Canada, des États Unis et du monde.

La présentation touchant le CCLIS a pour but d'exploiter les atouts collectifs afin d'élaborer un modèle éducationnel axé sur les étudiants et fondé sur les compétences, dont l'objectif est d'exercer un ***leadership concerté pour changer le système de santé***. Le CCLIS est bien placé pour diriger l'initiative proposée. Au cours des dix dernières années, les gouvernements canadiens national et provinciaux (des États), ainsi que des établissements universitaires et de soins, ont assuré le leadership en éducation interprofessionnelle et en soins concertés aux niveaux organisationnel, pratique et politique en élaborant, en mettant en œuvre et en évaluant des initiatives. D'autres pays ont déjà adopté un grand nombre de ces initiatives.

De par l'apprentissage et l'innovation au premier cycle, aux cycles supérieurs, dans les études postdoctorales, en éducation continue et en perfectionnement professionnel, les écoles participant à ce regroupement canadien sans pareil apportent de l'expertise et de l'expérience de divers types en formation des professionnels de la santé. Chaque partenaire fait bénéficier le regroupement d'avantages exceptionnels, comme des liens avec des réseaux mondiaux, des systèmes de santé et de formation en santé intégrés à l'échelle régionale, l'adaptation culturelle, l'éducation interprofessionnelle, le leadership et la formation pour le changement, la responsabilité sociale et les compétences culturelles et cliniques.

En explorant et en exploitant les compétences en leadership concerté, les capacités, les outils et les ressources nécessaires pour changer le système de santé, il pourrait être possible d'instaurer l'apprentissage transformatif de la nouvelle génération de chefs de file qui agissent en collaboration. Cela améliorerait le transfert des connaissances, permettrait d'avoir une nouvelle main-d'œuvre de la santé et produirait des leaders guidés par la responsabilité sociale qui pensent à l'échelle mondiale.

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PROPOSAL

APPENDICES - *See Accompanying Document*

1. Overview

The **Canadian Interprofessional Health Leadership Collaborative (CIHLC)** Proposal is a multi-institutional and interprofessional partnership that includes the faculties and schools of medicine, nursing, public health and programs of interprofessional education (IPE), representing numerous health care professions at five universities. The Collaborative, led by the University of Toronto, consists of the University of British Columbia, Northern Ontario School of Medicine, Queen's University and Université Laval as regional leads, as well as their affiliated networks across multiple sites in Canada, the United States and globally. The CIHLC covers a multitude of health care professions and interprofessional teams serving and meeting the needs of diverse and culturally sensitive groups such as Aboriginal, Francophone and inner-city populations. Given the diversity of the programs, the CIHLC is committed to and has capacity for distance education and learning, as well as flexibility in innovative curriculum development, implementation and evaluation.

Each partner within the CIHLC brings unique and specific strengths in their expertise and experience in health education and leadership. They have also worked collaboratively in similar types of initiatives and programs across Canada as well as globally.[1] Institutional leaders, including Dr. David Naylor, President, University of Toronto, among the participating universities in the CIHLC have offered their support for this proposal and have committed to providing funding and resources for its implementation. Appendix A provides a series of letters of support. In addition, the CIHLC has prepared, in principle, a draft memorandum of understanding (MOU) that would immediately be acted upon should it be successful in the IOM Board of Global Health's international call to establish a North American Forum on Innovation in Health Professional Education.

The focus of the CIHLC proposal is on the theme of ***collaborative leadership for health system change***, transforming health and teaching across Canada with approaches that can be transferable globally. The following describes our approach as it relates to the objectives of the IOM Global Health Forum. Our submission is presented in two documents. The first is the main proposal in compliance with the RFP requirements and the second document encompasses all appendices.

2. Canadian Collaborative Proposed Structure

A. The Vision

The CIHLC's vision is:

> *Collaborative Leadership for Health System Change to Globally Transform Education and Health*

There is significant international activity aimed at improving global health.[2] CIHLC partners are developing global health strategies and incorporating them into health education curricula. Our vision of collaborative leadership for health system change builds upon these global initiatives to enable faculty and learners to become collaborative leaders, ultimately improving health outcomes through innovation in research and education. For example, through its global health strategy,[3] developed by the Faculty of Medicine of the University of Toronto, a key aim is to create a strategic and coordinated global health model in the provision and development of diverse, learner-focused education programs. Similarly, at the University of British Columbia, global health courses are offered for students participating in its Faculty of Medicine's Global Health Education Consortium.[4]

The CIHLC has the capacity to focus on the types of collaborative leadership skills and competencies that students and learners require to effectively work in diverse and culturally sensitive environments. The premise is that for transformative change to happen

in education and practice, a new kind of leadership is required to respond to emerging societal trends, such as health disparities and complexity of chronic illnesses, and the movement towards community-centred care. This means that innovation needs to take place at, within, and across health professional education in order to transform change at the health system level through collaborative leadership.

The **purpose and overall goal** of the CIHLC is to create a pan-Canadian collaborative that will act as a central resource and facilitator in the co-creation, development, implementation and evaluation of a global collaborative leadership model.

***Collaborative Leadership* defines a leader who can:**

- Lead change in the face of uncertainty and ambiguity
- Hold multiple lenses and perspectives
- Strengthen and build relationships
- Lead across and navigate complex systems
- Ask questions with a generative and learner lens
- Embraces transformative learning
- Reflect on and sense what is needed most in a system

Source: Collaborative Change Leadership Program, University Health Network and University of Toronto, 2010.[5]

The model will be targeted at health professional learners and it will be able to be adapted and customized for use in any international health care and/or education setting. In creating a transformative collaborative leadership model, the key **objectives** are to:

1. Develop a collaborative leadership model for health system change that can:

    b. Identify collaborative leadership competencies required to build teamwork across health professions and health care workers in community, hospital and primary care settings;

    c. Identify the collaborative leadership competencies that will be required for health system change;

    d. Develop a collaborative leadership curriculum that is flexible and meets clinical, regional, local, cultural and global needs;

    e. Ensure that the leadership curriculum will meet the common accreditation standards to be applied for all health professions; and

    f. Address the needs of educators and learners by identifying the resources, infrastructure and supports needed in order for them to become collaborative leaders.

2. Build and leverage existing partnerships within Canada and abroad that will be enhanced through the facilitation and implementation of collaborative leadership programs and knowledge translation.

3. Utilize existing IT mechanisms (e.g., video conferencing, multi-disciplinary simulation, online resources) and social media to maximize cost-effective methods to effectively support communities in leadership training.

4. Develop an evaluation framework that measures planned and emergent change at the educational, practice and system levels.

The CIHLC objectives are designed to develop a generic and flexible collaborative leadership model that would encompass a series of programs that will:

- Leverage current training programs within the Collaborative that have already been successful in their local context;
- Identify trends in collaborative leadership research;
- Allow for customization for rural, urban, and geographically diverse settings;
- Address education gaps in leadership across the health professions;
- Enable curricular reform that will:
    - Include collaborative leadership competencies, based on the definition of collaborative leadership, covering supervision, interprofessional and provider-patient

communications, clinical medical ethics, and clinical analytical skills that are evidenced-based—areas that are in alignment with the suggested IOM projects;

  - Address emerging population health that include social, cultural diversity and health disparities in order to identify learning opportunities through community engagement;
  - Address emerging health system changes in service delivery; and
  - Embed interprofessional education.

- Support evaluation and performance measurements of efficacy and outcomes; and
- Ensure sustainability for health system change and reform using key performance indicators.

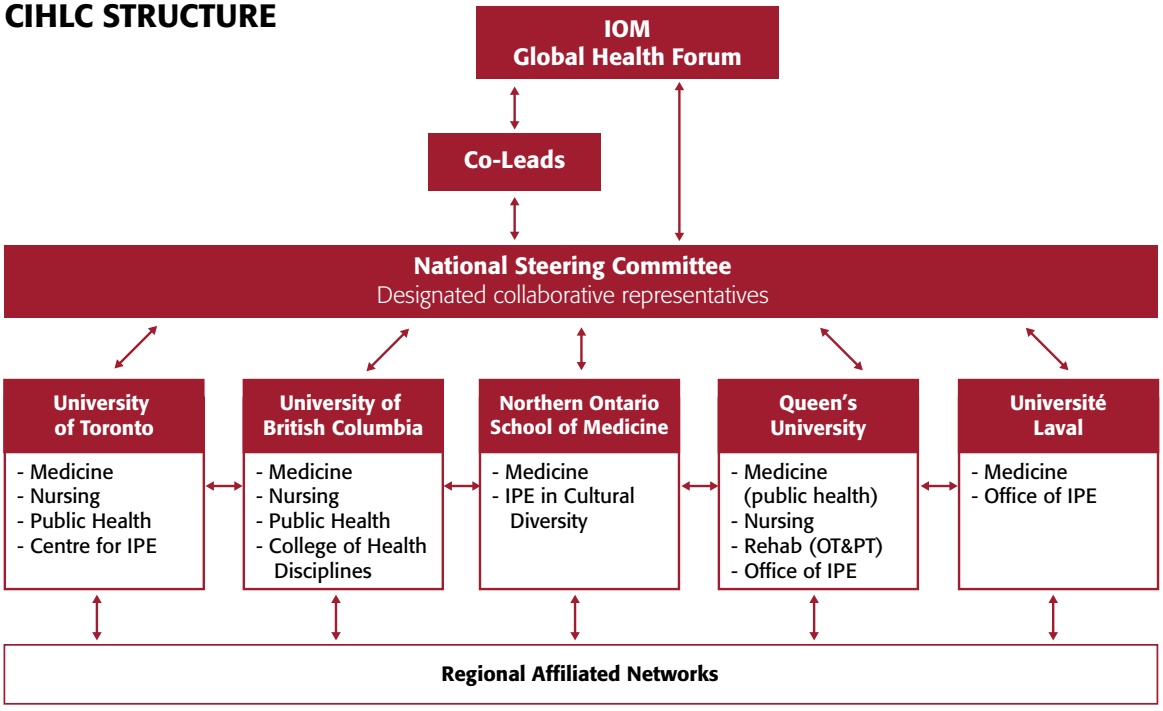
The CIHLC is unique in that it will effectively use its connections and collective accomplishments to develop a collaborative leadership training model for use across countries and complex health care systems.

B. Structure

The structure shown below will enable the CIHLC to achieve its objectives.

Reporting to the IOM Global Health Forum, the National Steering Committee is composed of six individuals from each university partner who are the designated innovative collaborative representatives for the North American Forum. The Committee will be led by two nominated leaders from the University of Toronto. The structure identifies the participating schools among each of the universities. Each university that is identified has formal partnerships within its own institution among its schools of medicine, nursing, public health and IPE. There are also existing partnerships within the five universities. For example, the Northern Ontario School of Medicine (NOSM) has a formal memorandum of understanding with the University of Toronto on its collaborative efforts in education and research initiatives. Each partner represents a region within Canada in the context of their regional and local affiliated networks. For example, the University of British Columbia covers western Canada, NOSM covers northern rural communities, University of Toronto in their affiliation with some universities in the Atlantic region, Queen's University in central Ontario and Université Laval in the province of Quebec. All of the universities are affiliated with national organizations and their regional counterparts such as the Association of Faculties of Medicine of Canada,[6] the Royal College

CIHLC STRUCTURE



of Physicians and Surgeons of Canada,[7] the College of Family Physicians of Canada,[8] the Canadian Interprofessional Health Collaborative,[9] Accreditation of Interprofessional Health Education,[10] Canadian Association of Schools of Nursing,[11] Association of Canadian Academic Healthcare Organizations[12] as well as regional health authorities. Each university has many partnerships with US and international universities. For example, the University of Toronto is partnered with the University of Indiana related to global health initiatives[13] and it has supported many American universities in their development of IPE programs (i.e., Connecticut, Minnesota and Virginia).

The University of British Columbia and Queen's University have partnered with interprofessional collaborative initiatives in the UK, Australia and New Zealand.[14,15]

CIHLC covers a multitude of health care professions and interprofessional teams serving and meeting the needs of diverse and culturally sensitive groups such as Aboriginal, Francophone and inner-city populations. In addition to the diversity of the programs and partnerships among the CIHLC institutions, there is a strong collective capacity for distance education and learning, as well as flexibility in curriculum development, innovation and evaluation.

3. Collaborative Leadership

The CIHLC proposes that the IOM consider a co-leadership model for this initiative. Leadership is a shared responsibility and therefore having co-leads allows the CIHLC to demonstrate co-ownership, mentorship, continuity, progressive leadership development and transparent collaboration across the multiple health professions that will form this pan-Canadian partnership. To this end, we collectively propose two individuals to co-lead the CIHLC: Dr. Sarita Verma, Deputy Dean, Faculty of Medicine & Associate Vice-Provost, Health Professions Education at the University of Toronto, and Ms. Maria Tassone, Director, Centre for Interprofessional Education, University of Toronto and Lead, Interprofessional Education and Care, University Health Network, whose resumes are in Appendix B.

This co-leadership model, endorsed by the National Steering Committee, is critical for a number of reasons: (1) the nature of interprofessionalism articulated by the IOM call will be successfully modeled given the fact that Dr. Verma is a physician and Ms. Tassone a physical therapist; (2) Dr. Verma is a well-established senior academic leader, who from a succession planning perspective at the university, will mentor Ms. Tassone as an emerging senior leader at mid-career; and (3) Dr. Verma represents the decanal level of the university and the ability to mobilize the resources necessary to advance this project, while Ms. Tassone represents leadership and content expertise in IPE and collaborative leadership programming.

Other designated lead institutional representatives are:

- Dr. Lesley Bainbridge, Director, Interprofessional Education, Faculty of Medicine, University of British Columbia
- Dr. Margo Paterson, Professor, Occupational Therapy Program and Director, Office of Interprofessional Education and Practice Queen's University
- Ms. Sue Berry, Assistant Dean of Integrated Clinical Learning, Northern Ontario School of Medicine
- Dr. Serge Dumont, Director, Office of Interprofessional Education, Pavillon Charles De-Koninck, Université Laval

Resumes of these representatives are in Appendix C and their joint letter of commitment to the CIHLC initiative is in Appendix D. These representatives are the key contacts for their respective universities including the faculties and schools of medicine, nursing, public health and programs of IPE. Their direct contact information is in Appendix E.
We acknowledge the IOM requirement is to put one name forward for the IOM Global Forum, and we are prepared to do so. If this is the case, then the CIHLC nominates Dr. Sarita Verma.

4. Implementation of the Canadian Collaborative

Over the next five years, the CIHLC will conduct several phases of work.

Phase 1 will engage the core partners in finalizing the draft MOU and establishing a secretariat infrastructure that will function at the University of Toronto. As this organizational implementation work is underway, the National Steering Committee will confirm levels of interest among Canadian, regional and international groups who wish to be involved in this initiative and the key informants to be invited to a consultation process in the next phase.

In ***Phase 2***, a comprehensive literature review will be conducted of both peer-reviewed and grey literature to establish the level and rigour of evidence related to leadership, collaborative leadership and health system change. Secondly, an environmental scan of collaborative leadership models will be conducted that includes an international survey and a series of regional consultations with schools of medicine, nursing, public health, business and programs of IPE. The scan will identify any existing innovative and transformative programs of leadership training within and external to health care as well as identifying best practice examples at both entry and post licensure levels. Best practice models and evidence from the literature review will be triangulated with regional, national and international experiences of collaborative leadership. Results of the survey and consultations will assist in conducting a needs assessment. During this phase, the evaluation framework will also begin to emerge, identifying key indicators that can be measured over time in both the leadership and the system contexts.

Phase 3 will focus on the development of a continuum of collaborative leadership modules, made up of the best practices identified in Phase 2 and new training modules that would be developed during this phase. New modules will be tested in a variety of contexts (i.e., academic, clinical and cultural) before finalization. Experiential learning, in both education and practice sectors, will be key to this training. Bringing students and educators together with practitioners and patients in clinical settings to develop a collaborative leadership model could enable the use of quality improvement as an anchor for collaborative leadership training in a relevant and real world setting.

A community of practice will be used to link the students, educators, practitioners and patients to share the lessons learned and to provide individual and organizational support. Tools for learning collaborative leadership will be developed using complex systems. Co-creation of the models with international partners identified in Phase 1 will assure cultural verification of the educational continuum and learning approaches.

In ***Phase 4*** the whole model will be rolled out through a number of local, regional and international partners. A comprehensive evaluation will be evident as part of Phase 4.

In the final ***Phase 5***, the complete model, comprising a continuum of modules, will be packaged for use and adaptation in any context and any region. Evaluation indicators and tools will be included so that users can effectively assess the impact of the collaborative leadership training program on health systems

globally. Please refer to Appendix F for an in-depth logic model of the implementation approach.

Leaders within the CIHLC will play a key role in the creation, implementation, evaluation and knowledge translation of this initiative. Participating partners within this unique collaborative bring varied levels of leadership, expertise and experience in health professional education through learning and innovation within the undergraduate, graduate, postgraduate, continuing education and professional development sectors. Each partner brings exceptional strengths to the collaborative, such as global networks, regionally-integrated health education and health care systems, IPE, change leadership and training, social accountability, and cultural and clinical competencies.

Both common and specific strengths are highlighted in the *Table 1* below.

A core strength among the university partners is the embedded and established competency-based IPE curricula and the collaborative partnership that currently exists across Canada on interprofessional competency development. For example, in 2001, UBC was the first Canadian university to establish a College of Health Disciplines whose development of an IPE pathway enables its IPE innovations to be used by all health and human service programs, as well as health authorities for practicing clinicians and leaders. A mandatory small group, case based learning experience modeled on "The World Café" approach is used at Queen's for all first year students in the Faculty of Health Sciences to explore professional roles, client/patient engagement in health care teams and decision making. These examples illustrate the capacity of the CIHLC to deliver on its objectives and implement its proposed collaborative leadership model.

Table 1

CIHLC Partners Common/Unique Strengths	Specific Strengths
• Existing infrastructures of schools of multiple professions in medicine, nursing and public health for health education and global health • Curriculum reforms in future education of professions[16,17] • Academic and community health sciences networks[18] • Affiliation agreements with local clinical sites, hospitals and communities and international • Well-established competency-based IPE curriculum[19,20,21,22] • Piloted teaching projects and programs in community and complex health, primary health care, determinants of health and chronic disease management that can be transferable globally[23,24,25,26] • Adoption of collaborative models and frameworks by other countries[27,28] • Faculty centres on research in education, teaching and learning[29,30] • National and regional collaborative health infrastructures[31,32,33,34]	• Collaborative Change Leadership programs (UofT & UBC)[35,36,37] • Explicit social accountability mandate (NOSM) • Cultural competencies in team building given the cultural diversity and health outcome disparities in Aboriginal, Franco-Ontarian, Rural and Remote communities[38] (NOSM) • Distributed model of community engaged medical education delivered through integrated use of information technology (NOSM) (UBC)

5. Budget and Resources

To date, the partners of CIHLC, who are faculty members, researchers and administrators have already contributed in-kind resources (i.e., faculty time and effort in curricula infrastructure to the coordination of the CIHLC) and will continue to do so should the CIHLC be selected by the IOM. The partners will be finalizing a draft MOU that will include funding in which partners will share in the costs of establishing and sustaining a secretariat to support the CIHLC over 5 years. The budget to implement the CIHLC is estimated at $300,000 per annum. A refined budget plan can be developed following further consultation with the IOM Board on Global Health. Among the CIHLC partners, resources and/or funding will also be provided by the Deans, across the schools, as they have provided their letters of support and commitment. (See Appendix A). Other sources of funding can also be provided by affiliated networks, health ministries of national and provincial governments as well as national and regional research institutions,[40] who have previously provided funding on projects as they relate to health education and global health. The University of Toronto, who will provide additional funding sources to house the secretariat on its campus, will be responsible for managing all funding resources related to the CIHLC and its activities.

6. Alignment with Lancet Commission

There are existing frameworks and programs that have articulated and implemented IPE and collaborative care at the organizational, practice and policy levels[41,42,43,44,45] within the education and health care systems across Canada. The concept of ***collaborative leadership for health system change*** is based on the Canadian Interprofessional Health Collaborative's paper entitled "A National Interprofessional Competency Framework".[46] Within this framework, it defines collaborative leadership as one of six key competency domains to enable interprofessional care. Descriptors that support the domain include the ability of learners and practitioners to (a) work together with all participants, including patients/families, to formulate, implement and evaluate care/services to enhance health outcomes; (b) support the choice of leader depending on the context of the situation; and (c) assume shared accountability for the processes chosen to achieve outcomes. In a shared leadership model, patients may choose to serve as the leader or leadership may move among learners/practitioners to provide opportunities to be mentored in the leadership role. This is an anchor and starting point describing potential curriculum content, learning strategies, learning outcomes and methods to determine if collaborative leadership practice competencies are an outcome. It provides structure for continuing faculty development so that learning facilitators are aware of the different processes they need to acquire in order to teach collaborative leadership.

In Canada, there are examples of collaborative leadership initiatives for health system change, such as transformative work in chronic disease management and social determinants of health that create the linkages among nursing, public and community health,[47] building primary health care systems,[48] leadership capacity framework,[49] and collaborations for system-wide change.[50]

These examples could form part of the building blocks in addressing population health needs and could be adapted globally as part of the CIHLC as well as addresses some topic areas outlined in the piloted projects as suggested by IOM in its RFP. The CIHLC initiative supports the objectives outlined in the Global Health (Lancet) Report as noted in *Table 2* on page 11.

The CIHLC also supports the recommendations of the RWJ-IOM Report on the *Future of Nursing: Leading Change, Advancing Health*[51] in removing scope of practice barriers, expanding opportunities for health professions to lead and diffuse collaborative improvement efforts, preparing and enabling the health workforce to lead change to advance health and build an infrastructure for data of interprofessional health care workforce.

Table 2

IOM Global Health Objectives		Canadian Collaborative
Instructional Reforms		
1. Adopt a competency-based curriculum	√	Competency-based leadership curriculum
2. Promote interprofessional and transprofessional education	√	Adoption of core principles
3. Exploit the power of IT for learning	√	eCommunity of Practice for communication; social networking analysis for measuring change
4. Harness global resources and adapt locally	√	Co-creation of leadership series with international colleagues
5. Strengthen educational resources	√	Comprehensive leadership series packaged for flexible and global use
6. Promote new professionalism	√	New wave of professionalism across health professions
7. Establish joint planning mechanisms	√	Webinars, video conferences
Institutional Reforms		
8. Expand from academic centres to academic systems	√	Expand to integrated academic systems
9. Link through networks, alliances and consortia	√	Use of national networks such as Canadian Health Leaders and Canadian Health Association
10. Nurture a culture of critical inquiry	√	

7. Information Technology Capabilities

All the partners of the CIHLC have the IT capacity to develop and implement effective technology enabled tools for learning and communication in IPE. This includes web conferencing, digital online resources and curriculum, and web broadcasting. For example, NOSM was the first medical school in Canada to be established in an age of technology enhanced learning and its ability to deliver undergraduate and postgraduate medical programs in more than a hundred locations over 800,000 square kilometres of this remote and rural area which is intrinsically linked to the use of information communication technologies. The UBC Faculty of Medicine works in collaboration with more than 4,000 clinical faculty and other universities, hospitals and health authorities to make distributed learning a reality.

This province-wide approach is made possible through a robust information technology system that allows instructors and students in several disparate locations to interact, taking learning beyond classrooms and into clinics and hospitals, whether they are in urban or rural areas in the province. The IT capacity among the CIHLC partners can be adapted globally. Associated costs for IT capacity and use related to CIHLC activities will be contributed in-kind by the university partners.

8. Description of Canadian Partners

University of Toronto – Faculty of Medicine

Brief History of Faculty

Founded in 1843, the Faculty came onto the world stage with Sir Frederick Banting and Charles Best's discovery of insulin in the 1920s. In the 1950s, the implantable cardiac pacemaker was invented and in recent years, the Faculty has led the way to link genes to diseases such as muscular dystrophy, cystic fibrosis, Alzheimer's disease and the discovery of stem cells in 1963. The Faculty offers health professions programs in Undergraduate Medicine, Postgraduate Medicine, Continuing Education and Professional Development, among various health disciplines including the Public Health (Dalla Lana School of Public Health), at a variety of academic levels.

Government Status

Publicly funded and overseen by the Council of Ontario Universities.

Annual Teaching Budget and its Sources

While the overall budget for the Faculty is $300 million, $201 million is allocated for teaching. Funding is provided by the Ontario government, tuition fees and endowments. The Faculty's overall research funding budget is $626 million through hospital research institutes and research grants.

Size of the Research and Clinical Faculty

The Faculty is 28 Departments, 2 Institutes and one School of Public Health, 4 Faculty Sectors, 15 Extra-Departmental Unit (EDU) Centres and Institutes, 3 second entry undergraduate programs, 74 MD residency programs, 13 graduate programs, 2859 full-time faculty as well as approximately 3,000 part-time, status-only and adjunct academic appointees. The total academic faculty is 5,822.

Size of the Student Body

The student body consists of 963 undergraduate students, 2,828 graduate students, 1,766 residents, 1,432 postdoctoral fellows and 1,130 clinical fellows. The Faculty's education and research programs serve more than 6,800 students and trainees including undergraduate and graduate programs, postgraduate clinical training and post doctoral research fellowships. There is an additional 22,000 which are continuing education registrants.

School's Accreditation Status

The Faculty is accredited by the Association of Faculties of Medicine (Liaison Committee on Medical Education/Committee on Accreditation of Canadian Medical Schools). The Faculty is fully accredited until its next site visit in May 2012.

Overview of the Curriculum

The undergraduate medical education (MD) program is four years in length. It consists of two years of preclerkship and two years of clerkship. In the preclerkship, students learn in a variety of settings (lecture theatre, small group classroom, anatomy laboratory, patient's bedside, community) about the full range of topics before moving to clinical training. In clerkship, third year students spend between 1 to 8 weeks on clinical rotations in various disciplines. In the fourth year, students have the opportunity to pursue a variety of electives in order to explore in greater depth areas of particular interest, especially for purposes of career selection. Student activities are guided by the CanMEDS competencies and the four principles of family medicine.

Interprofessional Curricular Activities/Initiatives

In 2005, the University of Toronto (UofT) Council of Health Sciences established an Office of Interprofessional Education (IPE) at the University to develop a competency-based and longitudinal IPE Curriculum for 1,200 students annually. In 2009, in partnership with the University Health Network and the Toronto Rehabilitation Institute, the Council established The Centre for IPE to advance both IPE and care. The Centre's mandate is embedded in the curriculum across the multiple health science faculties representing 11 health science professions. A major initiative is the annual Interfaculty Pain Curriculum since 2002. This program involves a one-week period

of instruction using large group sessions and problem based learning groups for health science students. All health science students are required to complete the IPE Curriculum which is currently comprised of over 50 learning activities. Additional information on the Centre can be found at http://www.ipe.utoronto.ca/

Clinical Settings Used for Teaching

Within the Faculty, the health professions programs are delivered across the University's three campuses in the Greater Toronto Area, the twelve fully affiliated hospitals and 19 community affiliated sites, and health care organizations. The Faculty joins twelve fully affiliated hospitals, each with its own research institute and foundation, to create the Toronto Academic Health Science Network (TAHSN) (www.tahsn.ca).

Nature of the Three Most Important Health-Related, International Clinical, Teaching or Research Partnerships in Existence at the University

1. **AGAP (Strengthening Primary Health Care Management)** was a partnership between Brazil and Canada that has benefited four low-income states in the north-eastern region of Brazil. Health managers in Alagoas, Ceará, Paraíba, and Piauí participated in a modular course focusing on strengthening the management of primary health care (PHC). The AGAP training program is based on the multiplier model and is designed to adapt to local needs and resources as wells as contribute to the improvement of state-specific health indicators including maternal and infant mortality, tuberculosis and mental health. Over 180 health managers and coordinators from both state and municipal levels developed 41 local interventions that affected 650 family health units throughout the region.

   See http://www.youtube.com/watch?v=A8JR_4u9SXo or visit the website at www.agapbr.org.

2. In 2007, the Department of Obstetrics and Gynaecology at the UofT partnered with the Department of Reproductive Health at Moi University in Eldoret, Kenya. This partnership, now known as **AMPATH Reproductive Health** (www.ampath-uoft.ca) is in collaboration with the UofT's Faculty of Medicine and is being facilitated through the AMPATH Consortium, a longstanding partnership between Moi University and other North American academic institutions, led by the University of Indiana (www.ampathkenya.org). This partnership is to support the existing infrastructure to improve the quality of women's and reproductive health care in western Kenya. Supporting the infrastructure also includes Moi Teaching and Referral Hospital and Health Centres in its catchment area, education at Moi University School of Medicine, including the establishment of post-graduate programs in medicine, public health and research with faculty, staff and students at the tertiary level program of study. To date, the ASANTE Consortium has been a successful partnership involving Moi's departments of general medicine, paediatrics and HIV/AIDS (including the rapid scaling-up of anti-retroviral therapy for HIV positive patients).

3. **Toronto Addis Ababa Psychiatry project** (TAAPP) – an eight year collaboration between the UofT and Addis Ababa University (AAU) Departments of Psychiatry produced an effective model for accelerating the creation of medical specialists in Ethiopia. This model has been adopted and is managed by AAU, with a mandate from the Government of Ethiopia to train medical, health and other specialists at a Master's and PhD level, to expand the health and university systems. The model involves six faculties at UofT and this partnership is enabling Ethiopians to train in-country so that a critical mass of medical specialists, subspecialists and PhD level health related and other academics, graduate in Ethiopia. Establishing a critical mass of specialists is important in developing and sustaining a comprehensive health care system that will also allow development and support of the complementary and allied health care professions including Ethiopia's community health care workers. As well, Ethiopia will have the ability to provide multidisciplinary faculty for their new universities (expanding from six to 31 in the near future).

University of Toronto – Faculty of Nursing

Brief History of Faculty

The Faculty has a long history of innovation and establishing Canadian 'firsts'. The Department of Public Health Nursing was established by educational innovator Miss E. Kathleen Russell in 1920 as part of the Department of Public Hygiene. Founded as a visionary initiative with strong support of the Rockefeller Foundation, the department was considered an experiment in educational science to build upon the traditional hospital-focused training of nurses to include social welfare and public health education. This initiative was in direct response to increased demand for public health nurses following the Spanish Influenza pandemic of 1919. These new public health nurses required preparation beyond what was available through hospital-based schools of nursing. The 3-year school evolved into a 4-year BScN degree program in 1942. The School developed a master's program in 1970 which led to Faculty status in 1972 and the PhD program followed in 1991. In 2001, the Faculty established a major new role for nurses through its Master of Nursing Acute Care Nurse Practitioner Program. The Faculty has a long history of educating nurses at the baccalaureate undergraduate level, and is renowned internationally for its educational programs and the quality of nursing research conducted by its faculty members. The Faculty is now known as The Lawrence S. Bloomberg Faculty of Nursing.

Government Status

Publicly funded and overseen by the Council of Ontario Universities.

Annual Teaching Budget and its Sources

The annual budget for the Faculty is $12 million primarily from endowments and donations.

Size of the Research and Clinical Faculty

The overall faculty is 400 with the breakdown of 50 appointed faculty, 275 clinical appointments, 100 clinical Instructors and 75 graduate preceptors.

Size of the Student Body

The BScN second-entry program is 170 students for the first year, 170 for the second year, 250 in the masters programs (125 nurse practitioners, 75 clinicians, and 50 administrators) with 40 in the Post Master's Nurse Practitioner program and 70 in the PhD program.

School's Accreditation Status

The undergraduate program is fully accredited by Canadian Association of Schools of Nursing in 2011 until 2018. The graduate program is accredited until 2014.

Overview of the Curriculum

The two year Bachelor of Science in Nursing prepares students to work with diverse populations, and to practice under the supervision of highly qualified professionals. In the first year, study is focused on the theory, research, and practice relevant to the care of patients including health and assessment skills, therapeutic communication, discipline and professional issues. In the second year, students are to take courses on professionalism and politics, and advanced nursing theory. This includes the complexity of persistent illnesses and primary health care. In preparation for independent practice after graduating, students will undertake a four-month continuous integrative clinical practicum at the end of the program. The Post-Master's NP Diploma is an innovative 20-month (Part Time) program designed to afford students who have completed graduate education the opportunity to develop the knowledge and skills required to practice as a Nurse Practitioner.

Interprofessional Curricular Activities/Initiatives

The Faculty has been involved with the Centre for IPE on its interprofessional, mentoring, preceptorship, leadership, and coaching program. This initiative is a collaborative partnership between the University and the Toronto Academic Health Sciences Network (TAHSN) that enable nurses in teaching hospitals to become active interprofessional

care learning laboratories for future generations of health care providers and plan for the future of interprofessional care (IPC) across the hospital sector.

More information can be found at http://www.ipe.utoronto.ca/initiatives/ipc/implc/

Clinical Settings Used for Teaching

Most of the training and education programs are conducted on clinical sites across the greater Toronto area and in Ontario that include hospitals, community centres, home care, public agencies, schools, Aboriginal reserves and in some care international clinical placements such as in India.

Nature of the Three Most Important Health-Related, International Clinical, Teaching or Research Partnerships in Existence at the University

1. **Nursing Leadership and Capacity Building in Primary Health Care**: A Brazilian and Canadian Partnership. This first ever nursing collaboration in primary health care (PHC) between the UoT and Brazilian Ministry of Health, health secretariats, and university partners in the Brazilian states of Acre and Mato Grosso do Sul will advance leadership and build capacity for the development of nursing professionals. This project provides nurses to enhance their capacity and leadership in order to fully realize their role as core primary health care professionals. Leadership will be fostered by providing practice-relevant and research-based education and training to nurses who oversee the planning, implementation, and evaluation of PHC programs in the aforementioned States. The program addresses issues of health inequity by developing PHC infrastructure. Family health practitioner teams currently provide community-based health care to almost 50% of the population in Brazil, with the goal of reaching 80%. Each team consists of a registered nurse, a physician, nurse auxiliaries and community workers and each team can care for up to 1,000 families.

   For more information go to: http://bloomberg.nursing.utoronto.ca/International_Office/BrasilBloomberg_Nursing_Collaboration.htm.

2. **Catholic Health Association of India and Faculty of Nursing**: These organizations have been working together to serve rural communities' lack of physicians and nurses. The Catholic Health Association of India proposed the development of a 1st Nurse Practitioner/ Primary Health Care course to address the shortage of healthcare workers in rural India. The main goal of this collaboration is for a reciprocal partnership in global health education for CHAI nurses and UoT nursing students.

   More information is available at http://www.chai-india.org/.

3. **Faculty of Nursing and Schools of Nursing at the University of Lleida, Lleida, Spain and the University of Tarragona, Tarragona, Spain**: The partnership is an exchange of academics for graduate education and collaborative research projects in the areas of community health (immigration as a social determinant of health), and clinical interventions (sleep disturbances among family caregivers). Areas of research at the University of Lleida are: 1) aging and psychosocial care, 2) clinical and epidemiological nursing, 3) quality of life, and 4) health promotion and education. Areas of research at the University of Tarragona are: 1) care-giving representations and practices, 2) family and community nursing, 3) health economics, 4) chronic pain, 5) psychosocial occupational health, 6) mental health and addiction, 7) health services management, and 8) women's health and gender, including nurses' health.

   See the following links for more information. www.eui.udl.es, www.masterinfermeria.udl.cat and/or wwwa.urv.net/centres/infermeria/ca/

Brief History of Faculty

The first generation of the School emerged in 1925-27 during the public health movement that led to the Rockefeller Foundation supporting three new public health schools at Harvard, Johns Hopkins and the School of Hygiene at the University of Toronto (UofT). Until 1975, the School of Hygiene was a major focus of public health and academic training. In 1975, the School merged with the Departments of Preventive Medicine and Behavioural Science in the Faculty of Medicine. In 1997, further merger of this Department with Biostatistics launched the Department of Public Health Sciences. In 2008, the Dalla Lanas donated $20 million to the University of Toronto's newly established School of Public Health. The School's mandate focuses on leadership in innovative, interdisciplinary research in public health, population health and health promotion. With over 300 faculty members from a wide range of disciplines, the School represents the largest concentration of academic population and public health researchers in Canada. The School has a partnership with the Department of Health Policy, Management and Evaluation on global health strategies and leadership.

Government Status

The Ontario Council of Graduated Studies within the Ontario Ministry of Training, Universities and Colleges approves the programs within the School.

Annual Teaching Budget and its Sources

In the last 5 years, 411 projects have been initiated or completed with total funding of $132,510,012. The majority of these funds were directed to the School where faculty perform their research. The amount directed to the School was $42,545,489. Funding is primarily funded through research grants and endowments. In 2008/09, total research funding in the School was in excess of $30 million.

Size of the Research and Clinical Faculty

Of the 316 faculty engaged at the School, 55 faculty are described as core, that is they hold their primary appointment in the School and are tenured/tenure stream. Composition of faculty includes 28 contractually-limited term appointed (CLTA) faculty, 178 status-only faculty, 14 adjunct faculty and 73 faculty cross-appointed from other departments in the University.

Size of the Student Body

The School has close to 400 graduate students enrolled in the School's doctoral and professional masters programs.

School's Accreditation Status

Currently, there is no Canadian process for accreditation. The Dalla Lana School of Public Health will be considering eligibility for accreditation by the US Council on Education for Public Health.

Overview of the Curriculum

The School offers doctoral training to prepare students for independent research and academic careers in the public health disciplines. There are currently three fields of study in the PhD program in biostatistics, epidemiology and social and behavioural health sciences. It also offers two professional master's programs designed to prepare public health practitioners, educators and researchers for careers in public health that includes epidemiology, community nutrition, occupational and environmental health, social and behavioural sciences and health (health promotion), and family and community medicine. The School also offers a Collaborative Doctoral Program in Global Health, through its Global Health Education Institute, that focuses on the relationships among local, regional, national, and international forces and factors that influence health.

See http://www.phs.utoronto.ca/PhD_Global_Health.asp

Interprofessional Curricular Activities/Initiatives

The approach to Global Health at the School is interdisciplinary and integrative. Global health focuses on the inter-relationships among local, regional, national and international factors influencing health, as well as the effective program and policy interventions that will address these

factors. A strong equity orientation means that emphasis is given to low-income countries, their relationships to high-income countries and marginalized populations in all countries.

Clinical Settings Used for Teaching

Faculty have linkages and formal partnerships with teaching hospitals as well as research institutes within the University, provincially and nationally in order that they continue to provide a diversity and richness of academic opportunities, central to the mission and operation of the School. Formal affiliations exist with teaching hospitals as well as the Ontario Agency for Public Health and Protection. In addition to the UofT agreement with Toronto Public Health/ City of Toronto, the School has formal and informal affiliations with the Greater Toronto Area local public health units as well as the Ontario government's Public Health Division for placements. These units look to graduates as key hires in the fields of epidemiology, health promotion, nutrition and public health physicians.

Nature of the Three Most Important Health-Related, International Clinical, Teaching or Research Partnerships in Existence at the University

1. **Centre for Global Health Research, St. Michael's:** One of the priorities of the Keenan Research Centre of the Li Ka Shing Knowledge Institute is global health. The Centre for Global Health Research (CGHR) (http://www.cghr.org/) was established in 2003. The CGHR uses biomedical, epidemiological, economic and research ethics sciences to develop evidence-based policies that can be adopted by organizations and governments. Research focuses on the epidemiology and prevention of premature mortality in developing countries, specifically on HIV/AIDS, tuberculosis and chronic diseases, as well as research ethics to advance equitable sharing of scientific benefits. Currently, CGHR is leading a largest epidemiological a study of six million people in 1.1 million homes in India.

   See *http://www.stmichaelshospital.com/research/global.php*

2. Faculty are engaged in multiple **educational and research initiatives** in various parts of the world through partnerships with international organizations (such as World Health Organization, Dignitas, MSF), universities (in countries such as Kenya, Zambia, Colombia, Uruguay, Spain, India, China, Mexico and Brazil) with funding from international funders such as IDRC, CIDA, SSHRC and Fullbright. Such partnerships have enabled faculty to provide educational exchange experiences and build capacity of public health professionals in other parts of the world as well as students at the School. There are two WHO Collaborating Centres linked to the School—one in Bioethics and one in Health Promotion—in recognition of the leadership of the University in both topics.

   See *http://www.who.int/collaboratingcentres/en*

3. The **Centre for Health and Development** evolved from over four years of collaboration between faculty members from the University of Port Harcourt, Port Harcourt, Nigeria and the UoT, that culminated in a formal partnership in 2001. The partnership is to collaborate on projects to enhance individual and social capacity to address health challenges in Nigeria. The partnership had received and implemented two research grants to investigate the health impact of the chronic conflicts in the Niger Delta of Nigeria. The preliminary results of the studies show a high prevalence of Post-Traumatic Stress Disorder and HIV/AIDS coupled with minimal community capacity to mitigate the diseases. In 2006, the partnership secured another grant to establish a Centre for Health and Development (CHD) at the University of Port Harcourt, Port Harcourt. The Centre aims to train 300 health workers in the management of people living with HIV/AIDS (PLWHA) in order to roll out anti-retroviral therapy (ART) in hospital and community-based settings, and build partnerships between health institutions and community-based organizations in the first six years of its existence.

   See http://www.chduniport.org

University of British Columbia – Faculty of Medicine

Brief History of Faculty

By 1944 the B.C. Medical Association, the Provincial Government and the University were actively discussing the establishment of a Faculty of Medicine. In 1949, the Faculty of Medicine was established at UBC and admitted its first class of 60 medical students in September, 1950. The Faculty of Medicine includes programs in medicine, physical therapy, occupational therapy, audiology and Speech sciences, medical laboratory science, midwifery and genetic counseling. In addition it houses several research centres and institutes. The UBC MD undergraduate program currently prepares students for practice in a rapidly changing world. It was the first distributed medical education program in Canada, designed to fully train students in communities across the province, where they may one day practice. Its strategic plan highlights five primary areas of commitment: 1) Transformative Learning; 2) Research Innovation and Excellence; 3) Health Care Innovation and Excellence; 4) Investment in People and Partnerships; and 5) Accountability and Sustainability.

Government Status

UBC is a publicly funded university and generally falls under the jurisdiction of the provincial *University Act* administered by the Ministry of Advanced Education.

Annual Teaching Budget and its Sources

Approximately $95 million (teaching only) from provincial government and tuition.

Size of the Research and Clinical Faculty

There are 4,497 clinical/adjunct faculty and 688 research faculty.

Size of the Student Body

The MD Undergraduate program for 2011-12 is 1,056 that includes Year 1- 288; Years 2, 3, & 4 at 256 each year. Apart from medical undergraduate students the medical program comprises 1,150 medical residents; 1,217 graduate students; 267 post doctoral fellows; 98 clinical fellows; 5,100 CME registrants; and 5,131 MD Alumni.

School's Accreditation Status

Fully accredited by CACMS and LCME.

Overview of the Curriculum

The undergraduate medical education (MD) program at UBC is four years in length. The program is delivered through four primary sites in the province: Vancouver-Fraser Valley, Prince George, Victoria and Kelowna. The curriculum consists of two years of pre-clinical and two years of clinical learning experiences. In the pre-clinical years (first and second years), students learn in a variety of settings (problem based learning, lecture theatre, small group classroom, anatomy laboratories, clinics, and community) in preparation for clinical training. In the third year, students complete clinical placements in various medical and surgical disciplines. In the traditional third year program, the placements in disciplines are sequential and most are provided in or close to the four major centres. In the Integrated Community Clerkship (ICC) third year program, students' experiences in the disciplines are interspersed throughout the year, and the students are assigned to a smaller community for the whole year. The ICC students can follow individual patients through the whole year, and thus participate in the patient's journey in holistic and interdisciplinary contexts. In the fourth year, students participate in a number of four-week electives all over the province, in other provinces and sometimes in other countries. There is also a specific capstone course, Preparation for Medical Practice, which enables students to apply previous and new learning in a case-based series of learning experiences and projects. Student activities within the medical education program are guided by the CanMEDS competencies and the four principles of family medicine. The UBC medical curriculum is currently in the midst of a major curriculum renewal process that is in part driven by the Future of Medical Education in Canada report. The anchor for the revised curriculum is social responsibility and accountability.

Interprofessional Curricular Activities/Initiatives

The medical education program has placed interprofessional education high on its list of priorities in its new strategic plan and for the past five years has supported a Director of Inteprofessional Education. Areas in which strides have been made include orientation which now include a 90-minute hands on session related to team based care; the Doctor, Patient and Society course in years 1 and 2 which now includes options for interprofessional learning, the integrated clerkships which now offer medical students the opportunity to follow patients through their treatment journey including visits with other health care providers; and the final year Preparing Medical Practice course which includes several interprofessional experiences related to Aboriginal health, eldercare, back pain, and medication reconciliation. A framework for IPE in medical education is under development and evaluation/assessment metrics are being tested and implemented.

Clinical Settings Used for Teaching

Community partnerships are critical as a high percentage of medical education is delivered at multiple hospital, community, clinic and international sites. All types of clinical setting are used for teaching medical students from acute tertiary care units to rural and remote communities, inner city clinics to state of the art surgical units, national diversity to international experiences, and Aboriginal health to community care. All areas in which physicians practice are offered to students as teaching sites.

Nature of the Three Most Important Health-Related, International Clinical, Teaching or Research Partnerships in Existence at the University

1. **UBC Global Health Initiative** (GHI) program runs global health projects in partnership with NGOs or institutions such as in the Peruvian Amazon. These projects are medical student-run, with faculty supervision, and are open to students from all faculties, from all distributed sites. UBC has already placed residents and 4th year medical students for elective rotations, starting in January, requiring participation in interprofessional knowledge translation (teaching presentations) to local health care workers, nurses, physicians, and community members. The Peru Project organizing team in Vancouver consists of family physicians, ER physicians, a pharmacist, an occupational therapist, a neonatologist, and a community leader.

   See http://globalhealth.med.ubc.ca/service/student-groups/global-health-initiative

2. **India Spiti Project** has involved not only medical students, but students from Engineering, Dentistry, and Land and Food Systems. This project uses an integrated approach to community development in order to improve health outcomes, focusing on key areas of anemia, oral health, water & sanitation, nutrition, etc. The Voice of Children, India project, also involves a team of four medical students who worked with a local NGO that has a mandate to advocate for women and children's rights. For the past two years, medical students have prepared health education workshops for village women and adolescent girls.

   See http://globalhealth.med.ubc.ca/service/student-groups/global-health-initiative/ghi-india-spiti-health-project/ & http://globalhealth.med.ubc.ca/service/student-groups/global-health-initiative/ghi-india-voice-of-children-project/

3. The **Uganda ACCESS** project focuses on health education, and this past summer 2011, a team of four medical students prepared health teaching workshops for Uganda nursing aide students, who subsequently taught health workshops to Ugandan high school youth. The first student team 2010 included two UBC nursing students and two medical students.

   See http://globalhealth.med.ubc.ca/service/student-groups/global-health-initiative/ghi-uganda-nacodi-project

University of British Columbia – School of Nursing

Brief History of Faculty

The University of British Columbia (UBC), was established in 1918, and was the first university in Canada to offer a nursing degree program. Ethel Johns, one of Canada's internationally recognized nursing leaders, was the first Director of the School in 1919. The university-based nursing program leading to a baccalaureate degree at UBC was recognized in Canada as a giant step toward expanding the science and scholarship inherent in nursing. The UBC School of Nursing has an international reputation for research and scholarship and a vision characterized by social relevance and excellence. The School offers a range of undergraduate and graduate programs, and in 2003 commenced an innovative nurse practitioner program. The School also houses an Office for Nursing Research and Teaching Scholarship which provides infrastructure support for scholarly activities and a Learning Resources Center designed to maintain cutting edge technological options for enhanced learning.

Government Status

Primarily provincial government.

Annual Teaching Budget and its Sources

Approximately $6 million.

Size of the Research and Clinical Faculty

There are 59 clinical faculty and 28 research faculty.

Size of the Student Body

Within the Bachelor of Science in Nursing (BSN) program there are on average 120 students in Year 3 and in Year. 4. Within the MSN program there is an intake of 50 per year (2-3 year program), in the nurse practitioner program there is an intake of 15 per year (2 year program) and the doctoral program averages five to 10 per year (4 year program).

School's Accreditation Status

The Faculty is accredited by the Canadian Association of Schools of Nursing 2009 (5 years) and The College of Registered Nurses of British Columbia 2008 (5 years).

Overview of the Curriculum

Under the Bachelor of Nursing Science Program, this is an 81 credit advanced standing program. Students enter this program in Year 3 either after completing a baccalaureate degree or achieving a minimum of 48 credits in another field of study at UBC or another recognized college or university. All nursing courses are taken in Years 3 and 4 plus a summer term between these years, resulting in a five term BSN program (i.e. 20 consecutive months of study). The program requires a minimum of four years of university education leading to a BSN degree.

Interprofessional Curricular Activities/Initiatives

The School participates in 2 key committees in the College of Health Disciplines: interprofessional curriculum and interprofessional practice education. It provides an orientation to collaborative practice for all new students and requires first year students to attend a major IPE activity put on for all first year students in health programs at UBC. In addition, the Nursing program participates in development of IP tools and resources. For example, nursing faculty have been key participants in the development of two IP pain management modules. Nursing students are also heavily involved in a student-led clinic in the inner city that is interprofessional and in pilot tests for all of the IPE teaching activities that are developed within the College of Health Disciplines.

Clinical Settings Used for Teaching

In the Vancouver lower mainland, a wide variety of placements in all the major urban and suburban hospitals, satellite hospitals, health centres and community are used: medical-surgical units (acute and chronic, general and specialist medicine and surgery), Elderly Care Units, Paediatric Units, Maternity Units, Mental Health Units (acute and Chronic), Community Health centres and Hospices, Outreach specialist centres (e.g. homeless, substance-dependency. The Faculty also uses rural areas in British Columbia for preceptorships, including First Nation communities.

Nature of the Three Most Important Health-Related, International Clinical, Teaching or Research Partnerships in Existence at the University

1. **International Partnership with Baba Farid University in India** to promote faculty exchange regarding research and teaching scholarship, led by Dr. Susan Dahinten. The UBC School of Nursing is working in active partnership with the Canada-India Education Society and its associated organization, the Guru Nanak Medical & Educational Trust in India to assist the faculty in the Punjab in the development of an internationally recognized baccalaureate nursing program. The partnership project is overseen by an Advisory Committee made up of members from the UBC School of Nursing faculty, the Canada-India Education Society, and nurses from the local South Asian community. This project has been ongoing since 2003.

   See http://www.gncon.in/collegeprofile.html

2. Dr. Craig Phillips is part of the **International Nursing Network for HIV/AIDS Research** work participating in a project involving work in the USA, China, Thailand, Puerto Rico, and Namibia. This work has been ongoing since 2007, and he is the Primary Investigator in this international research collaborative at the Vancouver site exploring the role of self in HIV-positive individuals managing their HIV.

   See http://www.aidsnursingucsf.org/network.html

3. Dr. Bernie Garrett (UBC)and Dr. Roger Cutting's (University of Plymouth, UK) **International Science Partnerships project** is an educational project involving interdisciplinary collaboration with science education students in the UK, and nursing students in Canada, Ethiopia and Zambia, using social networking tools to explore aspects of scientific philosophy and thinking in research and inquiry. Students from these disparate sites have been partnered using social networking tools to discuss subjects as part of their course work. The project has been ongoing since 2009.

   See http://blogs.ubc.ca/realscience

University of British Columbia – School of Population & Public Health

Brief History of Faculty

The function of a school of population and public health has been under the auspices of the department of Healthcare and Epidemiology in the Faculty of Medicine at UBC for many years. After a long process of consultation, the decision was made to create a new School of Population and Public Health at the University in Spring 2008 approved by Senate. Its goal is to provide a vibrant interdisciplinary academic environment at a critical time in the development of public health in Canada. The School's research examines local, national and global health challenges and spans six broad themes: epidemiology and biostatistics, global health and vulnerable populations, health care services and systems, cccupational and environmental health, public health, emerging threats and rapid response and social determinants of health.

Its mission is to create, share and apply knowledge to protect and improve well being and to promote equity in the health of people and communities at home and around the world.

Government Status

UBC is a publicly funded university and generally falls under the jurisdiction of the provincial *University Act* administered by the Ministry of Advanced Education. The School of Population and Public Health falls within the Faculty of Medicine.

Annual Teaching Budget and its Sources

$4,959,284 from General Purposes Operating Fund.

Size of the Research and Clinical Faculty

The clinical faculty is 61, the adjunct faculty is 50 and the research faculty is 48.

Size of the Student Body

Masters of Health Sciences (MHSc) is 59; Masters of Public Health (MPH) is 74; MSc Occupational and Environmental Health is 27; Masters of Health Administration (MHA) is 83; MSc is 25; PhD is 89; The total is 357.

School's Accreditation Status

Currently, there is no Canadian process for accreditation.

Overview of the Curriculum

Each program features its own curriculum, with some degree of overlap. MSc and PhD students share a number of core requirements, including statistics for health research, analytical methods in epidemiological research and methods.

Interprofessional Curricular Activities/Initiatives

For the Public Health and Preventive Medicine Residency Program, the two Lower Mainland training options (one resident per 'site') are St. Paul's Hospital and Greater Vancouver, with the Greater Vancouver option involving rotations at several hospitals throughout the Lower Mainland. As other sites in the province are also used, core sites also include: BC Centre for Disease Control in both the Environmental Health and Epidemiology divisions, WorkSafe BC, First Nations and Inuit Health, Vancouver Coastal Health Authority and a Rural Health Authority. Elective sites include: BC Centre for Excellence in HIV/AIDS, BC Cancer Agency, and the Office of the Provincial Health Officer.

Clinical Settings Used for Teaching

In the Vancouver lower mainland a wide variety of placements in all the major urban and suburban hospitals, satellite hospitals, health centres and community are used: medical-surgical units (acute and chronic, general and specialist medicine and surgery), Elderly Care Units, Paediatric Units, Maternity Units, Mental Health Units (acute and Chronic), Community Health centres and Hospices, Outreach specialist centres (e.g. homeless, substance-dependency. The Faculty also uses rural areas in British Columbia for preceptorships, including First Nation communities.

Nature of the Three Most Important Health-Related, International Clinical, Teaching or Research Partnerships in Existence at the University

Faculty members are involved in the following projects.

1. Dr. Analee Yassi conducts local and international research **projects towards empowering workforces and communities regarding determinants of their health**. She works closely with colleagues in infection control in promoting healthy healthcare—with current projects in Canada, Latin America and South Africa. Collaborative efforts to reduce the spread of HIV, TB and other infectious disease in the healthcare workforce figure prominently in her research.

2. Dr. Yassi is also co-lead in **innovative international, intercultural, interdisciplinary community-university partnership projects** across Ecuador.

3. Dr. Patricia Spittal is working in **special social and cultural vulnerabilities women face in extremely high risk contexts**, including the sex trade, in Uganda as well as conducting work in Northern Uganda on a project that is addressing HIV/AIDS prevention programming needs of children affected by civil strife, including child soldiers.

   For more information about the above partnerships, go to http://www.spph.ubc.ca.

Northern Ontario School of Medicine

Brief History of Faculty

The School welcomed its first MD students in September 2005. It became the first new medical school in Canada in over 30 years, and only the second new medical school in North America. It is the first Canadian medical school hosted by two universities, over 1,000 kilometres apart. NOSM is the Faculty of Medicine for Lakehead University in Thunder Bay and Laurentian University in Sudbury. NOSM is committed to the education of high quality physicians and health professionals, and to international recognition as a leader in distributed, learning-centred, community-engaged education and research. NOSM is a made-in-the-North solution that is attracting attention from around the world for its innovative education model. In just six years, NOSM has become a world leader in community-engaged medical education and research, while staying true to its social accountability mandate of contributing to improving the health of the people and communities of Northern Ontario.

Government Status

Public funded and overseen by the Council of Ontario Universities.

Annual teaching budget and its sources

The overall budget is $39.2 million, which is comprised of funds received from the provincial Ontario government, tuition and other fees.

Size of the Research and Clinical Faculty

Size of the research and clinical faculty: The School brings together over 70 community teaching sites inclusive of hospitals and community organizations and clinical teachers, nearly 1,000 clinical, human, and medical sciences faculty, and approximately 200 employees.

Size of the Student Body

Northern Ontario School of Medicine (NOSM) admits 64 MD students in each year. Twenty-eight of these students are based primarily at the School's West Campus at Lakehead University in Thunder Bay and 36 are at the School's East Campus at Laurentian University in Sudbury. NOSM is part of a Consortium of Physician Assistant Education which is based in the Department of Family and Community Medicine at the UofT's Faculty of Medicine and admits 22 students each year. Training is delivered by the Consortium of PA Education, comprised of the UofT, the Michener Institute for Applied Health Sciences, and NOSM, with the degree conferred by the UofT. NOSM also admits up to 16 dietetic interns for a program of 46 weeks in duration, in addition to, coordinates Occupational Therapy, Physiotherapy, and Speech-Language Pathology and Audiology in Northern Ontario's teaching communities.

School's Accreditation Status

NOSM is accredited by the Association of Faculties of Medicine (Liaison Committee on Medical Education/ Committee on Accreditation of Canadian Medical Schools). NOSM is fully accredited until 2012.

Overview of the Curriculum

The School offers a unique "hands-on" four-year MD program, based on a distributed community engaged medical education model, and is organized around five themes: northern and rural health, personal and professional aspects of medical practice, social and population health, foundations of medicine and clinical skills in health care. Classroom learning in the first and second years is mostly in small groups, patient-centred case based learning, and is complemented by whole group sessions and clinical learning from the beginning of year one. Rotations include in rural, remote and Aboriginal communities throughout Northern Ontario. In the third year of the program, students spend their entire academic year living, learning, and experiencing - first-hand - medical practice in twelve medium-sized communities throughout the North in their Comprehensive Community Clerkship (CCC). NOSM PGY3 programs include Emergency Medicine, Anesthesia, Enhanced Skills Maternity Care, Care of the Elderly, and Self-Directed Enhanced Skills. The Northern Ontario Dietetic Internship Program (NODIP) is administered by the NOSM, in collaboration with

multiple preceptors, communities, and facilities throughout Northern Ontario. This program offers diverse and distributed experiences in the provision of nutrition care across the health-care continuum. The Bachelor of Science Physician Assistant degree (BScPA) is a full-time professional, second-entry undergraduate degree program. Physician Assistants (PAs) are skilled health professionals who work as physician extenders in a variety of health-care settings, providing patient/client care under supervision of a licensed physician.

Interprofessional Curricular Activities/Initiatives

NOSM has an integrated IPE curricula throughout the 4-year UME program, IP learning exists within the academic curricula, in addition to the continuum of care in clinical experiences and rotations in community and hospital settings. Experiential IP learning takes the form of a variety of different learning opportunities delivered by the Health Sciences and IPE Unit of the Community Engagement Portfolio. Examples include community and interprofessional learning (CIL), IP competency development based on the CIHC National Competency Framework, both intra and interprofessional learning are enhanced by instituting an electronic learning portfolio integrating a mentorship approach between junior and senior level learners and will be used through the continuum of learning, integrated community experiences in clinical settings and IP facilitation skills.

Clinical Settings Used for Teaching

Across Northern Ontario community teaching sites, NOSM learners (medical students, residents, and learners from other health disciplines such as rehabilitation studies, physiotherapy, dietetics, and physician assistants), are gaining relevant clinical experience under the guidance of health-care professionals in community hospitals, clinics, and family practices. NOSM's success is very much a result of those many partnerships and collaborations with individuals, communities and organizations including Aboriginal and Francophone, hospitals and health services, physicians and other health professionals, universities and colleges, information communication technology organizations, and other medical schools.

Nature of the Three Most Important Health-Related, International Clinical, Teaching or Research Partnerships in Existence at the University

1. **THEnet (Training for Health Equity Network)** - NOSM is a key partner in an international network of innovative health professional schools around the world holding a mandate for social accountability. This network measures success not by the number of graduates or research publications but rather how they meet the needs of societies and disadvantaged communities they serve. Collectively their work concentrates on evaluation of social accountability, building learning communities and capacity development.

   See http://www.thenetcommunity.org

2. **The Network: Towards Unity for Health and Rural Wonca NOSM** is in partnership with 2 key international organizations in the planning of a joint world conference in 2012. The conference is a partnership of 5 international organizations with the overall goal to convene health professionals, educators, students and researchers from all parts of the world to address five areas of concern: rural, remote, and underserviced healthcare and health professional education; integration of the individual and population health approaches to education and service; innovations in longitudinal integrated curricula; community-engaged health professional education; and social accountability in the health professions education.

   See http://www.rendez-vous2012.ca

3. Flinder's University located in Adelaide and Darwin Australia and the NOSM's partnership builds upon the principles of **"Globally Engaged and Community-Based Medical Education"** in creating opportunities for hosting joint biannual education conference, as well as, providing educational and scholarship for faculty and learners.

   See http://gcemem2010.flinders.edu.au/GCEMEM2010%20Registration%20Brochure.pdf

Queen's University – Faculty of Health Sciences that includes schools of medicine, nursing and public health

Brief History of Faculty

The University was established by Royal Charter of Queen Victoria in 1841, 26 years before Canadian confederation. Classes were first held in 1842. One of the earliest degree-granting institution in the united Province of Canada, and the first to establish a student government. Queen's student body represents 83 different countries, along with every Canadian province and territory. The Faculty is drawn from some of the most prestigious institutions in the world, and Queen's faculty members regularly receive international recognition and numerous teaching awards for their research and innovative contributions.

Government Status

Publicly funded and overseen by the Council of Ontario Universities.

Annual Teaching Budget and its Sources

Annual teaching budget and its sources: The Faculty of Health Sciences (FHS) has three discrete budgets for its schools broken down as follows: medicine (SOM) is $35 million; nursing (SON) is $4 million and rehabilitation (SRT) is $5 million.

Size of the Research and Clinical Faculty

There are 100 full time equivalent (FTE) research and 500 clinical faculty members with adjunct appointments to the school of medicine. There are 18 FTE faculty and 50 clinical teachers in the school of nursing. There are 21 FTE faculty and 200 clinical adjunct appointments in the school of rehab.

Size of the Student Body

There are 100 student learners admitted each year to the SOM for a total of 400 undergraduate medical students and 458 postgraduate medical residents at any given time. A total of 410 students are admitted to the undergraduate nursing program and 40 students in the graduate program. Within the SRT, there are a total of 66 students accepted into each of the occupational therapy and physical therapy professional programs each year for a total of 132 students admitted each year for a total of 264 OT and PT students in the SRT. In addition, there are currently 20 doctoral level students and 18 research masters students enrolled in the SRT Rehabilitation Science program.

School's Accreditation Status

There are 17 departments within the SOM including the Department of Community Health and Epidemiology that is responsible for Public Health. Under graduate medicine is accredited by CACMS (Committee on the Accreditation of Canadian Medical Schools) and LCME (Liaison Committee on Medical Education) which is a joint accreditation process. Accreditation of post graduate education was done by the Royal College of Physicians and Surgeons of Canada and College of Family Physicians of Canada in October 2011. The final results will be provided in January 2012. The SON is fully accredited until 2013. Within the SRT, both of the occupational therapy and physical therapy programs are undergoing accreditation with onsite visits scheduled in Winter 2011. They have previously been accredited for seven years.

Overview of the Curriculum

The undergraduate program in the SOM is a four-year competency based medical curriculum with longitudinal clinical experience through all 4 years of the program. Years 1-2 are primarily foundational and years 3 to 4 are more clinically oriented. The School of Nursing offers seven programs: a four year undergraduate, an advanced standing two year undergraduate, degree program for registered nurses, a nurse practitioner certificate program, a master's thesis, a master's primary health care, and a PhD. There are two streams in the master's program: chronic illness, and women and children's health. The field for the PhD is Transitions. The curricula are competency based at the undergraduate level, utilizing multiple teaching strategies including experiential learning using simulations, volunteers, and clinical practice. There are four programs in the SRT, all at the graduate level. There are two-year,

twenty-four month masters professional programs in Occupational Therapy leading to the degree of MSc (OT) and in Physical Therapy leading to the degree of MSc (PT), each being the entry-level degree to practice. The curriculum utilizes a variety of learning strategies including case-based, team-based and experiential learning with clinical placements throughout both programs. There are also masters and doctoral research programs in Rehabilitation Science, leading to the degree of MSc (Rehabilitation Science) and PhD (Rehabilitation Science) respectively. Two fields are offered: Human Motor Performance and Disability and Wellness in the Community. While students vary in their times to completion, the master's program usually requires two years and the doctoral program about four years to complete.

Interprofessional Curricular Activities/Initiatives

The Office of Interprofessional Education and Practice (OIPEP) was founded in 2007 to support to faculty and student learners in all three Schools of the FHS. In February 2009, the FHS Faculty Board adopted the Framework for Interprofessional Education outlining its commitment to interprofessional education (IPE) for all health sciences students. Based on the key concepts, principles and model laid out in this document, OIPEP developed, implemented and evaluated a number of IPE activities for students, provided professional development initiatives for faculty and clinicians, and led two research projects based on faculty-clinician partnerships. (http://meds.queensu.ca/oipep).

Clinical Settings Used for Teaching

The SOM deploys three fully affiliated teaching hospitals in Kingston and approximately 10 affiliated partnering hospitals throughout southern Ontario. In addition, student learners in the SON and the SOR use these sites for clinical placements.

Nature of the Three Most Important Health-Related, International Clinical, Teaching or Research Partnerships in Existence at the University

1. **The NCIC Clinical Trials Group** is located in the Cancer Research Institute at Queen's University. It is a cooperative oncology group which carries out clinical trials in cancer therapy, supportive care and prevention across Canada and internationally. It is one of the national programmes and networks of the Canadian Cancer Society Research Institute (CCSRI), and is supported by the Canadian Cancer Society (CCS).

2. **CARENET and the International Nutrition** is a group of health care professionals from across the country who collaborate with each other to understand and improve palliative and end-of-life care through research, healthcare/patient tools and communication and decision making between patients, their families and health professionals. CARENET operates The International Nutrition Survey. To date, there have been three international period prevalence surveys of nutrition therapies in Intensive Care Units (ICUs), with over 150 ICUs participating each year. This ongoing quality improvement (QI) initiative, aims to compare current nutrition practices in ICUs within and across different countries. The aim of the initiative is to illuminate differences, highlight strengths and weaknesses, that will lead to practice improvements.

3. **International Centre for the Advancement of Community Based Rehabilitation** (ICACBR) is an organization committed to mainstreaming disability and advancing the concept of community based rehabilitation (CBR) practice in partnership with women and men with disabilities and their communities around the world. All of ICACBR's activities for the past 20 years have been directed towards achieving international excellence in CBR education, policy, service delivery and research.

   Details of ICACBR projects worldwide can be found at http://www.queensu.ca/icacbr/projects.html.

Université Laval – Faculty of Medicine

Brief History of Faculty

Founded in 1852, Université Laval is the oldest university in Canada and was the first institution in North America to offer higher education in French. Its main campus is located in Quebec City, the capital of the province. Founded in 1853, the Faculty of Medicine is the oldest faculty and the first one to offer medical education in French in Canada. Within the Faculty, the schools of nursing and public health (www.pha.ulaval.ca) (www.fsi.ulaval.ca) (www.fss.ulaval.ca) are incorporated into its curriculum as well as interprofessional education.

Government Status

Founded by Royal Charter, Université Laval is a publicly-funded independent institution.

Annual Teaching Budget and its Sources

The annual faculty teaching budget is 55 million.

Size of the Research and Clinical Faculty

The faculty is composed of 3,250 professors and teachers, 1,800 professional employees and 160 administrative employees. There are five research centers representing 30 research units and 117 million in research funding. The Réseau Universitaire Intégré de Santé (RUIS has the responsibility to coordinate tertiary health care services, teaching and research provided by each university's faculty of medicine and its associated teaching hospitals.)

Size of the Student Body

As of September 2011 there are 2,100 undergraduate students, 927 graduate students, 800 post-medical students and 150 post-doc students.

School's Accreditation Status

The Faculty is fully accredited until 2014.

Overview of the Curriculum

Laval University has implemented in 2008 a strong curriculum network on interprofessional education in health, which involves our faculties of Medicine, Nursing, Pharmacy, and Social Sciences supported by a large partnership within the health care organizations network. Characterized by innovative interdisciplinary pedagogy, Laval University curriculum in health disciplines is a model that supports a concerted integration of our academic programs, training courses, and continuing education in health care organizations.

Interprofessional Curricular Activities/Initiatives

The IPE curriculum is composed of a 3 credits mandatory course for 7 health disciplines teach by an interfaculty professors team (nursing, medicine, social work) that is strongly supported in the classroom by a clinicians mentor including a specific training for our students (physicians, nurses and social workers) with IPE component. There is a continuing education curriculum for clinicians in clinical settings. The faculties of nursing, pharmacy and social sciences are strongly committed to the IPE curriculum. See http://www.rcpi.ulaval.ca

Clinical Settings Used for Teaching

The teaching hospital network of Université Laval, teaching and clinical activities of the Faculty of Medicine includes 7 affiliated hospitals, 12 family medicine teaching units, 2 regional clinical campus and over 300 clerkship sites.

Nature of the Three Most Important Health-Related, International Clinical, Teaching or Research Partnerships in Existence at the University

1. **Creation of three interdisciplinary and inter collaboration courses.** Issued from an inter faculty collaboration, in order to promote interdisciplinary collaboration among future global health professionals, three interdisciplinary and inter collaboration courses are offered to students from health undergraduate programs. The three courses are mandatory and prerequisites to each other.

2. **Family medicine postgraduate program.** The family medicine postgraduate program is based on interdisciplinary collaboration. Within the twelve

family medicine teaching units, medical residents are trained on interdisciplinary and collaboration with nurses and social workers.

3. **Continuing Medical Education.** Since Spring 2011, the RCPI (Réseau de collaboration sur les pratiques interprofessionnelles en santé et services sociaux) offers a four days interprofessional training program. This program is dedicated to grassroots clinicians and managers from health and social services for enhancing collaborative practices in their clinical environment within the teaching clinical network of Université Laval. This training program is funded by Health Canada, the Quebec Ministry of health and social services and is also supported by the RUIS (Réseau Universitaire Integré de santé).

9. Summary

The CIHLC proposal is designed to leverage our collective strengths to develop a learner-focused and competency-based model aimed at ***collaborative leadership for health system change*** locally and globally. The CIHLC is well-positioned to deliver on its proposed initiative in that the Canadian national and provincial governments, as well as academic institutions, in the past ten years, have already demonstrated leadership in establishing IPE and collaborative care at the organizational, practice and policy levels. Many of the Canadian initiatives have already been adopted by other countries.

Participating schools within this unique Canadian collaborative bring diverse areas of expertise and experience in health professional education through learning and innovation within the undergraduate, graduate, postgraduate, continuing education and professional development sectors. Each partner brings exceptional strengths to the Collaborative, such as global networks, regionally-integrated health education and health care systems, interprofessional education, change leadership and training, social accountability, and cultural and clinical competencies.

By exploring and implementing the collaborative leadership competencies, capacities, tools and resources necessary for system change, transformative learning for a new generation of collaborative leaders could result. This would enhance knowledge translation, build capacity for a new health workforce and generate globally-minded leaders guided by social accountability.

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