DEPARTMENT OF FAMILY MEDICINE ACCOUNTABILITY REPORT

2010/2011 & 2011/2012

UNIVERSITY OF ALBERTA
FACULTY OF MEDICINE & DENTISTRY
Department of Family Medicine

DEPARTMENT OF FAMILY MEDICINE ACCOUNTABILITY REPORT

2010/2011 & 2011/2012

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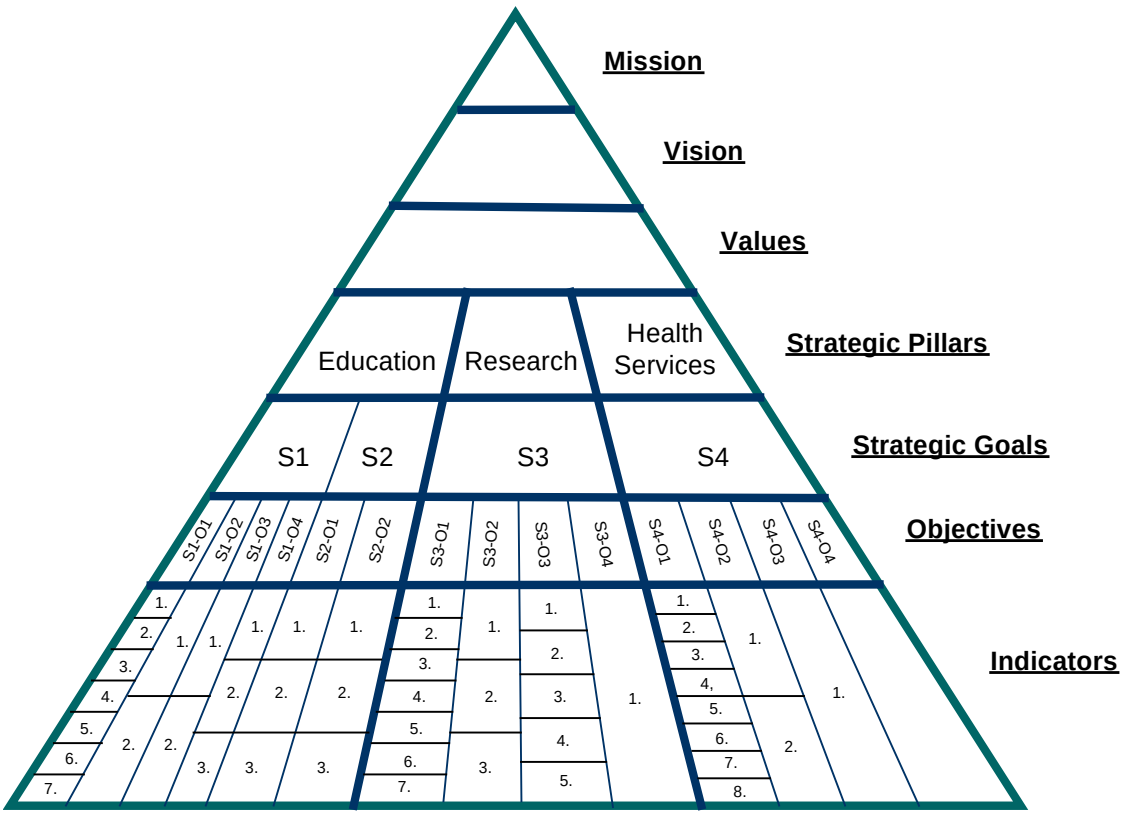
1.0 INTRODUCTION

This Accountability Report covers two years of academic activity in the Department of Family Medicine for the periods July 1st to June 30th each year. Academic activity within the department is measured using a ***balanced scorecard*** strategic management framework.



The department recently reviewed and revised the goals and objectives of its strategic plan to ensure alignment with its vision and mission. The revised AARP goals and objectives will guide the department as it develops a leadership role in primary care, education and research.

The following four strategic goals were identified:

- Place learners in family medicine centered experiences with high caliber teachers.
- Make family medicine an appealing career choice for medical students.
- Conduct innovative family medicine and medical education research.
- Provide safe and effective healthcare.

Our Vision:

We will excel at providing modern, innovative family medicine education, primary health care research and health information management. Our department and its graduates will be effective agents of primary health care changes in Alberta.

Our Mission:

To educate medical students in the principles of primary care and the discipline of family medicine, to prepare future family doctors to provide comprehensive health care, to contribute to family medicine research and literature and to develop and implement innovations to improve primary care services for the benefit of our communities.

2.0 EDUCATION PROGRAM

Strategic Goal # 1 (S1) – *Place learners in family medicine centered experiences with high caliber teachers.*

Four objectives and 14 indicators have been defined for this goal.

The first objective relates to the department's ability to provide comprehensive family medicine education through the **Triple C Competency-based Curriculum**, which has four components: (i) competency-based, (ii) "continuity" in both education and patient care, (iii) "comprehensive" education and patient care, and (iv) to ensure our training program is "centered" in family medicine.

Two distinct streams are required to evaluate continuity from the resident's perspective: **clinical continuity** focuses on the resident's ability to develop a panel of patients they become familiar with and feel responsible for over time, and **educational continuity** focuses on the resident's assignment to the same preceptor / advisor / supervisor for the majority of their clinical days. Focusing on educational continuity by ensuring the resident spends most of their clinical time with their primary preceptor leads to increased clinical continuity.

Table 1: Resident Continuity

S1-Objective 1: **Provide a Triple C competency based curriculum (competency based, *continuity, comprehensive, centered in family medicine)***		**2010 - 11**	**2011 - 12**	**Target**
Indicator 1: Percentage of residents achieving target continuity with patient panels [(1)(2)]				
i.	Total visits by residents / 12 months		17,630	
ii.	Patients with visits to same resident twice over 12 month period		57%	50%
iii.	Patients with visits to same resident three times over 12 month period		39%	
iv.	Patients with visits to same resident four times over 12 month period		30%	
v.	Patients with visits to same resident five times over 12 month period		22%	
vi.	Patients with visits to same resident six times over 12 month period		11%	
Indicator 2: Percentage of clinical half days spent with primary preceptor supervision		81%	85%	85%

[(1)] 2010-2011 data not available. Targets for panel continuity are not well defined. We hope that at least 50% of all resident visits are repeat visits indicating the ability to follow up with patients. Everything over two visits is a good indication of the resident developing a panel of patients who identify that resident as their provider.
[(2)] Data shown is from the four larger teaching sites; rural and community data not included.

Much of the essential and critical learning for residents occurs in family medicine clinic settings where assessment of learners is shifting from a sole focus on medical knowledge to a focus on competence across multiple domains, including professionalism, communication skills and patient-centered care. To ensure comprehensiveness, learners are evaluated across a core group of essential skills and behaviors referred to as *Sentinel Habits and Clinical Domains*. A formative evaluation process consisting of direct observation and documentation of events and feedback is used, along with a summative report every four months to track a resident's progress to competence.

Results are collected by means of a Competency Based Assessment System (CBAS) pioneered by the department. An on-line version, e-CBAS, was piloted in 2010 and has since been implemented. e-CBAS is being adapted for use by the College of Physicians and Surgeons of Alberta (CPSA) and is being considered by other departments and universities.

Table 2: Triple C Curriculum

S1-Objective 1: **Provide a Triple C based curriculum (*continuity, comprehensive, centered in family medicine)***	**2010 - 11**	**2011 - 12**	**Target**
Indicator 3: Percentage of residents achieving FieldNote targets[(1)]		25%	100%
Indicator 4: Total number of FieldNotes created over 12 month period[(2)]	5028	4728	5152
Indicator 5: Percentage of residents achieving a pass in the **CCFP** exam first time	91%	91%	100%
Indicator 6: Percentage of resident rotations with inner-city populations*(/26 blocks)*	4%	4%	
Indicator 7: Number of weeks of rotational experiences that occur in family medicine environments	41%	46%	

[(1)]The process of documenting observations and feedback on the electronic system is fairly new and required a substantial amount of change management. The FieldNote target per resident was 44. The range was from 0-122 per resident.

[(2)]Total number of FieldNotes for 2010-2011 was higher because the total included pilot data from previous year that was not archived. 2011-2012 was strictly one year's data.

S1, Objective 2, represents the opportunities for graduate licensed physicians to obtain skills beyond the basic family medicine education objectives. Advanced skills, which can be integrated into general practice, are representative of a community need or a personal interest and fall into one of the following three categories: **nationally accredited programs** such as family practice anesthesia, palliative care, care of the elderly and emergency medicine; **regional programs** such as obstetrical surgical skills, occupational health, sports medicine and women's health; and **custom requests** such as a resident wanting additional obstetrical skills for the purpose of working in an underserved community.

Table 3: Enhanced Skills

S1-Objective 2: **Provide opportunities for family medicine graduates to develop enhanced skills in response to community need**	**2010 - 11**	**2011 - 12**	**Target**
Indicator 1: Application and enrollment in advanced skills program.	70	77	
Indicator 2: Successful completion of advanced skills program.	12/12	11/12	12

S1, Objectives 3 and 4, relate to the Department's commitment to ensuring all faculty and staff have the skills and knowledge required in the continuously evolving environments of teaching, research, and administration.

Table 4: Knowledge Translation and Faculty Development

S1-Objective 3: **Foster knowledge translation of best practice and innovation in family medicine education**	**2011** [(1)]		
Indicator 1: Number of faculty presenting education workshops and presentations	29		
Indicator 2: Number of teaching faculty on national and international education committees	22		
S1-Objective 4: **Provide educators with the opportunity to develop skills to keep up with evolving curriculum**	**2010 - 11**	**2011 - 12**	**Target**
Indicator 1: Number of Faculty development sessions held	19	12	
Indicator 2: Number of participants in Faculty Development sessions	110	82	
Indicator 3: Number of faculty involved in producing education support documentation or products		21	

[(1)] *Metrics from Annual report data, therefore based on calendar year 2011*

Strategic Goal # 2 (S2) – *Make family medicine an appealing career choice for medical students.*

Two objectives and six indicators have been identified for this goal.

Adequate exposure to the discipline of family medicine and excellent family medicine rotational experiences in medical school increase the medical student's level of interest in family medicine as a career. In recent years, family medicine physicians have had expanded roles in teaching core courses in first and second year medical school and have been increasingly integrated as advisors or coordinators of the clerkship years.

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.**	**2010 - 11**	**2011 - 12**	**Target**
Indicator 1: Number of students matching to University of Alberta Family Medicine after Round 1 ***CaRMS***	25	29	
Indicator 2: Number of student evaluations of the ***community-based experience*** rated as good to excellent	93%	92%	
Indicator 3: Mean overall rating of the ***Family Medicine Clerkship*** program from the graduation survey as compared to the national average	4.4	4.3	4.0 National Average
S2-Objective 2: **Increase exposure of University of Alberta's medical students to modern, progressive family medicine**	**2010 - 11**	**2011 - 12**	**Target**
Indicator 1: Number of weeks of ***family medicine electives*** year 3 and 4 provided by Department of Family Medicine faculty and preceptors	179	197	
Indicator 2: Number of hours spent teaching undergrad courses by Department of Family Medicine faculty or preceptors	645.5	675.5	
Indicator 3: Number of hours spent coordinating undergrad courses by Department of Family Medicine faculty or preceptors	147	175	

3.0 RESEARCH PROGRAM

Strategic Goal # 3 (S3) – *Conduct innovative family medicine and medical education research.*

Four objectives and 17 indicators have been identified for the Research Program. Since most of the research program's data is captured from the Faculty of Medicine & Dentistry's calendar year annual reports rather than the academic year, the research program data in this report is based on the 2011 calendar year and corresponds with the Faculty's annual reports.

The Research Program is becoming a leader in primary care and medical education research. The program hosts the Capital Health Chair in Primary Care Research, as well as the Chair in Health Informatics Research. In 2013, a primary care research network will be established as a province-wide, practice-based shared laboratory.

The Education Support Program (ESP) continues to develop and evaluate an innovative competency-based assessment framework to assess residents in their clinical environments. The tool and framework have been adopted by the College of Physicians and Surgeons of Alberta to assess Family Practice physician candidates applying to Alberta.

Critical appraisal is an essential skill for all family physicians. The department's research curriculum encourages development of critical thinking through its requirement that residents prepare and present Practice Quality Improvement Projects (PQIs) and through completion of several Brief Evidence-Based Assessments of Research (BEARs).

The department's two research centres, the Medically At-Risk Driver Centre and the Centre for the Cross-Cultural Study of Health and Healing, continue to conduct research related to the medically at risk driver and to cultural issues in healthcare.

Table 6: Research Activity (Grants & Publications)

S3-Objective 1: **Conduct research to improve primary care and medical education**	**2011**
Indicator 1: Number of new research grants awarded	16
Indicator 2: Total new grand funding awarded *(dollars)*	$595,247.63
Indicator 3: Number of grants in progress (*cumulative)*	53
Indicator 4: Total grant funding in progress (*dollars)*	$2,247,616.71
Indicator 5: Number of peer reviewed publications	58
Indicator 6: Number of non-peer reviewed publications	24
Indicator 7: Number of books and chapters	6

The knowledge acquired through research and scholarly activity is disseminated through papers, books, manuals, posters and oral presentations. Department members cover a broad range of topics. Of the presentation data recorded in Table 7, 11 were workshops and six were Plenary or Keynote addresses made at major conferences.

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**	**2011**
Indicator 1: Number of presentations to policy makers, health professionals, stakeholders	
i. Oral Presentations	103
ii. Poster Presentations	91
Indicator 2: Number of peer reviewed presentations	143
Indicator 3: Number of knowledge translation products, tools, manuals produced	10
S3-Objective 3: **Expand research expertise**	**2011**
Indicator 1: Percentage of research projects with linkages to other disciplines, locally, regionally, nationally and internationally.	61
Indicator 2: Number of **new degrees**, certificates and diplomas obtained by faculty	2
Indicator 3: Number of research summer students *(person months)*	35 months
Indicator 4: Number of faculty who supervise fellows, graduate students, and independent study students	9
Indicator 5: Number of grad students, (*Masters, PhD, fellows, post doctoral and independent study students)*	10
S3-Objective 4: **Influence the health research agenda in Canada**	
Indicator 1: Number of positions on research funding organization committees, ethics, review and advisory boards	See Appendix A

4.0 HEALTH SERVICES PROGRAM

Strategic Goal # 4 (S4) - *Provide safe and effective healthcare.*

Three objectives and 11 indicators have been identified for the Health Services Program.

Performance of any service industry can be measured by client wait-time for service. The Department of Family Medicine measures two types of delay at the four department managed sites: delay **for** an appointment and delay **at** the appointment. Delay **for** an appointment is measured using the indicator "time to **third next available**" (TNA). While appointments may be available sooner, choosing the third eliminates much of the variation resulting from anomalies in the scheduler, i.e., late cancellations. Delay **at** the appointment is measured by the indicator **Cycle time**, the complete amount of time a client spends in the clinic from check in to check out, and **Red Zone time**, a subset of cycle time showing how much of the cycle time was spent with a provider. Due to the nature of teaching practices, **cycle time and red zone time** should not be compared to non-teaching primary care clinics in the community.

Table 8: Academic Teaching Site Delay Indicators

S4-Objective 1: **Improve access to healthcare**	**2010 - 11**	**2011 - 12**	**Target**
Indicator 1: Average time to 3rd next available appointment (days)			
Clinic A	9.6	6	5
Clinic B	4.6	4.5	5
Clinic C	4.8	7.9	5
Clinic D	No data	6.2	5
Indicator 2: Average cycle time of appointments (*minutes from check in to check out)*			
Clinic A	No Data	60	35
Clinic B	No Data	54	35
Clinic C	No Data	60	35
Clinic D	No Data	48	35
Indicator 3: Average red zone time *(time spent with provider, in minutes)*			
Clinic A	No data	26	20
Clinic B	No data	31	20
Clinic C	No data	26	20
Clinic D		32	20

The department's four academic teaching sites have participated in Access Improvement Measures (AIM), a made-in-Alberta improvement framework and methodology. Continuity of patient care is one of the key principles of AIM; research shows that when patients consistently see the same care provider, care is better, outcomes are better, and satisfaction is higher for the care provider and the patient.

Attention to continuity requires close attention to physician panels or the list of patients who have identified a certain clinician as their primary care provider and for whom that clinician is responsible. In an academic teaching practice, an ideal panel size allows for both a good learning experience for residents and the best possible access to care for patients. We define active patients as those who have had an appointment at the clinic in the past three years, excluding deceased patients and patients who have moved.

Utilizing allied team members and finding innovative ways to deliver care other than "whites of the eyes," contributes to a reduction in the "**average return rate**" which, consequently, enables clinics to take on new patients.

Table 9: Academic Teaching Site Activity

S4-Objective 1: **Improve access to healthcare - continued**	**2010 - 11**	**2011 - 12**	**Target**
Indicator 4: Continuity rate of provider panel (percentage of patients seeing own provider)			
Clinic A	83	83	75
Clinic B	73	66	75
Clinic C	72	84	75
Clinic D	No data	83	75
Indicator 5: Number of new patients accepted to practice			
Clinic A	189	228	
Clinic B	340	220	
Clinic C	No data	No data	
Clinic D *(working on building panels for new physicians)*	No data	1863	
Indicator 6: Average return visit rate / 12 month period			
Clinic A	3.5	3.5	
Clinic B	4.2	4.2	
Clinic C	No Data	3.5	
Clinic D	No Data	4	

Table 9 Continued			
Indicator 7: Panel size – patients seen in the past 3 years	**2010 - 11**	**2011 - 12**	**Target**
Clinic A	No data	5377	
Clinic B	3694	4034	
Clinic C	No data	4693	
Clinic D	No data	3484	
Indicator 8: Utilization of Primary Care Network allied health service professionals and programs (number of events)			
Clinic A	1155	334	
Clinic B	472	944	
Clinic C	289	680	
Clinic D	0	0	

The process of quality assessment and improvement in clinical practices are priorities of the Department of Family Medicine. It is critical that residents have the opportunity to develop the skills necessary to evaluate their own practices upon graduation.

Table 10: Academic Teaching Site Practice Quality Improvement

S4-Objective 2: **Foster best practice and innovations in primary care**	**2010 - 11**	**2011 - 12**	**Target**
Indicator 1: Number of practice quality improvement initiatives in academic teaching clinics.			
Clinic A	20	12	
Clinic B	24	19	
Clinic C	21	16	
Clinic D	No data	13	

An integral part of improving clinical practice is ensuring clinicians have access to all the tools required to perform their work, including a qualified service provider Electronic Medical Record (EMR). Two of the department's academic clinics are long-standing users of EMRs, and they have implemented a module within the EMR to help clinicians and their teams automate, track, remind and create care plans for patients' health screening and chronic disease monitoring

maneuvers. The remaining two academic clinics are relatively new EMR users and are in the early stages of using the module.

Table 11 indicates population health screening completion rates for patients who have had an appointment in the past 18 months and who meet the criteria set for each health screening maneuver.

Table 11: Academic Teaching Site Health Screening Completion Rates

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(1)**	**Clinic D(1)**
Mammogram	72%	89%	60%	41%
Pap Smear	81%	54%	63%	37%
Blood Pressure	89%	99%	81%	69%
Fasting Glucose	87%	99%	74%	59%
LDL (Cholesterol) Female	90%	86%	75%	63%
LDL (Cholesterol) Male	99%	87%	77%	67%
Bone Densitometry	57%	49%	24%	18%
Stool for Occult Blood	38%	25%	22%	25%

(1)Fairly new adoption of the health screening module in the Electronic Medical Record

Alberta is becoming a leader in primary care reform. The Department of Family Medicine encourages faculty and senior support staff to participate in health care renewal initiatives that will result in better health care for all Albertans.

Table 12: Leadership and Advocacy In Healthcare

S4-Objective 3: **Demonstrate leadership and advocacy in healthcare delivery policy**	**2010 - 11**	**2011 - 12**	**Target**
Indicator 1: Number of provincial, national and international committees or working groups affecting policy attended by faculty or senior support staff.		31	

5.0 Glossary of Terms

Average return rate – the average number of visits per patient per year to a clinic. Number is determined by taking the total number of visits and dividing by the total number of unique patients coming in for a given year.

Can-MEDS – a framework for medical education that sets clear and high standards for essential competencies expected of physicians in Canada.

Can-Meds FMU – Can-Meds from a family medicine perspective, a specific set of undergrad family medicine competencies.

CaRMS – *the Canadian Resident Matching Service,* a not-for-profit organization that works in close cooperation with the medical education community, medical schools and residents/students, to provide an electronic application service and a computer match for entry into postgraduate medical training throughout Canada.

CCFP Canadian College of Family Physicians exam – the certification examination in family medicine.

Community based experience – mandatory 1st year course in medical school where each medical student attends a community family medicine clinic for nine half-days over the year where they observe and practice interviewing and examination skills with patients with their family medicine preceptor.

Continuity Rates – percentage of patients seeing their primary care provider. Determined by the number of patients of a panel coming in for a given month dived into the number who saw their primary care provider.

Department Managed Sites – Grey Nuns Family Medicine Centre; Misericordia Family Medicine Centre; Family Health Clinic, Northeast Community Health Centre; and the Royal Alexandra Family Medicine Centre.

Enhanced Skills - *program* in which licensed physicians can obtain additional skills beyond the basic family medicine curriculum.

Family Medicine Clerkship Program – mandatory core clinical rotation in 3rd year of medical school (Clerkship year) where medical students learn to manage family medicine patients while spending 4 weeks in an urban Edmonton family medicine clinic and 4 weeks in a rural Alberta family medicine clinic. There is also a mandatory academic curriculum that is concurrent to the clinical experience.

Family Medicine Electives – medical students choose to spend 2-4 weeks in a family medicine clinic for a clinical elective rotation between the end of 2nd year of medical school and graduation after 4th year.

FieldNotes – documentation of an observed event and feedback given. FieldNotes for each core competency and clinical domain are required for all residents. An electronic workbook is used to create, store and sort the FieldNotes for assessment purposes.

3rd Next available appointment – a measure of office system performance. It is a count of the 3rd next available schedule slot for a provider. We use the third as the first 2 may be defects – cancellations. By the 3rd we generally see openness in the schedule.

Peer reviewed –the evaluation of creative work or performance by other people in the same field in order to maintain or enhance the quality of the work or performance in that field.

Non-peer reviewed – work or performance not reviewed by ones peers.

Primary preceptor – resident's assigned advisor primarily responsible for the educational experience and assessment of that resident.

Provider panel – population of patients assigned to a specific provider. The provider takes responsibility over this group and they are identified as his / her panel or roster of patients.

Residents – postgraduate medical students.

Sentinel Habits – high level core competencies that should guide learning and assessment over the duration of a residency program and beyond.

Triple C Curriculum – the goal of Triple C is to ensure that every family physician training program in Canada develops graduates who are: competent to provide comprehensive care, prepared for the evolving needs of society, and taught the best available evidence on patient care and medical education. Components of Triple C curriculum – comprehensive, continuity and centered in family medicine.

Appendix A

Faculty with positions on research funding organization committees, ethics, review and advisory boards.

Research funding organizations, committees, ethics, review (journal, grant, abstracts) and advisory boards	# of faculty
Associate Editor, Canadian Medical Education Journal	1
Associate Editor, Evidence-Based Medicine	1
Board Member, Canadian Primary Care Sentinel Surveillance Network (CPCSSN)	1
Book Reviewer, University of Alberta Press	1
Book Reviewer, University of Toronto Press.	1
Chair, Knowledge Synthesis Grant Committee, Canadian Institutes of Health Research.	1
Co-Chair, The National Practice Facilitation Workshop, the BETTER project	1
Co-Director, Centre for the Cross-Cultural Study of Health and Healing	1
Committee Member, Collaborative Health Innovation Network (CHIN), Advisory Committee (Alberta Innovates)	1
Committee Member, Practice Based Research Network Conference steering committee – North American Primary Care Research Group.	1
Consultant, US Task Force on Competence Evaluation, American Academy of Family Physicians	1
Developer, The Competency-Based Achievement System (Copyright Nov 29, 2011)	2
Director, Evidence & Continuing Professional Development Program, Alberta College of Family Physicians	1
Editor, Department of Family Medicine Research Report	1
Editor, Tools for Practice Canadian Family Physician,	1
Grant Reviewer, MSI Foundation.	1
Member and Research Advisor, Homeward trust research committee.	1
Member, Alberta Asthma Working Group, Alberta Health Services.	1
Member, Board of Directors, College of Family Physicians of Canada (2009 – 2012)	1
Member, Board of Directors, Research and Education Foundation. College of Family Physicians of Canada	1
Member, Canadian Expert Drug Advisory Committee, Canadian Agency for Drugs and Technology in Health (CADTH)	1
Member, Canadian Task Force on Preventive Health Care.	1
Member, Consortium of Longitudinal Integrated Clerkships.	1
Member, Editorial Board, Evidence-Based Medicine.	1
Member, Executive Committee, Alberta College of Family Physicians.	1
Member, Guideline Development Group, (Primary Care Headache Assessment and Management Guideline), The Alberta Ambassador Program, Institute of Health Economics	1
Member, International Advisory Editorial Board, British Journal of General Practice.	1
Member, International Research Committee, International Primary Care Research Group.	1
Member, Fellowship Directors' Committee, Canadian Academy of Sport and Exercise Medicine	1
Member, National family medicine research directors group, Canadian College of Family Physicians.	1
Member, National Working Group on Faculty Development, College of Family Physicians of Canada.	1
Member, Olympic and Paralympics Sports Medicine Committee, American College of Sports Medicine	1
Member, Task Force on United Sates Anti-Doping Agency, American College of Sports Medicine	1
Member, Team Physician Education Committee, Canadian Academy of Sport and Exercise Medicine	1
Member, Towards Optimized Practice Headache Guidelines Working Group, Alberta Medical Association Towards Optimized Practice (TOPS)	1
Member, Women's Issues in Sport Medicine, Canadian Academy of Sport and Exercise Medicine	1
NAPCRG Representative to CONCERT (COPD Outcomes Based Network for Clinical Effectiveness and Research Translation) Group to advise the AHRQ (Agency for Healthcare Research and Quality)	1

Appendix A Continued

- President, Alberta College of Family Physicians (Feb 2010 – Feb 2012) 1
- Research Consultant, Physician Learning Program and Division of Continuous Professional Learning, University of Alberta 1
- Research Director, Family Physicians Airways Group of Canada 1
- Reviewer for Type 2 Diabetes Screening Guidelines, The College of Family Physicians of Canada. . . . 1
- Reviewer, Aboriginal Peoples' Health, Canadian Institutes for Health Research. 1
- Reviewer, Advances in Health Sciences Education. 1
- Reviewer, AFPRN Research Presentations, Annual Scientific Assembly, Alberta College of Family Physicians 1
- Reviewer, Annals of Family Medicine. 1
- Reviewer, Association for Medical Education – Europe. 1
- Reviewer, British Journal of General Practice. 2
- Reviewer, British Medical Journal 1
- Reviewer, Canadian Association for Medical Education 1
- Reviewer, Canadian Family Physician. 5
- Reviewer, Canadian Journal of Medical Education. 1
- Reviewer, Canadian Journal of Rural Medicine. 2
- Reviewer, Canadian Medical Association Journal. 2
- Reviewer, College of Family Physicians of Canada – Janus Research Grants 3
- Reviewer, Edmonton Inner City Health Research and Education Network Research Day 1
- Reviewer, Faculty of Medicine & Dentistry CIHR Internal Review Program 1
- Reviewer, Family Medicine Forum - College of Family Physicians of Canada 2
- Reviewer, Healthcare Policy 1
- Reviewer, Journal of Applied Gerontology 1
- Reviewer, Journal of Chronic Obstructive Pulmonary Disease. 1
- Reviewer, Journal of Primary Care and Community Health. 1
- Reviewer, Journal of the American Board of Family Practice. 1
- Reviewer, Journal of the American Medical Association. 1
- Reviewer, Journal of the Board of Family Medicine 1
- Reviewer, Medical Care. 1
- Reviewer, Medical Education 1
- Reviewer, Medicine & Science in Sports & Exercise 1
- Reviewer, National CPD fund, Association of Faculties of Medicine of Canada 1
- Reviewer, National Family Medicine Clerkship Multiple Choice Question Bank, College of Family Physicians of Canada. 1
- Reviewer, National Family Medicine Clerkship Rotation Clinical Presentation Objectives, College of Family Physicians of Canada. 1
- Reviewer, North American Primary Care Research Group Conference 2
- Reviewer, Online Virtual Patient Series, College of Family Physicians of Canada 1
- Reviewer, PLoS Medicine. 2
- Reviewer, Primary Care Respiratory Journal 1
- Reviewer, Tools for Practice, The Alberta Medical Association. 1
- Treasurer, Research and Education Foundation, The College of Family Physicians of Canada 1
- Vice Chair, Board of Directors, Canadian Resident Matches Service (CaRMS) 1

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