Appendix I

Accountability Report 2015-16

Department of Family Medicine
Faculty of Medicine & Dentistry
University of Alberta

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The Department of Family Medicine

VISION

Alberta has a well-integrated, primary-care-based health care system in which all have access to a family physician who provides timely, proactive, individualized, comprehensive and continuity care through an interdisciplinary team of healthcare professionals led by that family physician. That team practices evidence-based, patient-centered care, and uses its own data, dialog with its stakeholders, and published research to continuously improve its service, quality, and safety.

MISSION

The Department of Family Medicine at the University of Alberta exists to teach the discipline of family medicine for the future of practice, and to produce scholarly work that improves the practice of family medicine and primary health care. We will achieve this outcome by developing and demonstrating excellence in:

1. Training residents for team-based, systems-based, socially accountable patient care and leadership,
2. Providing medical students with high-quality education, and serving as role models of academically excellent, quality-and-safety-driven, socially accountable generalists;
3. Conducting and disseminating clinical, educational, epidemiological, and health services research that improves the teaching and practice of family medicine and primary health care.

CORE VALUES

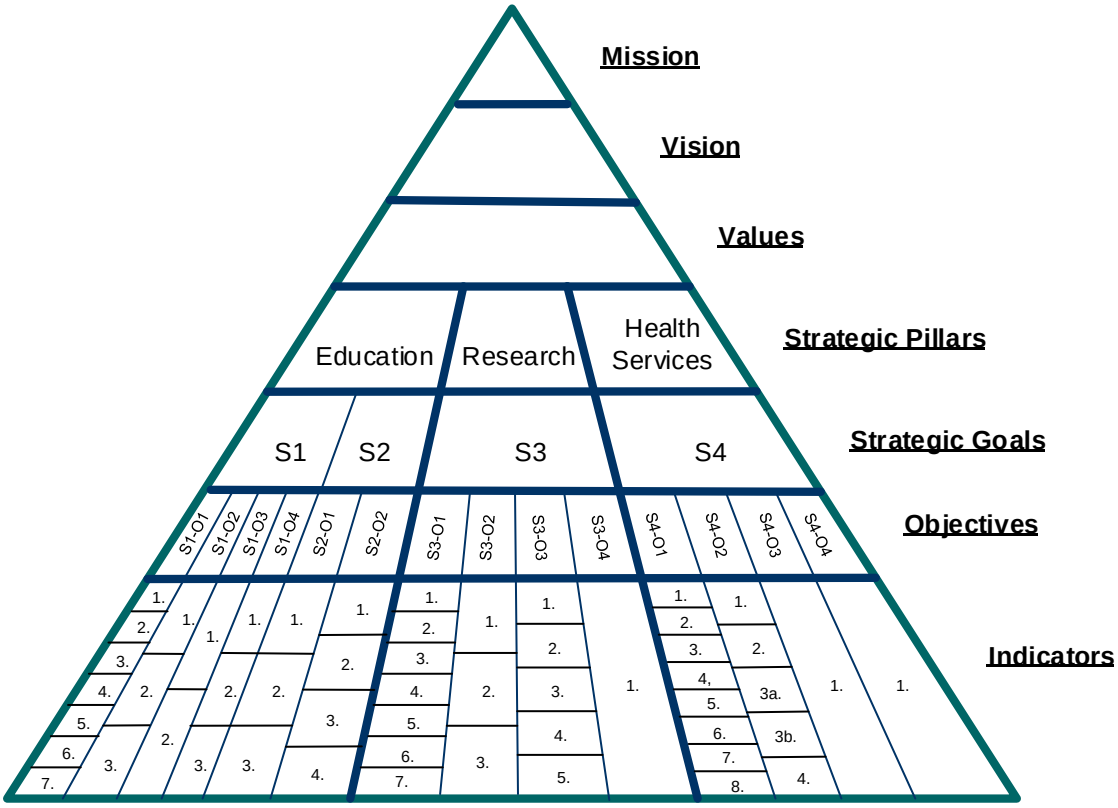
We are a learning organization; we seek constantly to improve how we do what we do for our learners, patients, communities, and other stakeholders, encourage and accept input from them, and use both our data and their feedback to improve.

We support a culture of accountability; Our Mission and how we pursue it will be responsive to our stakeholders; we are responsible with resources allocated to us and transparent in how we use them.

We are committed to mission-focused innovation; we are creative thinkers, producing high-quality academic work that we share freely with others, as well as welcoming what others have to share with us.

ACCOUNTABILITY FRAMEWORK

The department's strategic plan has been crafted to facilitate achievement of the Vision and Mission of the Department of Family Medicine. The core of the strategic plan consists of the *Accountability Framework.* This **balanced scorecard** strategic management framework is designed to support the objectives of this department balanced across the areas of Education, Research and Health Services. Key indicators for each objective are tracked to ensure progress towards achieving the stated objectives. This Accountability Report covers the academic activity in the Department of Family Medicine for the periods July, 2015 to June 30, 2016.



Education

Family Medicine Education is aligned with the Triple C Competency-based curriculum (competency-based, continuity of education and patient care, comprehensive and centered in family medicine). Much of the learning occurs in the family medicine environments and assessment of learners is done with a focus on competencies across a group of essential skills called *Sentinel Habits*, *Clinical Domains* and *Priority Topics* as observed by the experts; their teachers.

The department's strategic direction begins in undergraduate medical education where they provide high quality education for medical students while role modeling the discipline of family medicine. It also goes beyond the continuum of residency to offer opportunities for licensed graduates to obtain advanced skills over and above the basic family medicine objectives in the Enhanced Skills program. Commitment to the continuous education of faculty and staff in the areas of teaching, research, clinical care and administration remain a priority for this department through our Faculty Development program.

The early part of 2016 brought about an explicit focus on quality and safety, quality improvement and social accountability and is reflected in the revision of the Mission and Core Values of this department.

S1- STRATEGIC GOAL – PLACE LEARNERS IN FAMILY MEDICINE CENTERED EXPERIENCES WITH HIGH CALLIBER TEACHERS AND PRODUCE GRADUATES THAT MEET THE NEEDS OF COMMUNITIES THEY SERVE.

Table 1: Resident Continuity

S1-Objective 1: **Provide a Triple C competency based curriculum (competency based, *continuity, comprehensive, centered in family medicine)***		**2013-14**	**2014-15**	**2015-16**
Indicator 1: Percentage of residents achieving target continuity with patient panels				
i.	Total visits by residents during their residency	22,075	37,435	33,287
ii.	Patients with visits to same resident twice during their residency	16%	17%	17.6%
iii.	Patients with visits to same resident three times during their residency	5%	6%	5.9%
iv.	Patients with visits to same resident four times during their residency	2%	2%	2%
v.	Patients with visits to same resident five times during their residency	1%	1%	1%
vi.	Patients with visits to same resident six times during their residency	2%	1%	1%
Indicator 2: Percentage of clinical half days spent with primary preceptor supervision		84.5%	87%	90%

Table 2: Triple C Curriculum

S1-Objective 1: **Provide a Triple C based curriculum (*continuity, comprehensive, centered in family medicine)***		**2013-14**	**2014-15**	**2015-16**
Indicator 3: Percentage of residents achieving FieldNote(1) targets *(2014-15 data erroneous due to a technical difficulty causing duplication of a number of notes)		61.7%	79.1%*	42.5%
Indicator 4: Total number of FieldNotes created over 12 month period *(2014-15 data erroneous due to a technical difficulty causing duplication of a number of notes)		5,245	8,897*	7,000
Indicator 5: Percentage of residents achieving a pass in the **CFPC(2)** exam first time		96%	96%	90.8%
Indicator 6: Percentage of FieldNotes across all Clinical Domains				
i.	Doctor-patient relationship / Ethics	12.6%	11.9%	10.8%
ii.	Care of adults	33.6%	34.7%	37.2%
iii.	Care of children and adolescents	11.8%	11.8%	11.6%
iv.	Care of the elderly	8.3%	8.1%	8.9%
v.	Care of the vulnerable and underserviced	4.1%	4.0%	3.6%
vi.	Maternity Care	8.3%	8.2%	7%
vii.	Palliative Care	2.2%	1.8%	2.3%
viii.	Surgical and procedural skills	11.1%	12.7%	12.1%
ix.	Not applicable	7.6%	7.0%	6%
Indicator 7: Number of weeks of rotational experiences that occur in family medicine environments		37%	43%	46%

(1)FieldNotes – the process of documenting a sampling of direct observations and feedback given across all clinical domains and sentinel habits. Notes are stored in an electronic format for ease of sorting, reflection and assessment. The intent is for the resident to have enough of a sampling of notes across all clinical domains and sentinel habits to show overall competency.

(2) College of Family Physicians of Canada

Table 3: Meeting Community Needs and Enhanced Skills

S1-Objective 2: **Provide opportunities for family medicine graduates to meet the needs of Albertans including the development enhanced skills**		**2013-14**	**2014-15**	**2015-16**
Indicator 1: Practice patterns after completion of Residency and Enhanced Skills Program			New Metric	
i.	Practicing in Canada		100%	Data not available
ii.	Practicing in Alberta		92%	Data not available
iii.	Unknown		8%	Data not available
Indicator 2: Applications to the Advanced Skills program			121	145
Indicator 3: Accepted enrollment / Successful completion of Advanced Skills program.			14/14	18/18

Table 4: Knowledge Translation and Faculty Development

S1-Objective 3: **Foster knowledge translation of best practice and innovation in Family Medicine education** ***(Research indicator; in 2015-16, based on 18 months data to catch up to the academic year reporting)***	**2013**	**2014**	**2015-16**
Indicator 1: Number of faculty presenting education workshops and presentations	108	37	35
Indicator 2: Number of teaching faculty on national and international education committees	11	17	20
S1-Objective 4: **Provide educators with the opportunity to develop skills to keep up with evolving curriculum**	**2013-14**	**2014-15**	**2015-16**
Indicator 1: Number of faculty development sessions held	9	3	3
Indicator 2: Number of participants in faculty development sessions	97	185	86
i. Number of Department of Family Medicine participants	94	173	81
ii. Number of Community participants	3	12	5
Indicator 3: Number of Faculty involved in producing education support documentation or products.	16	17	23

S2- STRATEGIC GOAL – MAKE FAMILY MEDICINE AN APPEALING CAREER CHOICE FOR MEDICAL STUDENTS

Table 5: Undergraduate Family Medicine Exposure

S2-Objective 1: **Use curricula aligned with Can-Meds and Can-Meds FMU to increase the number of University of Alberta medical students choosing family medicine.**	**2013-14**	**2014-15**	**2015-16**
Indicator 1: Number of University of Alberta students matching to University of Alberta Family Medicine after Round 1 ***CaRMS***	37	39	30
Indicator 2: Number of student evaluations of the Longitudinal Clinical experience *(previously called Community-based experience*)rated as good to excellent	96%	96.5%	95.5 %
Indicator 3: Mean overall rating of the ***Family Medicine Clerkship*** program from the graduation survey as compared to the national average /5	3.1	4.2	4.1
S2-Objective 2: Increase exposure of University of Alberta's medical students to modern, progressive Family Medicine	**2013-14**	**2014-15**	**2015-16**
Indicator 1: Number of weeks of ***Family Medicine electives*** year 3 and 4 provided by Department of Family Medicine faculty and preceptors	209	219	218
Indicator 2: Number of hours of undergrad teaching by Department of Family Medicine faculty or preceptors	1,024	1,105	8,429
Indicator 3: Number of weeks spent coordinating undergrad courses by Department of Family Medicine faculty or preceptors	236	345	127.5
Indicator 4: Residents as teachers – Number of hours of Resident teaching; OSCE's, TOSCE's	580	709	364

Research

The Department of Family Medicine at the University of Alberta is a leader in primary care health systems and medical education research. Members cover a broad range of research topics and disseminate research findings through papers, books, manuals, presentations and workshops at local, provincial, national and international conferences. The research focus of this department is in conducting and disseminating research that improves teaching, the practice of family medicine and primary health care. Research data in previous reports was based on a 12-month **calendar** year; January – December, while Education and Health Services reported on the 12-month **academic** year, July – June. In order to standardize the reporting process for future reporting periods across all areas, the Research data for this report is based on 18 months of data; January 2015-June 2016.

S3- STRATEGIC GOAL – CONDUCT INNOVATIVE FAMILY MEDICINE AND MEDICAL EDUCATION RESEARCH

Table 6: Research Activity (Grants & Publications)

S3-Objective 1 **Conduct research to improve primary care and medical education** *(This year 18 months reported to catch up to academic year reporting)*	**2013**	**2014**	**2015-16**
Indicator 1: Number of new research grants awarded **DoFM faculty are PIs or Co-Investigators on the grant and funding administered/held by University of Alberta **or** other organizations*	44	27	46
Indicator 2 : Total value of NEW grant funding *(actual dollars)* received and held by DoFM, University of Alberta *(total amount of new funding in account for year reported- e.g. if total grant = $100,000 but only $50,000 was received during 2014, only $50,000 is reported here). [Information obtained from e-TRAC]*	$1,840,661.	$559,132.	$2,141,746.
Indicator 3: Number of grants in progress (*cumulative)* **DoFM faculty are PIs or Co-Investigators on the grant and funding administered/held by University of Alberta **or** other organizations*	23	54	48
Indicator 4 (a): Total value of grant funding NEW and IN PROGRESS (dollars) (*cumulative)* currently held by DoFM, University of Alberta in the year reported. [*Information obtained from e-TRAC. *Excludes U of A internally funded projects (e.g. NAAFP, almost all summer studentships, other funding from within U of A)]*	$4,833,557.	$5,081,719	$5,614,533
Indicator 5: Number of peer reviewed publications	82	78	159
Indicator 6: Number of non-peer reviewed publications	29	12	19
Indicator 7: Number of books and chapters published	3	8	4

Table 7: Research Activity (Research Findings)

S3-Objective 2: **Engage in the translation of research findings to inform on education and on policy in primary care**	**2013**	**2014**	*(18 months)* **2015-16**
Indicator 1: Number of presentations to policy makers, health professionals, stakeholders			
i. Oral Presentations *(excludes educational presentations such as faculty development, courses, etc.)(Peer reviewed)*	77	116	137
ii. Poster Presentations (research)	59	123	101
iii. Workshops	10	10	16
Indicator 2: Number of peer reviewed presentations (research: poster& oral)	146	252	254
Indicator 3: Number of knowledge translation products, tools, manuals produced	26	61	89
S3-Objective 3: **Expand research expertise**	**2013**	**2014**	*(18 months)* **2015-16**
Indicator 1: Percentage of research projects external collaboration, locally, regionally, nationally and internationally.	68	138	208
I. Local	68.7%	61.6%	66.3%
II. Regional	10.7%	6.5%	6.2%
III. National	17.3%	25.4%	25.5%
IV. International	3.3%	6.5%	2.4%
Indicator 2: Percentage of faculty with advanced degrees	55%	72.5% *(n=29)*	64.3% (n=27)
Indicator 3: Number of research summer students *(person months)*	42 months *(n=7)*	27.5months *(n=8)*	19 months *(n=9)*
Indicator 4: Number of grad students, (*Masters, PhD, fellows, post-doctoral and independent study students)*	4	17	36
Indicator 5: Number of faculty who supervise fellows, graduate students, and independent study students	2	7	17
S3-Objective 4: **Influence the health research agenda in Canada**	**2013**	**2014**	*(18 months)* **2015-16**
Indicator 1: Number and descriptions of positions on research funding organization committees, ethics, review and advisory boards (Details of positions and placements page xvi)	16	19	42[3]

[3] *(For details of faculty names and positions see page xvi)*

Health Services

The vision of the department is to ensure residents are part of a health system that ensures all patients will have access to a family physician and a team of interdisciplinary healthcare professionals that provide proactive, timely, individualized, comprehensive and continuous care. We role model by evaluating our own data to continuously improve the evidence-based, patient-centered care we provide. Measurement and evaluation are critical components to building organizations where quality improvement is part of the common culture.

Access to primary care services when the patient needs them and continuity with their primary care physician or their team improves patient care, patient and provider satisfaction and ultimately lowers health care costs. We monitor panel sizes on a regular basis to ensure quality patient care while meeting the educational needs of our family medicine residents. Panels then form the basis for patient continuity of care. The following data is from our four academic teaching sites.

S4- STRATEGIC GOAL – PROVIDE SAFE AND EFFECTIVE HEALTHCARE.

Table 8: Academic Teaching Site Delay Indicators

S4-Objective 1: **Improve access to healthcare**	**2013-14**	**2014-15**	**2015-16**
Indicator 1: Average time to 3rd next available appointment (days)			
Royal Alex FMC	5.2	4.9	4.6
Grey Nuns FMC	3.5	4.6	5.6
Misericordia FMC	4.3	4.6	3.3
NECHC FMC	4.3	7.1	5.5
Indicator 2: **Average cycle time of appointments (minutes from check in to check out)**			
Royal Alex FMC	47.9	52	50.7
Grey Nuns FMC	54	60	62
Misericordia FMC	54	56	58
NECHC FMC	47	56	46
Indicator 3: Average red zone time *(time spent with provider, in minutes)*			
Royal Alex FMC	30	27	26
Grey Nuns FMC	N/A	N/A	N/A
Misericordia FMC	30	33	30
NECHC FMC	25	33	19.5

Table 9: Academic Teaching Site Clinical Activity

S4-Objective 1: **Improve access to healthcare - continued**	**2013-14**	**2014-15**	**2015-16**
Indicator 4: Continuity rate of provider panel (% of patients seeing own provider)			
Royal Alex FMC	79%	79%	81%
Grey Nuns FMC	80%	81%	83%
Misericordia FMC	85%	86%	86%
NECHC FMC	80%	76%	85 %
Indicator 5: Number of new patients accepted to practice			
Royal Alex FMC	213	242	260
Grey Nuns FMC	232	307	213
Misericordia FMC	178	154	95
NECHC FMC	734	397	549
Indicator 6: Average return visit rate / 12 month period			
Royal Alex FMC	3.4	3	3.3
Grey Nuns FMC	3.3	3	3
Misericordia FMC	3.2	3.1	3.1
NECHC FMC	3.7	2.4	3.3
Indicator 7: Panel size – patients seen in the past 3 years			
Royal Alex FMC	5,515	5,500	5,556
Grey Nuns FMC	3,418	4,403	4,361
Misericordia FMC	4,575	4,642	4,558
NECHC FMC	4,620	5,017	5,147
Indicator 8: Utilization of Primary Care Network allied health service professionals and programs (number of events)			
Royal Alex FMC	1,900	1,617	1,777
Grey Nuns FMC	772	663	743
Misericordia FMC	868	780	711
NECHC FMC	52	21	557

Table 10: Academic Teaching Site Practice Quality Improvement

The four academic teaching clinics have successfully maintained a culture of continuous quality improvement informed by measures for many years. Role modeling quality and safety in primary care and quality improvement has become an important focus of this department's curriculum.

S4-Objective 2: **Foster best practice and innovations in primary care**	**2013-14**	**2014-15**	**2015-16**
Indicator 1: Number of practice quality improvement projects / initiatives in academic teaching clinics.			
Royal Alex FMC	7	24	15
Grey Nuns FMC	12	10	5
Misericordia FMC	12	7	5
NECHC FMC	N/A	21	20

Tables 11a and 11b: Academic Teaching Site Health Screening Completion Rates

The four academic teaching clinics as well as one of our affiliated community clinics (the University of Alberta Family Medicine Centre) enrolled in the Towards Optimized Practice, Alberta Screening and Prevention Program (ASaP) as a Primary Care Organization (PCO). As a PCO, aggregate screening data for the PCO as a whole is provided at baseline, 6 month and 12 month intervals. The intent is to measure at baseline, implement new processes for opportunistic and outreach screening programs, then measure at 6 month intervals to see if changes made have resulted in improvement. In addition, screening rates for other PCO's as well as the Alberta average are provided to PCO's.

The data from the ASaP Program is derived from randomized chart audits of patients who had been into the clinic for a medical appointment in the past 12 months. Those results are seen in Table 11b.

At the four academic teaching sites however we have been measuring screening rates for the past 3 years on the entire panel of **active** (**active-seen in the past 36 months**) patients through the use of reporting tools which are part of the Electronic Medical Record. Those results appear seen on Table 11a.

Screening rates in Table 11a only take age, sex into account as the criteria for eligibility for each maneuver. It does not take into account patient preference or the fact that a maneuver may not have been medically indicated. For this reason, a rate of 100% would be inappropriate.

Table 11a: Electronic Medical Record Screening Data (complete panel)

S4-Objective 2:
Foster best practice and innovations in primary care (continued)

Indicator 2:
Percentage of population health screening completion rates.

	Clinic A		Clinic B		Clinic C		Clinic D	
	2015	**2016**	**2015**	**2016**	**2015**	**2016**	**2015**	**2016**
Mammography	74%	70%	73%	80%	56%	53%	84%	86%
Pap Test	62%	64%	52%	67%	42%	46%	44%	39%
Blood Pressure	66%	64%	79%	78%	48%	52%	58%	55%
Plasma Lipid Profile(Female) **Guidelines changed to every 5 years in 2016**	76%	89%	70%	59%	63%	79%	72%	71%
Plasma Lipid Profile (Male) **Guidelines changed to every 5 years in 2016**	75%	82%	69%	81%	65%	80%	63%	74%
Colorectal Cancer Screening -Colonoscopy last 10 years or Sigmoidoscopy last 5 years or FIT test last 2 years	60%	58%	66%	54%	50%	45%	54%	43%
Diabetes Screen – One of Hemoglobin A1C or Fasting Glucose	80%	87%	76%	86%	69%	61%	65%	82%
CV Risk Calculation (Framingham) Males	10%	20%	14%	25%	9%	12%	69%	87%
CV Risk Calculation (Framingham) Female	14%	19%	21%	24%	13%	13%	76%	54%
Height once	89%	87%	92%	95%	69%	77%	82%	88%
Weight 3 year	70%	79%	72%	77%	57%	61%	66%	78%
Smoking 1 Year	37%	34%	40%	32%	30%	30%	51%	49%
Exercise Assessment 1 year	35%	32%	54%	28%	19%	17%	46%	45%

Table 11b: Alberta Screening and Prevention Data (Random Audit)

Indicator 2: Percentage of population health screening completion rates. (As of December 2016)			
Screening Maneuver	**PCO(Patient care Organization) Baseline (%)**	**12 month follow up (%)**	**Change (%)**
Alcohol	17.78	50.56	32.78
Blood Pressure	72.78	81.39	8.61
Colorectal Screening	48.32	70.73	22.41
CV Risk	10.06	41.18	31.12
Diabetes Screening	82.38	76.50	-5.88
Exercise	20.00	62.22	42.22
Influenza	5.83	43.06	37.22
Height and Weight	40.83	58.89	18.06
Lipids	79.89	75.40	-4.49
Mammogram	61.84	75.31	13.47
Pap Smear	64.36	74.19	9.84
Tobacco	38.06	61.23	26.67
DFM Overall Scores all Maneuvers Combined	40.98	62.86	21.88
Alberta Experience for Comparison – Overall Scores, all Maneuvers Combined	48.89%	64.46%	30.46%

Table 12: Academic Teaching Site Patient Medical Home Scores

In the early part of 2016 the four academic centers rolled out the Patients Medical Home Phase 1 Assessment (Primary Care Network Evolution). This tool helps clinics assess their own processes and activities related to Patient's Medical Home implementation concepts, helps them to see where the gaps are and then be able to formulate an action plan to move the clinic forward. Phase 1 focuses on engaged leadership, capacity for improvement and panel and continuity. Phase 2 will be completed in the next academic year.

Indicator 3C: PCNe Practice Level Patient's Medical Home Assessment (*Scores /12; where 1 is the lowest score and 12 the highest possible score)*								New Metric for 2015-16
PCN-E Assessment Score – Phase 1	**Clinic A**		**Clinic B**		**Clinic C**		**Clinic D**	
		2015		2015		2015		2015
Engaged Leadership /12		6.75		6.25		6		7
Quality Improvement /12		7.25		7.25		8.25		7.5
Panel and Continuity /12		7.25		7.5		8.25		7
Overall Consensus Score		7 (Level B)		7.3 (Level B)		7.5 (Level B)		7 (Level B)

PCN-E Assessment Score – Phase 2- *In Progress, will be reported in the 2016-17 report*	**Clinic A**		**Clinic B**		**Clinic C**		**Clinic D**	
		2016		2016		2016		2016
Team Based Care /12								
Organized Evidence Based Care /12								
Patient-Centered Interactions /12								
Enhanced Access /12								
Care Coordination /12								

Table 13: Leadership and advocacy in Primary Healthcare Policy and Education in Quality and Safety.

S4-Objective 3: **Demonstrate leadership and advocacy in healthcare delivery policy.**	**New Metric 2014-15**	**2015-16**
Indicator 1: Number of provincial, national and international committees or working groups affecting policy attended by faculty or senior staff.		
S4-Objective 4: **Educate and support in Quality and Safety in primary Care**	**New Metric 2014-15**	**2015-16**
Indicator 1: Number of large group sessions or sessions to clinics	0	4
Number sessions for learners	4	4

Faculty Members on Research Funding Organizations

1. **Au, Lillian**
    a. Interviewer, Assistant Dean Search and Recommendation Committee

2. **Allan, GM**
    a. Editorial Advisory Board, *Canadian Family Physician*
    b. Advisory Board, Canadian Cardiovascular Society, Canadian Lipid Guidelines
    c. Advisory Board, Simplified Primary Care Lipid and CVD Guideline
    d. Co-director, Diagnosis and Management of Osteoporosis, TOP guideline

3. **Bell, N**
    a. Member, Canadian Task for on Preventative Health
    b. Guideline Reviewer, National Health and Medical Research Council (NHMRC), Australia

4. **Campbell-Scherer, D**
    a. Member, Steering Committee, Bone and Joint Canada

5. **Cave, AJ**
    a. Grant Reviewer, Canadian Thoracic Society Grant
    b. Grant Reviewer, CIHR Final Review Panel
    c. Chair, Primary Care Group, Pediatric Asthma Pathway Committee, Alberta Health Services
    d. Co-Chair, Asthma Working Group/Respiratory Clinical Network
    e. Director, Family Physicians Airways Group of Canada
    f. Member, Board of Directors, MSI Foundation Alberta
    g. Grant Reviewer, MSI Foundation
    h. Reviewer, Canadian Thoracic Society

6. **Charles L**
    a. Member, Health Research Ethics Board – Panel B, University of Alberta

7. **Chmelicek J**
    a. Grant Reviewer, Janus Continuing Professional Development Grants, CFPC

8. **Donoff M**
    a. Co-Chair, Towards Optimized Practice Chronic Disease Management Project

9. **Drummond N**
    a. Grant Reviewer, CIHR Foundation Grant Program

10. **Garrison S**
    a. Member, Family Medicine Forum Advisory Committee, CFPC
    b. Chair, Family Medicine Forum Research Committee, CFPC

11. **Green LA**
    a. Member, Primary Health Care Steering Committee, Alberta Health
    b. Chair, Measurement and Evaluation Working Group, Alberta Health

12. **Gruneir A**
    a. Grant Panel Member, University Hospital Foundation Medical Research Competition
    b. Grant Panel Member, Health Services Evaluation and Intervention Research, CIHR
    c. Grant Panel Member, Health Reason Training, CIHR
    d. Member, Quality Indicator Working Group, Alberta Health Continuing Care
    e. Member, Health Quality Ontario Long-Term Care Public Reporting Delphi Panel

13. **Keenan L**

a. Grant Reviewer, Oral Health and Community Engagement Fund
b. Grant Reviewer, First Live Pilot Host, CIHR
c. Grant Reviewer, Mini-Grant Initiative, Western Group of Education Educational Affairs

14. Koppula S

a. Grant Reviewer, The College of Family Physicians of Canada Janus Grants

15. Moores D

a. External Reviewer, Niagara Falls Community Health Centre, Accreditation Canada Surveyor

16. Ross S

a. Grant Reviewer, Canadian Association of Medical Education

17. Salvalaggio G

a. Member, Health Research Ethics Board – Panel B, University of Alberta
b. Member, Participatory Research in Primary Care Working Group, North America Primary Care Research Group
c. Member, Alberta Research Network for Addiction and Mental Health

18. Szafran O

a. Grant Review, Janus Research Grants, CFPC
b. Grant Review, Canadian Institutes for Health Research

19. Triscott J

a. Grant Reviewer, Research Support and Research Catalyst Grants, Island Health
b. Reviewer, Canadian Task Force on Preventative Health Care Reviewer