Accreditation of Interprofessional Health Education (AIPHE)

National Forum

Ottawa
February 17-18, 2009

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Introduction

To help ensure that interprofessional education (IPE) is embedded in health and human service education programs in Canada, Health Canada funded six professions (medicine, nursing, pharmacy, physical therapy, occupational therapy, and social work) representing eight accrediting bodies, to work together to address accreditation standards for IPE.

In late 2007, a project secretariat was established in the Association of Faculties of Medicine of Canada and the Accreditation of Interprofessional Health Education (AIPHE) Steering Committee was struck to begin the process of developing shared principles to support these standards.

In early 2009, the document *AIPHE Principles and Implementation Guide* was published and distributed in English and French. The guide describes the rationale for this effort, articulates guiding principles, and provides sample standards, examples of evidence, and a list of useful resources for IPE.

On February 17 and 18, 2009, approximately 50 people took part in a forum held in Ottawa to review and launch the AIPHE document as a resource for implementing change. Those invited included members of the Steering Committee, representatives from various national associations (accrediting, regulatory, academic) aligned with the six AIPHE partners' health professions, provincial and federal policy makers, student representatives, and American colleagues representing accrediting bodies for medicine, nursing and pharmacy programs.

This report presents a summary of the discussions that took place at this forum. Because it is intended as a reference document for the creation of a marketing toolkit as well as the preparation of a final AIPHE document, it provides considerable detail to support these activities.

Objectives

The objectives of the forum were to:

1. Orient participants to the AIPHE document; explore feedback; discuss how it was developed, its potential impact on health education, and how IPE paves the way for interprofessional practice.

2. Provide a venue where health education policy makers and implementers could share information and expertise, learn from one another, and continue to build a network focused on the implementation of AIPHE.
3. Provide input to the development of a toolkit for using the principles in the AIPHE document to support the development of new accreditation standards or the implementation of existing standards that incorporate IPE.
4. Identify, describe and discuss common challenges related to standards implementation both within and among organizations, and exchange or develop "best practices" in these areas.
5. Suggest strategies for leveraging the AIPHE investment made to date.

Participants

Fifty-three participants affiliated with national associations were invited to attend the forum. They were selected as being instrumental in promoting the AIPHE standards to the eight accrediting bodies partnering in this initiative, able to help build capacity for implementation through access to resources, knowledgeable about how to make accreditation for interprofessional health education work, and interested in learning about accreditation for IPE.

Opening Remarks

Dr. Mary Ellen Jeans, co-chair of the AIPHE initiative, welcomed participants on behalf of her co-chair, Dr. Dianne Delva, and thanked them for taking time out of their busy schedules to carry out this important and strategic work.

Dr. Jeans emphasized the importance, in launching the AIPHE document, of finding innovative ways to translate knowledge into action. She reviewed the many steps in the process that have led to this meeting—from the establishment in October 2007 of the Steering Committee and Project Secretariat to the release of the document in both official languages earlier this year—and noted that the people involved have learned to work together in a very constructive way.

The stakeholders invited to attend this forum, she explained, were chosen as representatives from accrediting organizations, regulatory authorities, and educational institutions to offer input on implementation strategies and issues. Feedback from the meeting (and from evaluation committee members who were present) will go back to the Steering Committee for use in developing profession-

specific communication toolkits. The forum report will be distributed and available on the new project website.

Dr. Jeans added that one of the great benefits of the project is that it has opened doors to collaboration among members of the professions—many of whom had never met before. She said that tremendous overlap has been found in some accreditation standards, so there are many commonalities and opportunities for synergy going forward.

In closing, Dr. Jeans introduced facilitator Dorothy Strachan, who reviewed the forum agenda and process. Ms. Strachan emphasized that the focus of the workshop is knowledge translation: that is, finding ways to get the AIPHE document off the shelf and used as a resource. One important outcome of the forum will be the development of several sample prototype toolkits, which will go to the AIPHE marketing consultant for consideration in creating a final toolkit for implementation. The last step will be to look at process challenges related to using the toolkit and develop ways to address them.

Part I: Accreditation—
What We Can Do to Enable IPE Integration

Survey: Where We Are Now

Participants were asked to indicate, on a scale of one to five (one meaning "not started yet" and five meaning "completely integrated"), the extent to which their organization (or a health organization with which they are familiar) implements standards based on the twelve principles in the *AIPHE Principles and Implementation Guide*. The results, based on the 37 responses received, were as follows:

1. The patient/client/family is the central focus of effective interprofessional collaboration and, therefore, of effective interprofessional education.
   Average of responses: 3.2
2. In order to educate collaborative practitioners, interprofessional education is an integral component of education for all health and human service professions.
   Average of responses: 2.8
3. Accreditation as one quality monitoring process for education, and regulation (licensing) as the quality control process for practice, provide consistent messages about interprofessional education and collaboration.
   Average of responses: 2.8
4. Required support structures for interprofessional education are considered in all aspects of accreditation including institutional commitment, curriculum, resources, program evaluation, faculty and students.
   Average of responses: 2.4

Discussion in plenary about the results of this activity confirmed the need to ensure that the AIPHE Principles and Implementation Guide is taken "off the shelf" and put into action.

Group Task: Ways to Support IPE Integration

Participants were asked to identify "what works" in terms of supporting the integration of health IPE in Canada. People were asked to jot down their top two answers based on their personal experience and then to come up with the top

four based on discussions with others at their table. Their results, shared in plenary, are summarized below:

- Adequate resources with enough staffing, funding, faculty development and time to implement
- Group simulations to model desirable behaviours
- Clear competencies, roles and responsibilities
- Field work and clinical placements
- Visible champions and role models
- Student/preceptor involvement, including "putting it on the exam"
- Broader buy-in, e.g., by having all levels of the health care system involved in systemic change, not just front line providers; by structuring services and the extent to which they promote interprofessional work (e.g., integration of services, mandated teamwork)
- The AIPHE document
- Good communication, including shared vocabulary/language.
- Interprofessional agreements that formalize how we work together, e.g., course work that cuts across professions in areas such as ethics, history
- Faculty recognition (e.g., bonus points through Faculty Evaluation Committees).
- Involvement in other professional evaluations.
- Physical proximity and opportunities to learn about one another (e.g., social activities)
- Facilitators to promote interaction
- Identifying and using available levers to create significant change, including power sharing, across the whole education system (undergraduate, post-graduate, professional development, etc.)
- A client-centred focus on patients and their families

Key Plenary Discussion Points

- IPE will receive more resources as the evidence base develops and is used to change practice and evaluate the impact.
- IPE activities should be recognized by universities as part of faculty promotion and tenure.

Part II: Background Document—
AIPHE Principles and Implementation

A member of the Steering Committee prefaced the discussion on the *AIPHE Principles and Implementation Guide* by explaining that the five thematic sections and example standards it contains were identified through extensive discussion and consensus that they resonated across the 8 accrediting bodies involved.

Document Strengths and Weaknesses

Participants were asked to identify what they liked most and least about the document, and to suggest ways in which it could be improved. The results of these table discussions are summarized below:

Strengths:

- The examples of standards and evidence are helpful.
- The document "is there and is done".
- The clarity and simplicity of the document make it easy to understand.
- IPE is clearly defined and operationalized.
- Information is well organized and presented.
- The document sets clear directions and is grounded in reality.
- The key words in the principles are well chosen.
- The quality of the translation is good.
- The resources provided are helpful.
- Web links to additional information are useful.

Things to Change:

- Include case studies and recommendations on how to apply the principles.
- Provide evidence of cost-effectiveness and other positive benefits in order to reduce resistance and attract funding support (e.g., proof of return on investment).
- Disseminate through web links to practitioners and health employers.
- Add more information on patients and their families and the benefits to them.
- Correct inconsistencies in the use of certain words (e.g., "classroom").

- Back up the statements on IPE for collaborative patient-centred practice (p. 7) with references.
- Define "core competency" in the glossary.
- Push the issue of how to evolve from practice placements for isolated disciplines to creating environments that support interprofessional placements.
- Acknowledge the scope for IPE at the policy level; the term "education for practice" implies a focus on clinical or direct practice.
- Add a section that acknowledges barriers (e.g., theoretical, skeptical, local) to implementation.
- Identify opportunities for students to work within administrative structures (e.g., scheduling of classes, team teaching).
- Give more credit to programs as agents of change to promote placements.
- Clarify the link to accreditors in the practice environment (e.g., hospitals, nursing homes).

Key Plenary Discussion Points

- The most powerful educational sites are clinics, not classrooms.
- Admissions criteria for academic health programs consider candidates who are predisposed to working at interdisciplinary sites.
- A vision of how all the pieces should fit together and who should be involved is needed.
- Where evidence exists, it should be put forward; where it doesn't, we should acknowledge that and do what we can to find it. There is good evidence of the value of IPE in certain settings (e.g., oncology, geriatrics, patient safety) and from studies in other countries (e.g., the United Kingdom).The toolkit should suggest sources of evidence and provide examples, so people know what to look for to assess whether they are meeting the standards. It would be very useful to validate IPE empirically.
- Nobody trusts a panacea; we have to be careful not to over-sell, because that generates skepticism.
- Dedicated funding is needed to undertake this kind of research.
- There are likely many other health-care professions that would be interested in becoming a part of this effort.
- A lot of the same issues are coming out of the task force on health education (which grew out of the task force on IPE). We have to be aware of what other groups are doing and connect with them in a meaningful way.

Part III: Building a Practical Toolkit for Implementing AIPHE

Dorothy Strachan (facilitator) and Andrea Burton, (communications and marketing consultant) provided an overview of the purpose of a toolkit and introduced the next group task, in which each table would create a prototype toolkit for the AIPHE document. This input will be used by Ms. Burton and the Steering Committee to determine the structure and content of a formal AIPHE toolkit.

It was noted that a toolkit should not be thought of as a "box" bounded by physical limitations. Forum participants were encouraged to be open-minded and innovative in their discussions and to focus on what is needed to get the document off the shelf. The bottom line is that people are very busy, so a good toolkit must be practical and easy to use.

Participants were divided into seven groups, and each was asked to develop a concept for the AIPHE toolkit. The groups then illustrated their concept on a flip chart and presented it in plenary.

Prototype A

Audience: Primarily accreditation bodies, with programs as a supplementary audience.

Format: Single toolkit to support a common approach; provides links to more specialized examples.

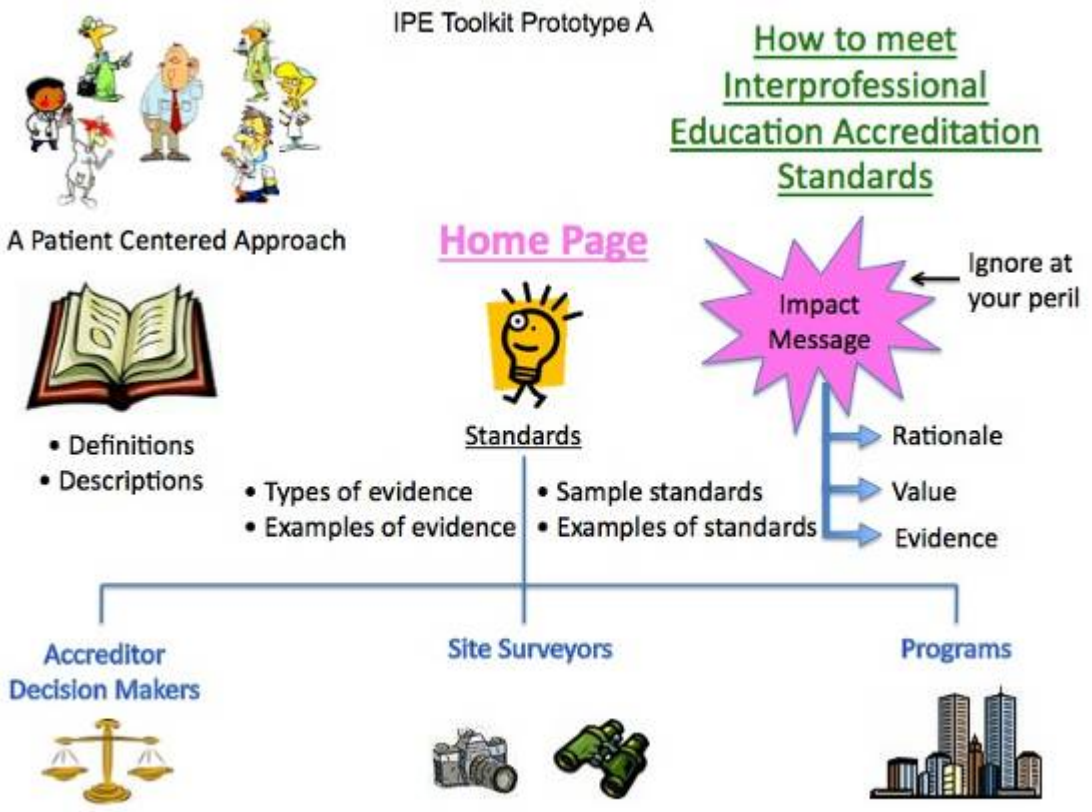
Content:

- *Why IPE is important*: clarifies rationale and provides examples of continuum (e.g., from education to practice, to policy, to benefits that support the rationale)
- *Sample standards*: includes sample standards, types of evidence, examples of evidence (e.g., simulated videos, links embedded in the toolkit).
- *Assessment*: contains information on how to measure/analyze (e.g., scenarios, training modules, expert views). Information for site surveyors focuses on training and includes examples of types of evidence and videos of site reviews to demonstrate how evidence is gathered.

- *Educational programs*: provides information and links for programs at different levels of experience (e.g., beginner to advanced) with regard to IPE, including curriculum and faculty development, student evaluation, how to combine campus-based and clinical learning, and recognizing teamwork.

Models and their Strengths:

- The Kellogg toolkit is a good example.



Prototype B

Audience: Accrediting bodies and other groups, including institutions, program developers, IPE developers, consumer groups, and the public.

Format: Single toolkit (portal) with subsections for other topics (e.g., governance, evidence, as in AIPHE booklet).

Content:

- The key message is the value of IPE to enable cultural change.
- *Marketing*: provides information tailored to various groups (e.g., testimonials, ways to encourage openness to a wide cross-section of providers and enable a cultural shift among consumers).
- *Evidence*: provides examples of the value of IPE to all stakeholders and of knowledge-translation methods (e.g., research results, links so people can contribute data quickly from diverse sites).
- *Barriers*: information on barriers and how to overcome them/negotiate solutions.
- *Glossary*
- *Research*: provides information on leading-edge practices, links to interactive learning resources, databases (e.g., Canadian Institutes of Health Research), statistics, best practices,
- *Other*: includes an IPE help line, a link for organizations that want to be connected to the portal, and plain language information for the public on what IPE is, who provides it, and how better health care is delivered as a result.

Dissemination Methods:

- CIHC links and other links (inclusive)
- Groups: accrediting bodies, IPE networks
- Methods such as
    - Facebook, websites
    - Professional organizations (accreditation, AAAC)
    - Media launch
    - Brochures IPE offices
    - Champions/spokespersons (key opinion leaders)
    - CIHC collaborations
    - Podcasts

Models and their Strengths:

- Websites and portals that are interactive, easy to use, and contain plain language information that is easy to locate are preferable. 1-800 numbers and other tools like templates and charts help personalize things (e.g., demonstrate the benefits of IPE club "membership").

Prototype C

Audience: Accrediting bodies

Format: A single toolkit to provide a framework for accreditors, with each profession looking at standards and evidence. The link to programs is through the evidence.

Content:

- *Resources*: Common definitions, elements (i.e., broad categories), examples of elements, and evidence used to demonstrate IPE.

Dissemination Methods:

- Common resource people (SWAT team) who physically attend various committee meetings.
- Iterative process that brings people back together to share and inform.

Models and their Strengths:

- The Travaillon Ensembles toolkit is useful because it contains the following elements:
    - theory/definitions
    - promising practices
    - DVD (view and discuss)
    - conceptual map

Prototype D

Audience: Accreditation bodies and survey teams; deans of professional schools, program administrators, and practice (practitioners, leaders, administrators).

Format: One toolkit with companion kits for unique, contextual aspects of professions, others.

Content:

- *Criteria for IPE interactions/experiences*: information on conflict resolution, team dynamics, and team-member contributions.
- *Diversity of learning methods*: information supporting fact that "one size does not fit all" (e.g., composition of teams depends on the needs of the client/family, examples of problem-solving case studies, clinical context and teachable moments "at the bedside").
- *IPE learning objectives for students*: explicit statements on required outcomes, information on collaborating, negotiating, and communicating so self/profession can prove??? collaborative approach within a team.
- *Evaluation tools*: ways to build up evidence.

Dissemination Methods:

- IP forums/national conventions
- Web-based and print-based material
- PowerPoint presentations for specific audiences
- Education: IPE coordinators at universities, deans, and students; and inter-university networks
- Practice: primary health networks, RHAs, health system administrators
- Accreditation: survey teams.

Models and their Strengths:

- The Knowledge is the Best Medicine toolkit (for pharmacists/clients) is a good example because it
    - is case-based,
    - is multi-media,
    - provides guidance for content,
    - is bilingual,
    - can be adapted to different teaching methods, and
    - contains evaluation tools.

- The Get a Grip on Arthritis toolkit (for professionals) is useful because it
    - is evidence-based,
    - provides accessible resources,
    - is multi-disciplinary, and
    - is user-friendly.

- The AFMC Faculty Development Program for Teachers of IMGs toolkit is a good model because it contains
    - PowerPoint presentations,

- examples using a variety of methods (simulations, role playing, video clips),
- printable checklists, and
- a contact list.

- The Virtual Professor toolkit's strengths include
  - a menu of tools, and
  - information o self-teaching and teaching others.

- The Safer Health Care Now toolkit is a good example because it
  - is evidence-based,
  - provides guidelines for action, and
  - enables evaluation.

Prototype E

Audience: Accreditors, educators, and students.

Format: A living toolkit that has endorsement from (and links to) accrediting organizations, and common horizontal threads, and is a motivator for IPE.

Content:

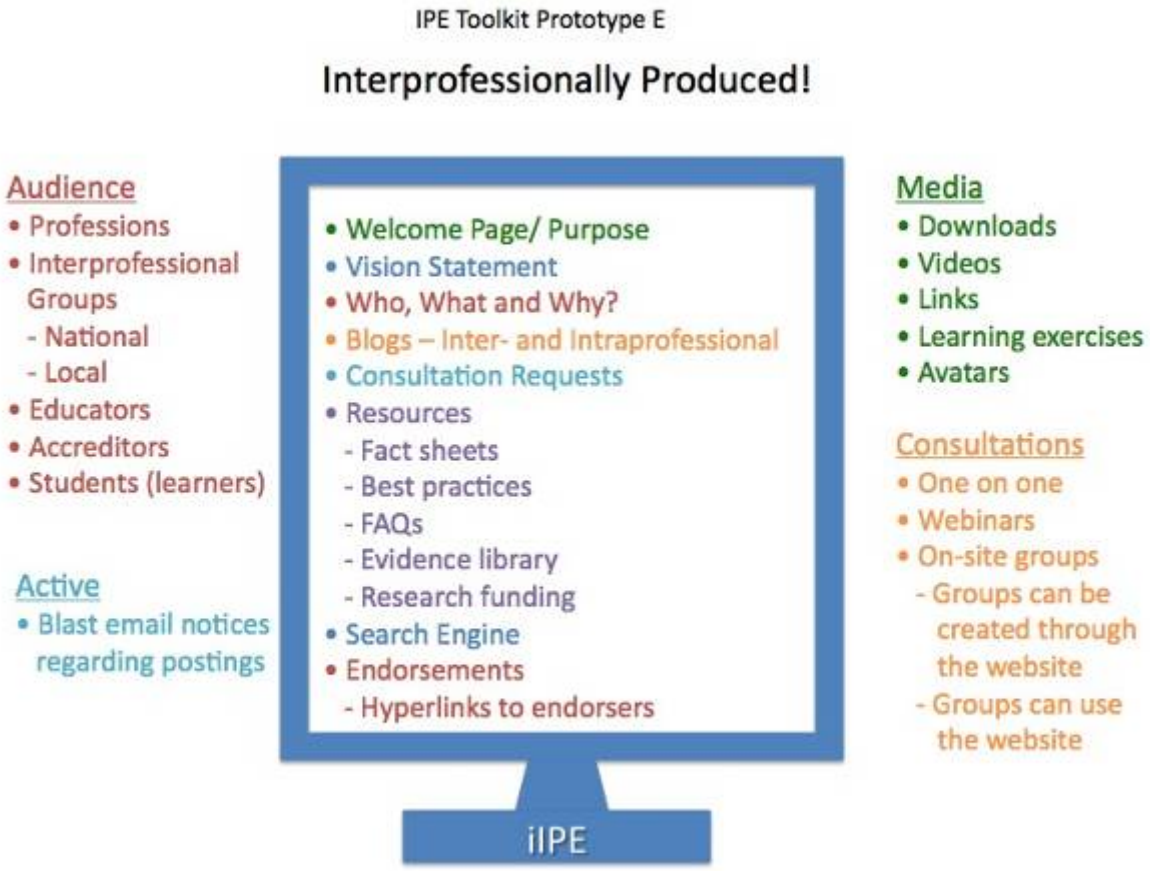
- *Expectations*: what an accreditation standard looks like and specific examples; CME "accreditation by the team for the team".
- *Definitions of competencies*: uniform language; learn about each other (huge assumptions/old turf battles); microsystems; common vision; good communication; common record; joint code of ethics?, respect diversity (tools of practice in different settings).
- *Evidence*: evidence library, case studies (what works and what doesn't).
- *BLOGS/blast e-mail*: research granting opportunities.
- *Resources*: provide help, not just information, through such things as consultation request system; fact sheets; downloads; videos; links; AVATARS (virtual patients).

Dissemination Methods:

- Web-based (BLOGS, blast e-mail, push-out to people)
- Press releases
- Direct mailings

Models and their Strengths:

- Training for on-site consultations that provides assistance and follow-up is helpful.
- Information on how secretariats of accreditation bodies can help is useful, as there is an urgent need for real-time assistance.



Prototype F

Audience: Accreditors and accreditation bodies, including affiliates (e.g. practice, patient safety), programs meeting standards, IPE champions, policy makers, and individuals involved in IPE implementation.

Format: One toolkit with common guidelines and standards for all professions (this does not preclude additional standards for specific disciplines), and sub-sections and examples that are specific to the educational setting. This facilitates the use of varying evidence for different educational programs related to the same standards and promotes collaborative modeling in practice.

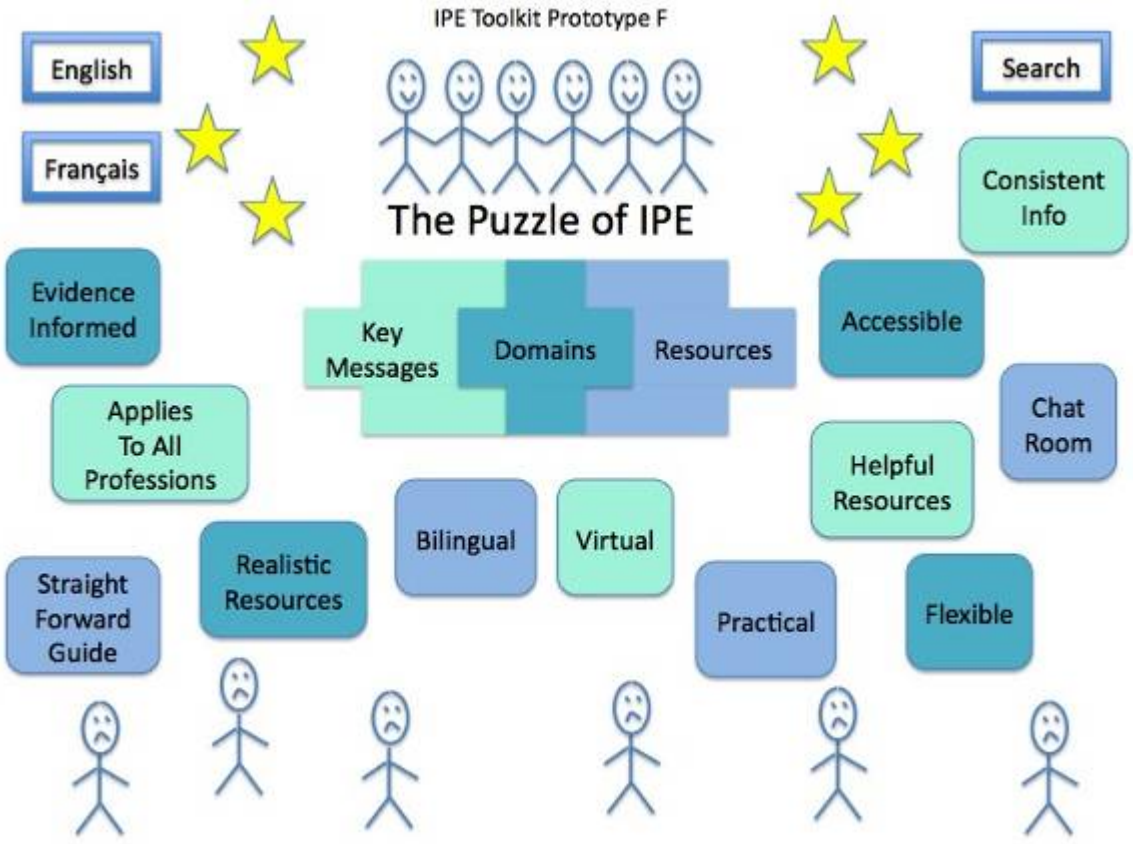
Content:

- *Key messages*: e.g., information on the purpose of the push for IPE (where we are; how we got here; and where we want to go); advancement of IPE within and across professions; improved quality of care leading to improved health.

- *Five domains*: e.g., how standards might be written for each domain but for varying disciplines; means for assessment.
- *Resources*: e.g., website, chat room, posting centre, IT support to make it happen.

Dissemination Methods:

- A dedicated group keeps website information up to date and ensures ongoing linkages across all accrediting and educational organizations with an interest in IPE.
- Targeted funds are donated by a benefactor to the CIHC to manage the system and ensure sustainability.
- A consistent branding logo assists in dissemination.
- New research evidence on IPE accreditation is disseminated through JAIPE (CIHC).



Prototype G

At its plenary presentation, this group noted that its members don't tend to use toolkits, and that producing one to support the AIPHE document may not make sense in light of the costs and ongoing maintenance involved. Questions about who would maintain and sustain such a toolkit and where it would be housed were also raised.

As a result, the group suggested linking to resources that already exist (e.g., the CIHC website) and using them to target accreditors and provide them with the kind of current information they need. It noted that the AIPHE document is a good starting point and that, overall, marketing is more important than creating a toolkit.

The group provided the following suggestions on the kind of information accreditors need and how it could be disseminated.

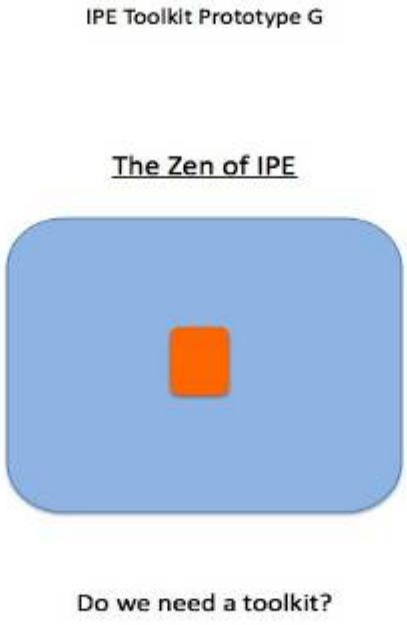
Content:

- *Types of evidence*: standards (indicators); why the change (e.g., demonstrate that IPE is effective); how, why, and what has worked elsewhere and what hasn't (e.g., rewards recognition, faculty development, tips and traps).
- *Glossary of terms*.
- *Self-Evaluation*: worksheet/framework; short-, medium-, and long-term growth factors.
- *Barriers*: what they are and how to overcome them; examples from other disciplines (e.g., engineering).
- *Experience*: detailed and focused information, including quotes; how to identify and support champions; creating and building change; calling on experts; skill-level assessment.

Dissemination Methods:

- On-line clearinghouse (repository of evidence and tools, literature, conferences)
- BLOGS: ever-green
- Marketing campaign: identify champions; get accreditation people to target specific universities; "set the stage".
- Profession-specific methods: journal articles; conferences; presentations to accreditation organizations; support "altruistic" self-interest--why should each discipline do this?

- Links to CIHC website: open access, e-watch, materials that are downloadable, presentable, and can be handed out.



Key Plenary Discussion Points

- Most groups went broader than accreditors with their audience and tried to come up with a toolkit that would also fit people trying to develop curricula, etc.
- What we've produced so far in the AIPHE document, with a bit of tweaking, is likely all the accreditors need. The process piece is the most critical aspect of what we need to do.
- Programs require guidance on what is expected from an accreditation process. If they have accreditation standards that are not open and transparent to the programs, they're going to have a disconnect.
- A lot of work has to be done before anything like this creates itself. Our prototype — a virtual toolkit that points to a whole bunch of other websites — would not necessarily require a lot of maintenance.
- We could have common definitions, case studies, and other information available through all of the accrediting bodies websites; seeing the same information on each would emphasize commonality and linkages.

- If we superimpose all of the presentations made today on top of one another, we'll be able to see the commonalities and the differences; the main needs are clear, the details just have to be worked out.
- If it's this easy for us to come up with the same kinds of conclusions, why should the next step be so hard? Where's the gatekeeper who prevents us from scaling up?

Part IV: Process Challenges in Implementation

Participants discussed the main challenges to developing and implementing standards related to AIPHE. The top ones identified by each group are summarized below:

- "Interprofessional" is often thought of as team focused, although many people practice in isolation. A more flexible approach is needed that will define it more in terms of collaborative care for patient benefit.
- We need high-level buy-in from key stakeholders that IPE is a priority and is in their best interest.
- We need resources to help faculty develop learning opportunities.
- At the accreditation agency level, the challenge is process logistics; at the institutional level, it is the structure of knowledge and how it prohibits cross-sharing; at the program level, it's getting buy-in; and at the practice level it is evidence to support the need for collaboration.
- When one profession is not compliant with an IPE standard and other professions are, the situation rapidly becomes more complicated.

Group Task: Challenges and Recommendations

Toward the end of the forum participants were divided into groups based on profession. They were asked to examine one of the challenges discussed in plenary and suggest actions to address it, focusing on areas where they could make a real difference. A summary of their discussions follows.

Pharmacy Group

Challenge: To get universities to make IPE a priority and facilitate organizational change.

Recommended Action: Speak with one voice: have accreditors and regulators from different health professions deliver a unified and powerful message to university administration.

Social Work and Occupational Therapy Group

Challenge: To define IPE as a collaborative process as opposed to a "team" process and encourage collaboration within professions/disciplines, among professions/disciplines, and with partners outside the health realm.

Recommended Actions:

- Dispel myths.
- Clarify definitions.
- Demonstrate different ways of delivering collaborative practice.
- Create collaborative learning units.
- Create communities of practice around IPE (e.g., educators, accreditors, employers).
- Foster research on costs/benefits at the individual and organizational levels (e.g., financial, quality of care, sustainability).

Physical Therapy Group

Challenge: To match what is happening in education accreditation with what is happening in service delivery accreditation.

Recommended Actions:

- Provide a forum for dialogue between education and service delivery accreditors to align and explore standards/outcomes/language (i.e., bring the two processes closer together).
- Raise the profile of and enable appropriate clinical placements and experiences for students in a collaborative environment (e.g., resources could be directed to this effort overall, with bonuses provided for collaborative environments and innovative practices).
- Improve service delivery.
- Have students provide input into evidence to support the accreditation of service delivery organizations.

Medical Group 1

Challenge: To ensure that students see and learn about successful teams (e.g., find teams and ensure that every student experiences IPE).

Recommended Actions:

- Identify excellent examples of interprofessional, team-based care.
- Mandate student experiences at these sites.
- Evaluate the performance of students and teams using learning objectives and reflective practice.

Nursing Group

Challenges:

- To get agreement across disciplines for IPE accreditation standards.
- To get buy-in from parties that IPE is a priority, particularly in light of competing priorities (e.g., number of nursing students, evidence to support the need for collaboration).
- To obtain the resources needed at the accreditation agency level (logistics and process); institutional level (structural changes to allow sharing); program level (integration into teaching); and practice level (evidence of teamwork).

Recommended Actions:

- Do a presentation on IPE accreditation at the next meeting of the board of directors of the Canadian Association of Schools of Nursing (CASN)—and, after that, to the executive.
- Use the CASN website and electronic newsletter to disseminate information on IPE and IPE accreditation.

Medical Group 2

Challenge: To enable majority buy-in of key stakeholders in the discipline of medicine.

Recommended Actions:

- Implement accreditation standards based on the level of skill that faculties/institutions demonstrate at fostering IPE.
- Develop an accessible annotated bibliography of evidence and identify the need for research.

Key Plenary Discussion Points

- It may not be difficult to reach people, as the appetite is out there.

- The Association of Accrediting Agencies of Canada (AAAC) may be a useful way of sharing information.
- How do we reach groups that are not in the Canadian Medical Association or the AAAC, such as respiratory technologists, paramedics, midwives, psychologists, etc.? It would be good to bring these other groups to a forum like this and do a show-and-tell and discussion on how we could help them move forward, as they have indicated that they are open to this.
- We could write something prior to our next forum to alert groups about what we're doing, so we can share our experiences and start to engage them in dialogue. We could get on the agenda at their meetings too.
- A good beginning would be to get the eight of us around a table and issue a joint policy statement on IPE to put on each of our websites.

Closing Remarks

In her closing remarks, Dr. Delva thanked the facilitator for guiding the AIPHE through this process, the forum participants for their efforts to move it forward, and the accrediting organizations for listening and participating. She said that the input provided on the potential structure and content of a toolkit and ways to overcome some of the challenges faced will be carried forward by the Steering Committee for discussion and implementation.

Dr. Delva said that she comes away from the forum stimulated, invigorated, and confident that the ideas discussed will bring about change. She stressed, however, that the task at hand cannot be accomplished alone and will require ongoing collaboration. The Steering Committee will meet directly after the forum to confirm next steps, and a forum report will be forthcoming. In the meantime, participants will receive a communiqué that they are encouraged to customize and send to others who may be interested in the forum discussions.

Appendices

Appendix I: Forum Agenda

Tuesday, February 17, 2009

6:00 pm Welcome, Opening Remarks: Dr. Mary Ellen Jeans, Co-Chair AIPHE Initiative, President and CEO, Associated Medical Services (AMS) Inc.
Purpose, Objectives, Agenda: Dorothy Strachan, Facilitator

6:30 pm **Part I: Accreditation — What Can We Do to Enable IPE Integration?**
Table and plenary discussion

Wednesday, February 18, 2009

8:30 am Agenda Review/Preview

8:40 am **Part II: Background Documents**
Plenary Discussion

9:30 am **Part III: Building a Practical Toolkit for Implementing AIPHE**
Toolkit framework: Andrea Burton, Marketing and Communication Consultant
Discussion
Small group work

11:20 am Presentations: small group work

1:30 pm **Part IV: Process Challenges in Implementation**
Identification and description of key challenges

2:00 pm Strategies to address challenges

2:15 pm Plenary Discussion: conclusions re challenges

3:20 pm Discussion: Engaging additional health professions

3:40 pm The AIPHE Initiative: Next Steps

3:50 pm Closing Remarks

Appendix II: List of Participants

		Last Name	First	Organization
STEERING COMMITTEE				
1	Dr	Bainbridge	Lesley	Accreditation Council for Canadian Physiotherapy Academic Programs (ACCPAP)
2	Dr	Birtwhistle	Richard	Committee on Accreditation of Canadian Medical Schools (CACMS)
3	Dr	Charles	Grant	Board of Accreditation of the Canadian Association for Social Work Education (CASWE)
4	Dr	Delva	Dianne	Associate Dean, Undergraduate Medicine, Dalhousie University (Co-Chair)
5	Dr	Grymonpre	Ruby	IPE Coordinator, IPE Initiative, University of Manitoba
6	Dr	Hill	David	Executive Director, Canadian Council for Accreditation of Pharmacy Programs (CCAPP)
7	Dr	Jeans	Mary-Ellen	President and CEO, Associated Medical Services (AMS) Inc. (Co-Chair)
8	Ms	Kennedy	Margaret	Assistant Director, Accreditation & Liaison, Royal College of Physicians and Surgeons of Canada (RCPSC)
9	Ms	Larocque	Suzanne	Director of People Services, Accreditation Canada
10	Ms	Maskill	Sue	Association of Faculties of Medicine of Canada (AFMC) *(ex-officio*)
11	Dr	Nasmith	Louise	College of Family Physicians of Canada (CFPC)
12	Dr	Orchard	Carole	Coordinator, Interprofessional Health Education & Research, University of Western Ontario
13	Dr	Rukholm	Ellen	Executive Director, Canadian Association of Schools of Nursing (CASN)
14	Ms	Van Benthem	Kathy	Director of Policy and Standards, Canadian Association of Occupational Therapists (CAOT)
OTHER PARTICIPANTS				
15	Ms	Beggs	Cathryn	Executive Director, Accreditation Council Canadian Physiotherapy Academic Programs (ACCPAP)
16	Mrs	Buck	Madeleine	Chair, Accreditation Bureau, Canadian Association of Schools of Nursing (CASN)
17	Dr	Busch	Angela	Chair, Canadian University Physical Therapy Academic Programs (CUPAC)
18	Dr	Busing	Nick	Secretary, Committee on Accreditation of Canadian Medical Schools (CACMS)
19	Ms	Butlin	Jennifer	Director, Commission on Collegiate Nursing Education (CCNE)
20	Ms	Davies	Janet	Consultant - Health Canada
21	Dr	Dumont	Serge	Dean, École de service social, Université Laval
22	Dr	Fuks	Abe	Chair, Committee on Accreditation of Canadian Medical Schools (CACMS)
23	Dr	Grégoire	Jean-Pierre	Dean, Faculté de pharmacie, Université Laval
24	Ms	Hobson	Sandra	Chair, Accreditation Council, Canadian Association of Occupational Therapists (CAOT)
25	Dr	Humphries	Paul	College of Family Physicians of Canada (CFPC)
26	Dr	Hunt	Dan	Co-Secretary, Liaison Committee on Medical Education (LCME)
27	Dr	Lefebvre	Fleur-Ange	Executive Director and CEO, Federation of Medical Regulatory Authorities of Canada (FMRAC)
28	Ms	MacDonald-Rencz	Sandra	Office of Nursing Policy of Health Canada (IECPCP)
29	Ms	Maddigan	Joy	Member, Advisory Committee on Health Delivery and Human Resources (ACHDHR) (Newfoundland & Labrador)
30	Ms	McElroy	Helen	Manager, Health Care Professionals, Health Care Policy Directorate, Health Canada
31	Dr	McKenzie	Brad	Co-Chair, Board of Accreditation, Canadian Association for Social Work Education (CASWE)
32	Ms	Miller	Carol	Director, Practice and Policy, Canadian Physiotherapy Association (CPA)
33	Ms	Neufeld	Kaaren	President, Canadian Nurses Association (CNA)
34	Mr	Nickerson	Jason	President, National Health Sciences Students' Association (NaHSSA)
35	Dr	Pasutto	Franco	President, Association of Deans of Pharmacy of Canada (ADPC)
36	Ms	Posgate	Libby	Director, Health Human Resources (Physicians), Ministry of Health of British Columbia
37	Dr	Stamler	Lynnette	President, Board of Directors, Canadian Association of Schools of Nursing (CASN)
38	Dr	Talbot	Lise	Past-President, Board of Directors, Canadian Association of Schools of Nursing (CASN)

39	Dr	Taylor	Elizabeth	President, Board of Directors, Canadian Association of Occupational Therapists (CAOT)
40	Dr	Tepper	Joshua	Co-Chair, Advisory Committee on Health Delivery and Human Resources (ACHDHR)
41	Mr	Vibert	Joseph	CEO, Canadian Alliance of Physiotherapy Regulators (The Alliance)
42	Dr	Vlasses	Peter	Executive Director, Accreditation Council for Pharmacy Education (ACPE)
43	Dr	Watkins	Todd	Director, Office of Professional Affairs, Canadian Medical Association (CMA)
44	Dr	Whitman	Lucinda	Accreditation Committee, Royal College of Physicians and Surgeons of Canada (RCPSC)
CONSULTANTS				
45	Ms	Burton	Andrea	Consultant - Communications and Marketing
46	Ms	Ebbs	Leslie	Consultant - Meeting and Report Writer
47	Ms	Liman	Yolanda	Consultant - Evaluation
48	Ms	Strachan	Dorothy	Consultant - Facilitator
49	Ms	Wisener	Katherine	Consultant - Evaluation
STAFF				
50	Ms	de Lucovich	Claire	Association of Faculties of Medicine of Canada (AFMC)
51	Ms	Moffatt	Catherine	Association of Faculties of Medicine of Canada (AFMC)