STANDARD 1: MISSION, PLANNING, ORGANIZATION, AND INTEGRITY

A medical school has a written statement of mission and goals for the medical education program, conducts ongoing planning, and has bylaws that describe an effective organizational structure and governance processes. In the conduct of all internal and external activities, the medical school demonstrates integrity through its consistent and documented adherence to fair, impartial, and effective processes, policies, and practices.

1.1 STRATEGIC PLANNING AND CONTINUOUS QUALITY IMPROVEMENT

A medical school engages in ongoing strategic planning and continuous quality improvement processes that establish its short and long-term programmatic goals, result in the achievement of measurable outcomes that are used to improve educational program quality, and ensure effective monitoring of the medical education program's compliance with accreditation standards.

Requirement 1.1-1

The medical school engages in ongoing strategic planning that establishes its short and long-term programmatic goals.

A. Describe how the medical school engages in ongoing strategic planning. Include in this response a description of how faculty members and other stakeholders are involved.

The Cumming School of Medicine (CSM) engages in an ongoing strategic planning and evaluation process based on broad consultation with the CSM community and external partners and stakeholders, benefitting from diverse perspectives. The process aligns with the University of Calgary's planning processes which include the strategic plan, institutional strategies (EDIA - Equity, Diversity, Inclusion and Accessibility, Indigenous Engagement, Mental Health, Sustainability, Global Engagement) and operational plans (i.e. Academic, Research, Community Engagement, Operational Excellence).

The past two strategic plans, 2009-2014 and 2015-2020, were both developed over several years through extensive consultation and engagement. The 2015-2020 plan was extended until 2023, with the new strategic planning process beginning immediately following the appointment of the new Dean in mid-2022. The new 2023-2030 strategic plan is a living strategy influenced by the CSM's focus on precision medicine and precision public health. The document will be updated over its lifespan to reflect opportunities and challenges that arise within and external to the CSM. Senior leadership and a Strategic Plan Working Group engaged an external consultant (J5 Design) to facilitate the process and solicit input from stakeholders to guide the creation of the new plan. Although past strategic planning processes have included faculty, students and staff, the most recent process included a concerted effort to engage groups beyond senior leadership (e.g. Deans, Department Heads and Institute Directors) in order to be as inclusive of as many viewpoints as possible. Strategic Plan Working Group membership was comprised of engaged faculty members from across education and research with diverse backgrounds, roles and thought processes. Advisory groups {i.e. Black Health, Clinical (including a Rural sub-group), Data (storage and management), Social Accountability & Planetary Health, EDIA, Education, Indigenous, Learners, MaPS (Management & Professional Staff) & AUPE (Alberta Union of Provincial Employees) Patients, Research} comprised of faculty, students and staff were formed based on an open call for participation. A survey was conducted in late 2022/early 2023 across the entire CSM community to collect information to guide future facilitation and communications regarding the process, and strategic planning workshops were held which were open to all in the CSM. The CSM plan was built alongside and informed by UCalgary 2030, the update to the university's strategic plan which was also released in 2023. The six identified priorities move the school to expand its social accountability mission to have impact for the people and communities (first priority pillar). The other 5 pillars include education, discovery science, a commitment to Indigenous health, striving for social justice through health equity and transforming health through a learning health system. The plan is accompanied by an implementation and metrics strategy with a budget plan to enable these objectives.

The present plan is called **Reimagining Health for All: Ahead of Tomorrow** (***Supplemental Appendix 1.1-1 A***) and it builds on the academic strength of previous plans as the CSM is a research-intensive faculty in a research- intensive university. The academic mission is built on the strength of multiple educational units and seven world class research Institutes. The focus on precision medicine continues to be embedded within the plan.

Beyond the initial strategic planning process, the CSM conducts interim assessments of Key Performance Indicators (KPIs) to monitor the progress of strategic priorities. Units, Offices and Programs within the CSM are required to provide data on KPIs that are meaningful within their individual context. The CSM Strategic Plan Key Performance Indicators 2020-22 document preceded the 2022-23 strategic planning process and reported on approximately 100 KPIs which were last updated in 2020. The

Planning & Priorities Committee will continue the KPI reporting and monitoring process alongside the annual review of the strategic plan. The KPIs for education are reviewed annually and adapted to meet the changing needs of students and faculty. The Senior Associate Dean Education meets with each Associate Dean responsible for the education portfolios {i.e., UME, PGME, Distributed Learning and Rural Initiatives (DLRI)} and reviews their KPIs.

The Strategic Education Council is currently undergoing a process to define implementation and monitoring strategies for the components of the Strategic Plan relevant to the education portfolios, including:

- Attend to the learner voice and elevate the learner experience
- Establish safe reporting mechanisms for concerns in the learning and working environment
- Enhance accessibility of all CSM programs to diverse members of our community
- Education programs proactively address EDIA and anti-racism in their curricula
- Value of teaching recognized by equitable remuneration and metrics for promotion
- Research and scholarship in medical education regarded as academic work and supported by Cumming School of Medicine

This process was initiated at Strategic Education Council in January 2024, and has led to the following outcomes:

- Regular quarterly meetings between the Dean, Vice-Dean Education, Senior Associate Dean, Education and student leadership to ensure the learner voice is heard in addition to student representation on committees
- Continued work on an appropriate, coordinated, improved mistreatment reporting strategy (see Standard 3.3) through the Precision Equity and Social Justice Office to establish safe reporting mechanisms for concern in the learning and working environment
- Formation of a working group to inform the re-development of the current Office of Health and Medical Education Scholarship (OHMES) to ensure research and scholarship in medical education are regarded as academic work and supported by CSM
- Focused approach on defining, measuring, and monitoring teaching and education metrics to ensure equitable remuneration and metrics for promotion through the Senior Associate Dean, Faculty Affairs with an investment in data analytics similar to what is used for monitoring research activity

Specific key performance indicators that are relevant to the education aspect of the Strategic Plan are in development through this process.

B. List the release dates of the two most recent strategic plans and if applicable, dates of any revisions to these plans.

The most recent CSM strategic plans were released in 2015 and 2023 (***Supplemental Appendix 1.1-1 A***). The 2015 plan was extended until 2023 while the strategic planning process directed by the new Dean started in 2022.

Requirement 1.1-2

The medical school engages in ongoing continuous quality improvement processes that result in the achievement of measurable outcomes that are used to improve educational program quality.

A. Describe how the medical school engages in continuous quality improvement.

Beyond the continuous monitoring of KPIs described in 1.1-1, the medical school undergoes several other internal and external reviews intended to contribute to the CQI process:

Accreditation Reviews

There are reviews conducted by external accrediting bodies for educational programs in the CSM other than Undergraduate Medical Education to ensure that national standards are met, and also serve as a means to improve the programs.

Education Program	Date of Last Accreditation Review	Accreditation Result	Program Quality Improvement Outcomes
Postgraduate Medical Education	September 2022	PGME – accredited institution with follow up by action outcomes report For the residency programs, there are: - 42 Accredited programs with follow up by regular review - 11 Accredited programs with follow up by action outcomes report - 8 Accredited programs with follow up by external review	Developing a QI framework that will include simple and standardized tools to encourage and guide QI initiatives at the program and institution level. Implementation will include training and personalized support.
Continuing Medical Education & Professional Development	November 2018	Full Compliance 11/12 Standards Partial Compliance 1/12 Standards	A successful audit from June-November 2021 resulted in compliance achieved for 12/12 Standards. A subsequent mid-term Internal Quality Audit is currently being conducted.
Advanced Technical Skills Simulation Laboratory	March 2023	Full accreditation continued - Adherent to 24/31 Standards Partially Adherent to 7/31 Standards	A review of the Partially Adherent Standards is occurring, with an Action Plan provided to the Royal College in May 2024.

CSM Unit Review

All UCalgary faculties are subject to an internal quality assurance process every 5-7 years mandated by the Provost's Office. The review focuses on the quality of a unit as it relates to overall academic activities and performance, including management, resources, structure and governance, personnel complement, educational programs, research productivity, partnerships, budget, and space, which are interconnected and drive the key deliverables in research and teaching and learning. A review team comprised of two Canadian deans, one international dean, and one UCalgary dean (or designate) conducts an on-site visit and provides a written report with recommendations. The last review was conducted in April 2023, and a report was provided which made the following recommendations:

1. Create separate Indigenous and EDIA initiatives in line with the broader University direction.
2. Transform the approach to addressing the University of Calgary Indigenous Strategy, ii'taa'poh'to'p
3. Build an extensive roadmap to EDIA
4. Revitalize the CSM community in a post-pandemic era
5. Revitalize academic staffing and personnel
6. Aligning structure with new CSM strategy
7. Create a 5–10-year capital & infrastructure plan
8. Develop a partnership strategy with current key and potential partners (e.g., AHS, Cancer Control Alberta). Supplement the Dean's Advisory Group to facilitate new linkages (e.g., community, industry, Indigenous engagement)
9. Enhance research productivity and impact

The majority of recommendations are addressed in the 2023 Strategic Plan, and an interim progress report to the Office of the Provost is due in 2025.

Curriculum Reviews

All undergraduate and course-based master's programs at UCalgary are required by the Provost's Office to undergo an internal curriculum review. The goal is to facilitate a collaborative, evidence-based decision-making processes for strengthening academic programs. The Bachelor of Community Rehabilitation (2023), Bachelor of Health Sciences (2019) and Undergraduate Medical Education program (2016) have been included in this process.

In addition to the curriculum review process mandated by the Provost's Office, the UME program undertakes regular curriculum reviews internally. The last review started in 2017-18 with the creation of the Undergraduate Curriculum Review Taskforce Committee, which was charged with making recommendations to the Undergraduate Medical Education Committee for review. Surveys conducted and hundreds of hours of focused observation identified several potential themes of change in the existing pre-clerkship curriculum which included increasing opportunities for generalist (non-specialist) perspectives in teaching and learning, the need for longitudinal courses spanning multiple body systems/areas of medicine and implementing scheduling changes designed to benefit learner wellness. The Re-Imagining Medical Education (RIME) initiative was subsequently developed in 2018 pursuant to the work completed by the Taskforce Committee (***Supplemental Appendix 1.1-2***). The RIME focus was on the content and educational development of the pre-clerkship curriculum, and ultimately resulted in a new pre-clerkship curriculum starting in July 2023 that has an increased focus on generalism, delivery of clinical content in a "spiral" model (i.e. reinforces previous learning and encouraging increases in content complexity as learner competency grows), and greater inclusion and integration of structural competencies and Indigenous health in all courses.

B. Provide two examples of measurable outcomes of continuous quality improvement processes used to improve undergraduate medical education program quality.

An example of recent CQI initiative is improving the accessibility of materials provided in the RIME curriculum. Early feedback in Block 1 from surveys and focus groups coordinated by the Assistant Dean, Program Evaluation, indicated that the podcasts used as the backbone of content delivery did not consistently have closed caption and transcript extraction options. Communication to the pre-clerkship educators with the directions for including closed captions was distributed, as well as specific notifications in the informal RIME directors meetings and the formal RIME Pre-Clerkship Committee meetings. The UME also embarked on retroactively applying closed captioning and transcript extraction to the current podcast, as well as a proactive approach for new content being developed that the podcasts have closed captions and transcript extraction capabilities prior to publishing to the curriculum platform. This has led to 100% of podcasts now having closed captions and transcript extraction capabilities, which better suits the needs of diverse learners. Subsequent feedback from surveys has acknowledged this improvement.

The second example with a measurable outcome change related to CQI was that of a clinical rating improvement noted after the Family Medicine pre-clerkship clinical experience was evaluated in a formalized manner, using the Manchester Clinical Placement Index (MCPI). In the Family Medicine pre-clerkship clinical experience (Year 1-Med 330 and Year 2-Med 430) the MCPI evaluation was used, and included several factors (leadership, reception/induction, people, instruction, observation, feedback, facilities and organization of placement) which are noted in Dornan's Clinical Placement index*. This was used in over 150 clinical placement sites, and the above factors are believed to be integral in allowing for a successful teaching/learning environment. This CQI initiative moved from a focus on the *teacher* to a *learning environment* focus, with the end product being more valuable feedback to preceptors and their clinics. When outlier data was found this allowed for specific faculty development opportunities. The qualitative data was used in an aggregate and anonymized form to provide overall feedback for continuing professional development of family medicine educators.

With the introduction of the MCPI the Family Medicine pre-clerkship experience saw higher ratings, and this was believed to be related to the valuable feedback given to each clinical placements lead regarding clearer expectation in the above noted areas. Student ratings improved over the years, are noted below.

Year	MDCN 330		MDCN 430		
2010	CL 2013	?		NA	
2011	CL 2014	?	CL 2013	?	
2012	CL 2015	4.1	CL 2014	?	Out of 5
2013	CL 2016	3.9	CL 2015	3.9	
2014	CL 2017	4.2	CL 2016	4.0	
2015	CL 2018	4.3	CL 2017	4.2	
2016	CL 2019	4.2	CL 2018	4.2	
2017	CL 2020	4.2	CL 2019	4.1	
2018	CL 2021	4.2	CL 2020	4.2	
2019	CL 2022	4.1	CL 2021	4.2	
MCPI Introduced					
2020	CL 2023	5.3	CL 2022	COVID	Out of 6
2021	CL 2024	5.3	CL 2023	5.6	
2022	CL 2025	?	CL 2024	Not evaluated	

*Dornan T, Muijtjens A, Graham J, Scherpbier A, Boshuizen H. Manchester Clinical Placement Index (MCPI). Conditions for medical students' learning in hospital and community placements. Advances in Health Sciences Education 2012; 17(5):703-16).

Requirement 1.1-3

The medical school engages in ongoing continuous quality improvement processes that ensure effective monitoring of the medical education program's compliance with accreditation standards.

A. Describe how the medical school ensures effective monitoring of the medical education program's compliance with accreditation standards.

Compliance with CACMS Standards is monitored on an ongoing basis through several evaluation strategies.

The last full accreditation occurred in 2016, with a relatively small number (10) of Elements cited as "Satisfactory with Monitoring" or "Unsatisfactory". Required status reports were submitted to CACMS in 2018, 2019, 2021, and 2023 to address remaining issues. All the flagged elements have since been moved to a satisfactory designation.

Compliance with CACMS Standards is also monitored as part of the Interim Accreditation process. The most recent process began in January 2019, with a full review of all 12 Standards by the I2020 Committee led by the Faculty Undergraduate Accreditation Lead (FUAL). The internal documentation process was completed in January 2021, and a virtual site visit by an external review team was conducted in May 2021 resulting in several recommendations intended to improve the quality of the program.

Regular review of the Standards is conducted by the Undergraduate Medical Education Committee (UMEC), with regular reports received from its sub-committees: RIME Pre-Clerkship Committee (RPCC), Pre-Clerkship Committee (PCC), Clerkship Committee (CC), Curriculum Innovation and Oversight Committee (CIOC), Research Committee and Student Evaluation Committee (SEC-UME). Those committees are charged with monitoring (and, when necessary, making modifications) the UME program components relevant to accreditation standards. This process is defined in the sub-committees' terms of reference.

As noted in 1.1-2, a full curriculum review was completed in April 2018, which ensured that compliance with CACMS Standards and Elements was current. Recent initiatives as a result of the continuous improvement / program evaluation processes include:

- Clerkship: Longer, better scheduling mechanism (4-week blocks, algorithm for increasing the likelihood of a desired clerkship schedule for individualized students based on their preference, recent addition of EPA assessments with mandatory completion and face-to-face observation and feedback integral to this process
- Launch of a new Career Exploration curriculum
- Launch of a Budget/Financial planning educational curriculum in response to student debt
- Change of the Anatomy course to a longitudinal course

The UME program has several internal and external outcomes measures that are used to guide the monitoring of accreditation standards and subsequent curricular changes. These include:

A: Student Assessments

1. End of pre-clerkship course examinations (including medical skills OSCEs)
2. Pre-clerkship clinical correlation evaluations (ITER)*
3. Pre-clerkship communication skills formative evaluation
4. End of clerkship rotation examinations
5. End of clerkship rotation ITERs
6. End of clerkship OSCE
7. Associate Dean's formative examinations
8. Pre-clerkship assignments evaluations (Course IV: Integrated Renal-Electrolyte and Endocrine -Metabolism Course, evidence-based medicine, Course V: Integrated neurosciences, Special Senses and Aging Course, Course VII: Psychiatry)*
9. MED 440 (AEBM) course evaluations/projects*
10. Integrative course preceptor evaluations*
11. Pre-clerkship electives evaluations*
12. Student feedback on Faculty of Medicine-Nursing inter-professional education session*
13. Pre-Clerkship ITERs in Family Medicine Clinical Experience (MED 330/430*, FMCE in RIME) – formative and summative
14. Daily learning event surveys – every learning event in pre-clerkship collects student feedback
15. Pre-clerkship Unit and block exams
16. Career Development Week ITERs

17. EPA 0 – Learner Accountability

B: Program evaluation

1. MCC Part I results
2. End of pre-clerkship and clerkship course evaluations
3. End of year (I, II, III) student feedback
4. AFMC CGQ
5. PGME program director survey
6. Alumni survey
7. Master Teacher feedback*
8. Post course/unit/block Faculty Feedback survey

* Denotes Legacy curriculum

The outcome measures (particularly student feedback of course/clerkships, MCC results, end-of-year student feedback, AFMC GQ, PGME program director survey, alumni survey) are compiled and regularly presented to UME management by the Assistant Dean – Program Evaluations. In addition, these measures were summarized yearly in a "Key Performance Indicators" document until 2021. This reporting was paused with the implementation of RIME, and work is underway to define appropriate performance indicators for the new curriculum. UME management includes the chairs of all the major committees in the UME curriculum, and thus this information is disseminated to UMEC, PCC, CC, CIOC, and SEC-UME through this route when necessary to support changes to the curriculum. The KPI data were presented at each of these committees for dissemination to course leaders and for discussion and will be reinstituted once new KPIs are defined.

Every course/clerkship presents yearly to PCC and CC, and student feedback data are particularly prominent in those presentations. Student feedback for each course/clerkship is also distributed to the UME management team. The template that is used for the formal yearly report by the course chair includes a section where they are required to describe how their courses attend to specific elements.

Each individual course chair/clerkship director receives relevant student feedback data for dissemination/discussion with their relevant course/clerkship committee. These data are part of the information that allows the course/clerkship chair to create their yearly report. They also receive a yearly request from the Assistant Dean - Program Evaluations regarding any edits they would like to see to the surveys, in order to collect data that are meaningful to the individual course committees.

B. Provide two examples demonstrating effective monitoring of the medical education program's compliance with accreditation standards.

Example 1: Element 9.8: Release of examination results in a timely manner (grades within 6 weeks):

The table below illustrates the timing from exam administration to release of grades. There has been a recent request to establish a set date for the release of examination scores, to help alleviate the stress that the students have with the uncertain timing, despite this being prior to the 6-week deadline. Medical student class representatives have voiced appreciation for initiatives put in place by the UME to set an exact date for score release following the request that was made to the Student Evaluation Committee (SEC) in the Spring of 2023.

Schedule for release of course marks (Class of 2025)

Course	Date of final component	Date for Marks Release
Anatomy I	March 7, 2023	March 27, 2023
Course 3	March 16 & 17 2023	March 31, 2023
MS I	March 22 & 23, 2023	April 11, 2023
Course 4	June 20, 2023	July 10, 2023
Course 5	September 8, 2023	September 29, 2023 (after Course 7 exam)
Course 7	September 29, 2023	October 20, 2023
Anatomy II	November 1,2023	November 22, 2023
Course 6	December 7, 2023	January 4, 2024
MS II	December 13 & 14, 2023	January 11, 2024

Example 2: Element 6.4: Outpatient/inpatient experiences

There are mandatory experiences in the pre-clerkship curriculum that allow for students to experience both inpatient and outpatient clinical opportunities. These experiences are in the form of mandatory primary care exposure during the pre-clerkship curriculum as well as career exploration weeks with mandatory clinical time. The primary care exposure is ambulatory in nature and the career exploration weeks could be inpatient or ambulatory. During the clerkship portion of the curriculum all students have both ambulatory and inpatient rotations. The ISA data for the 2023 year noted that 100% of respondents indicated both inpatient and outpatient experiences during their training (see Element 6.4 for details). These experiences have been continued within the RIME pre-clerkship curriculum.

1.1.1 SOCIAL ACCOUNTABILITY

A medical school is committed to addressing the priority health concerns of the populations it has a responsibility to serve. The medical school's social accountability is:

- ***a) articulated in its mission statement;***
- ***b) fulfilled in its educational program through admissions, curricular content, and types and locations of educational experiences;***
- ***c) evidenced by specific outcome measures.***

Requirement 1.1.1-1

The medical school is committed to addressing the priority health concerns of the populations it has a responsibility to serve.

A. Table 1.1.1-1 A

Table 1.1.1-1 A | Populations that the Medical School has a Responsibility to Serve (Core Appendix) Source: School-reported

List the population(s) that the medical school has a responsibility to serve. Provide a short title in Column 1 and a brief description in Column 2. Add rows as needed.	
School-identified population(s)	Brief description
Indigenous peoples	Indigenous peoples in Alberta, including First Nations, Métis and Inuit. 'Aboriginal' as defined by the Government of Canada in section 35 of the constitution includes First Nations (Status, Non-Status), Métis, and Inuit peoples. The term Aboriginal is used in Canada interchangeably with the term Indigenous in alignment with the United Nations Declaration on the Rights of Indigenous Peoples (2007). Indigenous peoples in Canada are diverse in culture, language, and belief systems and often identify with specific nations, communities and/or traditional languages. Examples of such include, but are not limited to: Cree/Nehiyaw, Ojibway/Anishinaabe, Blackfoot/Niitsitapi (Kainai, Piikani, Siksika), Stoney Nakoda (Bearspaw, Chiniki, and Goodstoney), Tsuut'ina, Dené, Inuit, Métis, Mi'kmaq, Mohawk, and, etc. Additionally, Aboriginal or Indigenous peoples and nations in Canada have communities, traditional lands, and tribal/kinship affiliations that cross over the 49th parallel, which was established as a colonial border between Canada and the United States of America. Examples of cross border nations include the Iroquois Confederacy and the Blackfoot Confederacy. The University of Calgary is located on the traditional territories of the people of Treaty 7 in Southern Alberta, which includes the Blackfoot Confederacy (comprising the Siksika, Piikani, and Kainai First Nations) as well as the Tsuut'ina First Nation and the Stoney Nakoda (including the Chiniki, Bearspaw and Goodstoney First Nations). The City of Calgary is also home to Métis Nation of Alberta (Districts 5 and 6).
Rural communities	Individuals residing in areas outside a census metropolitan area or census agglomeration (source: StatsCan).
Equity-deserving groups facing health inequities	Equity-deserving groups are communities that face significant collective challenges in participating in society. This marginalization could be created by attitudinal, historic, social and environmental barriers based on age, ethnicity, physical and mental ability, economic status, nationality, race, sexual orientation and gender diversity, etc. Equity-deserving groups are those that identify barriers to equal access, opportunities and resources due to disadvantage and discrimination and actively seek social justice and reparation. Examples include but are not limited to communities experiencing low income, houselessness, racialized communities (e.g., Black population, Jewish, etc.), ethnoreligious groups, newcomers (including immigrants and refugees), those with gender and sexual diversity, persons with disabilities, those experiencing the impacts of colonization, etc.

B. Describe how the medical school identifies the priority health concerns of the populations named in Table 1.1.1-1 A.

The Cumming School of Medicine (CSM) has various mechanisms in place to support the identification of health priorities in our communities and the implementation of co-creative responses. These mechanisms strategically span the micro to the macro - from individual staff and leadership roles, to projects, programs and initiatives, to entire units and offices, to the governance structures of the CSM. Descriptions of the mechanisms below outline how the school identifies the priority concerns AND what the school is doing to address those priorities (the commentary below answers section B but also answers much of section C. "*Provide evidence the medical school is committed to addressing …"*).

Inclusive Governance Project-This is a Social Sciences and Humanities Research Council (SSHRC) funded initiative. The Inclusive Governance Project is currently working to co-design a new governance model for the CSM that will place equity-deserving, rural and Indigenous communities at the centre of the decision-making process, so that CSM research, innovation, education and service products are aligned with community priorities. The governance model is being designed by community, for community, and has already engaged over 250 individuals representing a diverse array of equity-deserving groups. A parallel path of leadership guides the project: a Steering Committee comprised of organization leaders representing immigrants/newcomers/refugees, rural communities, gender and sexual orientation diversity, seniors, children, francophones, houseless communities, faith-based groups, disability, women fleeing violence, etc., works alongside an Indigenous Guiding Circle, comprised of Indigenous community members and Elders. Through novel and groundbreaking methods, the Inclusive Governance Project bridges divides – be that geographical, cultural, or generational – while amplifying the voices of those traditionally overlooked. By facilitating collaboration and dialogue it ensures that diverse voices are heard and respected, enabling the CSM to effectively address community priorities and challenges and seize emerging opportunities. Born from a commitment to equity and social justice, this initiative embodies the school's dedication to community engagement and collective empowerment. At its core, the project aims to support social accountability at the macro level of the institution – ensuring that where and how decisions are made ("governance") is centered around equity-deserving, rural and Indigenous voices.

One Child Every Child Initiative (Canada First Research Excellence Fund) **-** The Government of Canada is investing $125 million in the University of Calgary's One Child Every Child initiative – one of the largest ever awarded to a university in Alberta. By bringing together researchers, community partners, health-care providers, equity-deserving groups, local, national and global stakeholders, educators and Indigenous communities, One Child Every Child dramatically improves the lives of children across Canada and beyond. This unprecedented local to global partnership from 25 countries is committed to helping all children be healthy, empowered and thriving. Over 250 unique health delivery organizations – from hospitals and rehabilitation centres to community outreach and home care providers – have joined the cause. CSM Faculty, staff and students are deeply involved in the initiative, leading various research and accelerator teams. One Child Every Child's equity, diversity and inclusion action plan identifies three priorities: Indigenous self-determination and health equity, inclusive governance, and disrupting child health inequities through an intersectional lens. "We met with equity-deserving organizations across Canada as we wrote our plan," says Dr. Bukola Salami, RN, PhD, professor of nursing, University of Alberta. "The voices and priorities of these national partners will allow us to accelerate outcomes for equity-deserving children."

The Alberta Children's Hospital Research Institute (ACHRI) employs various mechanisms to collaborate with community and develop partnerships to ensure their research efforts are community-based and impactful. The Child Health and Wellness Research Strategy was developed through engagement with child and youth-facing agencies, community members and leaders. The One Child Every Child initiative brings together researchers, community partners, health-care providers, equity-deserving groups and Indigenous communities to improve the lives of children across Canada and beyond.

Indigenous, Local & Global Health (ILGH) Office - The mandate of the CSM's Indigenous, Local & Global Health Office is to sustain and strengthen longitudinal community partnerships and relationships to advance social accountability initiatives in the school and co-foster health equity in equity-deserving communities. The ILGH office works to bring a variety of community voices into the life, culture and activities of the CSM to identify community health challenges and priorities. The office does this by developing partnerships, co-generating knowledge and programs, expanding community-engaged education and research and supporting the alignment of school priorities with community needs and interests. The ILGH Office has a number of staff, faculty and leadership positions dedicated to engaging and partnering with Indigenous, local and global communities around education, service, innovation, research and advocacy. The ILGH Local team has partnerships with over 50 Calgary-based community organizations serving equity deserving groups, to support the **UME Community Engaged Learning (CEL) Program**. Through on-the-ground engagement in the CEL program, UME students expand their knowledge and understanding of the current health challenges, priorities and opportunities in the community. Community partners are empowered to help students learn about the issues most relevant to the community, within the community setting, with opportunities to engage directly with those with lived

experience. The **ILGH Global team** works closely with nine partner medical schools in the global South around community-determined priorities and initiatives, to foster bidirectional learning in low resource settings, advance co-research and enhance equity approaches. Grounded in balanced partnerships, reciprocity, anti-racist and anti-colonial approaches, the global health program seeks to support the shift toward meaningful engagement to address global health and social inequities in our core partnership sites, which ultimately builds capacity, motivation and readiness to foster health equity here at home as well. Recent global partnered projects include Health Adolescents and Young People (HAY!), which is engaging over 3,000 village health team members and hundreds of health providers and managers to improve adolescent and young people health in southwest Uganda; and SIM for Life which has been designated as the simulation skills leader in maternal, newborn skills training by the Ministry of Health in Uganda and is engaging multiple countries (Mwanza, Tanzania, Nigeria, etc.) in the second phase of the project to scale up. The **Indigenous team** regularly engages various Indigenous Elders, students, faculty and community members around initiatives to identify priorities and set directions, such as the **Indigenous Health Dialogue** (below) and the Traditional Knowledge Keepers in Residence Program, which supports a group of Elders to visit the medical school regularly to engage with students, faculty and staff, provide teachings and strengthen protocol at events and ceremonies. The team also works to support and engage Indigenous medical students, staff and faculty within the CSM, advance Indigenous Health research and innovation, and build institutional knowledge and capacity around Indigenous health.

Indigenous Health Dialogue (IHD) - The Indigenous Health Dialogue (IHD) was established by a group of committed individuals – faculty, trainees, and leadership - to enhance existing Indigenous health initiatives, create new opportunities for programming and purposefully respond to the Truth and Reconciliation Commission's (TRC) Calls to Action. This was an effort to strengthen coordination around Indigenous health initiatives within the CSM; the IHD actively explored what the TRC Calls to Action mean for our school and community partnerships, as a means of building faculty and community capacity for aligning goals and outcomes. Grounded in Indigenous principles that promote collaboration, non-hierarchy and non-coercion in decision making processes, the IHD carried out a series of internal and community engagement activities to strategically bring together CSM faculty and leadership with Indigenous community stakeholders (i.e., leaders, planners, educators and service professionals) to challenge, clarify, refine and define directions for Indigenous health initiatives within the CSM. Through these activities, the IHD has involved input from some 250 individuals whose ideas contribute to the vision outlined in the "Report on Indigenous Health Dialogue of Truth and Reconciliation within the Cumming School of Medicine**"** (Crowshoe, Henderson, and Barnabe; 2020).

The Indigenous Health Program Advisory Committee (IHPAC) meets annually to provide direction to the development, implementation and evaluation of Indigenous Health Program (IHP) activities, and direct IHP engagement with external stakeholders and Indigenous communities and organizations. The IHPAC holds the CSM accountable to the principles inherent within the TRC and the directions arising from the TRC's Health Legacy Calls to Action. Specifically, the IHPAC will facilitate and guide the IHP in achieving the mandate of the Indigenous Health Dialogue (IHD) and its five directions.

Distributed Learning and Rural Initiatives (DLRI) Office - The mission of the CSM's DLRI is to "engage communities, inspire social accountability and create opportunities. At DLRI, we believe in providing quality healthcare to the people of rural Alberta. We strive to accomplish this goal by fostering and sustaining meaningful relationships between medical educators, healthcare professionals in training, individuals and families living in rural communities. Our commitment to education, research and continuous improvement results in the recruitment and retention of dedicated and skilled rural physicians". Among leadership and staff positions, the DLRI has a Team Lead, Community Engagement dedicated to working with faculty preceptors and rural communities to support medical education. Through a recent pilot project, ***Facilitating Community Involvement in Undergraduate Medical Education Rural Clinical Experiences***, the DLRI worked directly with rural communities to gather information they deemed important for learners and future physicians to know to better prepare them to work in that community. The project recognized there are distinct communities within communities (e.g., Latter-day Saints, Hutterites, Indigenous communities, etc.) that are unique regarding their health beliefs and practices, health care access, etc.

In April 2023, the DLRI collaborated with the **Centre for Health Policy** at the O'Brien Institute for Public Health to hold a rural town hall in Pincher Creek Alberta. Through Empowering Rural Alberta Through Informed Health-Care Conversations, Town Hall Series, residents, providers and decision makers came together to discuss the rural healthcare crisis facing the province (a current health priority of rural Alberta communities). The town halls have acted as an avenue to help the community understand the issue and sparked conversations about grassroots efforts local citizens can engage in to improve physician recruitment and retention in their own community.

The town hall was one of two public events hosted in conjunction with the release a set of policy briefs titled Alberta 2023: Health System Challenges and Opportunities (a collaborative effort between DLRI, the Centre for Health Policy and rural communities)**.** The first brief released, Priorities to Improve Care in Rural Alberta, is meant to help all Albertans understand the current healthcare crisis in rural Alberta and includes suggestions toward a more sustainable system. Released before the April 2023 election, the brief sought non-partisan commitment from the winning political part to improve Alberta's rural health situation in three key areas (1) a commitment to rural health teams

able to provide comprehensive health care including obstetric and surgical services, (2) a commitment to team-based practice models with staffing levels that promote long-term retention of health professionals, and (3) a commitment to educating the future health-care workforce in rural Alberta, for rural Alberta. In response, the current Alberta government has committed $224.8 million for Rural Medical Education Training Centres to increase the number of physicians outside of Alberta's major cities and $43 million for a Rural Teaching School at the University of Lethbridge that will operate under the UCalgary medical curriculum and grant UCalgary degrees. The initiative is meant to open more doors of opportunity to attract, educate and retain the health workforce that is greatly needed in rural areas, by centering training on rural students more likely to work in rural communities. Under the plan, the University of Calgary, University of Alberta, University of Lethbridge, and Northwestern Polytechnic will work together to develop new Rural Medical Education Training Centres (RMETCs) in Grand Prairie and Lethbridge.

The DLRI is also working to radically increase the size of the UCLIC (University of Calgary Longitudinal Integrated Clerkship) Program, from 24 spaces to 54 spaces over the next three years, in alignment with the need for more rural physicians. The UCLIC program is a one-year clerkship option for 3rd year medical students interested in learning medicine in a generalist environment, based in a family medicine practice in a rural or regional community (e.g., Brooks, Canmore, Cardston, Crowsnest Pass, Drumheller, High River, Lethbridge, Pincher Creek, Raymond, Rocky Mountain House, Stettler, Sundre, Taber, Yellowknife NWT). The educational goals of the program include establishing a patient-centered, community based, pedagogically sound clerkship in selected rural and regional Alberta communities to encourage students to pursue generalist careers in rural communities. The program also works to strengthen and enhance the relationships between rural/regional communities and urban tertiary teaching institutions.

The **O'Brien Institute for Public Health** (OIPH) works to catalyze, enable and promote research building networks and apply knowledge translation to put research to work for societal impact. The networks of O'Brien include the Group for Research with Indigenous Peoples (GRIP) – a network of more than 130 health researchers, students, Indigenous community members and organizations, health systems providers and government agencies with a focus on the achievement of Indigenous Health; Sex, Gender and Women's Health Research Unit – whose mission is to create research related to sex, gender and women's health that will meaningfully contribute to improved health of Canadians. There are also various member initiatives focused on the health of equity-deserving groups, including the Black Youth Mentorship and Leadership Program.

The Health Equity Hub is an initiative of O'Brien that arose out of community agencies serving equity-deserving populations requesting academic support, and today is working to support health equity scholars to translate research into social change and improvements in service delivery (health care and community programs). The Hub's vision is to serve as a trusted source of community connection, partnership, knowledge sharing and health research that aligns research activities to community priorities. During the November 2023 Hub Forum, community agencies, government officials, and UCalgary faculty, staff and students came together to identify and discuss key systemic disparities in our public health system and the role the O'Brien Institute for Public Health should play in addressing these disparities. Among the key systemic disparities identified were (i) access to the health care system, mental health supports, and health literacy supports, (ii) economic disparities in our society, including high levels of poverty and unemployment and the need for a living wage, and (iii) social and cultural differences that go under-recognized in our current system. Part of the structure of the Hub is a Community Engagement Connector position dedicated to facilitating conversations and connections between the community and academia, as well as a Student/Trainee Engagement position that works to support learner development and capacity building in community engaged research.

Refugee Health YYC, an initiative of O'Brien, is a research, innovation and education platform closely partnered with Mosaic Refugee Health Clinic in Calgary working to understand the current health issues of refugees in Canada and train medical students, residents and fellows to provide clinical support to Calgary's refugee community. Recently, leading clinical scholars of Refugee Health YYC prepared a briefing note, Characterizing Canada's Refugee Healthcare System: Structures, Processes, Coordination and Barriers Amidst Mass Refugee Resettlement, to inform national-level refugee healthcare standardization and improvement opportunities. Many of the directors and leads regularly give lectures to medical students on current trends, challenges and opportunities in refugee/newcomer health in the Canadian context.

The **Stopping Violence Before It Starts** project is an initiative O'Brien provided catalyst funding for, that supports collaboration with Indigenous communities and individuals to prevent domestic and sexual violence. The aim of the project is to support Alberta's prevention framework for violence against Indigenous people by mapping root causes and identifying policy recommendations to stop violence before it starts.

The **Patient and Community Engagement Research (PaCER)** unit at the O'Brien Institute for Public Health is committed to finding better and more creative ways of engaging patients in health care and creates public and health-related venues for a collective patient research voice. The unit works to improve the interface between patients and the health care system through engaged research and creates public and health-related venues for a collective patient research voice.

Precision Equity and Social Justice Office (PESJO) – is a centralized equity, diversity, inclusion, acceptance (EDIA) resource for the CSM to dismantle oppressive learning and health systems, and to achieve social justice. The office meaningfully engages with our community, applying a Precision Equity approach to support the delivery of targeted and tailored interventions. They work to translate EDIA community priorities into CSM guidelines, processes and policies; design and deliver EDIA and anti-oppression education, literacy and curriculum; and collaborate on several initiatives, such as pathway to entry programs, food insecurity, etc. They also provide regular newsletters that include community engagement, have a community pantry and have set up a local Fresh Routes to offer affordable produce to the CSM community.

Health Equity and Systems Transformation (HEST), Senior Associate Dean – This senior leadership position is responsible for establishing the CSM as a partner for health equity in the community, including defining community priorities and partnerships and working with CSM units to fulfill the mandates of social accountability to address the priority health concerns of the population we serve. The HEST portfolio was created to advance health equity, inclusion and anti-racism within the medical school and to action the school's social accountability mandate externally. The faculty member currently in this role is also the founder and President of the Black Physicians' Association of Alberta.

The **Department of Clinical Neurosciences**, **Health Equity Rounds Committee** has been organizing quarterly grand rounds focused on topics about care for equity-deserving groups since December 2020. To date, care for the following topics have been discussed: (1) care for incarcerated populations, (2) care for Indigenous patients, (3) accommodating spirituality/religious beliefs, (4) care for persons with disability, (5) care for persons experiencing homelessness, (6) antisemitism in healthcare and medical education, (7) anti-Asian discrimination in healthcare, (8) trauma and violence-informed care. Guest speakers are routinely invited to present on these topics and representative case scenarios are used to discuss practical steps physicians can take to address the identified problems and implement health equity concepts. The department services the entire population of southern Alberta, western Saskatchewan and eastern British Columbia, which includes a significant rural population with specific medical and social issues.

The **Libin Cardiovascular Institute's Community and Partners Advisory Committee (CPAC)** engages patients and family-caregivers in inclusive priority setting processes to identify priorities for patient-oriented research in cardiovascular health. CPAC also is engaged in an ongoing capacity around communications and sustainability planning, grant proposals, workshops and various projects led by members of the institute.

The **Canada Research Chair (Tier 1) in Black and Racialized Peoples Health** is a CSM faculty member and is working to create an online resource to improve mentorship of Black people at the CSM, and directly mentors Black medical students in the faculty.

CSM Strategic Planning, 2023 Advisory Groups - In addition to bringing together a Working Group of CSM community members to work directly with the consultants facilitating the strategic planning process, several advisory groups were created to consider important questions about the future. The strategic planning advisory groups and some of the questions they were tasked with answering included:

Black Health Advisory Group – *what needs to change at CSM to foster authentic inclusion and sense of belonging for Black faculty?*
Equity, Diversity, Inclusion and Accessibility Advisory Group - *how do we foster ongoing principles of EDIA in CSM? Where are the gaps in EDIA in CSM?*
Indigenous Advisory Group - *how do we continue to foster Indigenous ways of knowing and being in CSM?*
Social Accountability and Planetary Health Advisory Group
Clinical Advisory Group - *how do we help solve education and access issues in rural Alberta?*
Patients Advisory Group

The Continuing Medical Education (CME) office and the Office of Faculty Development and Performance (OFDP) also have some important educational initiatives. The CME office hosts Alberta Sexual Assault Course and Conference – which intends to primarily serve rural communities, providing sexual violence education as well as techniques in trauma informed care. OFDP has bystander, reconciliation teaching – educational offerings include quite a focus on community needs.

C. Provide evidence that the medical school is committed to addressing the priority health concerns of the populations named in Table 1.1.1-1 A.

Much of what is outlined in section B addresses this question and the evidence presented in 1.1.1-2. The new CSM Strategic Plan also speaks in depth of the commitment to this area.

The new 2023 CSM Strategic Plan puts people and communities at the centre and prioritizes social justice through health equity. At the launch of the new plan, Dean Todd Anderson commented, "we are committed to creating a people first strategy to elevate and recognize our members for all they do to contribute to the success of the CSM. Just as important to our mission are the people we work with outside of the school, our community partners, patients, the broader research community, Alberta Health Services, other UCalgary faculties, provincial and federal government partners, our funders, the City of Calgary, rural Albertans and our Indigenous communities. Our role is to collaborate, co-create and solve mutually important problems. That is the privilege and responsibility that we have been entrusted with and which we can achieve through outstanding academic work and social equity."

Underlying principles of the plan include "engage with individuals and communities to learn from their lived experiences," "grow the societal impact of research to benefit communities," "create parallel pathways for self-determined Indigenous engagement with CSM," "improve rural access to care," and "engage with patients."

Strategies under the plan include:

- Build Indigenous health education content across all educational units.
- Support strategies for equity of access and authentic inclusion of Indigenous perspective and people within all levels of the CSM.
- Promote Indigenous people and knowledge while dismantling barriers and bias within the institution.
- Require all faculty and staff to take Indigenous anti-racism training.
- Grow capacity for equity and promote Indigenous-based approaches in the CSM.
- Engage in a formal institutional decolonization process.
- Require all new faculty to complete the Indigenous Canada Massive Open Online Course.
- Require ethical and rigorous Indigenous health research within our institution that effectively responds to community identified priorities.
- Evaluate the differences in health status, health behaviours, health service use, costs and outcomes of rural and urban populations in Alberta, using data from AHS and primary care practices.
- Sustain and expand health and UCalgary relationships and respond to community priorities.
- Identify and support leads in Indigenous health, Black health, immigrant and refugee health, disability and health, 2SLGBTQIA+ health, women's health and other equity deserving groups.
- Create and enhance programs to address stress, mental health, opioids and addiction.
- Develop and evaluate a program that addresses racism and discrimination in Canada's health systems, using a participatory approach that involves racialized and marginalized communities, health system partners, and other partners.
- Compare the health status, health behaviours, health service use, costs and outcomes of racialized and non-racialized populations in Alberta. Use this data together with community priorities to devise interventions that address aspects of the quintuple aim.
- Address Black health inequities through Black population-based research.
- Build capacity to recruit, support and retain learners and faculty working in social and environmental determinants of health.
- Implement and evaluate a health learning system approach to improve the quality and safety of health care for new immigrants.
- Enhance accessibility of all CSM programs to diverse members of our community.
- Engage community in the co-design of educational curricula, research mandate and sharing the health ecosystem.
- Proactively address EDIA and anti-racism in education program curricula.

CSM Social Accountability Task Force - A task force for Social Accountability in the CSM began work in the summer of 2020, completing several important tasks including the creation of a CSM-specific social accountability definition and recommendations to further advance the social accountability of the school. The Social

Accountability Task Force presented their recommendations at the October 20, 2022, meeting of the CSM Priority and Planning Committee, where they were accepted and approved.

Social Accountability Definition
A commitment to social accountability obliges us, as the Cumming School of Medicine, to direct our education, research, service activities, and resources towards the priority health and equity concerns of the communities we serve. As a dynamic process, social accountability directs us towards critical praxis, ensuring we are responsive to community needs - in continuous collaboration with community and stakeholders.

Department of Family Medicine - "As a department, we are committed to improving Equity, Diversity and Inclusion, addressing anti-racism, and working towards decolonization and reconciliation. Our physicians are dedicated to leadership and advocacy - with many contributing to local, provincial, and national organizations to voice the needs of primary care and ensure a strong family medicine presence."

Department of Community Health Sciences – "At Community Health Sciences, our commitment is to create with communities. That's why we're building a culture of authentic engagement. Relationships are the heart of our approach to service, and we work to harness the collective knowledge of all parties to find innovative solutions to some of today's most pressing public health challenges."

Department of Emergency Medicine – "Achieving patient and health care system outcomes cannot be done in isolation. Coordination between providers within the hospital is essential, and in particular with diagnostic imagining and specialty care. Members were also clear that additional investment is required to adequately support the acute needs of patients who require post Emergency Department follow up care. This includes recognizing and supporting the needs of people living with mental health and addiction issues, those living in rural or remote communities, and aging populations, which may require a transition to long term care. Additionally, members were strongly supportive of including a distinct goal targeting equity, diversity and inclusion (related to both the patient and provider experiences. Members acknowledged that the Emergency Department's role is only part of the patient's journey. Better coordination and collaboration with primary care in the community is required."

Department of Medicine Strategic Priorities – (2) Build capacity to care for Indigenous peoples, members of visible minorities, members within the 2SLGBTQ+ community, refugees, and persons experiencing addictions & mental health issues (9) Create an equitable, diverse, and inclusive DOM free from discrimination, racism, bias and harassment.

Department of Surgery Strategic Plan, Focus – Social Accountability and Community: We are responsible as surgeons for the needs of the people we serve, work with, and train.

Requirement 1.1.1-2
The medical school's social accountability is:

a) articulated in its mission statement
b) fulfilled in its educational program through admissions, curricular content, and types and locations of educational experiences
c) evidenced by specific outcome measures

A. Provide a copy of the medical school's mission statement. Label and highlight the section(s) where the medical school's social accountability is articulated. (***Appendix 1.1.1-2 A***) (Core Appendix)

Required Appendix 1.1.1-2 A – Mission - CSM 2023 Strategic Plan

CSM 2023 Strategic Plan - portion of mission statement
"We drive positive change in health equity and social accountability through discovery, inclusive excellence and continuous learning."

CSM Strategic Plan (2015 – 2020) Mission - We must fulfill our social responsibility to be a school in which the common goal of improved health guides service, education and research. We must foster the collective pursuit of knowledge and its translation, through education and application, to better the human condition.

B. Provide evidence that the medical school's social accountability mission is addressed in each of the following areas:
   i. Admissions
   ii. Curricular content
   iii. Types of educational experiences
   iv. Locations of educational experiences

i. Admissions

Indigenous Health Program (IHP) Pre-Admissions Recruitment, Mentorship, and Ongoing Support
The *Indigenous Health Program* is committed to supporting Indigenous learners, staff, and faculty at the CSM. The IHP facilitates the inclusion of Indigenous peoples and knowledge within the CSM and supports institutional initiatives in education, research and healthcare that aim to improve health outcomes of all Indigenous peoples. The IHP is overseen by the Assistant Dean - Indigenous (Dr. Lindsay Crowshoe; Piikani Nation).

Objectives:

1. Support the development of a pool of qualified potential Indigenous applicants for programs within the CSM.
2. Support Indigenous applicants during the admissions process, and Indigenous learners throughout their program
3. Provide support and professional development initiatives for Indigenous peoples at the CSM
4. Provide effective training opportunities regarding Indigenous health for all CSM learners, staff and faculty

The IHP facilitates many activities and programming including academic support, wellness resources, cultural engagement, educational opportunities, admissions guidance, mentorship opportunities and more. The IHP facilitates a Traditional Knowledge Keeper in Residence Program, supporting a group of Elders to visit the medical school regularly to engage with students, staff, and faculty, provide teachings and strengthen protocol at events and ceremonies. The IHP also cares for the Indigenous Hub – a ceremonial space open for use by students, staff, and faculty, and provides a physical space for Indigenous knowledge and inclusion at the Foothills Campus.

Specific to admission to the Undergraduate Medical Education program, the IHP offers pre-admissions workshops to inform prospective Indigenous MD applicants about the admissions process, practice MMI stations, share current Indigenous MD learner stories and experiences, and facilitate question and answer sessions. The IHP also offers an Indigenous Student Mentorship program, connecting both current and prospective Indigenous students with upper-year Indigenous learners, residents, or physicians. The IHP offers hands-on workshops led by medical students and residents for both on- and off-reserve high school and junior high students. These workshops are paired with various recruitment and engagement activities, aimed at encouraging Indigenous students to consider career options in the field of medicine.

The IHP offers various engagement opportunities for medical learners including professional development, networking and social events. The IHP hosts an annual gathering welcoming incoming Indigenous medical students. In addition, the annual CSM Indigenous Graduation celebration has recently been expanded to include a Celebration of Excellence for all Indigenous learners, staff and faculty, recognizing the on-going accomplishments and achievements of Indigenous members of the CSM community.

Indigenous medical learners and residents are also provided with various professional development opportunities, including opportunity to attend the Indigenous Physicians Association of Canada (IPAC) Annual Mentorship Gathering and AGM. The IHP also covers annual IPAC membership costs for Indigenous learners and residents.

Additionally, the IHP works closely with the Admissions office for policy and process improvements for the Indigenous Admissions Pathways. An Indigenous Faculty member sits on the Admissions Committee as well as the MMI case writing committee to ensure the inclusion of Indigenous specific MMI stations in the interview process and advises on other cases as needed. The IHP team also works in collaboration to advocate for changes to admissions structures, such as the new requirement for Indigenous specific education prior to matriculation in the UME program, and to help find Indigenous file reviewers for UME applications.

Indigenous Canada, Massive Open Online Course (MOOC) Pre-Admissions Requirement for all UME Applicants
All CSM applicants offered admissions are required to provide proof of completion of the *Indigenous Canada, Massive Open Online Course (MOOC)* offered by the Faculty of Native Studies, University of Alberta or a University of Calgary course equivalent. Indigenous Canada MOOC is a 12-lesson free online course that explores the different histories and contemporary perspectives of Indigenous peoples living in Canada. From an Indigenous perspective, this course explores complex experiences Indigenous peoples face today from a historical and critical perspective highlighting national and local Indigenous-settler relations.

Pathways to Medicine - Pipeline Program for Rural, Indigenous and Low-Socioeconomic Students
Pathways to Medicine (P2M) is a CSM scholarship program that targets, enrolls and supports graduating high school students from low socioeconomic, rural and Indigenous backgrounds in their journey to becoming a physician. Recipients of this "pipeline" program receive financial support, participate in an extensive MD preparatory program, and are guaranteed admission into the CSM MD after completing their undergraduate studies, subject to the fulfillment of predefined MD admission criteria (GPA, MCAT and interview requirements). Some benefits of the program include tuition support, mentorship, educational enrichment, clinical shadowing, research experience and MCAT/MMI preparation courses. As of May 2023, 38 graduated high school students have entered the program since the first intake of five P2M scholars in 2016. Thirteen P2M scholars have received their undergraduate degrees, nine P2M scholars have matriculated into the CSM MD program and three P2M scholars from the first cohort recently received their CSM MD degrees.

UME Admissions Commitment to Equity, Diversity and Inclusivity
"We are committed to a fair, transparent, and socially accountable admissions process. We strongly value equity and diversity in our selection procedures. We value the importance of strong academics and of being well-rounded and committed to the community. During the file review we equally weigh academic and non-academic components of the application." – UME admissions package welcome message.

The CSM is dedicated to creating a community representative of all Albertans and their experiences. There is a commitment to processes that advance equity and inclusion for all applicants and encourage applicants to celebrate what makes them unique and individual. The enrollment of a diverse group of medical students improves not only health care delivery in the province of Alberta but also the educational experience of all MD students at the University of Calgary. The CSM MD Admissions Committee is committed to broadening participation in medicine from individuals from traditionally under-represented groups. Accordingly, applicants from less traditional pre-medical backgrounds and under-represented groups are strongly encouraged both to apply and to highlight their background and experiences in their applications. Similarly, applicants who have had to overcome significant adversity or personal struggles in pursuit of a career in medicine are welcome to share and reflect on those struggles in their applications if they feel safe and comfortable doing so. This may be done in the top ten experiences or via essays in which applicants are asked to reflect on their power and privilege or barriers to same.

UME Indigenous Applicant Process (IAP)
The CSM encourages and supports applications from candidates who identify as First Nations, Inuit, and/or Métis. If applicants wish to declare Indigenous identity within the meaning of the Constitution Act of 1982, they must provide documentation to the Office of MD Admissions of their Indigenous identity. The ILGH Office works collaboratively with the MD Admissions Office to ensure the Indigenous Applicant Pathway is meeting the needs of the community and provides consultation and advice on pathway operations. Applicants of Indigenous Applicant Process will have members of the Black, Indigenous and People of Color community engage in their file review and are guaranteed interviews. The files are otherwise anonymized to reviewers. Applicants to IAP may also include an optional personal essay

highlighting why they have chosen to apply through this application stream. IAP applicants will also have their application scores adjusted according to historical Indigenous applicant cohort data.

UME Black Applicant Admissions Process (BAAP)
The CSM recognizes that there is a need to increase diversity and promote equity at all levels of medicine, including the undergraduate medical education admissions process. Historically, members of the Black community have been under-represented in both the applicant pool, and in undergraduate medical classes. In June 2020, in response to the Calls to Action released by the Calgary Black Medical Students Association, and with their collaboration, the BAAP was introduced to support Black medical student representation at the University of Calgary. The BAAP aims to limit any disadvantages Black applicants face during the application process attributed to their race or ethnicity. The BAAP is an optional opportunity for Black applicants. Those who choose to be part of the BAAP will undergo the same application process and are held to the same standards as the remainder of the applicant pool. The difference is that they will have members of the Black, Indigenous and People of Colour (BIPOC) community engage in their file review and interview. Applicants to the BAAP may also include an optional personal essay highlighting why they have chosen to apply through this application stream. The files are otherwise anonymized to reviewers.

UME Alternative Admissions Process, Rural Applicants
With the objective of increasing physician recruitment to rural settings, the CSM appreciates that the admission of students from rural communities will result in a greater chance of returning physicians back to these settings upon graduation. During the file review stage, file reviewers can flag a limited number of applicants who demonstrate an exceptional ability to assist the CSM in meeting its social accountability mission. Applicants who identify as rural are asked to write an essay reflecting on their rural experiences and connections to add to their admissions package. The Admissions Committee reviews these applicants using a holistic assessment process. If the application scores in other areas are deemed acceptable, the committee reserves the right to offer admission regardless of the individual component application scores or the final application score. Please note applicants do not 'apply' for the Alternative Admissions Process and can only be put forward by file reviewers assessing their application.

ii. curricular content

<u>UME Legacy Pre-Clerkship Curriculum</u> (*the Class of 2025 is the last cohort that will complete CSM Legacy Pre-Clerkship curriculum)

Program goals of the Legacy curriculum at the CSM included, "provide an environment that fosters collegiality, ethical practice and professionalism among students, faculty and allied health professionals to produce future physicians capable of working cooperatively within a team of health care providers, able to provide comprehensive, socially competent heath care to our socio-culturally diverse population with a goal of social accountability to all global citizens". Graduation Educational Objectives of the UME program specify that at the time of graduation, the student will be able to "apply a comprehensive patient-centered approach in the evaluation and care of patients including sensitivity to differing sexual orientation and gender identity, cultural and spiritual beliefs, attitudes and behaviours, economic situations, etc." The Graduation Educational Objectives are achieved through competencies aligned with the CanMEDS roles, including *Health Advocate* (i.e., ability to identify the determinants of health and barriers to health care access, specifically for the vulnerable/marginalized populations).

- The *Global Health* units (MDCN 320 and 420) of the Legacy UME curriculum aimed to develop student competencies in health equity (as it relates to wealth distribution, social and climate justice), interconnectedness of health locally and internationally (i.e., migration, travel, conflict, climate, disease burden, globalization), advocacy (SDoH as barriers to health, appreciating contexts, utilizing resources to better serve patients), cultural awareness, community engagement and community-led change, and building partnerships for innovative health solutions and improving health in low resource settings. The course covered topics such as trauma informed care, immigrant and refugee health, climate change and health, implicit bias, racism, Indigenous health, gender diversity, advocacy, etc.
- The *Communications* unit (MDCN 320) contained objectives around gathering the personal and social history of a patient, communicating with patients where there is a language barrier, active listening and empathetic communication.
- The *Ethics* unit (MDCN 320) contained objectives related to recognizing and understanding the impact of diverse cultures on medicine and ethical challenges, as well as lectures and small groups on cultural pluralism.

- The *Professionalism and Physician Health* unit (MDCN 320 & 420) contained an Indigenous health reflection and what that means for professionalism, in addition to cases that incorporated objectives on how culture and gender might influence professional relationships in medical school.
- In the *Population & Public Health* course (MDCN 340) students learned about determinants of health, burden of disease and health systems. A large portion of the course was dedicated to Indigenous health and covered topics such as the Truth and Reconciliation Commission of Canada's Calls to Action, historical trauma, residential schools, structural barriers to health, racism and discrimination, cultural safety, etc. The course also overviewed Canada's health system and international health systems, as well as homelessness, addiction, mental health, sexual identity, gender identity and disability.
- The *Applied Evidence Based Medicine* course (MDCN 345) contained lectures on how equity, diversity and inclusion intersect with research (e.g., incorporating other ways of knowing, diversity of the research team, interpreting research findings for underrepresented groups, etc.)
- The Renal, Endocrine and Obesity unit of Course 5 (MDCN 410) had learning objectives related to multidisciplinary care, social determinants of health, and barriers to care.
- The *Neurosciences and Aging* course (MDCN 450) presented guiding principles related to the care of older adults, including attention to biological, psychological, social and functional factors.
- The *Children and Women's Health* course (MDCN 460) contained lectures on equity, diversity and inclusion in women's sexual and reproductive health, sexual violence, contraception for diverse and vulnerable populations, racism in pediatrics, fertility care for transgender populations, and the psychosocial aspects of breast cancer.
- *Psychiatry* (MDCN 470) covered various mental health issues (suicide, PTSD, anxiety, mood disorders, etc.) and overviewed the interconnections between culture and psychiatry and family medicine and psychiatry. The course also covered transgender health as it relates to psychiatry.

RIME Curriculum

Medical schools have a moral obligation to be socially accountable and ensure that future physicians can address unmet needs to improve overall societal wellbeing (WHO, 1995; Health Canada, 2001). This means medical schools must do more than training physicians to be "professionals" who are clinically knowledgeable and possess technical skills, but rather cultivate physicians who are change agents who collectively will improve health and wellbeing in the communities they serve. To do this, medical school curricula should be proactive in anticipating the dynamic and emergent needs of society. To better meet these needs, the CSM undertook a re-design of the pre-clerkship undergraduate medical program, called Re-Imagining Medical Education (RIME). This new curriculum came into effect July 2023 and focuses on spiral delivery of patient-centered clinical presentations rooted in generalism.

The RIME curriculum includes a longitudinal component which provides an opportunity for students to dive into clinical and scholarly areas of importance to them as future physicians, within the frame of service to the communities they intend to serve. A commitment to social justice, advocacy and health equity is also critical for students to be successful given the underpinning principles of humanity, humanism and humility in the new curriculum.

Within the RIME curriculum, the following topics and patient presentations are covered:

Social justice and advocacy in medicine	Structural determinants of health	Indigenous health, effects of colonialism
Sex and gender	Race, ethnicity and culture	Wealth and health
Public health and health equity	Global health and global health equity	Stigma and problematic language in medicine
Implicit bias	Cultural competence	Language barriers
Medicalization of bodies and appearance	Religious discrimination and spiritual sensitivity	Complementary and Alternative medicine
Justice and bioethics	Rural communities and disparity	Race in maternal health

Priority populations include structurally vulnerable populations and communities, such as Indigenous communities, rural communities, racialized communities, Black, elderly, persons with disabilities, global communities, immigrants/refugees/newcomers, gender diverse, sexual diversity, people living in poverty, people who use drugs, etc. Systems and structures relevant to health that are covered include systems of power and domination, education, health systems and services, social systems and community supports, climate, housing, globalization and industrialization, employment, occupation and labour, wealth distribution, income inequality and poverty, food security, legal systems, and human rights. Trauma-informed care is also covered in depth, including adverse childhood events, violence against gender and sexually diverse communities, racialized trauma, sexual, domestic and intimate partner violence, incarcerated individuals, and trauma at the hands of health care providers.

RIME Community Engaged Learning (CEL) - a component of RIME Professional Role 1 is Community Engaged Learning, which includes educational content and activities delivered on campus by community partners and leaders in health equity and structural competency, as well as a year long longitudinal in-community placement for all CSM medical students (more detail in *Types and Locations of Educational Experiences*, below*)*. Community Engaged Learning is designed to support learners in developing the skills and values necessary to meet the needs of the community, especially equity-deserving groups, and is mandatory for all students. CEL honours the knowledge, expertise and lived experience of community partners and invites them to be co-educators in medical education. It also works to provide learners with the opportunity to learn in community contexts, early on in their medical training. The CSM's Indigenous, Local and Global Health Office has worked to establish respectful, reciprocal relationships with over 60 community organizations in the greater Calgary area to support Community Engaged Learning for medical students both on campus and in community. In Blocks 1 and 2, community partners and those with lived experience are invited to the medical school to

educate students on topics such as Indigenous health care, care of the elderly and ageism; gender affirming care; immigrant, newcomer and refugee health; houselessness, addictions, substance use and trauma informed care; ableism; gender-based violence; anti-fat bias and stigma; etc. Students also participate in educational activities related to advocacy, implicit bias, social determinants of health, rural health care, and interprofessional education.

RIME & Legacy Indigenous Health Curriculum (CSM UME refers to the previous pre-clerkship program as "Legacy curriculum") **-** Indigenous health curriculum is delivered to all UME medical students as an integrated part of the core curriculum; these include lectures and small group sessions during the first and second year. Indigenous health education focuses on the development of three key themes related to the social and historical impacts on Indigenous health. These themes include (1) the influence of social determinants of health on Indigenous peoples, (2) the influences of Indigenous worldview and perspectives in relation to contemporary perspectives on health behaviours and outcomes and, (3) the impact of historical and contemporary relationship issues between Indigenous peoples and dominant society arising from both social exclusion and multigenerational trauma. Indigenous health curriculum focuses on education of the deep causes of the health inequities faced by Indigenous populations, bringing an understanding of how multigenerational trauma from colonization and residential school experiences continue to influence health outcomes. The program brings in a balance of social, cultural and biomedical knowledge implemented within a clinical context where medical learners will be able to situate themselves within the social constructs framing Indigenous health outcomes and task learners to critically examine societal causes as well as those inherent within the medical approach. Further, medical learners are engaged with a narrative approach that utilizes cognitive dissonance, reflection, humour, humility and Indigenous traditional decision-making approach to facilitate a deeper and more insightful exploration and understanding of Indigenous health.

iii. / iv. Types and locations of educational experiences

Legacy Curriculum (Pre-Clerkship) Community Engaged Learning - As part of the Population Health course (MDCN 340), medical students participated in a mandatory community-engaged learning program. The Community Engaged Learning Program developed by the Indigenous, Local & Global Health (ILGH) Office, provided experiential learning opportunities designed by community partners to explore bias, privilege and positionality; upstream determinants of health and the lived experience of equity-deserving communities; advocacy for patients' non-medical needs; and how to interact respectfully and build relationships with communities using a patient-centered approach. Over twenty different community partners have partnered with the ILGH Office for community engaged learning. The Legacy CEL program was a week-long experience for students, where community partners delivered education in a virtual setting and students completed implicit bias training and other educational activities to prepare them to go into community. Students then completed a 2-3 day in-community placement with the community partner they are matched with, and then returned to campus in the final day of the week for bystander training, small group discussions and writing exercises to critically reflect on their community experiences.

RIME Curriculum

Family Medicine Clinical Experience (FMCE), RIME Block 1 and 2: Professional Role
Through this portion of the UME program, first year medical students see, experience and – with guidance – participate in the delivery of rural and urban Family Medicine across southern Alberta. The preceptor physicians for this experience deliver community-based, generalist, continuity of care within a Patient's Medical Home (PMH). In the FMCE students experience the breadth, depth and variety of community Family Medicine. Whether rural, urban or satellite location, students see practices that are Generalist Family Medicine and apply learning to a wide range of patients in a longitudinal experience. Students develop communication and history-taking skills, taking patients' biopsychosocial contexts (feelings, ideas, expectations, etc.) and social contexts (e.g., low literacy, poverty, abuse, etc.) into account.

Community Engaged Learning (CEL), In-Community Longitudinal Placement, RIME Block 2 and 3: Professional Role
In addition to the on-campus, community delivered education in Block 1 under Professional Role, medical students complete a year-long placement in community as part of Community Engaged Learning in Block 2 and 3 of the RIME curriculum. The Indigenous, Local and Global Health Office establishes relationships with community partners and works to match students with a partner they are interested in learning from. All medical students complete 13, half day shifts over the course of the year in community with the partner they have been matched with. During that time, partners engage students in activities they feel will help educate them on the social determinants of health, the complexities in community, the lived experiences of equity-deserving groups, and the community resources outside of medicine that play a crucial role in health and wellbeing. Students are also expected to be a valuable resource to their community partner during their time in community, as reciprocity is a key foundation of our community partnerships. During this period, students also engage in a sharing circle led by Indigenous Elders, an Indigenous Blanket Exercise held on Tsuut'ina nation, self-reflection exercises and small group discussions, as a way to deepen their understanding and learn from one another.

Career Exploration Program: Professional Role – Rural Placements
The Career Exploration Program is designed to support students in obtaining detailed consideration in multiple career paths in early medical school, through career coaching and conversations with faculty members, three career development weeks (three distinct disciplines) and large group sessions. Students may select a rural Alberta placement for their career development weeks, which is coordinated through the Distributed Learning and Rural Initiatives Office (DLRI). Students also have the option of doing an International (Global) Career Development week.

Clerkship (Year 3)

Rural Medicine

Training physicians to meet the healthcare needs of rural Albertan's is part of the school's social accountability to address the healthcare needs of the populations it serves. The CSM's office of Distributed Learning and Rural Initiatives (DLRI) creates opportunities to further medical learning in rural communities. The office supports rural experiences for undergraduate medical students, the University of Calgary Longitudinal Integrated Clerkship (UCLIC) and various other Canadian remote and isolated rural experiences. Within DLRI a working definition of 'rural communities' includes communities of less than 30,000 not connected to a major metropolitan area. DLRI carries out a wide range of activities related to rural education, supporting early student experiences in rural areas, rural rotations in pre-clerkship and clerkship, supporting the University of Calgary Longitudinal Integrated Clerkship (UCLIC), and supporting rural teaching faculty. Rural mentorship and shadowing opportunities are also provided to first and second-year medical students, supporting observation and learning around the diverse and unique range of skills needed in rural settings.

During the clerkship year (year 3) of the UME program, students rotate through a variety of medical specialties - spending from two to eight weeks in each – and 14 weeks of elective opportunities. During this time, students learn in hospital wards, ambulatory care clinics, doctor's offices, emergency rooms, community hospitals, etc. Two streams of clerkship are available to students: (i) the rotation-based clerkship, which includes eight mandatory clerkship rotations and 14 weeks of elective time, or (ii) the 32-week UCLIC program.

- The **University of Calgary, Longitudinal Integrated Clerkship (UCLIC)** uses family medicine as the foundation of clerkship, encouraging students to pursue generalist careers in rural communities. Supported by the DLRI office, UCLIC students are based in a family practice in a rural or regional community and learn the generalist specialties in an integrated fashion by following their patients from the clinic to specialty consults, surgery, delivery, etc. This longitudinal approach allows students to develop an appreciation for the natural history of illness and continuity of care. Educational goals of the program include, "establish community-based, patient-centered clerkship in rural and regional Alberta communities," "develop new rural academic medical careers paths for present rural physicians," and "strengthen and enhance relationships between rural/regional communities and urban tertiary teaching institutions."
- The **Family Medicine Clerkship** (MDCN 502) is divided into a 4-week urban and 4-week rural/regional rotation (FM 4+4). Clinical experiences include geographically diverse locations spanning all quadrants of the city. During these rotation blocks the student will be immersed in the discipline of Family Medicine by joining clinics in the community. Common clinical problems in family medicine will be emphasized, including acute and chronic conditions from paediatrics to geriatrics. The primary responsibilities of family physicians as identified by the College of Family Physicians of Canada will be highlighted, these include: (i) providing comprehensive medical care for all people, ages, life stages and presentations, and (ii) advocacy for access to culturally safe, affordable, high-quality, and comprehensive health care, along with social conditions that promote health.
- *Psychiatry Clerkship* (MDCN 510). Objectives of this clerkship rotation include, "develop understanding of the psychiatric patient, the skills to perform a psychiatric assessment and the management of psychiatric clinical presentations with integration of basic knowledge obtained from the non-clinical setting". Clerks perform a variety of assessments including child and adolescent behavioural and learning assessments, elderly cognitive function, competency assessments, safety assessments for suicide/abuse, and mental status examinations. Four weeks of the rotation are spent in adult psychiatry and two weeks in child psychiatry.
- *Obstetrics and Gynecology Clerkship* (MDCN 512) has objectives related to sexuality, gender affirming care and infertility.
- *Electives* (MDCN 514) – students can select from a catalogue of electives that includes public and rural health electives, in addition to electives in family medicine and "arts in medicine" (humanities).
  Rural Electives (DLRI) – students can select to participate in a two-week rural clerkship elective, managed by the DLRI office.
  Global Health Clerkship Elective - Based on the evidence of best practices in global health, UCalgary shifted to a global health elective offered in clerkship instead of pre-clerkship stage, for a longer period of 4 weeks, in small groups of up to 5 trainees paired with host country learners at a similar stage in UME, led by a clinical preceptor licensed for that country. The GH Elective will occur in August-September in SW Uganda.
  Refugee Health Electives – medical students can complete electives shadowing physicians supporting refugees at the Mosaic Refugee Health Clinic and other hospital settings through the Refugee Health YYC.
- *Comprehensive Clinical Skills Curriculum for Clerkship* (MDCN 520) - Contains course objectives such as "apply a comprehensive patient-centered approach in the evaluation and care of patients including sensitivity to differing: sexual orientation and gender identity, cultural and spiritual beliefs, attitudes and behaviors, economic situations".

Indigenous, Local & Global Health Office (ILGHO)

The Indigenous, Local & Global Health Office facilitates various community-engaged learning activities at the CSM, focusing on engagement with equity-deserving communities with an emphasis on listening to and co-creatively responding to community priorities, as part of the CSM's larger social accountability mandate and commitment to truth and reconciliation.

Some of the Indigenous, local and global community-engaged learning opportunities provided through the office include:

- **Traditional Knowledge Keepers (TKK) in Residence Program** – the ILGHO was awarded an intercultural capacity building grant from the Office of Indigenous Engagement at UCalgary for a Traditional Knowledge Keepers in Residence program. The program has eight Elders from various communities in Southern Alberta and beyond who visit the medical school on a rotation schedule and engage in meetings with students, faculty and staff. Elders provide teachings and workshops, strengthen protocol at events and ceremonies, and build relationships with students.
- Through long-standing partnerships with various international communities, the ILGHO provides elective global health learning and training opportunities to UME students. Electives take place in low-middle income countries and aim to achieve the following learning objectives: (i) identify how social determinants affect health in the community, (ii) understand the role of physicians and other health care providers in the community, and (iii) describe local health structure and how health care service is delivered and accessed by the community. Students participating in these electives are required to attend three pre-departure training sessions, a post-return

debrief, and complete a written assignment and evaluation. **Global Health Electives** are now offered only at Clerkship stage, with a licensed preceptor, and with a reciprocity component of co-learning with host country medical students.

Student-Driven Initiatives

- Calgary Student Run Clinic – The Student Run Clinic is a non-profit organization as of November 2021, and works to provide accessible, timely, and quality medical care to Calgary's inner-city population. Currently running at two sites in Calgary, the clinic coordinates physicians and medical student volunteers to help deliver primary care services, aiming to provide preventative medicine, health counselling, education, and community services to Calgary's under-served populations.
- Various student-led groups and initiatives including Black Medical Student Association, Canadian Alliance of Medical Students Against Human Trafficking, Students for Integrated Training in Community Health (STICH), Clinical French Interest Group, Disability Inclusion and Advocacy Group, Family and Rural Medicine Interest Group, Medical Students for Gender and Sexual Diversity, Student-Senior Isolation Prevention Program, Calgary Asian Medical Students Association, Muslim Medical Association of Canada, Calgary, Planetary Health Interest Group, Students for Health Innovation and Education (SHINE), Calgary Students for Interprofessional Collaboration, and Calgary Jews in Healthcare.

C. Table 1.1.1-2 C

Table 1.1.1-2 C | Medical School's Social Accountability Outcome Measures — Source: School-reported

For each required area of fulfillment of the medical school's social accountability mission, provide outcome measures used by the medical school.	
Areas for fulfillment	Medical school social accountability outcome measure(s)
Admissions	The admissions goal is to attract and retain a diverse body of students into medicine, especially those of under-represented backgrounds (i.e., Indigenous, low-SES, Black, rural, etc.). Initiatives are well established through the Pathways Program, Black Applicant Admissions Process (BAAP) and the Indigenous Applicant Process (IAP). Internal school data is closely tracked, including the number of applicants, admission offers and acceptance rates. The Admissions Office received an A+ (100%) grade on the 2023-4 Black Medical Students Association of Canada (BMSAC) report card, on criteria including 1. The improvement of admissions data collection practices; 2. Transparency of admissions criteria; 3. The waiver of application fees for low SES; 4. The regular review of the admissions committee for lack of diversity and inherent bias and 5. The development of the pathway programs to counter underrepresentation were collectively evaluated and considered excellent. To increase visibility the Admissions Office, in co-operation with the Indigenous, Local and Global Health Office and the Office of Distributed Learning and Rural Initiatives, puts on 4-6 information sessions per year outlining opportunities to pursue a career in medicine, dispelling myths of the paths to medicine, and outlining the admissions process and the different pathways that are available to be successful. In addition, each Fall the Admissions Office holds an Open House for high school students and undergraduates from diverse backgrounds to address any concerns or perceived barriers. It is through the Pathways Program that information sessions are run at high schools in less advantaged areas of the city. These locations are usually home to the city's first-generation immigrant and Indigenous populations. Also, to remove financial barriers, information is provided to all interested applicants about the MCAT fee assistance and waiver programs. In 2023, the Admissions Office worked with the AAMC to open up additional testing sites in rural Alberta to offset the travel barrier for rural and remote applicants. The UME Office also provides a bursary program to aid applicants from low SES households to attend the MMI.

	There is detailed diversity data and medical student recruitment initiatives outlined in Standard 3, Requirement 3.3-2. For the planned 2026 expansion to Lethbridge a sub-committee is being formed to address rural and remote admissions for the new medical school campus that will include rural medial students, public leaders from rural communities, indigenous leaders, and regional academic leaders. They are tasked to develop a rural and remote index that will become a part of the admissions framework.
Curricular content	**Curricular Content Goal: Educate and empower students to meet community needs:** Support and encourage students to pursue career pathways in areas most in need (i.e., family medicine, generalist practice, rural medicine, Indigenous health, vulnerable populations, etc.) and educate students with the skills and knowledge they require to meet the needs of vulnerable and underserved communities (i.e., social determinants of health, Indigenous health, interdisciplinary teamwork, anti-racism, advocacy, etc.). 2a) # of learning objectives related to social accountability in the core curriculum (e.g., anti-racism, health equity, vulnerable populations, advocacy, social determinants of health (SDoH), generalism, interdisciplinary care, rural health, Indigenous health, etc.) **RIME Curriculum:** Ableism – 11 learning objectives Ageism – 5 Anti-Fat Bias – 5 Indigenous Health - 20 Mental Illness Bias – 5 Neurodiversity – 2 Harm Reduction/Substance Use – 11 Poverty – 3 Sex & Gender – 10 Race/Ethnicity/Culture – 22 Planetary Health – 5 Global Health – 55 (taken from AFMC Global Health Competencies 2015) Community Engaged Learning – 10 Advocacy - 8 **Legacy Curriculum:** Anti-Indigenous bias – 3 Global Health – 20 Global Health Covid Response - 10 Advocacy for vulnerable populations – 4 Gender Affirming Care – 6 Refugee & Immigrant Health – 10 Trauma Informed Care – 5 Planetary Health – 5 Community Engaged Learning – 10

	2b) # of learning opportunities that introduce and develop Indigenous health and related issues in the curriculum (e.g., Indigenous history, cultures, and rights; anti-racism and cultural competency; healing practices; etc.). RIME Curriculum: There are 10 four-hour sessions specifically dedicated to Indigenous health teaching in the RIME curriculum. In addition, there is a Sharing Circle led by Indigenous Elders that is mandatory for all students in the Block 1 of the Community Engaged Learning course, and a mandatory Blanket Exercise on Tsuut'ina Nation in Block 2. There are topics around Indigenous health woven longitudinally into multiple weeks of the curriculum, i.e.; Diabetes in Indigenous communities, the co-history of tuberculosis and colonization in Canada, etc. Legacy Curriculum: A 2hr session on Indigenous health principles and SDoH was presented in the Population Health course, as well as a session on Diabetes in Indigenous communities, and a 2-hr session on Anti-Indigenous Racism was presented in the Global Health Unit. 2c) # and % of MD graduates who demonstrate social accountability competencies upon graduation *(e.g., % of MD graduates who agree/strongly agree that they are "appropriately trained to care for individuals from diverse backgrounds, prepared to integrate the SDoH into management plans, prepared to provide culturally competent care, committed to advocate for access to health care for members of traditionally underserved populations, etc." - AFMC Graduation Questionnaire).* 1. *Percentage noting <u>agree or strongly agree</u> -2023 AFMC GC:* a. *Appropriately trained to care for individuals from diverse background:**88%*** b. *Prepared to integrate the SDoH into management plans:**91.7%*** c. *Prepared to provide culturally competent care:**83.4%*** d. *Committed to advocate for access to health care for members of traditionally underserved populations, etc.* ***88.7%*** 2c) # and % of MD graduates who go into family medicine or generalist specialties. Year # in match # (%) Family Med # (%) Emergency Med # (%) Internal Med # (%) Pediatrics # (%) Sx(gen surgery) 2024 161 42 (26.1 %) 8 (5.0%) 26 (16%) 5 (3.1%) 15 (3 gen)-{9.3%(1.9%)} 2023 149 46 (30.9 %) 7 (4.7%) 18 (12.1%) 4 (2.7%) 15 (10%) 2022: 153 39 (25.5 %) 7 (4.6%) 28 (18.3%) 10 (6.5%) 18 (11.8%)
Types of educational experiences	**Types of Educational Experiences Goal: Increase the number of team-based, interprofessional, community-engaged, self-driven and problem-based learning approaches to support student-centred learning and the development of critical thinking, reflective practice, problem solving and lifelong learning skills.** 3a) # of community-based learning opportunities that expose students to vulnerable, underserved and marginalized communities (e.g., DLRI, Global Health, Indigenous Heath, and Community Engaged Learning (CEL) opportunities etc.) <u>Legacy Curriculum:</u> **The Community Engaged Learning Course:** <u>Pre-clerkship:</u> Students attended four sessions, each 3-4 hours, with a community partner from an equity-deserving population in a large group setting <u>Clerkship:</u> **The Community Engaged Learning (CEL) course:** A) Students are exposed to 3-4 community partners in a large group setting, and then spend three days outside of the medical school with an equity-deserving community partner. B) ILGH related electives: There is an option for students to do an international elective in clerkship facilitated by the Indigenous,

Local and Global Health Office (see 3b below)

RIME Curriculum:
Pre-clerkship:
The Community Engaged Learning (CEL) course:

A) Block 1 - there are 6 large group sessions each 3-4 hours where equity-deserving communities present to the students, in total there are 17 communities that students are exposed to from areas of unstable housing, food insecurity, refugee and immigrant health, substance use/addiction/harm reduction, human trafficking, gender-based violence, etc. One morning is also spent in a *Sharing Circle* with Indigenous Elders.

B) Block 2 & 3– Students are placed with a community partner longitudinally outside of the medical school for 13 sessions of four hours each. There are a total of 40+ community partners that students can choose from for their placement. In addition, students spend one morning on Tsuut'ina Nation for a Blanket Exercise facilitated by Indigenous community members and Elders.

Clerkship – There is an option for students to do an international elective in clerkship facilitated by the Indigenous, Local and Global Health Office (see 3b below).

3b) # and % of MD students who participate in elective community-based learning in low-resource, underserved, Indigenous, rural, global, etc. settings

i) ILGHO runs preceptored electives to underserved and marginalized countries. These were on hold through the pandemic but students in the class of 2024 onward once again have opportunities to carry out global electives.

September 2023 — 4 students to Uganda (Class of 2024)- 2.5% of class
May/June 2024 — 5 students to Uganda, 6 to Tanzania (Class of 2025)- 6.5% of class
Sept 2024 (planned) — 4 students to Nepal (Class of 2026)- 2.8% of class

ii) UCLIC — 25 (13.7%) students for Class of 2025 and projected to be 24 (13.4%) for Class of 2026. The bulk of the clerkship (May-March) is completed in a rural or regional site, which could be considered underserved communities.

iii) All rotation-based clerks complete four weeks of family medicine in rural/regional sites (underserved communities-100% of students). Typically, in each clerkship block, one student completes Obstetrics-Gynecology and/or Pediatrics in Medicine Hat.

iv) All students from classes of 2022 - 2025 completed a week of Community Engaged Learning electives where they were taught about socially important topics (bystander training, health inequality, cultural sensitivity) and then spent 2-3 days working with a community partner agency to learn about the services provided by the organization as well as the lives of the people using the agencies' services. Examples are organizations serving new immigrants, Indigenous groups, mental health service providers (non-medical) etc. This was eliminated after the Class of 2025 as the relevant content has been moved into pre-clerkship as the mandatory Community Engaged Learning component of the longitudinal Professional Role course.

3c) # of Indigenous health professionals and educators

- # of Faculty who are Indigenous – Three full faculty members, One AMHSP. Three more Indigenous scholars may be coming into tenure-track positions with the CSM Inclusive Excellence Cluster Hire.
- # of Leadership who are Indigenous – currently two

<table>
<tr><td></td><td>
# of Elders involved in education + number of sessions offered # of ceremonies, sharing circles, etc. offered – currently, 10 Indigenous Elders are regularly engaged.
3d) # of faculty and leadership who have completed cultural competency / anti-racism training / decolonizing your syllabus workshops / Reconciliation Leadership Foundations course / etc. (2023 data is presented below)
Teaching Excellence Program Faculty Development, n = 60
RIME faculty development for course directors, n = 100
Decolonizing your syllabus workshop, n = 130
PLUS 4I Reconciliation Leadership Foundations, n = 100; PLUS 4W, n = 44
</td></tr>
<tr><td>Locations of educational experiences</td><td>
Locations of Educational Experiences Goal: Educate students in under-resourced / marginalized / vulnerable and diverse community settings: Early and longitudinal exposure of students to diverse community practice settings to build understanding of these communities and encourage future practice in these areas.
4a) # of community settings students are educated in:
The ILGHO has developed partnerships with over 60 Calgary-based community organizations, most of which serve equity deserving groups. All pre-clerkship students in the RIME curriculu, must attend shifts with one or more of the community partners. A minimum of eight hours must be spent in this setting. All students must complete at least four weeks (~200 hours) of their family medicine clerkship in a rural setting, most of which are under-resourced, include marginalized populations and include vulnerable and diverse community settings.
Approximately 13-18% of clinical clerks complete their clerkship in a setting that meets the above criteria (under-resourced / marginalized / vulnerable and diverse community settings) with the breakdown for the Class of 2026 below. This is the University of Calgary Longitudinal Integrated Clerkship (UCLIC).
UCLIC Program
<table>
<tr><th>Class of:</th><th>2022</th><th>2023</th><th>2024</th></tr>
<tr><td>Applicants</td><td>18</td><td>17</td><td>26</td></tr>
<tr><td>Enrolled</td><td>18</td><td>15</td><td>23</td></tr>
<tr><td>Rural Communities</td><td>11</td><td>11</td><td>13</td></tr>
</table>
<table>
<tr><th>Rural Community</th><th># Students in Class of 2026</th></tr>
<tr><td>Arrowwood/Vulcan</td><td>1</td></tr>
<tr><td>Brooks</td><td>3</td></tr>
<tr><td>Canmore</td><td>2</td></tr>
<tr><td>Cardston</td><td>2</td></tr>
<tr><td>Crowsnest Pass</td><td>1</td></tr>
<tr><td>Diamond Valley</td><td>1</td></tr>
<tr><td>Drumheller</td><td>2</td></tr>
</table>
</td></tr>
</table>

High River	2
Lethbridge	5
Pincher Creek	2
Raymond	1
Rocky Mountain House	2
Sundre	3
Taber	2
Yellowknife	2

4b) # of hours students spend learning in/from community partners.
At a minimum student will have ~ 208 hours learning in/from community partners over their three years in medical school. Depending on choices, such as UCLIC, Global electives, electives with community partners, etc, the number of hours may be significantly higher.

1.2 CONFLICT OF INTEREST POLICIES

A medical school has in place and follows effective policies and procedures applicable to board members, faculty members, and any individuals with responsibility for the medical education program to avoid the impact of conflicts of interest in the operation of the medical education program, its associated clinical facilities, and any related enterprises.

Requirement 1.2-1

The medical school has in place and follows effective conflict of interest policies and procedures applicable to:

i. board members
ii. faculty members
iii. any individuals with responsibility for the medical education program

A. Provide copies of any policies or procedures intended to prevent or address financial or other conflicts of interest related to i) board members, ii) faculty members and iii) any individuals with responsibility for the medical education program. Highlight and label the appropriate sections (i – iii). (***Appendix 1.2-1 A***)

Required Appendix 1.2-1 A1 – UCalgary Code of Conduct (i & ii specifically, and applies to iii)
Required Appendix 1.2-1 A2 –CSM Disclosure and Management of Potential Conflicts of Interest in Relationships with Industry (ii specifically, and applies to iii)
Required Appendix 1.2-1 A3 – CSM Disclosure and Management of Potential Conflicts of Interest in Relationships with Industry – Appendices (ii specifically, and applies to iii)
Required Appendix 1.2-1 A4 - CSM Disclosure and Management of Potential Conflicts of Interest in Relationships with Industry – Procedures (ii specifically, and applies to iii)
Required Appendix 1.2-1 A5 – Online COI Declaration Form *(i, ii and iii)*
Required Appendix 1.2-1 A6 – COI Declaration Message to Faculty *(ii)*
Required Appendix 1.2-1 A7 – COI Approval Process – CSM Dean
Required Appendix 1.2-1 A8 - UCalgary Lobbyist Registry Form (ii specifically, and applies to iii)
Required Appendix 1.2-1 A9 – AHS Code of Conduct (ii)
Required Appendix 1.2-1 A10 – AHS Conflict of Interest Bylaw (ii)

Required Appendix 1.2-1 A1

Conflicts of interest are managed through several policies and procedures within the University and CSM. In 2015, General Faculties Council approved a campus-wide Code of Conduct policy that governs its directors and employees and that includes provisions relating to COI. This policy applies to employees, academic staff members, students, postdoctoral scholars, and appointees (i.e., members of the Board of Governors of University and Alumni and Senate). It requires disclosure of conflicts, the requirement that people do not take part in decision making if it could lead to a COI, people not use their position to influence or seek to influence a University decision that would result in a COI, people can only engage in Outside Professional Activity in alignment with the Collective agreement, not accept gifts unless they are of a nature that could be reciprocated, and other provisions.

Required Appendices 1.2-1 A2-4

CSM Disclosure and Management of Potential Conflicts of Interest in Relationships with Industry policy, procedures, and appendices are provided as *Appendices 1.2-1 A2-4*. The University procedure related to policies delineates policies as either University (i.e., campus wide) or Department (i.e., Faculty level). This policy is applicable across the CSM and is administered centrally under the Office of the Senior Associate Dean, Education with support from the Med-IT unit.

All faculty members engaged in research must sign an Annual Compliance and Eligibility Certificate to acknowledge that they have read and will comply with University of Calgary Policies and Procedures, and other relevant policies related to the conduct of research (e.g., Tri-Council, NIH). Failure to comply leads to suspension of all research funding. This is handled through the Vice President Research. All faculty members engaged in research funded through the US Public Health Services (e.g., National Institute of Health) must also complete financial conflict of interest information through the Vice President Research's Office.

Required Appendix 1.2-1 A5
The Conflict of Interest declaration is completed through an on-line form.

Required Appendix 1.2-1 A6
This message regarding the Conflict of Interest declaration is sent to CSM faculty members annually.

Required Appendix 1.2-1 A7
This screenshot depicts the on-line COI review/approval process.

Required Appendix 1.2-1 A8
Under the federal lobbying Act, the University of Calgary is legally required to report all pre-arranged meetings and telephone calls held with Designated Public Office Holders (DPOH) - federal elected representatives, political staff, and senior departmental officials. These interactions are required to be registered with the Office of the Commissioner of Lobbying in Canada each month. While not required by law, the university also tracks similar information on interactions with elected representatives, political staff, and senior departmental officials in the provincial and municipal governments.

Required Appendices 1.2-1 A9-10
CSM learners who are enrolled in Alberta Health Services Clerkship Rotations at clinical sites are governed by the Alberta Health Services Code of Conduct and follow the Alberta Health Services Conflict of Interest Bylaw to ensure compliance. Faculty members who work as employees of Alberta Health Services or perform clinical teaching at clinical sites are also governed by the Alberta Health Services Code of Conduct and follow the Alberta Health Services Conflict of Interest Bylaw to ensure compliance.

Requirement 1.2-2
The medical school has in place and follows effective policies and procedures to avoid the impact of conflicts of interest in the operation of:

i. the medical education program
ii. its associated clinical facilities
iii. any related enterprises

A. Describe how the policies/procedures are used to avoid the impact of conflicts of interest in the operation of the i) medical education program, ii) its associated clinical facilities and iii) any related enterprises.

The CSM Dean works with faculty members on all COI mitigation plans. There are generally three categories of Conflict-of-Interest mitigation, those requiring special attention and specific approval, those permitted with oversight, and those that are routinely allowable.

Specifically, faculty and clinical faculty must make a full annual disclosure of their potential conflicts of interest to the university. To avoid the impact of COI in the operations of the school, faculty members must:

- seek explicit approval before embarking on studies funded by companies in which they or their families have a financial interest
- receive approval before sitting on a review committee that judges a technology in which they or their families have an interest
- receive approval to serve as a managing executive for a profit-making biomedical company
- disclose to the public their financial interest in any subject that they discuss in a research publication, a formal presentation, or an expert commentary, and do so as they speak or publish.

As recommended by the guidelines, the Dean of the medical school has appointed a standing committee, the Committee on Conflict of Interest, to review activities that are disclosed and implement procedures for approval and oversight.

Additionally, sponsored events must comply with defined Gift Acceptance Guidelines (***Supplemental Appendix 1.2-2 A***), as outlined by the Gift Processing and Compliance Office. These guidelines are available on the CSM website, and also specifically communicated and discussed with class representatives for event planning. This process is also supported by a member of the Gift Processing and Compliance Office, who is available to navigate specific issues with faculty members and students.

B. Provide an example illustrating how conflict of interest was managed for a faculty member with academic and teaching responsibilities in the medical education program.

The UME has a process for managing a conflict of interest for faculty members with academic and teaching responsibilities in the medical education. A COI instrument is included with clinical assessments to monitor conflicts related to *Element 12.5 Non-Involvement of Providers of Student Health Services in Student Assessment / Location of Student Health Records*. COIs completed by the preceptors are flagged and a follow-up email is sent to the preceptor asking for an explanation. Actions based on the explanation include one of the following a) correct ITER if COI flagged in error, b) accept ITER if conflict is not significant or mitigated, c) accept ITER with education regarding the policy, or d) reject ITER. This process has been very effective, enabling the small number of conflicts to be reconciled. In 2023, a change was made to the process that now requires the faculty member reporting a COI to provide an explanation with their initial COI report, facilitating and expediting the follow-up required by the UME office.

As a recent example of this process, a student was assigned to an elective with their own family physician as the preceptor due to an oversight. The preceptor identified the COI on the ITER, and the Assistant Dean Clerkship followed up with the preceptor by email and outlined the COI policy. The student had only worked one day with the preceptor, and the UME office was able to find another preceptor to complete the ITER.

1.3 MECHANISMS FOR FACULTY MEMBER PARTICIPATION

A medical school ensures that there are effective mechanisms (including committee structures) in place for any faculty member to directly participate in decision-making related to the medical education program, including opportunities for discussion about, and the establishment of, policies and procedures for the program, as appropriate.

Requirement 1.3-1

The medical school ensures that there are effective mechanisms in place for direct faculty member participation in decision-making related to the medical education program.

A. Table 1.3-1 A

Table 1.3-1 A | Standing Committees (Core Appendix) Source: School-reported

List all major standing committees of the medical school and provide the requested information for each.				
Committee	Reports to	Total number of voting members	Total number (%) of faculty voting members	Total number (%) of faculty voting members who are elected
Undergraduate Medical Education Committee	Strategic Education Council	16	15 (88%)	5 (33%)
Admissions Committee	Faculty Council	14	8 (57%)	7 (88%)
Admissions File Review Sub-Committee	Faculty Council	61	14 (23%)	0 (0%)
Student Academic Review Committee	Faculty Council	12	8 (67%)	8 (100%)
Undergraduate Medical Education Management Committee	Associate Dean, UME	11	5 (45%)	0 (0%)
Curricular Innovation and Oversight Committee	Undergraduate Medical Education Committee	19	15 (79%)	0 (0%)
Pre-Clerkship Committee	Undergraduate Medical Education Committee	34	29 (94%)	0 (0%)
Clerkship Committee	Undergraduate Medical Education Committee	29	22 (76%)	0 (0%)
RIME Pre-Clerkship Committee	Undergraduate Medical Education Committee	17	12 (71%)	0 (0%)
Student Evaluation Committee	Undergraduate Medical Education Committee	24	18 (75%)	0 (0%)
Research Committee	Undergraduate Medical Education Committee	10	9 (90%)	0 (0%)
Competency Committee	Undergraduate Medical Education Committee	13 (5 pre-clerkship and 8 clerkship)	5 (100%) and 8 (100%)	0 (0%)

Faculty members have excluded the administrative team, students, residents and community members

B. Describe how the medical school ensures that there are effective mechanisms in place for direct faculty member participation in decision-making related to the medical education program.

All of the major standing committees have significant faculty representation, and faculty members represent the majority of voting members in 83% of the standing committees.

The individual terms of reference of the standing committees provide for wide representation across the faculty, and call for faculty nominations for Undergraduate Medical Education standing committees are circulated to all CSM faculty members.

In December 2020, the CSM launched a committee structure working group (co-chaired by Drs. Pamela Chu and Kannin Osei-Tutu). The role of this committee was to make recommendations about how to break down barriers and create processes for equity, diversity and inclusion on committees. General guidelines were provided and important CSM committees were reviewed with respect to terms of reference that are not inclusive. Standardized interview processes were introduced. This committee contained broad representation from across the faculty. Many of the recommendations are noted below and have since been implemented.

There is a formal CSM Nominating Committee and initiatives have included the following:
1. Terms of Reference Template for CSM EDI committees
2. Equity centered best practice guidelines for CSM committee formation, composition, and structure

The above resources are provided for anyone at the CSM forming/chairing an EDI Committee or any general CSM committee, and available to all CSM EDI Leads.

In addition, with broad stakeholder input (OPED/PESJO Advisory Committee, ILGHO, UCalgary OEDI, UCalgary Human Resources, etc), specific best practice recommendations for Search and Selection Committee formation, composition, and structure were developed. The products of this work included the following: CSM Equity Centered Search and Selection Operating Standard which addresses best practices recommendations for Selection Chairs, and Selection Committees CSM Equity Centered Selection Course which includes seven on-line learning modules for those participating in a CSM Selection process. Module 3 specifically addresses "Activating a Selection Committee".

Requirement 1.3-2

The medical school ensures that there are opportunities for faculty member participation in discussions about, and the establishment of, policies and procedures for the program, as appropriate.

A. Describe how the medical school gives all faculty members the opportunity to participate in discussions about, and the establishment of, policies and procedures for the program, as appropriate.

Academic staff are provided updates on policy changes via email communications from the Dean, the Associate Dean or Assistant Deans as needed. Faculty Council meetings are held regularly, are well-advertised and allow time for presentation and discussion of policy-relevant material. All decanal level positions report in person to Faculty Council on their portfolios and bring policy change requests to Faculty Council. Academic staff vote to approve policy changes. UME operational policies and guidelines are available via the public MD Program website.

Many new guidelines are being developed related to EDI initiatives. These will be reviewed by CSM leadership and then brought forward to Faculty Council for further input and approval. These will then be posted on CSM websites for broad adoption.

Department Heads are also key conduits to providing faculty members with information on policy changes. Department Heads meet monthly to discuss policies of relevance to faculty members. Department Heads also attend the Leadership Forum meetings, held most months of the academic year. Minutes are provided from these meetings and often PowerPoint presentations are attached. Unless otherwise instructed because information is still at a confidential stage, Department Heads are encouraged to bring information to their department members. This is often done through department meetings that again are held most months through the academic year. Large departments with many divisions may involve division leaders in the department meetings, who then hold regular meetings with their division members. A central role of Department Heads is to understand their faculty members' perceptions on an issue and represent those opinions at Department Head, Leadership Forum and other relevant meetings.

The seven Research Institutes engage a large number of full-time faculty, and they also have mechanisms such as town halls and retreats to encourage faculty members to provide feedback on Institute initiatives.

Faculty members are provided with many different methods to provide input on the UME program. At the end of every course in the pre-clerkship, all faculty who have taught in a course are provided with the opportunity to complete a faculty survey that requests input on the organization and content of the particular course. Faculty are also

invited to provide narrative opinions about what is and is not working well in that course. The results of these surveys are reviewed by the UME leadership and passed on to the respective Block, Unit and course chairs who share the information with the applicable committee. Committees have the role of deciding which of the feedback to act on and how to make changes in the course or provide faculty development to respond to that feedback.

Many of the content courses (Legacy curriculum courses I-VII), as well as the RIME curriculum units, are organized with leadership from within particular departments and divisions within the school. These course leaders are therefore directly in touch with divisional and departmental leadership and work with educational leadership in their departments. As such they are well placed to receive input on their course from their colleagues. Some divisions provide explicit opportunities for these discussions at division and departmental meetings and retreats. As an example, the Department of Psychiatry devotes a day each year to an educational retreat that explores all aspects of education at both the undergraduate and postgraduate level.

The leadership within UME (Associate and Assistant Deans, Directors) are all active clinicians who are involved in the provision of medical care at clinical sites throughout the city. This allows for a prominent profile of these individuals and enables for discussions with colleagues that will often include thoughts about how the UME program is performing and how change might be considered.

There have recently been two curricular review processes that have solicited input from faculty regarding the curriculum. Following the prior full accreditation review in 2016, a Curriculum Review Task Force was struck to undertake a high-level review of the curriculum; the results were presented to UMEC in May 2018. This task force requested input from students, faculty and alumni via both an online process (a virtual 'wishing well') and a physical repository (a model 'wishing well' that was situated outside the UME office for several weeks), and 289 responses were received. The Curriculum Review Task Force made several recommendations to UMEC regarding the curriculum, most of which were approved at UMEC and subsequently implemented.

In 2018 the UME Director of Teaching Innovation and a small working group undertook a design thinking process to conduct a more granular review of the medical content teaching within the pre-clerkship. While much of the work of the project involved direct data collection within the classrooms, input was also sought from students and faculty via interviews and focus groups. The RIME initiative was approved by the university and the Ministry of Education, and the new curriculum was launched July 1, 2023. The curricular changes were presented at several departmental grand rounds.

In a broader attempt to reach out to the faculty-at-large, the UME emails a message to the entire faculty (clinical and full-time) each year. This is included as part of the yearly communication that is sent to teaching faculty in order to ensure that correct information is disseminated. A faculty member who answers "yes" to the question "do you have any comments/suggestions to send us to improve our program?" will have a box open up to complete their comments.

Preceptors are provided, at the time ITERs are sent to them via one45, with a link to the school's "Big 10 graduation objectives" and a link to the relevant course/clerkship objectives. They are asked to acknowledge receipt and review of these objectives prior to signing off on the ITER. This acknowledgement is completed by all faculty completing clinical evaluations.

The UME Academic Technologies team created and supports an application (Vera) that reconciles faculty with both their contracts and, if appropriate, their supplier information for payment. The reconciliation of these data is facilitated by the application, and performed by financial staff from across the educational departments and Human Resources.

B. Describe any mechanisms other than faculty meetings (such as written or electronic communications) that are used to inform faculty members about issues of importance at the medical school.

- Regular messages from the Dean are emailed by the Dean's Office to inform faculty members directly regarding important issues.
- CSM Communications uses email lists to communicate periodically with the three faculty categories (full-time, clinical, adjunct), e.g. to promote awards and funding opportunities.

- The CSM website contains current information regarding all aspects of the school.
- The CSM intranet is a secure and centralized domain that posts school news, events and announcements, and internal documents such as administrative forms, policies and procedures, and contacts. Faculty Council meeting agendas, minutes and dates are accessible on the intranet by faculty and staff.
- The Electronic Bulletin Boards on-site at the Health Sciences Centre advertise upcoming events of interest to faculty.
- All of the pre-clerkship courses provide an end-of-course survey to all the faculty members participating in the course. This feedback is reviewed by the Assistant Dean-Pre-Clerkship, and then sent to the pre-clerkship course chairs. Responses to the survey questions regarding faculty development needs are shared with the Office of Faculty Development and Performance.

RIME Curriculum

The development of the RIME curriculum involved information related to the curriculum change that was provided at the departmental and clinical divisional levels. Those involved with teaching and in the clinical realm had opportunity to hear about and participate in the innovative changes. Opportunities to develop the curriculum were distributed broadly to all staff, and there was broad representation from most departments in both the curriculum development as well as the teaching of the curriculum.

1.4 AFFILIATION AGREEMENTS

In the relationship between a medical school and its clinical affiliates, the educational program for all medical students remains under the control of the faculty of a medical school, as specified in written affiliation agreements that define the responsibilities of each party related to the medical education program. Written agreements are necessary with clinical affiliates that are used regularly for required clinical learning experiences; such agreements may also be warranted with other clinical facilities that have a significant role in the clinical education program. Such agreements provide for, at a minimum:

- ***a) assurance of individual medical student and faculty member access to appropriate resources for medical student education***
- ***b) primacy of the medical school's authority over academic affairs and the education/assessment of medical students***
- ***c) role of the medical school in the appointment and assignment of faculty members with responsibility for medical student teaching***
- ***d) specification of the responsibility for treatment and follow-up when a medical student is exposed to an infectious or environmental hazard or other occupational injury***
- ***e) shared responsibility of the clinical affiliate and the medical school for creating and maintaining an appropriate learning environment that is conducive to learning and to the professional development of medical students***

Requirement 1.4-1

In the relationship between a medical school and its clinical affiliates, the educational program for all medical students remains under the control of the faculty of a medical school, as specified in written affiliation agreements that define the responsibilities of each party related to the medical education program. Written agreements are necessary with clinical affiliates that are used regularly for required clinical learning experiences; such agreements may also be warranted with other clinical facilities that have a significant role in the clinical education program. Such agreements provide for, at a minimum:

- *a) assurance of individual medical student and faculty member access to appropriate resources for medical student education*
- *b) primacy of the medical school's authority over academic affairs and the education/assessment of medical students*
- *c) role of the medical school in the appointment and assignment of faculty members with responsibility for medical student teaching*
- *d) specification of the responsibility for treatment and follow-up when a medical student is exposed to an infectious or environmental hazard or other occupational injury*
- *e) shared responsibility of the clinical affiliate and the medical school for creating and maintaining an appropriate learning environment that is conducive to learning and to the professional development of medical students*

A. Provide the signed/executed affiliation agreement (requirements a-e highlighted) for each clinical teaching site at which students complete the inpatient portions of required clinical learning experiences including integrated longitudinal clerkships. This does not include clinical teaching sites only used for electives or selectives. (***Appendix 1.4-1 A***)

Required Appendix 1.4-1 A1- Alberta Health Services Student Placement Agreement
Required Appendix 1.4-1 A2 - NTHSSA Undergraduate Placement Agreement
Required Appendix 1.4-1 A3 - Covenant Health Student Placement Agreement

In Alberta, Student Placement Agreements are the primary means to guide the relationships involving educational matters. A similar template for this is used by the University of Calgary for all of its partner organizations for required clinical learning experiences.

Although the terms of these agreements are indefinite (i.e. no end date), the AHS/UCalgary agreement is currently under review by AHS and UCalgary legal departments with the intent to define an end date.

B. Table 1.4-1 B

Table 1.4-1 B | Affiliation Agreements — Source: School-reported

For each inpatient clinical teaching site or regional health authority used for required clinical learning experiences, provide the page number in the current affiliation agreement and highlight the passages containing the following information:

a. assurance of individual medical student and faculty member access to appropriate resources for medical student education
b. primacy of the medical school's authority over academic affairs and the education/ assessment of medical students
c. role of the medical school in the appointment and assignment of faculty members with responsibility for medical student teaching
d. specification of the responsibility for treatment and follow-up when a medical student is exposed to an infectious or environmental hazard or other occupational injury
e. shared responsibility of the clinical affiliate and the medical school for creating and maintaining an appropriate learning environment that is conducive to learning and to the professional development of medical students

Add rows as needed for each campus/teaching site / regional health authority.

Campus	Clinical teaching site or regional health authority	Date agreement signed	Page number(s)				
			(a) Access to resources	(b) Primacy of program	(c) Faculty appointments	(d) Environmental hazard	(e) Learning environment
	AHS – Student Placement Agreement	July 30, 2013	Pages 6-8	Pages 6-9	Page 7-8	Page 11	Pages 6-9
	NTHSSA Student Placement Agreement	February 2018	Pages 7-9	Page 1	Pages 3-4 &10	Pages 13-14	Pages 1&10
	Covenant Health Student Placement Agreement	November 1, 2014	Pages 6-8	Pages 6-9	Page 8-9	Page 11-12	Page 6-9

There has been previous concern regarding the ability of the affiliation agreement to cover "d" above, which is *specification of the responsibility for treatment and follow-up when a medical student is exposed to an infectious or environmental hazard or other occupational injury.* This was noted as unsatisfactory in the 2016 CACMS review, and subsequently discussed with UCalgary Legal Services. ***Supplemental Appendix 1.4 A*** addresses the previous concern and how this was resolved.

1.5 RESPONSIBILITIES AND PRIVILEGES OF THE DEAN

A medical school has and publicizes policy documents that describe the responsibilities and privileges of its dean and those to whom the dean delegates authority (e.g., vice, associate, assistant deans), department heads, senior administrative staff, faculty members, and committees.

Requirement 1.5-1

The medical school has policy documents that describe the responsibilities and privileges of its dean and those to whom the dean delegates authority (e.g., vice, associate, assistant deans), department heads, senior administrative staff, faculty members, and committees.

A. Provide appropriate sections of the medical school bylaws or similar policy documents that describe the responsibilities and privileges of its dean and those to whom the dean delegates authority. Label and highlight these documents as appropriate. (**Appendix 1.5-1 A**)

Required Appendix 1.5-1 A contains the following committee terms of reference and senior leadership job profiles. For clarity, the following summary table includes the major positions and functions of the committees described in detail in the attached terms of reference and job profiles:

Leadership Positions: These roles constitute the Dean's Executive and are delegated authority by the Dean.	
Dean – Dr. Todd Anderson	Responsible for the overall administration and operations of the Faculty of Medicine
Vice Dean – Dr. Bev Adams	Responsible for Associate Dean, People, Culture, and Health Promotion, and Department Heads Reports to the Dean
Senior Associate Dean, Education – Dr. Lisa Welikovitch	Responsible for all educational units, Advanced Technical Skills Simulation Laboratory, the Office of Health and Medical Education Scholarship, and Director of Educational Operations Reports to the Dean
Senior Associate Dean, Faculty Affairs – Dr. Richard Leigh	Responsible for faculty integration with the Academic Medicine & Health Services Program and the University of Calgary Medical Group. Oversees alumni engagement, communication, and donor relations. Reports to the Dean
Senior Associate Dean, Health Equity & Systems Transformation – Dr. Kannin Osei-Tutu	Responsible for the Office of Faculty Development & Performance, Indigenous, Local & Global Health Office, and the Precision Equity and Social Justice Office Reports to the Dean
Senior Associate Dean, Health Research – Dr. Braden Manns	Responsible for health research conducted at the CSM, including the Associate Dean, Clinical Trials and the Associate Dean, Innovation and Commercialization Reports to the Dean
Senior Associate Dean, Research – Dr. Savraj Grewal	Responsible for the research institutes at the CSM, as well as research infrastructure and grants Reports to the Dean
Senior Director – Rose Yu	Non-medical faculty responsible for administrative services, business operations, privacy and records and partners with University of Calgary Facilities, Finance, Human Resources, Information Technology, and Risk Reports to the Dean

Committees	
CSM Faculty Council	Faulty Council was established pursuant to the Post-Secondary Learning Act (PSLA) and has those powers granted under the Post-Secondary Learning Act and Terms of Reference, subject to the authority of the General Faculties Council (GFC) of the University. The Faculty Council serves as the Faculty's senior academic governing advisory body in the academic affairs of the Faculty and is the framework under which the Dean exercises their responsibilities and privileges.
CSM Faculty Council Committee	

Strategic Education Council	The Strategic Education Council (SEC) is the senior education committee in the CSM. The role of SEC is to 1) assist in the creation and implementation of the CSM's education strategic vision and mission by anticipating educational trends/needs and addressing them with innovative solutions while maintaining educational excellence and leadership in learning, and 2) manage the educational powers, responsibilities and functions as delegated by Faculty Council.
Strategic Research Council	The Strategic Research Council (SRC) is the senior research committee of the CSM and 1) fosters research excellence within the CSM and 2) develops and implements the strategic research plan of the CSM. The SRC also includes committees for Operations, the Centre for Advanced Technologies Research Infrastructure, and Research Assessment.
Alberta Health Services (AHS) Calgary Zone & University of Calgary Faculty of Medicine Joint Council	The Alberta Health Services (AHS) Calgary Zone & University of Calgary Faculty of Medicine Joint Council, is co-chaired by the Dean and informs the role's responsibilities pertaining to the partnership between AHS as the provincial health care provider and the CSM.

Terms of Reference:
CSM Faculty Council
CSM Faculty Council Committee
Strategic Education Council
Strategic Research Council (+ SRC Operations Committee, SRC Centre for Advanced Technologies Research Infrastructure Committee, and Research Assessment Committee)
Alberta Health Services (AHS) Calgary Zone & University of Calgary Faculty of Medicine Joint Council

Senior Leadership Job Profiles:
Dean
Vice Dean
Senior Associate Dean Education
Senior Associate Dean Faculty Affairs
Senior Associate Dean Health Equity and Systems Transformation
Senior Associate Dean Research
Senior Associate Dean Health Research
Senior Director

These roles constitute the Dean's Executive and are delegated authority by the Dean.

Requirement 1.5-2
These policy documents are publicized.

A. Describe how these policy documents are made known within the medical school.

These policy documents are openly available on the CSM and/or the University of Calgary's website. Students, faculty, and staff members are able to search the site to find relevant and up to date documentation.

All full-time (GFT) faculty members of CSM are members of Faculty Council and receive email invitations to Faculty Council meetings, along with the agenda and minutes of previous meetings.

Agendas and minutes for meetings of the Faculty Council Committee, the Strategic Education Council and the Strategic Research Council are routinely provided to members of those committees and are accessible to any GFT faculty member on request via a secure SharePoint website.

Policies, and specifically policy changes, from Faculty Council Committee and the Strategic Education Council are reviewed and discussed at the Undergraduate Medical Education Committee, which has student representatives from all three classes. Any relevant policies or policy changes are then communicated to students via their representatives.

1.6 ELIGIBILITY REQUIREMENTS

A medical school ensures that its medical education program meets all eligibility requirements* of the CACMS for initial and continuing accreditation and is either part of, or affiliated with, a university that has legal authority to grant the degree of Doctor of Medicine.

**** Details are found in the CACMS Rules of Procedure.***

Requirement 1.6-1

The medical school ensures that its medical education program meets all eligibility requirements of the CACMS for initial and continuing accreditation.*

A. Provide a signed letter from the dean of the medical school confirming that the medical education program meets all the eligibility requirements specified in the CACMS Rules of Procedure. (***Appendix 1.6-1 A***)

Required Appendix 1.6-1 A – Eligibility Requirements Letter

The Undergraduate Medical Education program at the University of Calgary fully meets the requirements specified in the CACMS Rules of Procedure.

Requirement 1.6-2

The medical school ensures that its medical education program is either part of, or affiliated with, a university that has legal authority to grant the degree of Doctor of Medicine.

A. Provide a university calendar entry or official document(s) that confirm that the medical education program is either part of, or affiliated with, a university that has legal authority to grant the degree of Doctor of Medicine. (***Appendix 1.6-2 A***)

Required Appendix 1.6-2 A – Calendar Entry

The University of Calgary Calendar is on-line only. The relevant section confirming that the medical education program is part of the University of Calgary is included as ***Required Appendix 1.6-2 A***.