



FULFILLING
Our **POTENTIAL**



UNIVERSITY OF TORONTO
FACULTY OF MEDICINE

APPENDICES
TO THE
PROCEEDINGS
REPORT

FULFILLING OUR POTENTIAL | A FACULTY OF MEDICINE STRATEGY RETREAT
APRIL 2, 2014 | INTERCONTINENTAL TORONTO CENTRAL, 225 FRONT ST. W.
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Fulfilling our Potential - Proceedings Report

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APPENDIX A: Participant List

Name	Title	Breakout Group
<i>Caroline Abrahams</i>	Director, Policy, Postgraduate Medical Education	1b
<i>Dimitri Anastakis</i>	Vice Dean Continuing Professional Development	1a
Michael Apkon	Chief Executive Officer, Sick Kids	5
Jane Aubin	Canadian Institutes of Health Research	3
Brian Bachand	Interim Executive Director, Advancement	6
Bob Bell	Chief Executive Officer, University Health Network	a.m. only
Katherine Berg	Chair, Physical Therapy	1a
Koman Bhasin	Director, Strategic Policy, Centre for Addiction and Mental Health	2
Kim Blakely	President, Undergraduate Medical Society	4
Heather Boon	Acting Dean, Leslie Dan Faculty of Pharmacy	5
Adalsteinn Brown	Director, Health Policy Management & Evaluation	5
Roberta Brown	Web/Digital Communications Specialist	6
Alison Buchan	Vice Dean, Research and International Relations	3
Elizabeth Buller	Chief Executive Officer, St. Joseph's Health Centre	5
Peter Burns	Chair, Medical Biophysics	2
Angela Colantonio	Professor, Occupational Therapy	4
Meg Connell	Director, Office of the Dean	6
Mary Anne Cooper	Director, Peters-Boyd Academy	4
Brian Corman	Dean of Graduate Studies and Vice-Provost Graduate Education	1b
Michael Dan	Campaign Cabinet	a.m. only
Denis Daneman	Chair, Pediatrics	1a
Luc De Nil	Speaker, Faculty of Medicine Council	1b
Terrence Donnelly	Campaign Cabinet	a.m. only
Victor Dzau	Chief Executive Officer, Duke Health System	a.m. only
Nancy Edwards	Chief Financial Officer, Faculty of Medicine	6
Sherif El-Defrawy	Chair, Ophthalmology	a.m. only
Marilyn Emery	Chief Executive Officer, Women's College Hospital	5
George Fantus	Associate Dean, Research	2
<i>Michael Farkouh</i>	Director, Heart & Stroke Richard Lewar Centre of Excellence in Cardiovascular Research	3
Michael Fehlings	Associate Chair, Surgery	2
Meric Gertler	President, University of Toronto	a.m. only
Ewan Goligher	Student, Clinical Investigator Program	3
Lisa Goos	Director, Knowledge Translation, Baycrest	2
<i>Avrum Gotlieb</i>	Interim Vice-Dean, Graduate & Life Sciences Education	1b

Name	Title	Breakout Group
Maureen Gottesman	Medical Director, Physician Assistant Program	1b
Eva Grunfeld	Vice Chair, Research, Family & Community Medicine	3
Daniel Haas	Dean, Faculty of Dentistry	5
Mark Hanson	Associate Dean, Admissions and Student Finance	1b
Gillian Hawker	Professor, Department of Medicine	3
Richard Hegele	Chair, Laboratory Medicine & Pathobiology	2
Keith Ho	PhD Candidate, Physiology	1b
Brian Hodges	Vice President Medical Education, UHN	4
Patricia Houston	Vice President Medical Education, St. Michael's Hospital	4
Robert Howard	Chief Executive Officer, St. Michael's Hospital	5
Howard Hu	Dean, Dalla Lana School of Public Health	5
Janet Hunter	Registrar, Undergraduate Medical Professions Education	6
Kevin Imrie	Vice-Chair Education, Medicine	1a
Ira Jacobs	Dean, Kinesiology and Physical Education	5
Jackie James	Vice President Medical Education & Director, Wightman-Berris Academy, Mt. Sinai	1a
Sheila Jarvis	Chief Executive Officer, Holland Bloorview Kids Rehabilitation Hospital	5
Prabhat Jha	U of T Chair in Disease Control	4
Jesse Kancir	President, Canadian Federation of Medical Students	1b
Allan Kaplan	Director, Institute of Medical Sciences	2
Brian Kavanagh	Chair, Anesthesia	3
Dermot Kelleher	Dean of Medicine, Imperial Coll. London	4
John Kingdom	Chair, Obstetrics & Gynecology	1a
Jonathan Kronick	Chief of Education, Sick Kids	1b
Mary L'Abbe	Chair, Nutritional Sciences	2
Julie Lafford	Director, Annual Giving & Alumni Relations	6
Sylvia Langlois	Associate Director, Interprofessional Education	1b
Helen Lasthiotakis	Assistant Dean, Faculty of Arts & Science	6
Marcus Law	Director, Medical Ed., Toronto East Gen.	4
Hin Lee	Program Manager, McLaughlin Centre	2
Karen Leslie	Director, Faculty Development	1a
Gary Lewis	Director, Banting & Best Diabetes Centre	2
Howard Lipshitz	Chair, Molecular Genetics	3
Fei-Fei Liu	Chair, Radiation Oncology	1b
Jonathan Livergant	PGY4, Radiation Oncology	1b
Stephen Lye	Executive Director, Fraser Mustard Institute for Human Development	4
Muhammad Mamdani	Director, Applied Health Research Centre, LKSKI	2

Name	Title	Breakout Group
Jerry Maniate	Chief of Med Ed, St. Joseph's Health Centre	1a
Philip Marsden	Vice Chair, Research, Medicine	3
Alberto Martin	Undergraduate Director, Immunology	3
Rosemary Martino	Interim Chair, Speech-Language Pathology	2
Stephen Matthews	Chair, Physiology	2
Sandra McGugan	Manager, Physician Scientist Program	1b
David McKnight	Associate Dean, Equity and Professionalism	4
Anastasia Meletopoulos	Academic Affairs Specialist	6
Golda Milo-Manson	Vice President Medical Education, Holland Bloorview Kids Rehabilitation	1b
Faye Mishna	Dean, Factor-Inwentash Faculty of Social Work	5
Alan Moody	Chair, Medical Imaging	3
Gary Mooney	Campaign Cabinet	a.m. only
Tim Neff	Chief Administrative Officer	6
Sioban Nelson	Vice-Provost, Academic Programs	5
Leslie Nickell	Assoc Dean, Health Professions Student Affairs	1b
Justin Nodwell	Chair, Biochemistry	2
Gilbert Omenn	Director of Computational Bioinformatics, University of Michigan	2
Julia O'Sullivan	Dean, Ontario Institute for Studies in Education	5
Christopher Paige	Vice President Research, University Health Network	3
Cathryne Palmer	Director, Medical Radiation Sciences Program	1a
Peter Pauly	Interim Dean, Rotman School of Management	5
Rick Penincer	Director, Medical Education, North York General Hospital	1a
Johanne Provencal	Assistant Vice-Provost, Health Sciences Sector	6
<i>Lloyd Rang</i>	Executive Director, Communications	5
Cheryl Regehr	Vice President and Provost	float
William Reichman	Chief Executive Officer, Baycrest	5
Charlotte Ringsted	Director, Wilson Centre	4
Jean Robertson	Director, Human Resources	6
Tom Robertson	Vice President, University Health Consortium	5
Wes Robertson	Director, Administrative Computing	6
Elizabeth Rochon	Professor, Speech-Language Pathology	1b
Paula Rochon	VP Research, Women's College	2
Brittany Rosenbloom	MSc Student, Institute of Medical Sciences	1a
Norman Rosenblum	Associate Dean, Physician Scientist Training Program	3
Jay Rosenfield	Vice Dean, Undergraduate Medical Professions Education	1a
Ruth Ross	Chair, Pharmacology & Toxicology	3

Name	Title	Breakout Group
Jim Rutka	Chair, Surgery	3
Tim Rutledge	Chief Executive Officer, North York General Hospital	5
Michael Salter	Associate Chief of Research, Hospital for Sick Children	2
Teenu Sanjeevan	PhD Candidate, Speech-Language Pathology	1b
Steve Scherer	Director, McLaughlin Centre	2
Suzan Schneeweiss	Academic Director, Continuing Professional Development	1a
Kaveh Shojania	Director, Quality Improvement & Patient Safety	3
Giacomo Silvestri	MSc Student, Physical Therapy	1a
Salvatore Spadafora	Vice-Dean, Postgraduate Medical Education	1b
Heather Taylor	Director, Facilities and Space Planning	6
<i>Alisha Tharani</i>	Manager, Toronto Academic Health Sciences Network	5
Ross Upshur	Dalla Lana School of Public Health	4
Sarita Verma	Deputy Dean, Faculty of Medicine	float
Catharine Whiteside	Dean, Faculty of Medicine	5
Lynn Wilson	Chair, Family & Community Medicine	4
Ian Witterick	Chair, Otolaryngology – Head & Neck Surgery	1a
James Woodgett	Director, Lunenfeld Research Institute (Mt. Sinai)	2
Virginia Wright	Director of Research, Holland Bloorview Research Institute	3
Christopher Yip	Director, Institute for Biomedical and Biomaterials Engineering	3
Trevor Young	Chair, Psychiatry	4
Catherine Zahn	Chief Executive Officer, Centre for Addiction and Mental Health	5
Ari Zaretsky	Vice President, Medical Education, Sunnybrook Health Sciences Centre	1b
Molly Zirkle	Director, Fitzgerald Academy	1b

Breakout Session Facilitator | Breakout Session Recorder

APPENDIX B: Retreat Agenda

TIME	ACTIVITY	LOCATION	SPEAKER(S)
7:45 am	Registration	Lower level foyer	
8:00 am	Breakfast	Ontario & Niagara Rooms	
8:30 am - 9:00 am	Opening remarks	Ballroom	Dean Catharine Whiteside
9:00 am - 9:30 am	Keynote address		President Meric Gertler
9:30 am - 9:45 am	Setting the stage		Deputy Dean Sarita Verma
9:45 am - 10:00 am	B R E A K		
10:00 am - 11:30 am	Moderated discussion	Ballroom	Academic health science networks: models and best practices Victor Dzau, Dermot Kelleher, Tom Robertson, <i>Moderated by Catherine Zahn</i>
11:30 am	Video presentation	Ballroom	Deputy Dean Verma will present a new Faculty of Medicine video
11:35 am – 12:20 pm	Poster session and lunch	Lower level foyer	Posters will be available for download at 11:00 am EST: www.cpd.utoronto.ca/fom/poster-session
12:20 pm - 12:30 pm	M O V E T O B R E A K O U T R O O M S		
12:30 pm - 2:15 pm	Breakout sessions	1A Humber Room 1B Halton Room 2 Wellington 3 Grenadier 4 Haliburton 5 Kingsway 6 Oakville	Group assignments are indicated on the back of guest name badges.
2:15 pm - 2:30 pm	B R E A K		
2:30 pm - 2:45 pm	Provost's reflection	Ballroom	Professor Cheryl Regehr
2:45 pm - 4:15 pm	Research panel		The Future of Research and Innovation, Jane Aubin, Gilbert Omenn, Nelson Spruston, <i>Moderated by Alison Buchan</i>
4:15 pm – 4:30 pm	Closing remarks		Deputy Dean Sarita Verma Executive Director of OSCER, Lloyd Rang
4:30 pm	Adjourn for reception	Ontario & Niagara Rooms	Dean Whiteside invites all guests to join them for a cocktail reception.
<p>PLENARY, DINING & POSTER SESSION are on the lower level BREAKOUT ROOMS are on the main lobby level WASHROOMS are located on both the main lobby and lower levels</p>			

APPENDIX C: Morning Plenaries

Dean Catharine Whiteside (slide deck)



**FULFILLING
OUR POTENTIAL**

 UNIVERSITY OF TORONTO
FACULTY OF MEDICINE

Dr. Catharine Whiteside, MD, PhD
Dean, Faculty of Medicine
Vice-Provost, Relations with Health Care Institutions

APRIL 2, 2014 | INTERCONTINENTAL TORONTO CENTRE
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Welcome

- International Guests
- University of Toronto Leaders
- Faculty of Medicine Academic and Administrative Leaders
- Students
- Campaign Cabinet Volunteers

Thank you

- Senior Leaders – Faculty of Medicine
- Office of CPD
- Office of Strategy, Communications and External Relations
- Sarita Verma – Deputy Dean
- Meera Rai – Director of Strategic Planning

Faculty of Medicine Strategic Academic Plan 2011–2016

... at the mid-point of implementation, are we *“Fulfilling our Potential?”*

Key Challenges as of 2011

- What is the core value of the Faculty of Medicine?
- What are the strategic research foci?
- How do we measure performance and define excellence in education and research?
- What is our role within the TAHSN community and more broadly among all the U of T affiliates?

Core Values Defined by ...

Vision: international leadership in **improving health** through innovation in research and education.

Mission: we **fulfill our social responsibility** by developing leaders, contributing to our communities, and improving the health of individuals and populations through the discovery, application and communication of knowledge.

Research Focused on ...

- Human Development
- Neuroscience and Brain Health
- Global Health
- Complex Disorders – diabetes, cardiovascular disease, musculoskeletal disorders, cancer

Dean's Report 2013–2014

Tells the story with specific performance measures

- Global rankings
- Fundraising targets
- Growth in enrolments and student support
- Accreditation of health professions programs



Systematically measuring key performance indicators to:

- Iteratively improve; and,
- Communicate about our achievements with evidence



Academic Unit Strategic Planning

Aligned with the goals of the

- Faculty of Medicine
- University of Toronto
- Collaborating hospital/research institute affiliates



Key Question:

What is the role of the university leadership when the majority of faculty, students and trainees spend the vast majority of their time and academic engagement in our affiliated hospitals and research institutes?



Core Principle of Strategy Implementation

Integration to achieve
Innovation and
measurable **Impact**



Recognizing Value

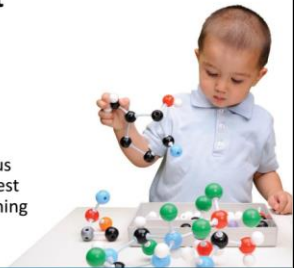
The **value** of U of T Departments, Centres and Programs is recognized when our leaders facilitate strategic collaboration with academic partners internal and external to U of T.



Fraser Mustard Institute for Human Development

... a U of T "big idea"

Aims to discover the optimal developmental trajectories for young children to prevent serious debilitations and to foster the best possible continuing health, learning and social functioning.



Integrating Education, Research and Healthcare



Toronto Dementia Research Alliance

- Baycrest
- CAMH
- St. Michael's
- Sunnybrook
- UHN
- U of T (Tanz CRND)

Mission:

Mitigate suffering from neurodegenerative disorders through understanding mechanisms and finding better targets for disease modification and earlier means to detect and treat these diseases.



Medical Psychiatry Alliance

- U of T (Dept. of Psychiatry)
- CAMH
- Sick Kids
- Trillium Health Partners

Mission:

The Alliance will create a new model of integrated care that is supported by a new approach to the education of health professionals and through innovations driven by research.



International Collaboration — Education/Research

First Joint PhD Program (at U of T)

- Faculty of Medicine, Dept. of Molecular Genetics
- Hong Kong University, Dept. of Biochemistry



National Collaboration — Research/Healthcare

With International Impact

Canadian Interprofessional Health Leadership Collaborative

- U of T
- UBC
- Northern Ontario School of Medicine
- Queen's University
- Université Laval

Goal: incubate and pilot ideas for reforming health professional education called for in the Lancet Commission report (2010) and the IOM's Global Forum on Innovation in Health Professional Education (2012).



Local Collaboration

Developing Integrative Thinking and Leadership

Leadership Education and Development (LEAD) Program for Medical Students

Competitive program for medical students with demonstrated leadership potential to take graduate courses and complete projects mentored by leaders in academia and health care administration to prepare a new generation of physician leaders.



Impact

“Improving Health” requires **innovation** enabled by knowledge flow and translation into practice through **integration** of research, education and clinical care.



Key Implementation Tactic: *Strategic Communication*

Office of Strategy, Communications and External Relations

- Improved communication with all stakeholders
- Consistent message about our “value”
- Collaboration with affiliates on co-branding achievements
- New website and social media communication and tracking
- New UT Medicine magazine
- Improved MedEmail format and content



We are “*Fulfilling our Potential*” ... but in the face of continual change and challenge we must adapt and adopt new implementation tactics to achieve our goals.



The Challenges

- Sufficient and sustained funding for research
- On-campus infrastructure – deferred maintenance and outdated research facilities
- Student tuition – flat-lined
- Reduced funding from MTCU for universities
- Co-branding between U of T and affiliate



The Opportunities:

- Lead and facilitate strategic collaboration to develop initiatives that accelerate innovation
- Target fund-raising and build private sector relations
- Optimize teaching and learning across affiliates to more strategically deploy existing capacity



To Fulfill Our Potential ...
let us chart the course for the next 2.5 years.



Our Keynote Speaker

President Meric Gertler

- Installed as U of T's 16th President in November 2013
- Dean of U of T's Faculty of Arts & Science (2008–2013)
- Research interests: geography of innovative activity and the economies of city-regions
- One of Canada's most highly cited geographers
- One of the world's foremost urban theorists and policy practitioners



APPENDIX C: Morning Plenaries

President Meric Gertler (full text remarks)

Thank you, Dean Whiteside, for that kind introduction.

I am delighted to be here and honoured to speak.

Over the next twenty or so minutes, I would like to share two key messages with you.

The second message – about partnership – will comprise the lion’s share of my remarks.

But it is my first message that I think is the most important and if there is one thing I hope you take away from my remarks today, it is this: Thank you.

Thank you for your leadership... for your scholarship, mentorship, and clinical expertise... for your commitment to research, and research-intensive education... for your dedication to your students, your colleagues, your patients, your hospitals, your extended communities, and your University.

As everyone knows well, so many of the challenges we face in the 21st century respect no borders, whether physical, geographical, or socio-economic. Everything from pandemics and public health to demographics and development are increasingly global problems.

Responding to these challenges is a noble and, crucially, a collective enterprise.

I am struck, looking out at this gathering, that many of the next discoveries in basic science, each with far-reaching and entirely unpredictable repercussions... many of the next advances in clinical practice, many innovations in education... and so many of tomorrow’s leaders in all of these fields... have their roots in this room today.

It is a humbling and inspiring thought.

So my first and most important message this morning is thank you for everything you do individually and together on behalf of our remarkable academic community.

Second Message: The Importance of Partnership

My second message picks up from my first message and takes me back to my installation address — it is hard to believe that was just five months ago...

In that address I identified a number of headwinds facing our community and institutions and I proposed three strategies to respond to them:

- Leveraging our location,
- Advancing international collaboration, and
- Re-examining or re-inventing undergraduate education.

I am not going to revisit these themes in any detail here. Instead, I want to focus on a precept fundamental to each of them: Partnership.

Indeed, I would suggest that partnership and excellence are the two key engines in the drive to fulfill our potential, just as they are – if you will forgive the mixed metaphor – the cornerstones of integration, innovation, and impact.

So let me spend the balance of these remarks reflecting on the nature of our partnerships and how I see them evolving at increasing scales and broadening scopes.

- Local/Institutional level -

Start with the partnership closest to home: our huge, diverse, and deep academic community.

The University of Toronto is an enormous physical operation. Let me try to give you a sense of the scale.

There are some 260 buildings and 1.7m gross square metres of built environment, across three campuses – if you converted that floor space into parking spots, they would stretch end-to-end from Toronto to Montreal and back.

All of this sits on something like 7m square metres of real estate – that's more real estate than the home football fields of every professional, university, and college football team in Canada and the United States combined.

And that doesn't count our partner hospitals and institutions.

On top of this, there are about 1,000 graduate, undergraduate, and professional programs. There are 44 libraries. We host some 82,000 students and about 18,000 faculty, staff, and librarians – added all up, that's about the population of St. John's NF.

This is fertile ground for collaboration and partnership. Indeed, traditional collaborations abound and are remarkably successful.

But such is the strength, breadth, and depth of the University of Toronto community that wonderfully inventive interdisciplinary collaboration thrives, too.

To take just one ‘only at U of T’ example of creative convergence: Prof Lorna MacDonald teaches performance, opera, and vocal pedagogy in the Faculty of Music. She also collaborates with the clinicians at Hospital for Sick Children’s Cochlear Implant Research Laboratory on laryngology, speech-language pathology, and pediatric voice and hearing care.

But as will be no surprise, in the context of such complexity, that challenges thrive in lockstep with opportunities.

For example:

- How can our community foster and enable collaboration? Or should we?
- How do we help create opportunities? Or can we?
- How do we understand the responsibilities and privileges of citizenship in our extended academic federation?

These are important questions requiring ongoing discussions. But one thing is clear: In responding to these challenges, Simcoe Hall should not be a barrier, as I know – from experience! – it is sometimes perceived to be. I hope familiarity with and respect for our community are two of my most important qualifications for the job of President, as they were for my predecessor.

Recognizing and acknowledging how Simcoe Hall is so often perceived outside its portrait-lined corridors is part of that respect.

Instead, Simcoe Hall has (or should have) the critical role of an honest broker and facilitator – just as the University of Toronto more generally is (or should be) an honest broker for the partners of in our community and beyond.

- Municipal / Provincial -

As we broaden our view to our local municipal and provincial communities, the University’s social obligations and mandates come into focus. The University of Toronto is a publicly assisted institution, funded in part by the people of Toronto, Ontario, and Canada. We receive our primary missions from them: advanced research and education. The same is true – with particular, institution-specific considerations – for the University’s partner hospitals. In a very real sense, our institutions work in partnership with our communities.

These constituencies rightly expect excellence. And they receive it.

Here are two proof points among many: The University of Toronto is Canada's only university consistently ranked among the top 20 or 25 universities in the world. And U of T ranks behind only Harvard in total research output worldwide.

These rankings speak to excellence in advanced research. We also respond with equal distinction to our mandate to help educate the people of Ontario. For example, the proportions of Ontario's medical practitioners educated in the University of Toronto and our partner hospitals are remarkable:

- More than a quarter of the province's medical doctors...
- Nearly 30% of the province's occupational and physical therapists...
- Half of Ontario's speech therapists...
- More than half of the dentists...
- Three quarters of the province's pharmacists...

The list goes on.

I suggest that the University of Toronto and our partner hospitals form a collaborative cluster that combines research excellence with accessible education in a way that few institutions in the world can match. In fact, I don't think there are any.

The hospitals, of course, have the added responsibility of helping to meet the clinical and public health needs of the city and the province. These are acute challenges.

I understand that results from a recent study of the Toronto Central LHIN [[check how to describe this and tighten language]] indicate that more than 35% of patients from the Bay Street Corridor, University and Kensington-Chinatown neighbourhoods presenting to hospital emergency departments reported having no primary care physician. Similarly, almost 40% of visits to emergency departments from Regent Park residents are for non-urgent care. These are striking data points and evidence of one of this century's greatest tests of public health: Urbanization.

There are countless ways we are responding to this test. Excellence in basic research is the most obvious. It bears stressing that this is not so obvious in all circles – especially in the context of a seemingly growing emphasis on fettered and focused research funding among the granting councils. Moreover, advances in health sciences (and even health policy) are not accidents or simply by-products of “putting in the time”. They are the direct results of decades of fundamental research – much of which might have seemed fruitless at the time. That research is meticulously confirmed, revised, rethought, and reapplied over generations. In a very real sense we are part of an intergenerational partnership.

Fortunately, our academic community is brilliant at fundamental research.

We are also brilliant at the other end of the fundamental / applied research spectrum. One small but compelling example of this may well be the extraordinary student-led, largely student-funded group called IMAGINE. As many here will know, IMAGINE is an inter-professional, student-run community health partnership aimed at promoting and providing health care to the core neighbourhoods of downtown Toronto. And when I say “inter-professional”, I mean it: the team has roots in a host of our Divisions, including Medicine, Pharmacy, Dentistry, Social Work, Nursing, and Public Health.

Yet there is an essential tension at the heart of our partnership with the city and the province. Our political leaders deserve praise for protecting funding for education and health from the sharpest cuts in a period of budget austerity and restraint. But there just isn't sufficient money to sustain or build upon what we have already achieved.

That would be troubling enough. But it is aggravated by poor or short-sighted policy decisions. Ontario has the lowest per-student funding of any province in Canada. It is weakly differentiated and insensitive to differences in jurisdiction-related costs – the province subsidizes the cost of educating a student in Toronto at the same rate as they subsidize the cost of educating a student in Nipissing.

Spending on infrastructure or deferred maintenance is regarded in some quarters as a cost rather than an investment. And utterly sensible pension solvency legislation would save our institutions millions of dollars tomorrow.

In addressing these tensions, our partnership serves us well. Advocacy with a single voice is powerful. This is especially true when governments of every stripe seem strained to rise above retail politics or populism. For a good example of this, let me turn to the national landscape...

- *National* -

After more than two years of coordinated advocacy efforts from across the post-secondary education and advanced research sector, the 2014 Federal Budget created the Canada First Research Excellence Fund.

Quoting from the Budget:

“Economic Action Plan 2014 proposes to create the Canada First Research Excellence Fund with \$1.5 billion in funding over the next decade to help Canadian post-secondary institutions excel globally in research areas that create long-term economic advantages for Canada.”

The most important part of this announcement was the Government's commitment to award the funding on the basis of excellence and tri-council funding performance.

I think it is worth noting that the Canada First Research Excellence Fund will go a long way to helping redress some of the perverse incentives in the Indirect Costs Program.

Let me spend just a moment elaborating.

As will be familiar to everyone in the room this morning, the Federal Indirect Costs Program was designed to help institutions meet the costs of providing researchers with adequate space and with a wide variety of support services – light, heat, cleaning, and so on. Bizarrely – and in total contrast with our peer jurisdictions – these so-called indirect costs are covered in Canada at a rate inversely proportional to the amount of research an institution does.

This program punishes excellence in research. It has been a constant thorn in our collective side – and the subject of frustrating advocacy for over a decade.

The trouble has always been that it is a tough sell in Ottawa. It doesn't make a good "announceable". I guess their thinking has been that the headline "Government to Augment \$272M In Research Funding by 50% to Keep Lights On, Labs Clean" doesn't win many votes.

Faced with this, we took an orthogonal approach.

The new Canada First Research Excellence Fund represents a sea change. Because it will be explicitly based on excellence and success in peer-reviewed Tri-Council funding competitions – and not the inverse – it rights the balance that the Indirect Costs Program had upended.

The Indirect Costs Program is still in place, but this new Excellence Fund is an extremely positive first step forward. It is a huge win for the University of Toronto community and the cause of higher education and advanced research in Canada.

And it was the product of a nation-wide partnership, led from Toronto.

Ultimately, I think our collective advocacy persuaded the highest levels of the federal government that the University of Toronto, the research hospitals in the Toronto region, and a select number of our peers across the country are vital national resources and must be promoted as such.

- *International* -

Indeed, these same institutions represent Canada's resources for the world and a vital conduit through which the world comes to Canada.

When one reflects on partnerships that extend beyond Canada's borders, partnerships among institutions of advanced education and research should be top of mind. This is particularly true of our institutions. Consider:

In 2012 alone, authors with a U of T affiliation collaborated on publications with over 8,000 institutions in hundreds of municipalities around the world.

This is an extraordinary number. According to Thomson Reuters besides U of T only one institution in Canada had more than 8,000 publications of any kind in 2012 – UBC had 8312. Furthermore, lest the quality be lost in the sheer quantity, consider our share of the past decade's most highly-cited publications from Canadian universities:

- 41% across all fields,
- 36% in surgery,
- 30% in social work,
- 42% in oncology,
- 33% in neuroscience,
- 34% in general and internal medicine...

The list goes on and on. Research from the University of Toronto has a disproportionate impact on the world.

Similarly, when the best universities in the world want to collaborate, they seek out the University of Toronto.

A recent study reported in *Nature* found that, "Exceptional research groups share ideas, resources and outcomes." No surprise. But the exclusivity of exceptional research groups is striking. The most frequent international partners of the University of Cambridge are the Max Planck Institutes, MIT, Harvard, CalTech, Berkeley, the University of Heidelberg, and two U of Ts: Tokyo and Toronto. Harvard's most frequent international partners are Imperial College London, University College London, the Max Planck Institutes, the Karolinska Institute, the University of Cambridge, the University of Geneva, and the University of Toronto.

The report's author correctly notes that: "Excellence seeks excellence". In fact, everyone seeks excellence. Institutions are lining up to partner with our Faculty of Medicine and the region's academic hospitals. Our international partnerships are flourishing – from every corner of the globe: from United States and Europe... to China, India, and Brazil... to Africa and the Middle East.

It is obvious why all of this matters. The Toronto region's institutions of advanced research and education form a vital gateway to Canada's global partners.

To tie all of these various threads together, at whatever scale we focus our gaze – from the institutional through the municipal, provincial, and national, to the international – partnerships drive integration, innovation, and impact. Partnership is a fundamental precept in helping us fulfill and increase our potential.

- *Conclusion* -

Let me conclude with an observation and an appeal.

First, the observation.

The University of Toronto's ability to excel at partnerships has helped define this institution for nearly 200 years. It was both fortuitous and telling that the University's attempt to build a hospital of its own at the turn of the 19th century – the Park Hospital as it was to be called – failed. This opportune failure provided the impetus for a century of remarkable collaboration and partnership at every level.

The Presidency of the University of Toronto is a daunting and humbling responsibility. I admit to a little trepidation over the summer as the date of my installation approached. However, my confidence in our collective future has grown with each passing day. My optimism is informed by our history of partnership and excellence and it is strengthened by the outstanding people I have the privilege of working with and for – not least among them, everyone in the room this morning.

And finally, the appeal.

I think we need to do a better job of celebrating our partnerships – of recognizing and paying tribute to what we have achieved together.

In that same spirit, I call upon us to renew and reinvigorate our partnerships – and when we do, we will take another step towards achieving our potential, and we will have that much more to celebrate tomorrow.

Thank you for your kind attention.

APPENDIX C: Morning Plenaries

Deputy Dean Sarita Verma (slide deck)



Dr. Sarita Verma, LLB, MD
Deputy Dean, Faculty of Medicine
Associate Vice-Provost, Health Professions Education

APRIL 2, 2014 | INTERCONTINENTAL TORONTO CENTRE
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**FULLILLING
OUR POTENTIAL**

 UNIVERSITY OF TORONTO
FACULTY OF MEDICINE

STRATEGIC GOALS 2011-2016

1. Prepare tomorrow's leading scientists and scholars, clinical professionals, and administrators who will contribute to fulfilling the goals of the Faculty of Medicine.
2. Lead research innovation that answers questions of societal relevance.
3. Translate discoveries to improve health, equity and prosperity in our community and around the world.

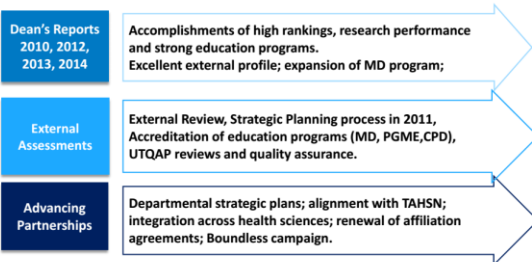


STRATEGIC GOALS 2011-2016

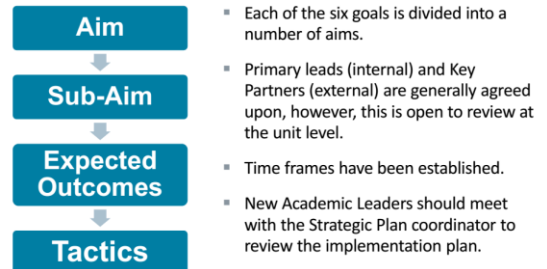
4. Share our innovations and expertise globally through strategic partnering to advance global health and international relations.
5. Create a collective vision for a shared academic future with TAHSN, University of Toronto Faculties, especially health sciences, and community partners.
6. Invest strategically in academic priorities in support of our learners, faculty, and staff to provide for their success.



STRATEGY IMPLEMENTATION



STRATEGY IMPLEMENTATION



STRATEGY IMPLEMENTATION

- Regular reporting requirements encourage focus on strategic priorities and maintain momentum in tracking progress.
- Reporting requires collection and preparation of multiple types of data across several major category areas.

- | | |
|-----------------|-------------------------------|
| 1. Education | 6. Advancement |
| 2. Research | 7. Strategic Communications |
| 3. Faculty | 8. Administration |
| 4. Global Reach | 9. Key Performance Indicators |
| 5. Rankings | |



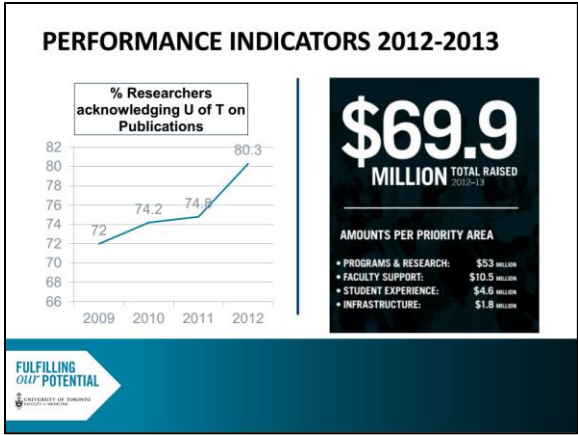
PERFORMANCE MEASUREMENT

2012-2013

Four performance targets were met or are on track to be met -

1. Fundraising
2. Researchers acknowledging U of T
3. Alumni relations
4. Data management



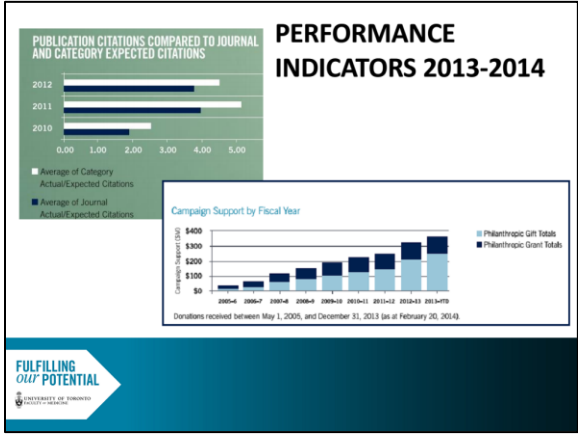


PERFORMANCE MEASUREMENT

2013-2014

- Research**
Publication citations (actual/expected) by journal and category
Percentage of faculty naming U of T on papers (*goal for Fall 2014 is 85%*)
- Fundraising**
\$500 million goal for Boundless campaign
\$50 million raised in 2013-14 (*30% for basic science, on-campus research*)
- Communications**
Growth in social media and earned media (*targets vary by platform: Facebook, Twitter, Instagram YouTube*)

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UNIVERSITY OF WATLINGTON



TODAY

- Assess our performance to date
- Focus, adjust or re-direct on our aims
- Correct our course as needed
- Critically in a rapidly evolving setting to recommend new goals/aims
- And setting the next steps looking forward to the future

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LET'S ASK OURSELVES


What are the next giant leaps forward for the Faculty of Medicine?

How do we position ourselves in an increasingly competitive global market?

What is the point of **convergence** across the University, affiliated partners and the public that creates the **catalyst** for **integration, innovation** and enhances our **collective impact**?

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How do we tap into boundless human potential to find solutions to these questions in order to meet our social responsibility?



po-ten-tial
pə'tenCHəl/
adjective: **potential**
having or showing the capacity to become or develop into something in the future.

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APPENDIX D: Panel Speaker Biographies

Morning Panel



Victor J. Dzau, MD

Victor Dzau is president and CEO of Duke University Health System, chancellor of health affairs and James B. Duke Professor of Medicine at Duke University. He was the Hersey Professor and chairman of the Department of Medicine at Harvard, and previously chairman of the Department of Medicine at Stanford University.

Dr. Dzau is recognized nationally and globally for a long and highly decorated career as a scientist, administrator and leader. His seminal research laid the foundation for the development of cardiovascular drugs (ACE and angiotensin inhibitors) that are now being used globally for the treatment of high blood pressure, heart attack and congestive heart failure.

For his outstanding scientific contributions he has received numerous awards and recognitions including the prestigious Gustav Nylin Medal from the Swedish Royal College of Medicine, the Polzer Prize from the European Academy of Sciences & Arts, the Ellis Island Medal of Honor, and the Distinguished Scientist Award of the American Heart Association, among many others. He has been awarded six honorary degrees, and a professorship in his name has been established at Harvard University.

Dr. Dzau has made significant impacts on healthcare through his leadership in translational research, health innovation, global healthcare strategy and delivery. Under his leadership, Duke has established Duke Translational Medicine Institute, Duke Global Health Institute, Duke-NUS Medical School in Singapore and Duke Institute of Health Innovation.

Dr. Dzau advises governments, businesses and universities worldwide, serving on advisory councils and boards of directors. He is a Council member of the Institute of Medicine (IOM) of the National Academy of Science USA, a member of the Board of Directors of Singapore Health System, former member of the Advisory Board of Canadian Institute for Health Research, former member of the Advisory Council to Director of National Institute of Health (NIH), chair of the NIH Cardiovascular Disease Advisory Committee and past chair of the Association of Academic Health Centers.

This July, Dr. Dzau will officially assume the role of President of the Washington DC-based Institute of Medicine.



Dermot Kelleher, MD

Professor Dermot Kelleher took up position as Dean of the Faculty of Medicine at Imperial College London on 1 October 2012. He was appointed Vice President (Health) in October 2013.

A graduate of medicine from Trinity College in Dublin, Professor Kelleher completed specialist training in gastroenterology in Dublin and subsequently received a Fogarty Scholarship for a research fellowship at University of California San Diego. He returned to Trinity in 1989 as the Wellcome Senior Fellow in Clinical Science and was subsequently appointed as Professor of Clinical Medicine in 2001. In 2006 he was appointed Head of School of Medicine and Vice-Provost for Medical Affairs.

Professor Kelleher's research has focused on the cell biology of immune responses both in terms of basic lymphocyte function and in relationship to mucosal immunology. His research has been focused on the immune response to many of the leading causes of infectious disease worldwide. He is the author of approximately 200 publications and 14 patents.

Professor Kelleher, in collaboration with Professor Hugh Brady at University College Dublin, obtained collaborative grant funding to establish the Dublin Molecular Medicine Centre, a joint venture between the three major medical schools in Dublin which provides a physical infrastructure for significant developments in medical biotechnology in Ireland. This has now become Molecular Medicine Ireland. He also held the inaugural directorship of the Institute of Molecular Medicine, a Trinity College Dublin facility at St James's Hospital.

Professor Kelleher is a founding member of Opsona Therapeutics, a spinout company at Trinity College Dublin based on development of therapeutic technologies founded on innate immunity and T-regulatory cells. Professor Kelleher has served as a member of the Board of the Health Research Board Ireland, the European Medical Research Council and the Wellcome Trust Clinical Interest Group. He also serves on several National Bodies in the Health sector and on the board of ICON plc.

A Fellow of the Academy of Medical Sciences (London), Royal College of Physicians (London), Trinity College Dublin, and the American Gastroenterology Association, he was awarded the 2011 Conway Medal by the Royal Academy of Medicine in Ireland.



Tom Robertson, MBA

Tom Robertson is the Executive Vice President, Member Relations and Insights, for the University Health Consortium (UHC) in Chicago, Illinois. In addition to overseeing this portfolio, Mr. Robertson also directs business strategy and development, product innovation, and clinical integration. In his former role as UHC's senior vice president of business strategies and tactics, Mr. Robertson most recently established the UHC Research Institute™, composed of two complementary research centers designed to address the critical needs of academic medical centers: improving effectiveness and efficiency in clinical care and ensuring economic sustainability.

Prior to joining UHC, Mr. Robertson served as vice president for Aon Consulting, where he managed relationships with Fortune 500 clients, concentrating on employee health benefits design and actuarial services. Previously, Mr. Robertson was director of planning for the nation's largest Taft-Hartley trust fund, negotiating regional and national managed care contracts. Beginning in 1979, Mr. Robertson spent eight years managing health maintenance organizations and was chief executive officer of health plans in South Carolina and Arizona. Mr. Robertson is a nationally recognized speaker in the area of health care economics, with a particular emphasis on academic medicine. He holds a bachelor's degree in biology from the University of Illinois and a master's degree in business administration from the University of Chicago.

UHC was formed in 1984 as an alliance of 120 academic medical centers and 299 of their affiliated hospitals representing the nation's leading academic medical centers. UHC's mission is to provide the lens through which an organization assesses all it does, creating knowledge, fostering collaboration, and promoting innovation to help members succeed.

UHC offers an array of performance improvement products and services. Powerful databases provide comparative data in clinical, operational, faculty practice management, financial, patient safety, and supply chain areas. Programs such as UHC's Imperatives for Quality and the UHC/AACN Nurse Residency Program™ offer opportunities for knowledge sharing and education. Listservers allow members from across the country to share information and demonstrate the power of collaboration.



Catherine Zahn, MD, MHS

(Panel Moderator)

Dr. Zahn joined CAMH as President and Chief Executive Officer in December, 2009. Dr. Zahn stepped into this position at a critical time for the organization. CAMH's bold transformation agenda includes its ambitious redevelopment project, integration and enhancement of clinical programs, expansion of research and innovation capacity, and continuing public education and social advocacy to challenge the stigma attached to mental illness and addictions.

Prior to this appointment, Dr. Zahn was Executive Vice President, Clinical Programs and Practice, at the University Health Network (UHN). She has held senior leadership roles in that organization for 12 years. Previous UHN positions have included Vice President and COO of TWH, Program Medical Director for Neuroscience and Division Head for Neurology. She was the inaugural chair holder for the Krembil Family Chair in Neurology. Dr. Zahn's reputation for hospital integration and her leadership of the renaissance of the Toronto Western Hospital (TWH) make her well equipped to lead CAMH during this pivotal time.

An honors graduate of the Faculty of Medicine at the University of Toronto (U of T), she completed her residency training in neurology at U of T. Dr. Zahn is a Fellow of the Royal College of Physicians and Surgeons of Canada and a Professor in the U of T Faculty of Medicine. She is a Fellow of the American Academy of Neurology and is internationally recognized for her contributions to neurologic education and to standards of practice in neurology. Dr. Zahn earned a Masters in Health Science Degree in Health Administration at U of T and has made numerous contributions to health care in Ontario through leadership in technology assessment, chronic disease management and stroke care coordination.

Recent honors include the U of T Faculty of Health Policy, Management and Evaluation prize for Innovation. Dr. Zahn was recognized by the Women's Executive Network as one of Canada's 100 most powerful women in the professional category. She continues to practice in her area of clinical and academic interest -- epilepsy and women with epilepsy.

Afternoon Panel



Jane Aubin, PhD

As Chief Scientific Officer for the Canadian Institutes of Health Research, Dr. Jane E. Aubin oversees scientific affairs at CIHR and provides expert advice on matters relevant to science and technology, potential opportunities and emerging orientations and trends in the national and international health research community. As Vice-President, Research and Knowledge Translation Portfolio, she is also responsible for all aspects of adjudication of grants and awards at CIHR, and finally, as a member of the Science Council, she participates in the development, implementation and reporting on CIHR's research and knowledge translation strategy.

Dr. Aubin is currently a member of the Faculty of Medicine at the University of Toronto, where she is Professor of Molecular Genetics and the Director of the Bone Program in the Centre for Modeling Human Disease. She has been Scientific Director and CEO of the Canadian Arthritis Network of Centres of Excellence and, for the past four years, Scientific Director of CIHR Institute of Musculoskeletal Health and Arthritis (IMHA). During her time as Scientific Director of IMHA, Dr. Aubin has shown outstanding leadership qualities and an unwavering commitment to working with others to improve the health and quality of life of patients with arthritis, musculoskeletal, oral and skin conditions.

Dr. Aubin received a B.Sc. (Hons; Chemistry and Mathematics) and the Gold Medal in Chemistry at Queen's University in Kingston. She then completed her Ph.D. in Medical Biophysics at the University of Toronto. She later did her postdoctoral training in Molecular Biology and Biochemistry at the Max Planck Institute for Biophysical Chemistry in Goettingen, Germany.



Gilbert S. Omenn, MD, PhD

Gilbert Omenn is Professor of Internal Medicine, Human Genetics, and Public Health and Director of the Center for Computational Medicine & Bioinformatics at the University of Michigan. He served as Executive Vice President for Medical Affairs and as Chief Executive Officer of the University of Michigan Health System (1997-2002). He was Dean of the School of Public Health, and Professor of Medicine and Environmental Health, University of Washington, Seattle (1982-1997). His research interests include cancer proteomics, chemoprevention of cancers, public health genetics, science-based risk analysis, and health policy. He was principal investigator of the beta-Carotene and Retinol Efficacy Trial (CARET) of preventive agents against lung cancer and heart disease; director of the Center for Health Promotion in Older Adults; and creator of a university-wide initiative on Public Health Genetics in Ethical, Legal, and Policy Context while at the University of Washington and Fred Hutchinson Cancer Research Center. He served as Associate Director, Office of Science and Technology Policy, and Associate Director, Office of Management and Budget, in the Executive Office of the President in the Carter Administration.

He served on the National Cancer Advisory Board, the NHLBI Advisory Council, the Society of Fellows for the National Center for Minority Health and Health Disparities, and the Director's Advisory Committee of the CDC.

Omenn is the author of 534 research papers and scientific reviews and author/editor of 18 books. He is a member of the Institute of Medicine of the National Academy of Sciences, the American Academy of Arts and Sciences, the Association of American Physicians, and the American College of Physicians. He chaired the presidential/congressional Commission on Risk Assessment and Risk Management ("Omenn Commission"), served on the National Commission on the Environment, and chaired the NAS/NAE/IOM Committee on Science, Engineering and Public Policy. He received the John W. Gardner Legacy of Leadership Award from the White House Fellows Association in 2004 and the Walsh McDermott Medal from the Institute of Medicine in 2008 for long-term contributions to the IOM and the National Academy of Sciences. In 2012 he was appointed to the Scientific Management Review Board of the NIH. In 2013 he received the David E. Rogers Award from the Association of American Medical Colleges, and was elected to the International Board of the Weizmann Institute of Science.

Omenn received his B.A. summa cum laude from Princeton, M.D. magna cum laude from Harvard Medical School, and Ph.D. in genetics from the University of Washington.



Nelson Spruston, PhD

Dr. Nelson Spruston is the Scientific Program Director and Laboratory Head at the Janelia Farm Research Campus (Howard Hughes Medical Institute) in Ashburn Virginia. He moved to Janelia Farm in 2011 after spending the first 16 years of his academic career in the Neurobiology department at Northwestern University, where he was the department chair from 2009-11.

Dr. Spruston's research looks at how the properties of individual neurons contribute to the computational performance of neural circuits controlling cognition and behavior. Most of this computation occurs in dendrites, so much of his work has focused on how structurally and molecularly sophisticated dendritic trees integrate thousands of synaptic inputs to generate action potential firing in the axon. His lab has studied how dendritic excitability is determined by the interactions between dendritic branching and the properties and distributions of dendritic ion channels and synapses, leading to insight concerning the role of backpropagating action potentials and dendritic spikes in synaptic integration and plasticity. His lab also made the surprising discovery that axons can perform sophisticated integrative functions. At Janelia Farm, he plans to continue this line of work, extending it to examine the integrative function of various genetically defined cell types in the hippocampus.

Dr. Spruston has a BSc degree from the University of British Columbia and a PhD from the Baylor College of Medicine. He did postdoctoral work at the Max Planck Institute for Medical Research in Heidelberg, Germany.

APPENDIX E: Breakout Discussions

Group 1A, The Integrated Learning Environment **Recorded by Paul Tonin**

1. Key successes we have achieved in the first half of our current strategic planning cycle

The group members were invited to comment on key successes. The following summary is not, then, a comprehensive list of successes, but rather a reflection of those successes raised and discussed by the group members.

Successful accreditation of all our education programs was a major achievement. While accreditation does not necessarily reflect educational innovation (and may, in fact, discourage innovation; more on that in the response to question 3), it is a very important mechanism for measuring and demonstrating the success of our academic programs.

The development and integration of (some or our) information systems (such as MedSIS/ POWER) to more effectively track and measure educational activities is a key success, particularly as it provides data necessary for evidence-based continuous quality improvement. (It was noted that we are fairly good at measuring outputs, we need to get better at measuring outcomes; more on that in the response to question 2).

The establishment of the Innovations + Education (i+e) Office has been successful in supporting educational innovation and the commercialization of educational initiatives.

The development of an Academy Membership Framework is an important component of creating a shared academic future with our hospital partners and building capacity.

The Office of Integrated Medical Education has contributed to the ongoing integration between the University and the affiliated hospitals. (It was noted integration between hospitals and academic departments needs some more work.)

The approval of a Faculty-level Diversity Statement was an important foundational moment which informed and continues to inform the development of diversity initiatives (e.g., entry survey, ISAP, Office of Indigenous Medical Education, increased financial aid for students with the highest level of financial need, SMP alumni tracking, “early exposure” outreach events).

Within the MD program, the changes to the clerkship – particularly the introduction of Transition to Residency (TRR) in 2011 – was a successful first step towards greater integration between undergraduate and postgraduate medical education. Also, two initiatives currently under development – i.e. the Longitudinal Integrated Clerkship and Preclerkship renewal – are encouraging signs of innovative changes to the MD program curriculum.

OtoSim and the orthopedic competency-based pilot were also referenced to two very successful curricular innovations. It was noted implementing more truly competency-based programming would require a shift in thinking, particularly among accrediting bodies, which privileges process (i.e. that

students need to complete a requirement in a certain way) over evaluation. (More on this in the response to question 3.)

2. Aims and objectives that we have yet to meet; assess each one based on continued relevance. Prioritize those that are still relevant as immediate, medium-term or longer-term priorities.

The working group attempted to work through each of the education goal sub-aims (1.1 to 1.9). They did not, however, have an opportunity to discuss each sub-aim.

While there have been important developments with respect to the enhancement and integration of information systems to more effectively track and measure educational activities, more work is required, particularly with respect to integration and harmonization across all health professional programs (e.g. the MRS program is on ROSI). Since systems integration is such a large, expensive and complicated task, this was identified as a very important but medium term priority.

While some progress has been made in IPE, more work needs to be done to move it from being an “add-on” to an integrated part of program offerings. One limitation is that IPE requires a good deal of scheduling/coordination, which is difficult to achieve without more effective and comprehensive systems integration across all health professional programs. Another limitation is that the learning environment does not always match the ideals of IPE, often resulting in a disconnect between what students are taught in theory and what they experience in practice. Clarification of the role of the Office of IPE (perhaps as part of its five year review) was put forth as an immediate priority, which could in turn inform medium term strategies.

Sub-aim 1.1: The need to come up with strategies to reduce and hopefully even reverse the limiting effects of external and internal barriers to educational innovation and change was discussed at length (see response to question three for more details).

Sub-aim 1.2: Simulation and e-learning (particularly the IT infrastructure required to support e-learning) were identified as two priorities that require a good deal of attention. With respect to e-learning, the role/mandate of the E-Learning Task Force was summarized. With respect to simulation, a particular suggestion was to come up with a strategy and process to encourage and support simulation centres to share, rent, lease, buy and sell simulation equipment. Keeping in mind that simulation is an augmentation of and not a replacement for clinical learning, a challenge – and perhaps medium term first step – would be to identify the nature and type of simulation that is required to support course/component/program educational objectives. How best to integrate simulation into our curriculum so that provides the best return on investment is an important question that requires particular attention.

Sub-aim 1.3: Consideration of the potentially limiting effects on diversity of the MCAT was put forth as a priority item for discussion. It was noted that the MD program is constrained by government with respect to enabling enrolment of a more internationally diverse student population, which was nonetheless identified as an immediate priority to re-examine.

Sub-aim 1.5: It was noted that there is a disconnect between the valuing of education scholarship (which has been an important and welcome shift) and the use of that scholarship to inform educational innovation and change. How to more effectively ensure that consideration of relevant education scholarship is an integral part of educational innovation was suggested as a medium term priority.

Sub-aim 1.6: The significant level of engagement of MD students in community-based projects that operate *outside* of the formal curriculum was noted and discussed, with the suggestion that attention be paid to how to most effectively harness (and not limit) that enthusiasm.

Sub-aim 1.9: It was noted that we do not effectively track our graduates, and that the ability to do so is highly relevant and should remain a priority. This tied back to earlier discussions regarding the need to develop more robust and integrated information systems, and so was identified as a medium term priority.

3. New priorities/directions that require attention over the next 2.5 years.

As noted above, there was a good deal of discussion about barriers to innovation and educational change. To support educational innovation, there needs to be greater attention paid to the limiting effects of external and internal barriers to change. While accreditation can play an important role in ensuring the ongoing quality of our programs, its importance in the life cycle of our academic program often hinders innovative change. That is, programs will understandably choose to take the safe road rather than the innovative road, lest they run afoul of accrediting bodies and run the risk of a poor review. Despite recent important advances (such as the “repatriation” of undergraduate medical education accreditation), the question of how we can use accreditation as a means to encourage – or, at the very least, not discourage – innovation remains a challenge that requires ongoing attention, including through active participation on national groups such as the AFMC and FMEC-related initiatives.

It was also noted that barriers to change also exist internally, both in terms academic and administrative silos that limit collaboration (the difficulties involved in creating dual degree was cited as an example) and a culture that discourages risk-taking. Too often, “on-the-ground” faculty and staff as well as academic leaders are encouraged to pursue initiatives that fit existing structures and have a clear path to success, and are discouraged from innovative pursuits that may be disruptive and not have a clear path to success. Building an ‘internal’ culture that actively supports the type of risk-taking and disruptive change that is often necessary for innovation is a foundational challenge that requires special attention.

APPENDIX E: Breakout Discussions

Group 1B, Education Across the Continuum Recorded by Caroline Abrahams

1. Key successes we have achieved in the first half of our current strategic planning cycle

a) Collecting and analyzing data to evaluate education quality:

Using MedSIS and POWER is not perfect but better than what was being done before. One full affiliate uses education data in their strategic planning process. They can measure very well how they are doing with respect to research re: publications and human trials – but what about education? Education metrics are not the same as journal impact factors. Several hospitals rely on PGME and UGME to provide them with feedback on their teachers and rotation experiences. Data could be better– but is the best that we have. Thematically in the last couple of years we are measuring education more. We still rely on student satisfaction outcomes. We need to develop metrics on quality of teaching which are robust and reproducible and which can be tract over time.

b) Ability to link investments to outputs and outcomes

Some departments/programs have made efforts to isolate the impact of government funding. One program has met with government to showcase their achievements with Ministry funding including the development of Ontario leaders in clinical practice as well as international leaders in developing clinical practice guidelines. It is recognized that we need better metrics to measure leadership and to measure return on investment.

c) Creation of TAHSN-e

Committee has been in place for 2 or 3 years and has recently piloted its inaugural survey of all health professional learners at TAHSN teaching sites. Provides a baseline for future measurement of the learner experience across many disciplines and many sites. Needs to focus on quality of the education, especially impact on behaviour and robust outcomes.

d) Integration and Interprofessional education

It was noted that many faculty and staff in the FoM are engaged in multiple initiatives often outside of their own administrative units in efforts to create innovative, learner centred solutions or new directions. In most programs the IPE curriculum has been well integrated, rather than an add-on, however we have not attained the level of IPE that we set out to do. More vigorous IPE programming is needed.

2. **Aims and objectives that we have yet to meet; assess each one based on continued relevance. Prioritize those that are still relevant as immediate, medium-term or longer-term priorities.**

Immediate

a) More creative use of data for measurement and assessment of impact.

Should acknowledge that we don't always disseminate knowledge through the "classic" ways – i.e. not publication but through workshops, different forms of scholarship and CPA. These need evaluation of innovation, scholarship, impact

Make better use of existing data to illustrate our impacts – depending on the audience. For example - how do the number of publications and journals impact? Promotions committees uses broad lateral views of other activities beyond publication for promotion.

Consider innovative new modes of outreach and communication to measure impact (i.e. tweets, hits, newspaper electronic subscription lists)

Tell stories to measure and illustrate impact. The anecdotal stories of both learner and faculty experiences are often much more appropriate for particular audiences (i.e. donors, foundation boards, government officials) than quantitative impersonal statistics.

b) Maximize access to important information to those who role model and drive change

Observation was made that many who are involved in teaching U of T learners do not have access to U of T libraries.

Longer term

a) Create measures and metrics to assess effectiveness and quality of basic science education in the Faculty of Medicine

Much of the emphasis focuses on medical education. In basic science – without patients, the focus must be on the student. They have course evaluation and most of the time they do research. In order to attract more grad students we need to quickly create metrics across the faculty. I.e. how are labs run, how do we measure the effectiveness and productivity of a graduate program. In the latest deans report it noted that the average time to graduate from a PhD is 6.5 years. Reason could be environment – but could also be lax requirements. New grad students don't seek out the available statistics. Many pursue grad studies as a back-up plan.

3. New priorities/directions that require attention over the next 2.5 years.

a) Possible creation of a Faculty of Health Sciences

Ultimate integration would be the melding of all Health Sciences faculties under a single umbrella at U of T although the trend is in the opposite direction with the evolution of a new Faculty in public health (The Dalla Lana School of Public Health). This would allow for governance and funding aligning with strategic priorities for integration and IPE. It might help to shape a culture shift and eliminate profession-specific and subject-specific silos. It could also facilitate shared core competencies or integrated admissions processes. It was noted that our traditional silo approach prevents true integration.

b) Develop measures of success in education via patient outcome measures.

Start working with evaluation experts to identify how to link patient outcomes to education of health professionals. For example – either through clinical outcomes or patient satisfaction measures can we prove that learner education is really making a positive impact on population health? Can we demonstrate that interprofessional education produces the best outcomes and harness the support of patients to advocate for team based approaches throughout the health care system?

c) Alignment of Joint Interests to facilitate joint decision making

The FoM must work very hard at bringing all of the players to the table. Every department, hospital and teaching site must be represented and prepared to buy in at the most senior level in order to push a collaborative agenda forward. A stumbling block is that we have 8 fully independent teaching hospitals with a research institute. Each of them could be a university on their own. All need to be present for the decision-making and all need to see the value for their own facilities in signing on to a big idea. In addition it's absolutely essential that we have a champion.

d) Training/Educating for the International Market

In today's context of increasing international demand for highly skilled health professionals and leading edge scientists we should focus on the international market to meet international needs and to generate revenues.

APPENDIX E: Breakout Discussions

Group 2, Innovation and Knowledge Translation

Recorded by Liam Mitchell

1. Key successes we have achieved in the first half of our current strategic planning cycle

Goal Two:

- The Faculty of Medicine, in collaboration with our hospital partners, has maintained its recruitment of highly qualified personnel despite the current financial landscape
- Greater clarity around EDUs has been achieved through clearer definitions and documentation
- The REB (ethics review) process through has also been clarified, making it easier to work with partners in different hospitals and units
- The coordination of CFI grant applications has ensured greater effectiveness by ensuring U of T faculty don't competing against each other in national competitions
- The Faculty is forging stronger research partnerships, such as the Toronto Dementia Research Alliance. It was observed these are most effective when they originate at the grass-roots rather than top-down, though institutions should act to facilitate such partnerships

Goal Three:

- The [Banting and Best Diabetes Centre](#) was recognized as a model of success for building a partnership between different U of T departments, hospitals and other groups such as [Techna Institute for the Advancement of Technology for Health](#) to leverage support for city-wide education efforts
- The improvement in knowledge transfer (KT) and commercialization was noted, particularly the support available through MaRS. It was noted these activities would be improved if they were a shared responsibility, like ethics, across the hospitals and the Faculty. However, concern was expressed that U of T is giving mixed messages on the desirability of working with industrial collaborators. Greater clarity would be welcome
- The learning from international fact-finding missions has been useful and suggests we are largely on the right path, but there are many more opportunities available from which we could gain

2. Aims and objectives that we have yet to meet; assess each one based on continued relevance. Prioritize those that are still relevant as immediate, medium-term or longer-term priorities.

Goal Two:

- We need to explore how U of T and hospital research foundations can collaborate with the aim of leveraging support for graduate students and faculty
- Student funding must be increased to maintain the current level of graduate student enrolment
 - CIHR changes are making this challenging, as faculty are seeing the next two years of potentially instable funding and opting not to accept new graduate students
 - It was also noted that fewer qualified students are opting to pursue graduate degrees, and are instead opting to enter the workforce

- We need to provide better career advice/development opportunities for graduate students and junior faculty members (SickKids' [Research Training Centre](#) provides a useful example, as does [Nutritional Science Student-Alumni Mentorship Program](#))
- Students should be viewed as knowledge generators, not revenue generators
- We need to identify innovative new student funding. Looking to the private sector or crowd funding may be options to consider

Goal Three:

- There needs to be greater support for KT and commercialization efforts. Many faculty members would rather write a CFI grant to obtain resources than write a patent, because there is support available to help write the grant application
- There is also a need to broaden the measures used to evaluate faculty performance, recognizing the value of developing new products or services that could be commercialized

3. New priorities/directions that require attention over the next 2.5 years.

Goal Two:

1. We need to continue to promote and support collaboration
 - Continue to break down silos to ensure our global competitiveness
 - Redefine the relationships between the University and research institutes. While they are currently cordial, they are not sufficiently enabling
 - We should ensure talent drives the relationship between institutions
2. We need to have a stable plan for succession planning, ensuring we don't simply replace faculty members after they've left, but ensuring junior faculty can benefit from the experience of those they are replacing

Goal Three:

- There is a need to develop a comprehensive strategy to guide KT and commercialization initiatives within the Faculty. While we recognize its importance, we have not fully articulated how it's direction or how we are going support it. Through the strategy, a clearer process can be identified and the efforts of U of T, MaRS, hospitals and other can be coordinated and leveraged to ensure greater impact
- In addition, the tools need to be developed that allow for greater collaboration within TASHN. Computer networks that don't talk to each other impede data sharing, which in turn impedes collaboration. Also, a system of incentives and rewards need to be provided to support collaborations

APPENDIX E: Breakout Discussions

Group 3, Integrated Health Initiatives

Recorded by Jim Oldfield

1. Key successes we have achieved in the first half of our current strategic planning cycle

- Created three new extra-departmental units (EDUs):
 - Fraser Mustard Institute for Human Development
 - Centre for Collaborative Drug Research
 - Institute for Global Health Equity and Innovation
- Integration across departments, centres and institutes, and with partner institutions
 - Heart and Stroke Richard Lewar Centre of Excellence in Cardiovascular Research
 - Multidisciplinary, multi-sited translation of innovation in cardiovascular research into clinical practice
 - Diabetes and Heart Disease Research Directed Grant Program
 - Department of Medicine
 - Integrating Challenge Grant competition, to support integrative research activities across the Department, from basic to applied and translational
 - Department of Medicine, Department of Family & Community Medicine
 - BRIDGES, which develops innovative models of health service delivery that incorporate hospitals, primary care clinics and community services, to provide integrated care for patients with complex chronic diseases
 - Established a Research Ethics Board for the Toronto Academic Health Science Network (TAHSN), to be in place by end of 2014
 - Extended a plan to increase graduate student enrolment to build research capacity in Ontario

2. Aims and objectives that we have yet to meet; assess each one based on continued relevance. Prioritize those that are still relevant as immediate, medium-term or longer-term priorities.

Immediate

- Better understanding between, and cooperation among, basic science and clinical/health services researchers
- Shift toward more funding for interdisciplinary projects, less for researchers per se
- Ensure that graduate education attracts high-quality students and, one by one, offers them opportunities to work at the “border zones” of multiple disciplines — if that’s where their interests lie

Medium-term

- Teams that embed translational approaches into their structure, e.g., the Terry Fox Foundation requires a KT specialist on many grants
- More multidisciplinary “working groups,” e.g., diabetes and heart disease group at Lewar Centre and others that aren’t “siloes” or studying only one disease
- Better integrate health services, e.g., BRIDGES

Longer-term

- Integrate research from discovery through translation to application in the clinic
 - Better recognize that the majority of applied clinical procedures come from basic research advances, the application of which was not predictable at the time of discovery; fund the entire spectrum of research accordingly
 - Perhaps devote more funding to the intellectual property/commercialization part of the research cycle
 - Create more TAHSN-wide shared resources, especially big projects like the Toronto Centre for Phenogenomics, to reduce redundancies and provide better large-scale infrastructure
 - Biobank
 - Simulation centre
 - Imaging, sequencing, genomics resources
 - Clinical trials centre/patient source
 - More multidisciplinary, multi-institutional grants
- Find a better approach to joint fundraising with the hospitals
 - Extra-departmental units: recognize that they can bring disparate researchers together to answer questions of societal relevance and provide a coherent face for fundraising, but that they can also siphon funds from departments and don't compete well for donor dollars with hospital-based centres
 - Convince research institute VPs that shared resources are worth their investment
 - Bring in more donor dollars through U of T fundraising so that the University has more power to partner with hospitals in the creation of shared resources

3. New priorities/directions that require attention over the next 2.5 years.

- Find a different model for funding that is not so dependent on philanthropy, which is not a viable long-term way to support research in smaller countries that don't have large sums of free capital

APPENDIX E: Breakout Discussions

Group 4, Global Reach

Recorded by Vitaly Kazakov

1. Key successes we have achieved in the first half of our current strategic planning cycle (based on the Faculty's Global Health Roadmap 2011-2016).

Goal 1: Engagement and Endorsement

In progress or completed:

- Academic units have been consulted, understand and endorse the global health vision and mission
- Academic units within the Faculty of Medicine have established goals, which align with the global health vision and mission
- Global health section created on the Faculty of Medicine website, including map populated with global health initiatives worldwide
- Profile of global health strategy developed, with a focused section in the Faculty of Medicine Annual Report
- The Faculty of Medicine engages in collaborative projects across and outside the Faculty that advance global health vision and mission
- The number, scope and impact of collaborative global health projects have increased

Goal 2: Optimize Collaborations

In progress:

- Governance and organizational structure for global health has been defined, including linkages to Faculty of Medicine's International Relations and Dalla Lana School of Public Health's Division of Global Health
- Well defined leadership for global health is in place
- Pre-departure protocols and orientation have been developed and standardized
- Cross cultural training, protocols and orientation modules have been developed
- Post-return protocols and evaluation have been developed and standardized

Goal 3: Advance Research Scholarship

In progress or completed:

- The Faculty of Medicine is successful in international global health competitions (e.g. Gates Foundation)
- Number of global health research projects with strategic partners has increased
- Environmental scan to establish baseline of global health research across the Faculty of Medicine has been completed
- Increased sustainable funding for global health initiatives

Goal 4: Learner Focused Education

In progress or completed:

- Education programs endorse and support the global health vision and mission
- Environmental scan and mapping to establish a baseline of educational programming, including level and credit, is completed
- Pre-departure orientation and cross cultural training embedded into global health curriculum
- Global health competencies established and defined in collaboration with national colleagues
- Education programs have integrated global health offerings along the education continuum
- Learners across all departments and sectors have educational offerings appropriate to their needs
- Reciprocal learning opportunities available and endorsed through the School of Graduate Studies, (e.g., joint Masters or PhDs)

Goal 5: Sustainable Partnerships

In progress or completed:

- Criteria for partnership engagement are confirmed
- The Faculty of Medicine identifies priority global health projects, which it will champion and support through capacity building and educational initiatives
- The key partnerships in which the Faculty of Medicine engages are understood, including the goals and objectives of the partnerships
- The continuum of types of partnerships and reciprocal expectations of those partnerships have been defined; this includes protocols for international relations, affiliation agreements, letters of intent and memoranda of understanding
- The Faculty of Medicine establishes metrics and a framework with core indicators to demonstrate impact of the global health strategy

2. Aims and objectives that we have yet to meet; assess each one based on continued relevance. Prioritize those that are still relevant as immediate, medium-term or longer-term priorities.

Prior to the discussion on the next steps in the Faculty's Global Health and International Relations strategy, the facilitators asked the participants to briefly identify what they viewed as current priorities of the Faculty's international engagement. Some of the responses included:

- Further enhancing and developing the Global Health network
- Assessing our international impact including both positive and negative consequences of our involvement
- Further involvement of faculty, staff, the student body and the broader Faculty of Medicine community in the Global Health efforts
- Coordinate resources and efforts across faculties, campuses and disciplines
- Examine global health from different perspectives (including an 'equity lens')
- Increase research on global perspective and contextual issues including research in education

- Better understanding the contextual issues in the environments where we engage
- Support for individual projects and initiatives
- Develop Global Health leaders at the University of Toronto
- Define incentives that are offered to international partners in global health
- Analyze the impact in global health activities across the Faculty to determine if we are investing our collective resources effectively
- Develop strategies to enhance the organization and communication of our initiatives
- Focus our efforts to reflect U of T's strengths and establish a framework for measuring the impact

The group discussed the outcomes that have not yet been fully met or addressed as outlined in the five goals in the Global Health Roadmap and the corresponding expected outcomes.

The next steps from the progress report of the Global Health Roadmap implementation included the following:

Goal 2: Optimize Collaborations

Next step:

- Toronto Global Health Network is established.

Goal 3: Advance Research Scholarship

Next steps:

- Business plan has been developed for endowed chairs
- Increased funding has been secured for capacity building with existing partnerships
- Faculty-wide annual Global Health Research event initiated
- Chair(s) established in global health research
- Number of global health scholars has increased
- Education Scholars Fellowship in global health is established in collaboration with the Wilson Centre
- Criteria for academic promotion in global health have been developed

Goal 4: Learner Focused Education

Next steps:

- Faculty development curriculum developed for global health
- Annual Grand Rounds for global health initiated
- Global Health Fellowships established
- Global Health Summer Institute established
- Visiting scholars in global health hosted by the Faculty of Medicine

Goal 5: Sustainable Partnerships

Next steps:

- The Faculty of Medicine and its partners demonstrate a sustained impact in global health as a result of progress in goals 1 – 4 above
- Using framework of core indicators, Faculty of Medicine tracks achievement in global health on a regular basis

After a brief review of the progress report's next steps, the participants broke into two groups. Each group reviewed the goals and expected outcomes of the Global Health Roadmap in more detail to specifically identify areas where continued efforts are required to move the Faculty of Medicine forward in its Global Health strategy. All of the areas of focus identified by the group are outlined below. They are listed according to the suggested time frame of implementation (immediate, medium and long term areas of focus), as well as the level of priority as determined by a vote of all session participants (identified as a priority by "most participants", "some participants" and "a few participants").

After productive discussions each group presented priority actions for moving forward with a number of synergies identified between the groups. The following priorities were identified:

Immediate areas of focus (to be started as soon as possible):

- Global Health Network- Identified as a priority by most participants: Establish a Toronto Global Health Network in partnership with the Institute for Global Health Equity and Innovation (IGHEI), with emphasis on an interprofessional, multi-disciplinary and cross-campus engagement. *(As relates to an expected outcome within Goal 2 in the Faculty of Medicine's Global Health Roadmap, "Toronto Global Health Network is established"; the participants emphasized importance of collaboration with IGHEI in the process of establishing the network).*
- Global Health Curriculum- identified as a priority by a few participants: Ensure and accelerate deliberate implementation and integration of Global Health across curricula *(As relates to an expected outcome within Goal 4 in the Faculty of Medicine's Global Health Roadmap, "Education programs have integrated global health offerings along the education continuum").*

Medium-term areas of focus (to be started within the next six to eight months):

- Global Health Leadership and Development- identified as a priority by some participants: Create opportunities for development of Global Health training for faculty and students including:
 - Fellowships and scholarships opportunities in Global Health *(As relates to Goal 2 in the Faculty of Medicine's Global Health Roadmap, "Education Scholars Fellowship in global health is established in collaboration with the Wilson Centre");*
 - Faculty development opportunities for acquiring or improving Global Health proficiency *(As relates to Goal 4 in the Faculty of Medicine's Global Health Roadmap as "Faculty development curriculum developed for global health").*
- Define Global Health- Identified as Lower Priority: Determine if the term Global Health is applied to the categorization and description of different initiatives with relative consistency across the University *(As relates to the Definition of Global Health by Koplan et al. in the Faculty of Medicine's Global Health Roadmap).*

Long-term areas of focus (to consider as we move into our next strategic planning cycle (2017-2022)):

- Academic Promotion in Global Health- identified as a priority by a few participants: Establish criteria for academic promotion in Global Health *(As relates to an expected outcome within Goal 3 in the Faculty of Medicine's Global Health Roadmap, "Criteria for academic promotion in global health have been developed").*

3. New priorities/directions that require attention over the next 2.5 years.

Medium-term areas of focus (to be started within the next six to eight months):

- Strengths in Global Health- identified as a priority by most participants: Global Health initiatives have shown the greatest success and impact when they are long-term (often multi-year / decades-long), sustainable and include comprehensive engagement. Both the Toronto Addis Ababa Academic Collaboration (TAAAC) and Academic Model Providing Access to Health Care (AMPATH) are examples of initiatives that have used this approach. In order to optimize U of T's ability to achieve our goals in Global Health, the Faculty of Medicine should build upon and invest in the long-term continuation of these and other programs. By leveraging the success of our current projects and models, the Faculty of Medicine could also expand our efforts in new Global Health initiatives that will maximize our impact. *(This strategic priority builds on the expected outcome within Goal 5 in the Faculty of Medicine's Global Health Roadmap, "Using framework of core indicators, Faculty of Medicine tracks achievement in global health on a regular basis".)*
- Global Health Leadership and Development- identified as a priority by some participants: Create targeted leadership programs in Global Health for faculty and healthcare administrators. *(This priority was not specifically outlined in the Faculty of Medicine's Global Health Roadmap; the group participants suggested that such programs would help developing more Global Health leaders).*
- Principles of Engagement- identified as a priority by some participants: the University of Toronto has established principles of engagement for initiatives in Global Health, which include:
 - Priorities and needs are jointly articulated by U of T and the partnering institution;
 - Ensure that the international partner institution have the capacity to benefit from the proposed engagement with U of T;
 - Create sustainable relationships with international institutions ensuring reciprocity and institutional commitment to maximize the impact of collaborations. *(As relates to the Faculty of Medicine's Global Health Roadmap's articulated Vision, Mission and Principles).*

Developing a Toronto Global Health Network, as outlined above, was identified as a priority project in order to move forward with our Global Health Strategy. There was also an informal discussion of forming a Global Health working group within the Network, which would enable a joint assessment of continued progress and help further identify priorities and directions in our planning cycle for the next 2.5 years.

APPENDIX E: Breakout Discussions

Group 5, Executive Leadership

Recorded by Lloyd Rang

NOTE: group 5 used a loosely structured format for their discussion. As a result, the session notes do not adhere to the order provided in the template, though they do reflect the discussion on all three questions:

1. Key successes we have achieved in the first half of our current strategic planning cycle
 2. Aims and objectives that we have yet to meet; assess each one based on continued relevance. Prioritize those that are still relevant as immediate, medium-term or longer-term priorities.
 3. New priorities/directions that require attention over the next 2.5 years.
- Need to remember that TAHSN exists because we wanted to ensure strong relations with the hospitals
 - In the last 15 years we've seen an improvement in hospital/university relations. There is more structure now
 - Working of subcommittees have become more formalized
 - There is a bit of money coming in through this ... a slow, incremental development in affiliation
 - There is a slow, progressive understanding that has resulted in increased collegiality and respect
 - MaRS and TDRA are two examples of integrative initiatives through TAHSN that have worked
 - Common credentialing for physicians is another, as is the research ethics board
 - The structure of education within the hospitals has changed, too
 - Not all hospitals within TAHSN are created equal – some are bigger in some areas, some more influential overall
 - Have had some success with education and research platforms in TAHSN, but need more
 - There is no collective strategy for research across TAHSN
 - A collaborative approach to platform/infrastructure money has been ineffective
 - We say we are dedicated to excellence and innovation, but “innovation” is a poorly understood and overused word
 - In UofT, we mean by “innovation” the application of knowledge
 - Innovation in research may mean innovation in the method of research – that is, curriculum innovation, for example
 - There are different levels of innovation: macro, micro and meso – TDRA is a macro, micro would take place at the level of the researcher, meso is teams
 - We should use TAHSN to create scaleable projects to pilot
 - A number of courses could be spread out among all health professions, creating efficiencies (ie: anatomy, mental health interviewing)
 - TAHSN partners are more alike than different, but often paralysed by difference
 - Need to choose a few points at which to innovate
 - Could use a big data approach with the university as the focal point of collection: the clinical becomes the research content when we aggregate data
 - Need to keep the vision in sight: how do we transform the health care system in Ontario?
 - Need to realize that, combined, we are a huge % of health care delivery in Ontario – need to realize we are the centre of the Health Care Universe (in a good way)

APPENDIX E: Breakout Discussions

Group 6, Supporting our Vision

Recorded by Suniya Kukaswadia

Speaker legend

WR-Wes Robertson

JR-Jean Robertson

PA-Peter Azmi

RB-Roberta Brown

TN-Tim Neff

KM-Kim Moran

MM-Monifa Miller

HT-Heather Taylor

AH- Allison Hardisty

MC- Meg Connell

LF-Lindsey Fechtig

BB-Brian Bachand

JL-Julie Lafford

CD-Craig Daniels

NE-Nancy Edwards

AM-Anastasia Meletopoulos

1. **Key successes we have achieved in the first half of our current strategic planning cycle**

- (WR) UME has organized certain roles and responsibilities differently
- (JR) Within UME, we conducted a major review of each of the units, and that has resulted in positive change
- (JR) We're always looking at various departments across the faculty and departments to make sure they have the staffing they need. We're building shared roles among the professional portfolios (senior management)
- (JR) Under Tim's guidance we meet on a regular basis and I think we have been able to develop strong collaborative relationships across the portfolios
- (WR) The Innovations + Education Office (I+E) and OSCER are new units that are outcomes of the internal and academic structures
- (PA) What underpins our business is what the University's business operations don't do—brand management, copy writing. How do we manage the University's brand, how do we price products, ensure Faculty are getting value, etc.
- (PA) One of the changes that led to this business was technology's impact on education. It's the intersection of how tech impacts education to bring about e-learning that gives us the ability to scale, modify and port education around the world. Before it was about bums in seats, and that meant more buildings were needed for more students. Now, students need more bandwidth
- (RB) OSCER has gone through a lot of growth. We're starting to round out the ability to tell the stories the Faculty has to share. We have Strategic Planning and Global Health under our group. We're pretty diverse and growing. We've started to push through things like social media and are working towards launching a new website pretty soon
- (RB) We've started a monthly communicators group meeting for all those who do communications for the Faculty that meets once a month so we can foster better dialogue and help each other identify and address issues
- Communications group—all the communications folks/those who do communications in the Faculty meet once a month so we can foster a better convo and help each other identify issues and solve problems
- (TN) We have a group that does this for business affairs

- (RB) That discussion has been very helpful and I think that's the kind of work we're hoping to do as we move forward
- (KM) One of the aims is to drive unrestricted revenue to departments in order to augment budgets/decreasing funding for important pieces of I+E
- (JR) We launched our new staff awards program and new employee program
- (TN) There have been enormous growth with resource allocation in existing departments Wes has 40 FTEs
- (WR) When I started there were 10-12 FTEs reporting to me
- (JR) Several years ago we decided to provide expertise in recruitment and now we have two recruitment specialists on staff and three staff members who focus exclusively on clinical and non-clinical side
- (HT) We are preserving space for other users, done multiple moves, sourced furniture, led renovations in order to make a case for facilities going forward
- (HT) In 2012, we created a facilities master plan for the Faculty using 13 Ex: Suitability for research and acceptable accessibility standards
- (TN) It's important to add new offices, but it's also essential to look at existing structures to ensure that resources are there to meet needs within limitations that are imposed upon us
- (BB) There's been tremendous growth (in Advancement). When Julie started there were 7 staff members and now it's 30. With the Boundless Campaign, medicine was given \$500 million to raise, which is a lot of money an environment that is filled with hospitals
- (TN) Advancement has been building relationships at the departmental level, supporting Chairs in learning how to fundraise
- (AH) DoM has two dedicated fundraisers
- (BB) Other departments have dedicated SDOs depending on the size
- (TN) 10-12 departments have service level agreements with Advancement
- (JL) We've built relationships with all of the departments over the last couple of years, which is a major development, teaching them what alumni engagement is and why do we need to invest in it. Now we have breadth—next step is depth
- (JL) We've established important partnerships with the Medical Alumni Association via a signed agreement
- (JL) We've also seen a sharp spike in annual giving (\$25,000 or less). That's tripled in the last six years to \$1.5 million last year
- (HT) We're doing multiple studies—looking at MSB and the Rehab Sciences building- What are people doing? What do they need? Can there be some realignments?
- (HT) We did a master plan for UME in conjunction with HR, but this is challenging given their steadily growing staff numbers
- (WR) Story of last five years is keeping up with demands—continual, exponential growth
- (WR) UME's video conferencing is up and running—it takes a lot of people to run it smoothly
- (WR) WebCV has been a multi-year project because it's been tricky; it's not about the technology - it's about changing how people work

- (CD) Anesthesia implemented five e-modules and I think other departments are working on these in some form
- (PA) The e-learning task force - don't pay twice for the same thing - we're doing an asset map for all e-learning products
- *(LF) We created an e-learning wiki for the E-Learning Task Force, enabling a rolling dialogue as it is easy to comment on and share resources
 - **see question two for context*
- (NE) There's been some great success in finances—moving the Tanz into the Krembil is one, Medical Psychiatry Alliance is another and indirect funding levels will come up with government relations people
- (TN) Financial health of the Faculty depends on management at the departmental level.
- (NE) The Dean, Tim and I meet annually with departments and I can see there is great engagement - they have financial plans in place and are paying more attention.
- (AM) There's no institutional memory with documentation. We need to write down processes, standard operating documents, templates. We need to be a place of connecting lines of communication for the Faculty and other health professions faculties.

2. Aims and objectives that we have yet to meet; assess each one based on continued relevance. Prioritize those that are still relevant as immediate, medium-term or longer-term priorities.

Immediate priorities

- (RB) As I travel around the faculty, I find that OSCER is still new to people and we still have a lot of work to do in terms of introducing ourselves
- (RB) Launching the new website is an immediate goal
- (MM) We want to create a goal of alumni engagement. I feel like there's an opportunity to create a culture of engagement for our faculty members as well. To do that we need to build momentum to pull all stakeholders involved together.

Medium-term priorities

- (AH) You're a little bit isolated when you do strategic planning; there is no dialogue between strategic planning departments and that needs to change
- (AH) There are so many unique things that we've developed in DoM that would benefit other departments, which would save time and money and prevent other staff from reinventing the wheel over and over again
- (AH) OSCER can help form a group
- (RB) Can we use OSCER's communications group as a model?
- (MC) All chairs are mandated to engage in strategic planning - they see each other and talk but it doesn't carry through
- *(PA) Other organizations use Wikis or intranets to bring together people with shared interests
- (AH) The big departments have invested money in strategic planning; a lot of the smaller departments can benefit from what the larger ones are doing
- (WR) intranets are fraught with failure and while I see the need I caution that it's not easy

Long-term priorities

- (KM) One of the aims is to drive unrestricted revenue to departments in order to augment budgets/decreasing funding for important pieces of I+E
- (BB) We need new volunteers to be board members; the hospitals have grateful patients—we need volunteers with contacts
- (BB) Online fundraising is huge and needs to be tapped
- (PA) UHN recently did Kickstarter group. Would advancement do that?
- (JL) We don't have the technology centrally to do that
- (HT) We need to determine what research facilities we need in the next ten years to attract and retain people in basic science
- (HT) We want UME to be open, public facing with the new admissions office as a Welcome Centre and the office as a real focal point for the Faculty in general
- (WR) Innovations and technology around e-learning. Why are we using technology to teach? Is it better? Sometimes we miss that—because we didn't consider goals and implications, We have to continue to think deeper about what is needed and why.
- (WR) People are working in silos, but there are possibilities for like-minded people to work together
- (KM) Having the discipline to focus on a strategy is difficult. As we go forward, we want complex partnerships and structures...every day it seems like we're taking it up one more level, but the infrastructure support isn't there
- (KM) Chairs are expected to do more, but they don't have training in complex deals. As we bring gifts in, we need to focus on donor relations after the fact. We need to staff this. The departments also need to do a lot of stewardship after a gift. Where does that skill set lie? Who should be doing it?
- (KM) Donor reporting back systems need to have made simple. The infrastructure behind the funding needs to be thought through
- (AM) There's no institutional memory with documentation. We need to write down processes, standard operating documents, templates. We need to be a place of connecting lines of communication for the Faculty and other health professions faculties.

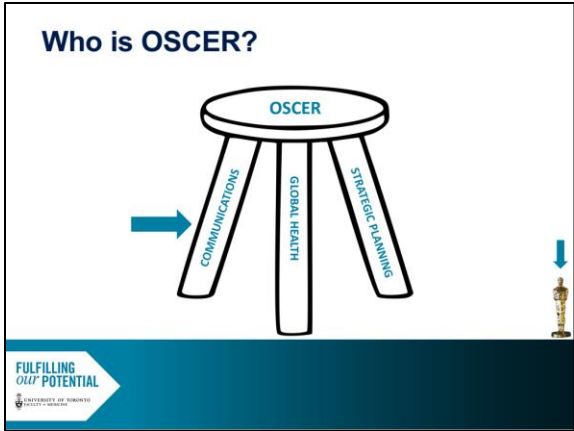
3. New priorities/directions that require attention over the next 2.5 years.

- (AH) We need to consider the impact of the CIHR funding changes. These changes are enormous for everyone. I think we need to have something looking forward. We need to re-strategize and step back.
- (TN) We are in a different environment of resource constraints. We're facing some huge threats, with CIHR being one of them. How do we address them? We need to provide adequate information to the Dean and communicate the consequences.

APPENDIX F: Afternoon Plenary

Lloyd Rang slide deck





Media has changed

- Traditional media in decline
 - Audiences fractured
 - Fewer health reporters
 - Internet is the alternative
 - Pay-walls block content
- Authoritative channels wanted
 - Credibility breaks through clutter

Digital News Surpasses Newspapers, Radio

Where did you get news yesterday?

NEW RESEARCH CENTER 2012 News Consumption Survey

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What are the sources of news?

More Americans Getting News Digitally and from Social Networks

2010	2012	Change	
Get news yesterday	%	%	
Not online/social	34	29	+5
Online	34	34	0
Cell, tablet, other mobile	--	17	--
Social networking	9	18	+9
Email	14	16	+2
Twitter	2	3	+1

Key Trends:

- 1). People going online for news
- 2). More people using phones
- 3). News via Facebook/Twitter/YouTube

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Becoming our own "newsroom"

Our Advantages:

- **Credibility:** A trusted source
- **Niche:** Great education/research stories
- **Capacity:** Channels, expertise, data
- **Interest:** Great people (students, faculty)

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Communications Priorities 2014

- Media relations and issues management
- Building newsroom/storytelling capability for Faculty (including video)
- Fine-tuning social media presence
- Tracking success/adjusting tactics using data
- Training and capacity-building across Faculty
- U of T Medicine magazine, MedEMail
- Web redesign and re-launch
- Enforcing consistent university/Faculty branding and logo use
- Dean's Reports, Strategic Plan Reports
- Event support

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OSCER: Communicating Our Potential

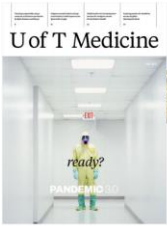
Medicine magazine — Before

- No identified audience
- No online component
- Lengthy articles
- Visual inconsistency
- Sporadic publication
- Short

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OSCAR: Communicating Our Potential

Medicine magazine — After




- Data on readership
- Special online content (video)
- Articles of varied length
- Strong, consistent visuals
- Regular publication
- Social media tie-ins

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FACULTY OF MEDICINE

OSCAR: Communicating Our Potential

Social Media — Before (not exactly as shown)



- No strategy for channels
- No coordination of posts
- No consistency of posts
- No consistency of visuals
- No video
- Limited growth

FULFILLING OUR POTENTIAL
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FACULTY OF MEDICINE

OSCAR: Communicating Our Potential

Social Media — After



- Channel-specific strategies
- Data analysis
- Goals and metrics created
- Video and original content
- Consistent/targeted growth
- Positive engagement

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FACULTY OF MEDICINE

OSCAR: Communicating Our Potential

Social Media — Measuring success

	Oct. 2013	Current (Mar. 14)	Target (Oct. 14)
Twitter Followers	5,557	6,704	9,000
Facebook Likes	1,064	1,326	2,000
Instagram Followers	223	464	1,000
YouTube Views	7,173	14,886	20,000



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