Appendix I

Accountability Report 2017-18

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

Table of Contents

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

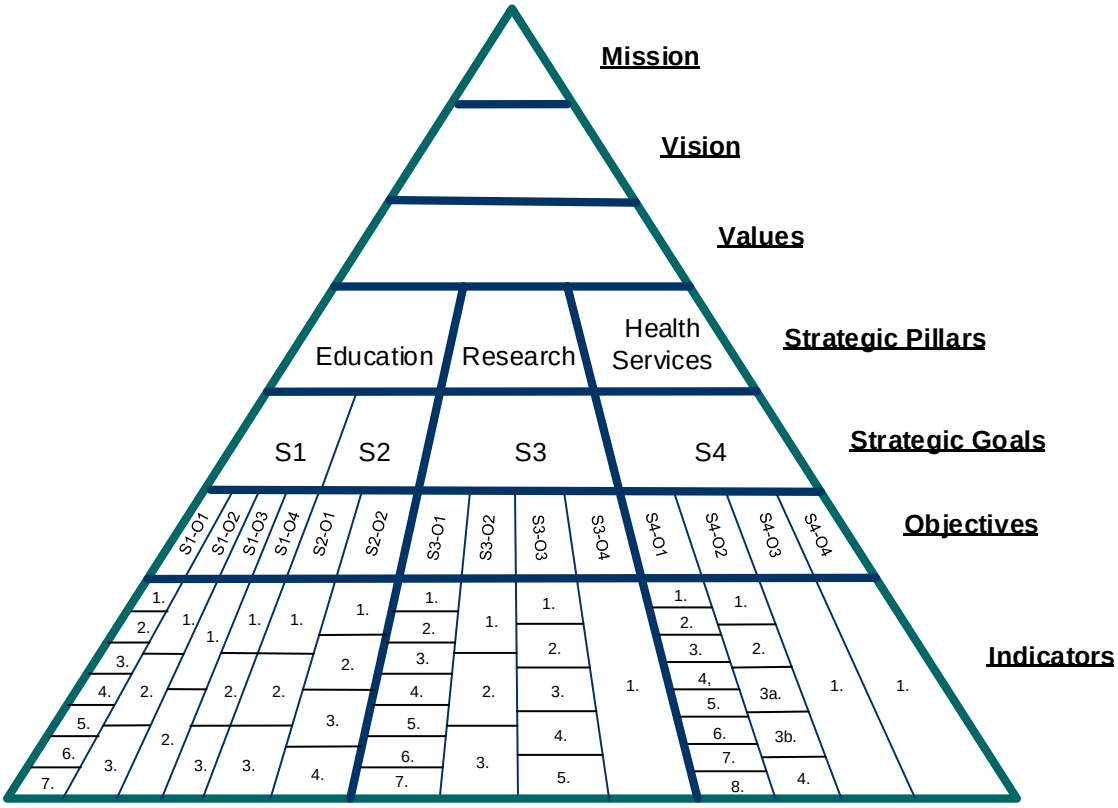
We are a learning organization; we seek constantly to improve how we do what we do for our learners, patients, communities, and other stakeholders, encourage and accept input from them, and use both our data and their feedback to improve.

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, 2017 to June 30, 2018.



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.

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)***		**2015-16**	**2016-17**	**2017-18**
Indicator 1: Percentage of residents achieving target continuity with patient panels. (Data for this indicator reflects residents placed in the four academic teaching sites)				
i.	Total visits by residents during their residency	33,287	32,761	36,023
ii.	Patients with visits to same resident twice during their residency	17.6%	16.9%	16.2%
iii.	Patients with visits to same resident three times during their residency	5.9%	9.3%	5.3%
iv.	Patients with visits to same resident four times during their residency	2%	2.5%	2.1%
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	1%	1%	1%
Indicator 2: Percentage of clinical half days spent with primary preceptor supervision		87%	90%	85.5%

Table 2: Triple C Curriculum

S1-Objective 1: **Provide a Triple C based curriculum (*continuity, comprehensive, centered in family medicine)***	**2015-16**	**2016-17**	**2017-18**
Indicator 3: Percentage of residents achieving FieldNote(1) targets	42.5%	44%	41%
Indicator 4: Total number of FieldNotes created over 12 month period	7,000	6776	6596
Indicator 5: Percentage of residents achieving a pass in the **CFPC(2)** exam first time	90.8%	90.8%	91%
Indicator 6: Percentage of FieldNotes across all Clinical Domains			
i. 10.8%	7%	10.8%	9%
ii. 37.2%	42%	37.2%	41%
iii. 11.6%	12%	11.6%	10%
iv. 8.9%	9%	8.9%	10%
v. 3.6%	3.8%	3.6%	3%
vi. 7%	6.7%	7%	7%
vii. 2.3%	2.2%	2.3%	2%
viii. 12.1%	9.9%	12.1%	10%
ix. 6%	6.6%	6%	8%
Indicator 7: Number of weeks of rotational experiences that occur in family medicine environments	46%	49%	45%

(1)FieldNotes – the process of documenting a sampling of direct observations and feedback given across all clinical domains, sentinel habits and priority topics. 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**	**2015-16**	**2016-17**	**2017-18**
Indicator 1: Applications to the Advanced Skills program	145	145	130
Indicator 2: Accepted enrollment / Successful completion of Advanced Skills program.	18/18	18/18	16/16

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)***	**2015-16**	**2016-17**	**2017-18**
Indicator 1: Number of faculty presenting education workshops and presentations	35	Included in research section	Included in research section
Indicator 2: Number of teaching faculty on national and international education committees	20	19	51[(3)]
S1-Objective 4: **Provide educators with the opportunity to develop skills to keep up with evolving curriculum**	**2015-16**	**2016-17**	**2017-18**
Indicator 1: Number of faculty development sessions held	3	16	22
Indicator 2: Number of participants in faculty development sessions	86	226	154
i. Number of Department of Family Medicine participants	81	131	114
ii. Number of Community participants	5	42	40
Indicator 3: Number of Faculty involved in producing education support documentation or products.	23	19	Data not available

[(3)] *See Appendix 1b for listing*

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.**	**2015-16**	**2016-17**	**2017-18**
Indicator 1: Number of University of Alberta students matching to University of Alberta Family Medicine after Round 1 ***CaRMS***	30	29	35
Indicator 2: Number of student evaluations of the Longitudinal Clinical experience *(previously called Community-based experience*)rated as good to excellent	95.5 %	96%	93.5%
Indicator 3: Mean overall rating of the ***Family Medicine Clerkship*** program from the graduation survey as compared to the national average /5	4.1	4.1	4.5
S2-Objective 2: Increase exposure of University of Alberta's medical students to modern, progressive Family Medicine	**2015-16**	**2016-17**	**2017-18**
Indicator 1: Number of weeks of ***Family Medicine electives*** year 3 and 4 provided by Department of Family Medicine faculty and preceptors	218	231	166
Indicator 2: Number of hours of undergrad teaching by Department of Family Medicine faculty or preceptors	8,429	6256	1650[(4)]
Indicator 3: Number of weeks spent coordinating undergrad courses by Department of Family Medicine faculty or preceptors	127.5	53	68
Indicator 4: Residents as teachers – Number of hours of Resident teaching; OSCE's, TOSCE's	364	1165	1368

(4) In prior years data LCE (longitudinal clinical experience) was included in error.

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, primary health care and to mentor residents in learning the important role research has in improving primary care. Residents are challenged through their personal Practice Quality Improvement projects to experience research using the quality improvement lens.

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)*	*(18 months)* **2015-16**	**2016-17**	**2017-18**
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*	46	32	38
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]*	$2,141,746.	$1,704,157.	$1,253,625.
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*	48	38	49
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)]*	$5,614,533	$5,728,925.	$7,412,734.
Indicator 5: Number of peer reviewed publications	159	140	147
Indicator 6: Number of non-peer reviewed publications	19	16	10
Indicator 7: Number of books and chapters published	4	2	3

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**	*(18 months)* **2015-16**	**2016-17**	**2017-18**
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)*	137	166	174
ii. Poster Presentations (research)	101	127	110
iii. Workshops	16	37	57
Indicator 2: Number of peer reviewed presentations (research: poster& oral)	146	252	341
Indicator 3: Number of knowledge translation products, tools, manuals produced	26	61	86
S3-Objective 3: **Expand research expertise**	*(18 months)* **2015-16**	**2016-17**	**2017-18**
Indicator 1: Percentage of research projects external collaboration, locally, regionally, nationally and internationally.	208	169	172
I. Local	66.3%	62.1%	60.4%
II. Regional	6.2%	9.5%	7.6%
III. National	25.5%	28.4%	32%
IV. International	2.4%	0	0
Indicator 2: Percentage of faculty with advanced degrees	64.3% (n=27)	60.5% (n=26)	65.1% (n=28)
Indicator 3: Number of research summer students *(person months)*	19 months *(n=9)*	*49.5 months (n=15)*	*46 months (n=13)*
Indicator 4: Number of grad students, (*Masters, PhD, fellows, post-doctoral and independent study students)*	36	35	20
Indicator 5: Number of faculty who supervise fellows, graduate students, and independent study students	17	17	15
S3-Objective 4: **Influence the health research agenda in Canada**	*(18 months)* **2015-16**	**2016-17**	**2017-18**
Indicator 1: Number and descriptions of positions on research funding organization committees, ethics, review and advisory boards (Details of positions and placements page xvii)	42	150[4]	124[5]

[5] *See Appendix 1a for listing*

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. Patient panels form the foundation for patient continuity of care.

In the Family Medicine program, the clinic is the curriculum. Role modeling in an environment that is patient- centered, practices team-based care and promotes the elements of the Patients Medical Home encourages residents to want to practice in similar environments upon graduation.
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**	**2015-16**	**2016-17**	**2017-18**
Indicator 1: Average time to 3rd next available appointment (days)			
Royal Alex FMC	4.6	5.4	2.3[(6)]
Grey Nuns FMC	5.6	4.4	5.2
Misericordia FMC	3.3	4.7	3.7
NECHC FMC	5.5	5	5.2
Indicator 2: **Average cycle time of appointments (minutes from check in to check out)**			
Royal Alex FMC	50.7	47	58
Grey Nuns FMC	66	59	57
Misericordia FMC	58	60	56
NECHC FMC	46	47	47
Indicator 3: Average red zone time *(time spent with provider, in minutes)*			
Royal Alex FMC	26	29	28
Grey Nuns FMC	N/A	N/A	19
Misericordia FMC	30	33	31
NECHC FMC	19.5	18	27

[(6)] There were some gaps in TNA and continuity data for RAH due to the preparation and subsequent move to the new clinic space.

Table 9: Academic Teaching Site Clinical Activity

S4-Objective 1: **Improve access to healthcare - continued**	**2015-16**	**2016-17**	**2017-18**
Indicator 4: Continuity rate of provider panel (% of patients seeing own provider)			
Royal Alex FMC	81%	84%	86%[(6)]
Grey Nuns FMC	83%	87%	87%
Misericordia FMC	86%	84%	80%
NECHC FMC	85 %	87%	88%
Indicator 5: Number of new patients accepted to practice			
Royal Alex FMC	260	379	205
Grey Nuns FMC	213	285	271
Misericordia FMC	95	76	112
NECHC FMC	549	352	235
Indicator 6: Average return visit rate / 12 month period			
Royal Alex FMC	3.3	3.3	3.2
Grey Nuns FMC	3	3	3.3
Misericordia FMC	3.1	3.1	3.2
NECHC FMC	3.3	3.6	2.9
Indicator 7: Panel size – patients seen in the past 3 years			
Royal Alex FMC	5,556	5,690	6406
Grey Nuns FMC	4,361	3,795	3996
Misericordia FMC	4,558	4,499	4605
NECHC FMC	5,147	5,074	4818
Indicator 8: Utilization of Primary Care Network allied health service professionals and programs (number of events)			
Royal Alex FMC	1,777	2185	1442
Grey Nuns FMC	743	695	694
Misericordia FMC	711	978	1500
NECHC FMC	557	1115	785

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**	**2015-16**	**2016-17**	**2017-18**
Indicator 1: Number of practice quality improvement projects / initiatives in academic teaching clinics.			
Royal Alex FMC	15	7	6
Grey Nuns FMC	5	8	10
Misericordia FMC	5	10	7
NECHC FMC	20	29	25

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 and 6 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 for comparison.

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 6 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 and 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.

	Royal Alex		Grey Nuns		Misericordia		NECHC	
	2017	2018	2017	2018	2017	2018	2017	2018
Mammography	69%	67%	76%	77%	56%	54%	84%	77%
Pap Test	65%	61%	74%	66%	51%	44%	64%	54%
Blood Pressure	64%	66%	80%	76%	51%	50%	52%	53%
Plasma Lipid Profile	78%	77%	77%	64%	71%	67%	75%	75%
Colorectal Cancer Screening -Colonoscopy last 10 years or Sigmoidoscopy last 5 years or FIT test last 2 years	61%	62%	67%	74%	44%	46%	54%	52%
Diabetes Screen – One of Hemoglobin A1C or Fasting Glucose	85%	85%	86%	87%	50%	39%	83%	83%
CV Risk Calculation (Framingham)	39%	35%		8%	34%	14%	59%	66%
Height once	87%	90%	96%	97%	77%	77%	75%	90%
Weight 3 year	69%	72%	76%	73%	59%	56%	52%	64%
Smoking 1 Year	39%	48%	38%	3%	27%	22%	67%	37%
Exercise Assessment 1 year	33%	46%	30%	21%	15%	12%	67%	34%

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

Indicator 2:
Percentage of population health screening completion rates**. (As of March 2018)**

Screening Maneuver	PCO(Patient care Organization) Baseline (%)	12 month follow up (%)	Change (%)
Alcohol	22.86	40	17.14
Blood Pressure	76.43	87.14	10.71
Colorectal Screening	67.59	66.97	-.62
CV Risk	23.08	27.78	4.70
Diabetes Screening	85.35	89.10	3.75
Exercise	22.08	23.75	1.67
Influenza	6.50	10.50	4
Height and Weight	60.71	69.64	8.93
Lipids	83.85	81.60	-2.25
Mammogram	63.16	61.54	-1.62
Pap Smear	66.42	69.70	3.27
Tobacco	43.93	57.14	13.21
DFM Overall Scores all Maneuvers Combined	50.56	57.14	6.57
Alberta Experience for Comparison – Overall Scores, all Maneuvers Combined	49.57	63.59	14.02

Previous Data – As of December 2016

Screening Maneuver	PCO(Patient care Organization) Baseline (%)	12 month follow up (%)	Change (%)
Alcohol	13.18	57.27	44.09
Blood Pressure	66.82	75.00	8.18
Colorectal Screening	45.05	72.73	27.67
CV Risk	6.54	50.50	43.95
Diabetes Screening	78.68	68.25	-10.42
Exercise	10.00	54.09	44.09
Influenza	2.73	44.54	41.82
Height and Weight	40.00	60.91	20.91
Lipids	73.83	69.31	-4.52
Mammogram	59.57	76.60	17.02
Pap Smear	66.41	73.11	6.70
Tobacco	37.73	64.55	26.82
DFM Overall Scores all Maneuvers Combined	37.29	61.93	24.64
Alberta Experience for Comparison – Overall Scores, all Maneuvers Combined	49.39	63.73	14.34

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 formulate an action plan to move the clinic forward. Phase 1 focuses on engaged leadership, capacity for improvement and panel and continuity. Phase 2 focuses on team based care, evidence based care, patient-centered interactions, enhanced access and care coordination. In 2017 all 4 clinics completed the second assessment, reviewed the results with their clinic teams, identified gaps and created an action plan that would inform their improvement work over the next year.

Methodology is a self-reflective exercise followed by a facilitated discussion which ultimately brings the team to consensus on a group score for each question. Scores are out of 12 with 12 being the highest level and closest to the PCHM target. All four clinics were in the Level B range of "Medical Homeness" which speaks to all of the hard work they have put in over the past few years. The exercise did highlight areas for improvement which they will continue to address.

(Survey not repeated in 2017-18)

Indicator 3C: PCNe Practice Level Patient's Medical Home Assessment (*Scores /12; where 1 is the lowest score and 12 the highest possible score)*								
PCN-E Assessment Score – Phase 1	**Royal Alex**		**Grey Nuns**		**Misericordia**		**NECHC**	
		2015-16		2015-16		2015-16		2015-16
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-	**Royal Alex**		**Grey Nuns**		**Misericordia**		**NECHC**	
		2016-17		2016-17		2016-17		2016-17
Team Based Care /12		6.6		10		8.4		8.2
Organized Evidence Based Care /12		5.4		7.8		6		6
Patient-Centered Interactions /12		7.3		7		5.8		7
Enhanced Access /12		7.7		9.2		8		8.75
Care Coordination /12		8.8		9.4		7.5		8
Overall Consensus Score		7.16 Level B		8.6 Level B		7.14 Level B		7.59 Level B

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.**	**2016-17**	**2017-18**
Indicator 1: Number of provincial, national and international committees or working groups affecting policy attended by faculty or senior staff.	No data	No data
S4-Objective 4: **Educate and support in Quality and Safety in primary Care**	**2016-17**	**2017-18**
Indicator 1: Number of large group sessions or sessions to clinics	0	3
Number sessions for learners	4	4

Appendix 1a

Faculty Members on Research Funding Organizations

1. Allan GM
    a. Co-Chair, Towards Optimized Practice ASAP Committee
    b. Member, Towards Optimized Practice Patients Communicated with Teams (PaCT) Committee
    c. Director, Programs and Practice Support, The College of Family Physicians of Canada (CFPC)
    d. Editorial Board, *Canadian Family Physician*
2. Babenko O
    a. Reviewer, Annual Scientific Assembly, Alberta College of Family Physicians
    b. Reviewer, CFPC Outstanding Family Medicine Research Article, DoFM
    c. Reviewer, North American Primary Care Research Group Annual Meeting
    d. Reviewer, Canadian Conference on Medical Education
3. Bell N
    a. Member, The eHeatlh Committee, Canadian Task Force for Preventative Health
    b. Member, Screening for Abdominal Aortic Aneurysm Working Group, Canadian Task Force for Preventative Health
    c. Member, Knowledge and Exchange Working Group, Canadian Task Force for Preventative Health
4. Brenneis F
    a. Member, Physician Resource Planning Committee, Government of Alberta
5. Campbell-Scherer D
    a. Grant Reviewer, PRIHS Mock Panel, Alberta Innovates
    b. Grant Reviewer, Fondazione Cassa di Risparmio di Padova e Rovigo
    c. Editorial Board, *Evidence-Based Medicine, British Medical Journal*
6. Cave AJ
    a. Chair, Pediatric Asthma Pathway Committee, Alberta Health Services
    b. Member, Board of Directors, M.S.I. Foundation
    c. Grant Reviewer, Lung Association
    d. Grant Reviewer, M.S.I. Foundation
    e. Grant Reviewer, Respiratory Panel, CIHR
7. Chan K
    a. Member, Home Living Capacity Mentoring Team, Alberta Health Services
    b. Member, Supportive Living Capacity Mentoring Team, Alberta Health Services
    c. Member, Alberta Dementia Strategy: Primary Health Care Working Group
    d. Member, Edmonton Zone Home Living Geriatric Consult Team Evaluation Committee
8. Charles L
    a. Member, Regional Specialized Geriatrics Program
    b. Co-Chair, Regional Transitions Working Group
    c. Member, Biomedical Ethics Committee
    d. Member, Edmonton Zone Decision-Making Capacity Assessment Advisory Committee, Alberta Health Services
9. Chmelicek J
    a. Member, CFPC Awards, CFPC
    b. Chair, Post Graduate Directors, CFPC
    c. Co-Chair, ACFP Opioids Task Force, CFPC
    d. Co-Chair, Presidential Diad, CFPC
    e. Advisor, Governance Review Committee, CFPC
    f. Accreditation Committee Member, University of Saskatchewan
    g. Grant Reviewer, Janus Continuing Professional Development Grants, CFPC
10. De Freitas T
    a. Member, Search & Select Committee for Clinic Director, Glen Sather Sports Medicine
11. Dobbs B
    a. Co-Chair, Community of Practice on Alternate Transportation for Seniors
    b. Reviewer, Annual Scientific Assembly – What's Up Doc?, ACFP

c. Member, Stroke Prevention in Elderly Patients with AF, Pfizer
d. Member, Age Friendly Edmonton Transportation Working Group
e. Member, Alternative Transportation for Seniors Advisory Committee
f. Member, Seniors Age-Friendly Strategy (Transportation, City of Calgary)
g. Member, St. Albert Seniors Working Group - Transportation

12. Donoff M
    a. Co-Chair, Health Quality Council of Alberta Care Planning Project
    b. Co-Chair, Towards Optimized Practice Chronic Disease Management Project
    c. Co-Chair, Patients Collaborating with Teams (Provincial)
    d. Advisory Board, Working Group on Certification of the College of Family Physicians, CFPC
13. Garrison S
    a. Member, Action Group for Advocacy in Research, CFPC
    b. Director, Pragmatic Trials Collaboration
    c. Grant Panel Member, University Hospital Foundation Medical Research Competition
    d. Grant Reviewer, FoMD Grant Assist Program, University of Alberta
14. Green LA
    a. Member, Primary Health Care Steering Committee, Alberta Health
15. Gruneir A
    a. Member, Quality Indicator Working Group, Alberta Health Continuing Care
    b. Grant Panel Member, Operating Grant: Secondary Data Analysis, CIHR
    c. Grant Panel Member, FOMD Grants Assist Program, University of Alberta
    d. Editorial Board, *PLOS One*

16. Humphries P
    a. Member, Industry Relations Subcommittee, CFPC
    b. Member, AHS Edmonton Zone Core Resource Team for Medical Assistance in Dying
17. Keenan L
    a. Chair, Planning Committee, International Qualitative Health Research Conference
    b. Director, Community Engaged Research, Faculty of Medicine & Dentistry, University of Alberta
    c. Divisional Director, Skills Society
    d. Grant Reviewer, Oral Health Community Engagement Fund Committee
    e. Grant Reviewer, Skills Society
    f. Member, Homeward Trust Research Committee
18. Khera S
    a. Member, Organization Committee, Provincial Conference on Innovative Primary Care Models for Seniors' Health
19. Kolber MR
    a. Director, Alberta Society of Endoscopic Practice
    b. Planning Committee, Practical Evidence for Informed Practice (PEIP) Conference
    c. Chair, Endoscopy Skills Days for Practicing Endoscopists and their Teams
    d. Co-Chair, GI for GPs Conference
    e. President, Electronic Medical Procedure Reporting System (EMPRS) Inc.
    f. Associate Editor, Tools for Practice, ACFP
20. Konkin J
    a. Chair, Year Four Development Committee, University of Alberta
    b. Chair, Generalism Working Group, PGME Collaborative Governance Council
    c. Member, PGME Collaborative Governance Council
    d. Member, Research Committee, Australian College of Rural and Remote Medicine
    e. Member, Consortium of Longitudinal Integrated Clerkship
21. Koppula S
    a. Member, Communications Committee, NAPCRG
    b. Member, Planning Committee for Annual Scientific Assembly, ACFP
    c. Member, Primary Care Alliance Editorial Board
    d. Member, Alberta AIM Faculty Member

22. Korownyk C
    a. Associate Director, Alberta College of Family Physicians, Tools for Practice
    b. Member, Opioid Taskforce, ACFP
    c. Editorial Board, Tools for Practice
    d. Member, Planning Committee, Practical Evidence for Informed Practice (PEIP) Conference
23. Lebrun CM
    a. Member, Olympic and Paralympic Sports Medicine Issues Committee, ACSM
    b. Member, Team Physicians' Committee, CASEM
    c. Member, Therapeutic Use Exemption Committee, Canadian Centre for Ethics in Sports
    d. Member, Women's Issues in Sport Medicine Committee, CASEM
    e. Member, World Squash Federation Therapeutic Use Exemption Committee
    f. Editorial Board Member, *Clinical Journal of Sports Medicine*
24. Manca D
    a. Chair, Research Showcase, Annual Scientific Assembly, Alberta College of Family Physicians
    b. Grant Reviewer, Alberta Innovates
    c. Member, Diabetes Infrastructure for Surveillance, Evaluation and Research Committee, Alberta Health Services
    d. Member, EMR Working Group, CFPC
25. Moores D
    a. Co-Chair, Complaint Review Committee and Hearing Tribunal Committee, CPSA
26. Nichols D
    a. Member, International Advisory Board to the Patan Academy of Health Sciences (Nepal)
27. Parmar J
    a. Member, Alberta Health Services Provincial Seniors and Primary Health Care Initiatives Committee
    b. Member, Alberta Health Services Provincial Clinical Knowledge Working Group, CK-CM on Frailty
    c. Member, Provincial Clinical Knowledge Working Group, Provincial Dementia Strategy (ADSAP), Government of Alberta
    d. Panel Member, Canadian Medical Association National Strategy on Seniors Care
    e. Member, Core Group, Integrated Geriatric Initiative – Central Zone Expert Advisory Working Group, Dementia Strategy, Seniors' Health Strategic Clinical Network
    f. Chair, Alberta Health Services, Provincial Geriatric Assessment Form Working Group
    g. Co-Chair, Care Partner Support Working Group, Provincial ADSAP
    h. Co-Chair, EZMSA QI Grant Advisory Committee
    i. Member, Kule Institute of Advanced Study (KIAS) Grant Planning Team
    j. Member, Alberta Seniors Care Coalition (ASCC)
    k. Member, iSENIORS Research Unit Advisory Committee
28. Ross S
    a. Member, Review Committee for Chair of Pharmacology
    b. External Reviewer, Kathryn Kodwitz, MSc, University of Toronto
    c. Member, Triple C Evaluation Advisory Group, CFPC
    d. Advisory Board, Secretary for the Board of Directors and Executive of the Canadian Association for Medical Education (CAME)
    e. Member, Certification Process and Assessment Committee, CFPC
29. Salvalaggio G
    a. Advisory Board, Alberta Addicts Who Educate and Advocate Responsibly (AAWEAR)
    b. Member, Health Research Ethics Board (Health Panel), University of Alberta
    c. Member, Participatory Research in Primary Care Working Group, NAPCRG
30. Schipper S
    a. Honorary Secretary Treasurer, Finance and Audit Committee, CFPC
    b. Member, Committee on Rural, Remote & Regional Initiatives
31. Triscott J
    a. Grant Panel, HSE Research Awards on Ageing, Dublin Ireland
    b. Member, Advisory Committee on Senior Care, ACFP

c. Member, Challenging Behaviors, Developing an Alberta Action Plan, Institute of Continuing Care Education and Research
d. Reviewer, Fellowship Awards, CFPC
e. Member, Planning Committee for Geriatric Medicine Conference
f. Member, Working Group for Care of the Elderly, ACFP

Appendix 1b

Faculty Members on National, International and Education Committees

1. Allan GM
    a. Director, Programs and Practice Support, The College of Family Physicians of Canada (CFPC)
2. Bell N
    a. Member, Clinical Prevention Leader Network Training Program, Canadian Task Force for Preventive Health
    b. Member, Knowledge and Exchange Working Group, Canadian Task Force for Preventive Health
    c. Member, The eHealth Committee, Canadian Task Force for Preventive Health
3. Campbell-Scherer DL
    a. Member, Steering Committee, Canadian Obesity Guidelines
4. Cave AJ
    a. Member, TOP Committee for Deriving New Guidelines for Asthma Management
5. Charles L
    a. Member, CFPC Working Group on the Assessment of Competence in Care of the Elderly
    b. Member, Health Care of the Elderly National Committee
6. Chmelicek J
    a. Chair, SaSK Accreditation Survey, CFPC
    b. Chair, Continuing Professional Development Committee, CFPC
    c. Co-Chair, ACFP Opioids Task Force, CFPC
    d. Co-Chair, Taskforce on Transition out of Practice, CFPC
    e. Member, Family Medicine Specialty, CFPC
    f. Member, MAINPRO + Working Group, CFPC
    g. Member, NCCPD Sub-Committee on CPD Credit, CFPC
    h. Member, Post Graduate Education Committee, CFPC
    i. Co-Developer, Red Book, CFPC
7. De Freitas
    a. Director, Joint Injection Workshop
    b. Coordinator, CASEM Exam
8. Garrison S
    a. Member, Action Group for Advocacy in Research, CFPC
    b. Director, Pragmatic Trials Collaboration
9. Gruneir A
    a. Member, Health Quality Ontario Long-Term Care Public Reporting Delphi Panel
    b. Member, Health Services Working Group, Canadian Longitudinal Study of Aging
    c. Member, Health System Planning and Evaluation Research Program, Institute for Clinical Evaluative Sciences
10. Humphries P
    a. Member, CBAS Committee: Research, Assessment and National and International Translational Team
11. Keenan L
    a. Advisory Board, 5Ast-MD – Improving Obesity Management Training in Family Medicine
    b. Member, Canadian Medical Education Research Committee
12. Konkin J
    a. Member, Distributed Medical Education Group, The Association of Faculties of Medicine of Canada (AFMC)
    b. Member, International Advisory Panel, Patan Academy of Health Sciences
13. Koppula S
    a. Member, Section of Teachers, CFPC
    b. Member, National Working Group on Faculty Development, CFPC
    c. Member, Scientific Planning Committee, Canadian Conference on Medical Education

14. Korownyk C
    a. Member, Steering Committee for Canadian Association of Gastroenterology Clinical Practice Guidelines on the Management of Irritable Bowel Syndrome
15. Lebrun C
    a. Member, Education Committee, American College of Sports Medicine (ACSM)
    b. Member, Faculty/Planning Committee, Advanced Team Physician Course Conference
    c. Member, Fellowship Director's Committee, Canadian Academy of Sport and Exercise Medicine (CASEM)
    d. Member, Continuing Professional Development Committee, CASEM
16. Lee A
    a. Member, Family Medicine Undergraduate Peer Consultive Review Committee, CFPC
17. Manca D
    a. Member, Chronic Disease Primary Prevention Research Initiative Think Tank
    b. Member, QI Bootcamp Workgroup, CFPC
    c. Member, PII – Practice Improvement Initiative, CFPC
18. Nichols
    a. Chair, David Cook Nepal Medical Education Fund
    b. Member, International Advisory Board to the Patan Academy of Health Sciences (Nepal)
19. Ross S
    a. Module Reviewer, Medical Council of Canada
    b. Module Reviewer, McMaster Modules
    c. Member, Program Evaluation Advisory Group, CFPC
    d. Member, Preparation for Research Education/Excitement/Enhancement/Engagement on Practice (PRE^{E}P) Action Group, CFPC
    e. Reviewer, Review Committee for Education Innovation Symposium Submissions, CCME
    f. Member, Scholars United, CFPC
20. Schipper S
    a. Director, Annual Forum, CFPC
    b. Advisory Group, Universities of St. Andrews and Alberta's Joint Medical Training Program