WE ARE
THE AMA

2015–16
Reports to the
Annual General Meeting

Patients First® is a registered trademark of the Alberta Medical Association.
Invite Two Patients

Help us make albertapatients.ca the most recognized online patient community in Canada.

Seeking 2 patients per physician

albertapatients.ca
2015-16 Reports to the Annual General Meeting

The 111th annual general meeting of the Alberta Medical Association will be held at 10 a.m. on Saturday, September 24, 2016, at the Hyatt Regency Calgary, Imperial Ballroom 4/6/8, 700 Centre Street SE.
AGENDA

O Canada

Call to Order

In Memoriam

President’s Valedictory  Dr. Carl W. Nohr

Minutes, 2015 Annual General Meeting

Nominating Committee Report  Dr. Richard G.R. Johnston

Elections: Speaker and Deputy Speaker, Representatives to CMA General Council 2017

Report from Representative Forum  Dr. Padraic E. Carr

• Report from the Board of Directors

Executive Director’s Report

Constitution and Bylaws Report  Dr. Edward W. Papp

Committee on Financial Audit Report/Financial Statements  Dr. T. Britt Simmons

Other Business

Next Meeting

• Saturday, September 16, 2017 – Edmonton

Adjournment

2015-16 Reports to the Annual General Meeting

The 111th annual general meeting of the Alberta Medical Association will be held at 10 a.m. on Saturday, September 24, 2016, at the Hyatt Regency Calgary, Imperial Ballroom 4/6/8, 700 Centre Street SE.
MISSION & VISION

Alberta’s physicians and the Alberta Medical Association (AMA) are committed to Patients First®.

Mission: Leadership and Support
The AMA stands as an advocate for its physician members, providing leadership and support for their role in the provision of quality health care.

Vision: Patients First®
Alberta’s physicians are committed to a health care system that facilitates wellness and delivers patient-and family-centered care:

- The provincial health care system is built around patients and families and defined by quality:
  - Acceptability
  - Accessibility
  - Appropriateness
  - Effectiveness
  - Efficiency
  - Safety

- Patients and families enjoy optimal health through access to:
  - Healthy lifestyle choices.
  - Healthy environments and opportunities.
  - Health service access based primarily on need, not ability to pay.

- The health care system has the resources to deliver patient- and family-centered care, with best evidence used to allocate resources to what is most effective and efficient in meeting health care needs.

- The relationship between physician and patient remains a cornerstone of the health care system, founded on mutual respect, dignity, compassion and trust. Care is delivered with, not to, the patient, including:
  - Patient choice of physician.
  - Physicians as agents of patients acting always in the patient’s best interests.
  - Clinical and professional autonomy of physicians.

- Providers and patients are partners with funders and managers, sharing the goal of a patient- and family-centered health care system with defined roles and responsibilities and clearly specified accountability.

Patients First® is a registered trademark of the Alberta Medical Association.
## IN MEMORIAM

*Members deceased since the last annual meeting are:*

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABLETT, David P. J.</td>
<td>Calgary</td>
</tr>
<tr>
<td>AGGARWAL, Jagan N.</td>
<td>Calgary</td>
</tr>
<tr>
<td>BARNES, Priscilla A.</td>
<td>Calgary</td>
</tr>
<tr>
<td>BORGERSEN, Kaj</td>
<td>Stony Plain</td>
</tr>
<tr>
<td>CHEUNG-LEE, Melody</td>
<td>Edmonton</td>
</tr>
<tr>
<td>CHUNG, Jeffrey F.</td>
<td>Drumheller</td>
</tr>
<tr>
<td>CLUGSTON, Timothy P.</td>
<td>Medicine Hat</td>
</tr>
<tr>
<td>FISCHER, Erwin L.</td>
<td>Edmonton</td>
</tr>
<tr>
<td>FRIEDMAN, Manuel W.</td>
<td>Edmonton</td>
</tr>
<tr>
<td>GIBBINS, Reginald R.</td>
<td>Edmonton</td>
</tr>
<tr>
<td>GOVENDER, SivalingumJ.</td>
<td>Edmonton</td>
</tr>
<tr>
<td>GRACE, Donald A.</td>
<td>Saanichton BC</td>
</tr>
<tr>
<td>GRAMLICH, Edwin N.</td>
<td>Sturgeon County</td>
</tr>
<tr>
<td>HO, David S.</td>
<td>Edmonton</td>
</tr>
<tr>
<td>KAMEL, Jean-Pierre</td>
<td>Calgary</td>
</tr>
<tr>
<td>KHARE, Umesh</td>
<td>Calgary</td>
</tr>
<tr>
<td>KRALT, Douglas G.</td>
<td>Edmonton</td>
</tr>
<tr>
<td>LYNCH, Roland F.</td>
<td>Calgary</td>
</tr>
<tr>
<td>MACADAMS, Charles L.</td>
<td>Calgary</td>
</tr>
<tr>
<td>MASON, Christine R.</td>
<td>Calgary</td>
</tr>
<tr>
<td>MCDougall, Gerald M.</td>
<td>Calgary</td>
</tr>
<tr>
<td>MENDES, Peter C.</td>
<td>Edmonton</td>
</tr>
<tr>
<td>MIX, Lawrence W.</td>
<td>Victoria BC</td>
</tr>
<tr>
<td>MORCOS, Fawzy H.</td>
<td>Edmonton</td>
</tr>
<tr>
<td>MOYER, Donald J.</td>
<td>Edmonton</td>
</tr>
<tr>
<td>POPOWICH, Jack W.</td>
<td>Edmonton</td>
</tr>
<tr>
<td>RACETTE, Paul C.</td>
<td>Medicine Hat</td>
</tr>
<tr>
<td>RODE, Melvin C.</td>
<td>Edmonton</td>
</tr>
<tr>
<td>SKELTON, David</td>
<td>Edmonton</td>
</tr>
<tr>
<td>SMITH, Suna A.</td>
<td>Camrose</td>
</tr>
<tr>
<td>VAUGHAN, William A.</td>
<td>Westlock</td>
</tr>
</tbody>
</table>
110th Annual General Meeting of the Alberta Medical Association (CMA Alberta Division) September 26, 2015

1. The 110th Annual General Meeting (AGM) of the Alberta Medical Association (CMA Alberta Division) was held on September 26, 2015 in the Ballroom of the Sutton Place Hotel, 10235 101 Street, Edmonton, Alberta.

2. O Canada was sung.

3. Call to Order
Dr. Darryl D. LaBuick presided as speaker and declared the 110th Annual General Meeting in session and duly constituted at 10 a.m.

4. Resolutions Committee
The Resolutions Committee appointed for the Representative Forum (RF) served as the Resolutions Committee for the AGM. Appointees were Dr. Fredrykka D. Rinaldi, Deputy Speaker, as chair, and RF Planning Group members Dr. Dianne E. Brox, Dr. Steven W. Chambers and Dr. Susan J. Hutchison.

5. Rules of Conduct
The speaker noted that business meetings of the association are conducted in accordance with Procedures for Meetings and Organizations (3rd edition) by Kerr & King.

6. In Memoriam
Sixty-one members passed away since the last Annual General Meeting. Dr. LaBuick read their names into the record followed by a minute of silence.

ANA ADAMACHE CALGARY
LEONARD L. ALDRIDGE CALGARY
MARGARET ALLAN ARMSTRONG HINTON
MYRON J. BABIUK EDMONTON
ARTHUR R. BAINBOROUGH LETHBRIDGE
PAMELA BARTON CALGARY
TERENCE H. BASSETT TORONTO ON
ERWIN W. BLOCK GRANDE PRAIRIE
WILLIAM BOBEY EDMONTON
STANLEY W. BOYAR PRIDDIS
ANTONIETTA D. CAFFARO EDMONTON
WILLIAM B. CARPENTER CALGARY
STEWARD C. CLARK CALGARY
MICHAEL X. COUGHLAN EDMONTON
LAWRENCE T. DIDUCH EDMONTON
VLADIMIR DZAVIK TORONTO ON
CYRIL B. FRANK CALGARY
FRANCIS G. GORE-HICKMAN LETHBRIDGE
BRIAN J. GORMAN CALGARY
LORNE R. HATCH EDMONTON
FRANK A. HERBERT EDMONTON
THEKKETHIL K. IDICULA EDMONTON
JAMES E. INGLIS HIGH LEVEL
PAUL IRWIN HAWKESVILLE ON
DAVID L. JUDGE EDMONTON
KENNETH J. JULSON CALGARY
AIDAN J. KAVANAGH EDMONTON
ALLAN KLEIN EDMONTON
WILLIAM H. LAKEY EDMONTON
BURNS J. LARSON CARDSTON
JOHN B. LEFSRUD EDMONTON
HANS S. LEWKE MILK RIVER
ANDREW N. LIN EDMONTON
JOSEPH A. MACKAY EDMONTON
LUTZ MARBURG NORTH VANCOUVER BC
JOHN T. MASON EDMONTON
ERNEST E. MCCOY VICTORIA BC
CORINNE G. MCKERNAN EDMONTON
JAMES F. MCMILLAN EDMONTON
BOHDAN MICHALYSYN EDMONTON
ARUMUGAM SIVA GANESHA NATHAN EDMONTON
ELENA M. O’CONNELL COCHRANE
JOSEPH H. PASCOE EDMONTON
SHERKAR PUTTASAWAMY BONNYVILLE
ANNE L. ROCHE EDMONTON
SHERI L. SAMUELS EDMONTON
PULIN B. SASMAL EDMONTON
JOSEPH J. SCALES EDMONTON
STAN V. SKREPNEK PALESTINE, TX
TERRY D. SOSNOWSKI SPRUCE GROVE
JAMES STANNERS FORT VERMILION
JOHN B. STILLWELL LETHBRIDGE
JOSEPH STORCER GRANDE PRAIRIE
CHARLES B. TEGGE EDMONTON
DEMITRIUS TODOSIJCZUK EDMONTON
TRUNG VU EDMONTON
DAVID J. WHARTON CALGARY
BRIAN H. WOODHEAD EDMONTON
C. MATHEW YALTHO EDMONTON
JOSE P. YAO FORT McMURRAY
SALMA YASEEN CALGARY

5
7. **President’s Valedictory**
   The outgoing president, Dr. Richard G.R. Johnston, reflected on his term as president and on its challenges and accomplishments. He thanked the directorate for its support during his term.

8. **Minutes**
   **Meeting of September 20, 2014**
   By formal motion, minutes of the Annual General Meeting of September 20, 2014, were accepted for information.

9. **Reports from the Nominating Committee**
   **2015 CMA General Council**
   Dr. Allan S. Garbutt, Chair, Nominating Committee, presented the report and the list of nominees.

   **MOTION**: Moved by Dr. Allan S. Garbutt, seconded by Dr. Brent T. Friesen:
   THAT the following Nominating Committee nominees for representatives to Canadian Medical Association General Council 2016 be approved (AMA President attends by virtue of position):
   - President-elect
   - Immediate Past President
   - Speaker or Deputy Speaker
   - Ten representatives to be named by the board
   - Ten representatives to be named by the Nominating Committee
   - Two physician appointees of the college, at least one of whom must be an elected member of the Council
   - One dean or a designate from his office
   - One student representative
   - One PARA representative
   “CARRIED”

   **Nominating Committee Members Elected by the Annual General Meeting**
   By due process the following were elected as members of the Nominating Committee for 2015-16:
   - Dr. John E. Bromley
   - Dr. Dianne E. Brox
   - Dr. Tobias N.M. Gelber
   - Dr. Tami L. Masterson

10. **Report from the Representative Forum**
    President-Elect Dr. Carl W. Nohr highlighted the issues addressed in the written report circulated to members.

    **MOTION**: Moved by Dr. Carl W. Nohr, seconded by Dr. Allan S. Garbutt:
    THAT the report from the RF be accepted.
    “CARRIED”

11. **Report from the Committee on Constitution and Bylaws**
    Dr. Edward W. Papp, Chair, Committee on Constitution and Bylaws, presented the report from the committee.

    **MOTION**: Moved by Dr. Edward W. Papp, seconded by Dr. Harold R. Chyczij:
    THAT proposed amendments to the Constitution and Bylaws outlined in the 2014-15 Annual Reports be authorized as approved.
    “CARRIED”

    **MOTION**: Moved by Dr. Edward W. Papp, seconded by Dr. Kimberly G. Williams:
    THAT the existing bylaws of the association be rescinded in their entirety and the bylaws as amended by resolution passed at this Annual General Meeting held on September 26, 2015, be adopted.
    “CARRIED”

12. **Report from the Committee on Financial Audit**
    Dr. T. Britt Simmons, Chair, Committee on Financial Audit, presented the report from the committee.
MOTION: Moved by Dr. T. Britt Simmons, seconded by Dr. Christine P. Molnar:

THAT the Auditor’s Report and the audited Financial Statements for the Alberta Medical Association for the year ended September 30, 2014, be received for information.

“CARRIED”

MOTION: Moved by Dr. T. Britt Simmons, seconded by Dr. James A. Harder:

THAT the firm of PricewaterhouseCoopers be reappointed as auditors for the Alberta Medical Association for the 2015-16 fiscal year.

“CARRIED”

13. Installation of Officers
Dr. Carl W. Nohr was installed as AMA president for 2015-16 by CMA president Dr. Cindy Forbes at the CMA President’s Luncheon.

14. Acknowledgments
MOTION: Moved by Dr. Carl W. Nohr, seconded by Dr. Allan S. Garbutt:

THAT the profession express its sincere appreciation to Dr. Richard G.R. Johnston, his wife Susan and their family for their service, sacrifice, and dedication to the profession over the past year.

“CARRIED”

MOTION: Moved by Dr. Carl W. Nohr, seconded by Dr. Allan S. Garbutt:

THAT the Annual General Meeting express its sincere appreciation to the Senior Management Team and staff for their dedication to the pursuit of the goals of the association.

“CARRIED”

MOTION: Moved by Dr. Carl W. Nohr, seconded by Dr. Allan S. Garbutt:

THAT the association express its sincere appreciation to Dr. Darryl D. LaBuick and Dr. Fredrykka D. Rinaldi for their conduct of this meeting.

“CARRIED”

15. Adjournment
There being no other business, the speaker adjourned the formal business session of the 110th Annual General Meeting at 11 am.

Following the annual meeting, delegates participated in the Margaret Hutton Lecture Series (Alberta Medical Foundation History of Medicine presentations).

Alberta Medical Foundation – Margaret F. Hutton Lecture Series
Dr. Dawna Gilchrist, Secretary-Treasurer, Alberta Medical Foundation, introduced the presentations on the following topics:

- The development and use of the stethoscope in the diagnosis of cardiac disease: A brief overview – Dahye (Jennie) Hong
- Health in Roman children: An analysis of rickets in fragmentary sub-adult remains from Isola Sacra (1st – 3rd c. AD) – Marissa Ledger
REPORT FROM THE BOARD OF DIRECTORS

To the Annual General Meeting  October 1, 2015 – September 30, 2016

Staying focused on the vision

1. The year 2015-16 was a year of significant change in Alberta, politically and economically. The association was not immune to these effects in the fifth year of our seven-year AMA Agreement with government. The AMA continued to look toward our vision of Patients First® in a patient- and family-centered health care system. We faced new opportunities to show the profession’s leadership. The professional responsibility of physicians to serve as stewards of the health care system took on new significance. This report outlines the many activities aimed at turning mission and vision into action.

Discussions about a new relationship with government

2. In summer 2015, the AMA began discussions with government to define a new relationship and achieve some gains in the health care system. As the fall 2015 annual general meeting heard, discussions continued under the new government through the summer. In November the parties reached a tentative agreement package that, if ratified, would have (i) sought to expand involvement (at various levels and in various ways) of other key stakeholders who may be impacted or have impact upon the working of the AMA Agreement; (ii) provided a vehicle to reach agreement on specific areas of innovation to improve the system and identify resources to put toward actual implementation; and (iii) dealt with some of the issues that have arisen with physician contracts when Alberta Health Services (AHS) is the payer.

3. Members were advised in a President’s Letter November 20 that a special session of the Representative Forum (RF) would be held December 12 in Edmonton to discuss the tentative agreement package. A few days before the RF, however, we received notification from Alberta Health (AH) that they would not ratify the agreement package as then structured, but wished instead to continue negotiations with the AMA. At the RF, Dr. Carl Amrhein, Deputy Minister of Health, reviewed the evolving and current fiscal situation in Alberta and the need for a stronger relationship between the profession and government in our respective roles.

4. Historically, health expenditures have been growing at approximately 7% per year, including the costs of physician services. Government spoke regularly through the year about “bending the health care curve.” This referred to the intention not to cut current health care spending, but instead to slow the rate of growth of the overall health budget.

5. Alberta physicians are still covered by our seven-year agreement through 2018. Over the contract term, the average increase in payment rates has been about 1%. Part of the difference between 1% and 7% was population growth of 1.5% to 2% annually. The rest of the difference came from increased utilization of physician services. Under the terms of the agreement, government is responsible for all the increased costs in the system.

6. Alberta’s fiscal situation creates challenges for both parties and the RF appreciated the opportunity to hear about government’s concerns and then discuss our own options. The RF agreed that – even though our 2011-18 agreement remains in place – it was important for the AMA to continue discussions with government.

7. We needed to talk about what kind of relationship we wished to have with each other, as well as the role that physicians will have in the management of the health system. For example, physicians can only accept increased financial risk for increased utilization of health care services if they are given the tools and the ability to manage it.
8. Although AHS was not a party to the AMA Agreement, the AMA regularly negotiates with it on behalf of physicians who work under contract to the health authority. One part of the (unratified) December 2015 tentative agreement package was an AMA/AHS bargaining framework to resolve many past and ongoing issues with AHS around contractual negotiations. The framework also created possibilities for improving relationships and expediting negotiations that have dragged on in the past. Framework elements were added to the list of items being considered as part of the larger AMA-AH talks.

9. Discussions proceeded through January to explore what might be possible and culminated in a Memorandum of Agreement (MOA), announced February 22, to dictate the terms of the next phase of negotiations. Discussions were to include proactively considering issues of sustainability (defined in terms of both financial factors and quality of care) with those of stewardship and physician leadership within the system to improve the care delivered to patients.

10. At time of writing, discussions were still underway. The commitment of both parties to the existing AMA Agreement has created possibilities for innovative discussions.

11. No changes to the AMA Agreement can be implemented without a ratification vote by members. The fall meeting of the RF will receive an update.

12. On a related note concerning that province’s discussions with government, at the spring meeting of the RF, the following motion was passed unanimously:

“That the AMA consider both fiscal and human resource contributions to the Ontario Medical Association in support of the current court challenge protecting physician rights.”

Accordingly, the AMA has extended an offer of assistance to the OMA.

13. Stewardship and the physician’s professional role as leaders were key components of government discussions. They were also subjects that President Dr. Carl W. Nohr wrote frequently about to members in President’s Letters over the course of the year. He characterized many of the things outlined in this AGM report as taking some first steps toward showing leadership – and being willing to do some difficult things to improve the system for patients.

14. Various aspects of discussion dealt with prioritizing projects and resource allocation. The president emphasized that managing the health care budget as stewards would require effective relationships, a shared understanding of priorities, an acceptance of risk and the tools to manage it.

15. In February, Dr. Nohr and CEO Michael A. Gormley participated in a health forum called “Physicians as Stewards of Resources – Roles, Responsibilities and Remuneration.” The event was hosted by the Institute of Health Economics and the O’Brien Institute of Public Health at the University of Calgary. The themes addressed were key to the AMA’s direction this year.

Other significant issues

16. Many times over the years the AMA’s expected activities have been supplemented by the emergence of large public policy issues that require response. This was the case with three topics this year: the debate around Physician Assisted Death – or Medical Assistance in Dying (MAID) as it eventually became named; the provincial government’s legislation for a sunshine list of publicly paid individual incomes; and the Fort McMurray wild fire.

Physician Assisted Death/MAID

17. The new federal government was responsible for tabling legislation in response to the decision of the Supreme Court of Canada (SCC) that called for the decriminalization of MAID. The original deadline of February 2016 was extended to June to allow the necessary work to occur. The Canadian Medical Association (CMA) took a lead role as advocate for physicians and patients.
18. Like society at large, the AMA membership was divided on the issue. The Board of Directors, though, believed that it was the association’s responsibility to help prepare physicians for the eventual reality of MAID, respecting the rights of patients while supporting individuals to act in accordance with their own beliefs.

19. Immediately following the spring RF meeting, the AMA hosted an information session that was broadcast live on the AMA’s website. Representatives of AH, AHS, College of Physicians & Surgeons of Alberta (CPSA) and the AMA provided information and answered questions about implementation of MAID in Alberta. The intent was not to re-open debate on fundamental questions, but instead to begin from the starting point of the SCC decision and consider where we needed to go to reach the point of providing access to MAID.

20. The federal government tabled legislation in the form of bill C-14 that was eventually passed a short time after the SCC deadline. The AMA’s position was that the bill struck a reasonable response between autonomy of physicians to choose with protection of patients to access the service. The preamble to the act specifically commits government to “respect the personal convictions of health care providers.”

21. AMA advocacy was integral to ensuring that the rights of physicians with conscientious objection to participating in MAID was protected within the CPSA Standards of Practice.

Sunshine list

22. Government introduced sunshine list legislation in the fall sitting. The act calls for publication of salary/income for all individuals paid by public dollars whose income exceeds $125,000. Physicians will be caught by the new law.

23. When tabling the bill, government clearly acknowledged that physician income data is different from others paid by the public purse and immediately offered to work with the AMA with respect to regulations for the legislation. This consultation took place in late winter and early spring. While the sunshine list went into effect for others on government payroll as of June 2016, physician fee for service (FFS) data was not immediately included. The only exception was the group of about 300 physicians who are employees of AHS. Gross payment data for the remainder of physicians may occur still in 2016. At time of writing the AMA had not been informed regarding government’s plans for timing or approach to the release.

24. Members were extremely concerned about the legislation. The president spoke with the media on the subject, pointing out that there are two key variables that determine individual physicians’ income: how much they work and how much overhead they pay. The latter concern is particularly significant for the high-overhead specialties. It is, accordingly, difficult to present the information without causing misinformation. Dr. Nohr also discussed the balance between public good and personal privacy. While the AMA supported increased transparency around government expenditures, we suggested that physician income data did not need to be identifiable. For example it could be reported without name or by group.

25. The AMA conducted some focus groups with members of the public to get a sense of how Albertans might react to the sunshine list. We found that they responded much more positively when they received information about how payments work and about overhead and business costs. The Physician Advocacy Group was struck following the spring RF to provide advice to the board regarding physician and public communication about negotiations and related matters. The group prepared a response for use when the sunshine list is released.

Fort McMurray wild fire

26. In May the largest wild fire in Alberta’s history destroyed large portions of Fort McMurray and the surrounding area. Physicians who practice in the area were affected along with their families and friends.

27. The AMA provided support by compiling updates on our website. We identified physicians with temporary accommodations for evacuees and also coordinated with others to direct information where it was needed. This included Wood Buffalo Primary Care Network (PCN) and AHS with respect to finding clinical space,
temporary work or volunteer clinical service. The PCn Program Management Office (PMO) and the Practice Management Program (PMP) provided extensive support. Our endorsed home and auto insurance provider, TD Insurance Meloche Monnex, kept the AMA closely informed about helping members with home and auto insurance claims. As requested by AHS, AMA Physician Locum Services provided locum coverage to supplement the reduced numbers of local physicians.

28. Discussions took place about what assistance would be available to physicians who returned to the community to assist with restoration. The AMA’s position was that, for a period where there would be reduced income due to inability to return to previous practice levels, these physicians should be supported by government in a manner similar to past disasters such as High River and Slave Lake.

29. Physicians were integral to the safe evacuation of the local hospital and other care facilities. They have been central to return-to-community efforts. Meantime, their colleagues across the province stepped up to offer support for housing, clinic space and work opportunities. Overall this terrible event created an opportunity to demonstrate the collegiality and sense of community among Alberta doctors.

2015-16 Business Plan and Budget

30. The AMA’s Business Plan establishes the long-term goals for the organization and the plans for moving toward these goals during a particular year. It describes the ends for the association as established by the Board of Directors and ensures that management’s plans are aligned with the goals and ends established by the board and RF. It is also the basis for assessing the annual performance of the CEO (and used by the CEO in discussing performance with senior staff).

31. The Key Result Areas (KRAs) under the mission and business plan were:

- Financial Health
- Well Being
- System Partnership and Leadership
- Health System Reform
- Health System Performance
- Health System Sustainability
- Ontario Health Insurance Plan

32. Each of the KRAs (described below) was built upon a number of long-term goals supported by short-term objectives for 2015-16 by which we marked progress toward the goals.

33. For this report to the AGM, commentary on key activities appears under the appropriate business plan/KRA headings. Each KRA has its own goals which appear accordingly. The complete 2015-16 Business Plan is available on the AMA website. (Visit www.albertadoctors.org and enter “business plan” in the top-left search box.) A year-end report card on the business plan will be presented to the RF.

Key Result Area 1: Financial Health

34. Under Financial Health, the AMA assisted and supported members in maintaining their financial health. This included negotiating with payers to ensure fair compensation, the provision of practice management services and offering financial products. Members in training were supported through a number of scholarships and bursaries.

Goal 1: Physicians are fairly compensated for their skills and training in comparison to other professionals.

35. This particular goal deals with the AMA’s core competency as negotiator on behalf of physicians. The recognition of the AMA as the formal representative of all physicians was also pursued in the appropriate venues; this role currently exists under agreement only.
36. In addition to the discussions with government, the AMA negotiated with AHS on behalf of independent contractors and non-fee-for-service physicians. Issues arising from these talks contributed to the aforementioned bargaining framework. Clinical Assistants and acute care coverage groups were some of those involved and conclusion is still outstanding pending the availability of the bargaining framework.

37. The Alternative Relationship Plan (ARP) PMO assisted 18 physician groups with applications for new ARPs, with seven new clinical ARPs implemented, bringing the province to a total of 54. The office also assisted 17 physician groups with applications for funding expansions to existing ARPs, with three funding expansions and two service changes implemented.

38. Meaningful involvement and support of academic physicians is something the AMA has been seeking to improve for a number of years. The AMA has been working with the faculties of medicine to establish an appropriate role in a province-wide academic framework for academic ARPs (AARPs). Focus group research was conducted with academic physicians to explore their perceptions of their voice in the AMA and in what ways they could be better assisted.

Goal 2: Physicians’ practice management decisions are based on sound management advice and best practice.

39. Billing support and advice continued to be a major activity for members. The Health Economics branch increased staff and resources for this in-demand assistance. The popular online Fee Navigator was further developed and improved based on member feedback. An app for Android and iOS platforms will be released. Fee Navigator provides extensive help with the complex Schedule of Medical Benefits (SOMB) and its rules. In 2015-16, almost 15,000 visitors accessed the application.

40. The Practice Management Program continued to support primary care practices and PCNs. In an effort to provide more integrated and aligned support for members, PMP was brought under a new portfolio for more efficient and integrated primary care support, also linking in the PCN PMO, the Physician Learning Program (PLP) and Toward Optimized Practice (TOP). There was continued interest in similar support for secondary and tertiary care practice. These remained out of scope of PMP under the existing agreement but the need has been identified for the future.

Goal 3: Reliable and best-in-class financial products are available to all members.

41. The alliance between the Provincial and Territorial Medical Associations and the CMA’s MD Financial Management was reviewed this year to examine service offerings and the member value provided.

42. With specific reference to insurance products, MD Financial Management and the AMA’s ADIUM Insurance Services reviewed and improved the referral process for members to provide a more integrated experience. ADIUM is working with a newly formed staff unit to provide better use of data analytics. We hope to learn more about what members need and value in order to provide better value and follow-up.

Key Result Area 2: Well Being

Goal 1: Physicians are supported in maintaining their own health and that of their families.

43. The AMA’s Physician and Family Support Program (PFSP) continued to be the primary vehicle for supporting the well being of physicians this year. New efforts were made to ensure that members in need could access the relevant services and that those services were coordinated with best efficiency. The number of physicians/family members contacting the program rose 15% in the 2015 calendar year. PFSP maintained its effective approach to educational activities, focusing particularly on rural physicians and resident physicians. The program also clarified its role with the universities with respect to remediation and accommodation for resident physicians.
Goal 2: The AMA is a broker in bringing together physicians, patients and families toward healthy communities. Physician and community contributions are supported and celebrated.

44. Out in the community, the AMA’s Youth Run Club enjoyed another successful year, enrolling 383 schools and engaging 22,000 children across the province. We were pleased to welcome MD Financial Management as a Bronze Level sponsor, contributing $10,000 to the year’s efforts. Alberta Blue Cross became a Gold Level Sponsor, contributing $25,000 a year for three years. Physiotherapy Alberta continued its support once again this year with another $10,000 sponsorship. We are extremely grateful for the generosity of these organizations.

45. With the support of the CMA, the AMA’s successful Emerging Leaders in Health Promotion Grant Program was increased from $10,000 to $20,000 this year. Six applications were approved, providing funding to resident physicians or medical students, working with a physician mentor, to deliver an innovative health promotion initiative in the community. We are proud of the excellent work of these young leaders. More information is available on the AMA website. Visit albertadoctors.org/about/awards/health-promo-grant.

46. The AMA’s Many Hands™ program continued to celebrate the volunteer and philanthropic activities of Alberta physicians. Visit albertadoctors.org/advocating/many-hands to read inspiring stories and learn more.

Key Result Area 3: System Partnership and Leadership

Goal 1: Working with AH, AHS and other partners, lead and influence positive change in the delivery of services.

47. The AMA has committed significant resources to support Choosing Wisely Alberta (CWA), which is an important component of promoting physician stewardship. As a result of this support and the coordination of CWA and the PLP, Alberta has been recognized as one of the leaders in integrating Choosing Wisely in Canada.

48. The CWA initiative is leading the coordination of nine steering committee member organizations, including TOP and PLP and with input of patient representatives. Toolkits for physicians to use to help disseminate Choosing Wisely programming were developed and are being further refined for specific audiences.

49. Early results of the Low Back Pain project identified high variance in imaging ordering patterns among physicians. Use of a Lumbar Screening Form resulted in a 13-20% reduction in MRIs for low back pain. Key learnings from physician interviews and patient focus groups suggested the need for better coordination with specialty programs. Three completed partnership programs (Vitamin D testing, appropriate use of antipsychotics in long-term care, and toxicology screening of psychiatric patients in the emergency room) resulted in significant improvements in appropriate ordering.

50. AMA sections were involved and primary care leaders focused on opportunities for activities in low back pain, Pap smears and DEXA for osteoporosis. Five CWA partnerships were initiated with AHS Strategic Clinical Networks (SCNs): Low back pain with the Bone and Joint SCN; spine access project and minor head trauma with the Emergency SCN diagnostic imaging project; red blood cell transfusion with the Emergency SCN Upper GI Bleed project; pre-operative care with the Surgery SCN; and psychiatric CWA topics with Addictions and Mental Health Project.

51. The AMA’s Vision for Primary Care continued to direct work extending paneling capability to PCNs and member physicians. Negotiations with AH included discussion of an optional blended capitation model for primary care. The AMA has been promoting such an arrangement for several years. The PCN Performance Management Report was launched and will be updated quarterly. Work continued to identify additional evaluation metrics. Significant progress was made in integrating quality improvement into PCN business plans.
52. In July the provincial government released a review of PCns – in particular of some elements of PCn operations in a sample of the total group. In a letter about the release of the report, the AMA president noted more than 10 years of PCn existence has resulted in better access to family physicians for more Albertans, fewer emergency department visits and shorter hospital stays. He pointed out that the report identified some immediate term problems, but did not acknowledge what has been accomplished or address what is needed to continue to improve patient care. Specifically, how can we build on the strong foundation that PCns have created?

53. The report identified areas for improvement and the AMA indicated that we are always open to working with government to improve care for patients and resolve issues. Dr. Nohr spoke of the report as an opportunity to move forward on delivering better care for Albertans. He identified things that need to occur:

- The report noted that Alberta Health is responsible for some of the challenges identified. The ministry can continue their efforts in primary care. This means policy development, evaluation of PCns and their initiatives and efficiency in processing business plans, etc.
- We need a structure to make decisions together in a way that is timely, balanced and transparent.
- There are other improvements to be made:
  - Fully enabling e-visits and other technological ways to improve access.
  - Allowing patients access to their own health information so they can actively participate in their care.
  - Improving information available to physicians so we can adjust what we do toward best practice.
  - Reforming the payment model – how physicians are paid for care in teams.

54. Work continued with AHS on multiple levels to develop an integrated primary health care strategy.

Goal 2: Key incentives and supports for physicians are aligned with the delivery of care and toward overall system objectives of timely access to quality care.

55. The AMA-AH Physician Compensation Committee (PCC) was the primary venue for work to align physician incentives with system objectives. One of its key responsibilities was implementation of the allocations arising from the AMA Agreement.

56. Accordingly, a cost-of-living adjustment of 1.1% was implemented April 1. The PCC implemented the allocation in a manner consistent with the Board of Director’s recommendations:

- $5 million for targeted items and the remaining allocation split on a 50/50 basis between overhead and dollar-per-section-allocation-equivalent components.
- Targeted items included:
  - Physician-to-patient secure videoconference.
  - Physician-to-physician secure videoconference.
  - Physician-to-patient secure messaging.
  - Expansion of telephone family conference fees to include patients located in community.
  - Expansion of Body Mass Index premiums to certain procedures in the emergency room and intensive care unit.
  - An increase in the fee for telephone calls to patients (03.05JR) from $15.12 to $15.88.

57. Work also began on gathering physician and section input for Allocation 2017 for AH/AMA Fees Advisory Committee and Allocation Working Group review. These groups were also asked to consider a resolution from the spring RF calling for a review and streamlining of allocation processes so that section changes may be made closer to the SOMB implementation date (vs. the current process requiring sections to submit their priorities almost one year in advance). Changes like these would not be totally in the control of the AMA.

58. PCC also completed a review of the business costs model. A consulting group was appointed.
to perform an assessment of the overhead model, with a final report reviewed by the PCC in July. At time of writing the committee was evaluating resources necessary to implement some of the review’s recommendations.

59. In the spring, the PCC completed a significant challenge. A process that is summarized in the April 19 PCC Update was used to select a list of 22 fees for review that eventually became a list of six. (To review the information, visit albertadoctors.org, enter PCC Update in the top-left search box and choose PCC Update Archives from the results.) As a result of the review – which was a precursor to a larger schedule-wide fee equity review in the future – two fees remained unchanged and four were reduced. The savings from these reductions must be retained within the Physician Services Budget but the method had not been determined at time of writing.

60. With this unprecedented process, Alberta demonstrated that there are ways for physicians and government to work together to align the fee schedule and payment mechanisms with modern practice. Dr. Nohr thanked the involved sections for their efforts to work with the PCC by providing information and insight to assist the committee, and for their ongoing willingness to continue to work with the PCC. This process showed the importance of appropriately engaging the physicians most involved as PCC works to further modernize the fee schedule. Lessons learned will help to inform new work in the future. This would include ensuring transparency and using the best-available information. There was general agreement that overhead measurement will be important and the model could be improved.

61. Regarding the broader, SOMB-wide fee relativity exercise. AMA sections have been pursuing intra-sectional relative values (INRVs) for many years. Following the fee review, the PCC began developing a standardized approach to establishing INRVs to account for overhead, time, intensity and complexity as well as the level of pre- and post-operative care inherent in surgical procedures. The Section of Pediatrics agreed to participate in a pilot project.

62. The PCC operated according to a set of Provincial Strategic Requirements in its first years of existence. A new set was proposed and discussed this year, although the needs may be affected by the larger AMA-AH discussions around stewardship of resources.

63. Physicians need appropriate health information to fully serve their role in caring for patients and acting as stewards. One significant need identified was secure communication between providers inside and outside of hospital facilities and particularly in community-to-community-provider communications.

64. At the direction of the board and RF, the AMA began development of a clinical secure messaging solution to be used in multiple settings for members. The vendor partner was Microquest and the product was called AMA dr2dr. The intent was to provide physicians with a proven, secure, convenient and useable communications solution in support of quality care and enhanced care coordination as recommended by the Health Quality Council of Alberta and others. AMA dr2dr was developed in a proactive, transparent and collaborative process. We informed and fully engaged our partners, including AHS, along the way.

65. Shortly after the official release of AMA dr2dr we received a communique and associated guidelines from AHS for the use of Clinical Secure Messaging (CSM) applications within AHS facilities (ahs-cis.ca/csm). At time of writing, additional clarity was still needed regarding the use of dr2dr in CSM. The RF will receive an update.

66. Efforts also continued to resolve a dispute with AHS and AH regarding extension of the AHS-sponsored EMR Information Sharing Framework to physicians using Sunrise Clinical Manager. Materials were developed to clarify privacy, information management and information-sharing-related requirements for PCNs.

Goal 3: Physicians and the AMA, in partnership with patients, play a leadership role in advocating and promoting a system characterized by Patients First®.

67. The AMA’s patient engagement portal albertapatients.ca had a successful first year of operation. At time of writing, 3,300
Albertans were actively engaged with an eventual goal of more than 10,000. The online community selects the topics it wishes to discuss. Key themes in year one were seniors’ care, emergency departments and wait times, focusing on the patient-journey aspects of these topics. Other topics discussed were the provincial mental health review and MAID. Retention rates were extremely high and participants expressed satisfaction with the experience of being a member of the community.

Healthy AMA

68. Additional activities that were undertaken related to the AMA’s healthy functioning as an organization. This included:

- Financial: The AMA conducted sustainable operations and established fully funded reserves as well as effectively stewarding the grant and program funds flowing through from the AMA Agreement.
- Knowledge: We pursued the second phase of a unified communications strategy for digital and telecommunication effectiveness. Additionally we launched a long-term member engagement strategy to better understand and thus serve members, including more robust analytics of member profile data.
- Relationships: The AMA maintained relationships with pharmacy and nursing leaders toward building an integrated health system.
- Workforce: A long-term space requirements strategy was explored, including co-location opportunities with MD Financial Management. We also investigated offering investment choice for staff participating in the defined contribution pension plan.

Other activities and issues

69. Outside of those things described so far and linked to the AMA Business Plan, the AMA was involved in many other activities that were consistent with our mission.

Governance Review Group (GRG)

70. The fall 2015 RF approved initiation of a governance review process to ensure that the RF structure itself continues to meet the needs of an evolving membership in an evolving health care system.

71. A special session including break-out groups was held during the spring RF. Further research took place in the spring and summer, including some dedicated sessions aimed at clinical and academic ARP physicians. The GRG will be reporting back to the RF at the fall meeting. The key questions for the group to address were:
- The purpose of RF.
- How members should be represented within the AMA, e.g., the role of sections.
- How the AMA can support sections to fulfil their roles.

Seniors’ care

72. The AMA continued its participation in the Alberta Seniors’ Care Coalition (ASCC), established by the Alberta College of Family Physicians. The AMA was one of the earliest members. The coalition now includes: AH, AHS (including the AHS Seniors’ SCN), the College and Association of Registered Nurses of Alberta, Alberta Pharmacists’ Association, College of Licensed Practical Nurses, and Professional Association of Resident Physicians of Alberta.

73. The AMA participated in work at the ASCC to determine how best to advance common interests with respect to seniors’ care. The coalition also agreed to moderate a discussion in the albertapatients.ca patient engagement portal with community members interested in the subject. This will take place in the fall.

Government relations

74. The AMA continued its non-partisan approach to government relations this year. Under the relationship established by our agreement, the president met regularly with the minister. At a more grass roots level, the Government Affairs Committee met to discuss strategy and build knowledge as well as talking with federal and provincial political leaders and industry experts. AMA senior staff interacted daily with the civil service at Alberta Health.

75. Encouraging Alberta physicians to engage with Members of Parliament and write to the federal finance minister, the AMA supported CMA efforts to advocate to the federal government for the needs of physicians in Canadian-
Controlled Private Corporations and a proposed change to the federal tax regime.

76. This would primarily affect incorporated physicians who have set up formal partnerships to support group medical practices. The CMA estimated that roughly 10% of Canadian physicians have formed these structures, many to meet the requirements of alternative funding plan agreements and accommodate enhanced clinical service provision and academic objectives.

77. If the changes move forward, these existing partnership structures may no longer be viable meaning the health system may lose the benefits associated with group medical structures: enhanced clinical service provisions and academic objectives. At minimum we anticipate there would be significant turmoil where these frameworks exist as structures are reorganized.

Canadian Medical Association

78. The 2016 CMA General Council (GC) was held August 21-24 in Vancouver. The 2016 AMA delegation was:
   • AMA President
   • President-Elect
   • Immediate Past President
   • Speaker
   • 10 representatives named by the board
   • 10 representatives named by the Nominating Committee
   • Two physician appointees of the CPSA (at least one to be an elected member of council)
   • One dean or designate
   • One student representative
   • One PARA representative

79. The CMA continued its Ambassador Program, established in 2014, to attract medical students, resident physicians and early career physicians to GC. Ten individuals in each category were selected from western Canada, based on an application process. The provincial and territorial medical associations were also encouraged to bring more young leaders to the meeting. In partnership with faculties of medicine, the AMA brought an additional eight medical students to the event.

80. New to GC this year was the Emerging Issues dialogue. This new session provided GC and CMA with a process for collecting and analyzing emerging issues (areas of concern) for the purpose of identifying and/or recommending strategic options for CMA. Criteria for discussion topics were: recently emerging national issues with significant ramifications for economic and professional well-being of a large number of physicians; provincial/territorial issues with high potential for spillover to other jurisdictions; national issues with potential of affecting health and well-being of a large number or segment of Canadians in the next 12 months.

81. Key sessions at GC included:
   • Health consequences of climate change.
   • The physician’s role in Indigenous Wellness and Canada’s health care system.
   • Integrated care: lessons and opportunities (featuring a segment with AMA President Dr. Carl Nohr).
   • Strengthening resilience in medical training and practice; moving from rhetoric to action.

82. On August 24 British Columbia rural physician Dr. Granger Avery was installed as the CMA president for 2016-17. Dr. Avery has been a rural physician for more than four decades and has been involved in medical politics for 30 years. He has a fervent interest in rural health: improving health of rural populations and supporting young doctors in rural practice. His most recent work has focused on physician privileging in hospitals, ensuring the rules which physicians must follow when attached to hospital work are fair.

83. Nine Albertans were honored by the CMA during GC. The awards and the outstanding recipients were:
   • CMA Medal of Honour for personal contributions to the advancement of medical research, education and health care delivery to the people of Canada. This is the highest honor bestowed by the CMA upon a person who is a non-physician: Alvin Libin, Calgary. Mr. Libin received the AMA Medal of Honor in 2015.
• CMA May Cohen Award for Women Mentors for outstanding mentoring abilities beyond normal professional duties by encouraging, facilitating and supporting mentees in leadership and career development: Dr. Brenda J. Millar, Grande Prairie.

• CMA Award for Young Leaders (Student and Resident Categories) for exemplary dedication, commitment and leadership in clinical, political, education, research and/or community service: Student Category, Ms Azalea R. Lehn Dorff, Calgary; Resident Category, Dr. Debraj Das, Edmonton, and Dr. Vera H. Krejcik, Calgary.

• CMA Dr. William Marsden Award in Medical Ethics for outstanding leadership, commitment and dedication to promoting and advancing excellence in medical ethics: Dr. Christopher J. (Chip) Doig, Calgary. Dr. Doig is a past president of the AMA.

• CMA Physician Misericordia Award for outstanding lifetime commitment to caring, compassion and support to enhance the overall health and wellbeing of physician colleagues: Dr. Jordan S. Cohen, Calgary, and Dr. Jane B. Lemaire, Calgary.

• CMA John McCrae Memorial Medal for exemplary service showing compassion, self-sacrifice and innovation beyond the call of duty benefitting the health or welfare of fellow military personnel and civilians: Lieutenant Colonel Dr. William R.G. Patton, Edmonton.

Awards

87. The highest honors of the Alberta Medical Association will be bestowed on six Albertans during the fall RF and AGM.

• AMA Medal for Distinguished Service for outstanding personal contributions to the medical profession and to Albertans that has contributed to the art and science of medicine and raised the standards of medical practice: Dr. John M. Conly, Calgary; Dr. Christopher J. (Chip) Doig, Calgary; Dr. Charles H. Harley, Edmonton.

• AMA Medal of Honor for extraordinary contributions by a non-physician to Albertans in medical/health research or education, health care organization or promotion: Dave Colburn, Edmonton; Jocelyn M. Lockyer, PhD, Calgary.

• AMA Award for Compassionate Service for serving as an inspiration to others with outstanding compassion, dedication and extraordinary contributions to volunteer or philanthropy efforts to improve the state of the community: Dr. Annalee Coakley, Calgary.

86. In June we also conducted a readership survey, as we do every two years. The results showed that 95% of physicians rely on the AMA for information about issues that affect physicians. The President’s Letter continued to be the most highly read publication at 85% reading it always or sometimes. MD Scope electronic newsletter came in second at 79% followed by the Digest magazine at 74%. For the first time in its history, a majority of members expressed a preference for reading Digest in electronic vs. paper format and that direction will be explored.

Member communication and research

84. At date of writing, members had received 22 President’s Letters.

85. Three member tracker surveys will have been conducted by the end of the association year. These surveys showed how members feel about important issues and the role and performance of the AMA. In the most recent survey, 83.5% agreed that the AMA is an effective advocate for physicians (only 5.6% disagree). 82% feel well-informed by the AMA about our activities and news. Results of tracker surveys were reported to members as feature stories in Alberta Doctors’ Digest.
88. An election was held for the position of president-elect 2016-17. Dr. Neil D.J. Cooper was the successful candidate.

89. Members of the 2015-16 Board of Directors
- Dr. Carl W. Nohr – President
- Dr. Padraic E. Carr – President-Elect
- Dr. Richard G.R. Johnston – Immediate Past President
- Dr. Kathryn L. Andrusky
- Dr. Sarah L. Bates (resigned effective April 15, 2016)
- Dr. Paul E. Boucher
- Dr. Neil D.J. Cooper
- Dr. Robin G. Cox
- Dr. Kimberley P. Kelly
- Dr. Christine P. Molnar
- Dr. Paul Parks
- Dr. Jasneet Parmar
- Dr. A. James Pope
- PARA observer: Dr. Kimberly G. Williams (term ended June 30, 2016); Dr. Michael R. Martyna (term began July 1, 2016)
- Medical Students Association observer: Hamza A. Riaz (term ended June 30, 2016); Finola M.H. Hackett (term began July 1, 2016)

90. The board met:
- **2015**
  - September 26 (post-RF)
  - October 30
  - December 1 (teleconference)
  - December 10-11
  - December 16 (teleconference)
- **2016**
  - February 5
  - March 11 (special meeting at RF)
  - April 14-15
  - May 19 (teleconference)
  - June 2-4
  - June 22 (teleconference)
  - July 14-15
  - August 7 (teleconference)
  - August 23 (special meeting at GC)
  - August 29 (teleconference)
  - September 14

91. Members of the Executive Committee:
- Dr. Carl W. Nohr – President
- Dr. Padraic E. Carr – President-Elect
- Dr. Richard G.R. Johnston – Immediate Past President
- Dr. Sarah L. Bates – Board Representative (term ended April 15, 2016)
- Dr. Christine P. Molnar – Board Representative (term began April 15, 2016)
- Dr. Paul Parks – Board Representative

92. The Executive Committee met:
- **2015**
  - October 9
  - November 20
- **2016**
  - January 15
  - March 18
  - May 10
  - June 24
  - August 16
This report outlines the many activities undertaken by the Alberta Medical Association (AMA) this past year on behalf of its members. It is a key element of our accountability back to physicians.

The document reflects the AMA’s focus on our vision of Patients First®, by fulfilling our mission of leadership and support for physicians. Staying true to the overall goals and objectives has been no mean feat – there has been anything but stability in the health care system and the economic and political environments. The organization has needed to be adaptable and to take on new ventures, many with an element of risk.

Hopefully, members will find evidence of this responsiveness in this report.

This past year saw the association take on new activities such as the individual fee reviews and the creation of a secure messaging product call AMA dr2dr. We improved services where needed, with the alignment of the Toward Optimized Practice, Primary Care Network Program Management Office and the Practice Management Program being one important example. Finally, we continued to provide and expand several important services including the Physician and Family Support Program, responding to legislation, negotiation advice and support, insurance products and the Youth Run Club.

Attention has also been paid to internal support and governance to carry out the work. During the past 12 months a review of governance through the Representative Forum (RF) and board has been carried out and the RF Governance Oversight Group has developed several tools for improving performance. We have also begun implementing a member engagement strategy, looking to enhance opportunities for member participation and to make better use of our extensive databases in understanding the needs of physicians. We work hard at our two-way communication to allow feedback and input from physicians and to keep them informed of important developments.

The AMA benefits from the active support and participation of physicians. Much is owed to those physician leaders working on numerous committees, RF and the Board of Directors.

I also want to recognize the contribution of my fellow staff. Their dedication in working for the interests of physicians is key to the success of the AMA.
PROPOSED NON-SUBSTANTIVE AMENDMENTS

To the Constitution and Bylaws of the Alberta Medical Association

<table>
<thead>
<tr>
<th>Present wording</th>
<th>Proposed wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.7</td>
<td>40.7</td>
</tr>
<tr>
<td>Not less than 30 days before the date fixed for election, each member eligible to vote shall receive:</td>
<td>Not less than 30 days before the date fixed for election, each member eligible to vote shall receive:</td>
</tr>
<tr>
<td>(i) a copy of the instructions to voters; (ii) a ballot listing the names of Members nominated for election of zonal delegate and the Regional containing their Practice Location;</td>
<td>(i) a copy of the instructions to voters; (ii) a ballot listing the names of Members nominated for election of zonal delegate and in the Region containing their Practice Location;</td>
</tr>
</tbody>
</table>

PROPOSED CHANGE

AMA Constitution and Bylaws – Nominating Committee

Memorandum

Date: July 20, 2016
To: Alberta Medical Association Members
From: Dr. Carl W. Nohr, AMA President
Subject: Proposed change – AMA Constitution and Bylaws – Nominating Committee

At the July 14-15 meeting, the AMA Board of Directors considered proposed amendments to the Nominating Committee’s role and responsibilities to enhance the efficiency and effectiveness of the committee, and bring it in line with best practice.

One of the changes – removing the president from the Nominating Committee – requires changes to the AMA Constitution and Bylaws (Articles 15.0 and 25.0, respectively). Best practice indicates that the president should not be involved in choosing his or her successor. To avoid that possibility, it’s proposed that the Constitution and Bylaws be amended.

The following excerpt from Robert’s Rules of Order, Newly Revised, is provided for reference:

“Designation of the Nominating Committee. The nominating committee should be elected by the organization wherever possible, or else by its executive board. Although in organizing a new society it may be feasible for the chair to appoint the nominating committee, in an organized society the president should not appoint this committee or be a member of it—ex officio or otherwise. The bylaws may provide that “the President shall appoint all committees except the Nominating Committee . . .” and that “the President shall be ex officio a member of all committees except the Nominating Committee . . .”; the exception should not be omitted in either case.”
Two substantive changes to the AMA Constitution and Bylaws are being proposed:

<table>
<thead>
<tr>
<th>Present wording</th>
<th>Proposed wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.0 Duties of Elected Officers</td>
<td>Amend 15.2(vi) to exclude the Nominating Committee</td>
</tr>
<tr>
<td>15.1 President</td>
<td>15.0 Duties of Elected Officers</td>
</tr>
<tr>
<td>15.2 The President shall:</td>
<td>15.1 President</td>
</tr>
<tr>
<td>(vi) be an Ex-officio Member of all Association committees;</td>
<td>15.2 The President shall:</td>
</tr>
<tr>
<td></td>
<td>(vi) be an Ex-officio Member of all Association committees, except the Nominating Committee;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>25.0 Nominating Committee</th>
<th>Amend 25.1 to remove the President as a member of the Nominating Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.1 The committee shall be composed of the Immediate Past President, who shall be chair, the President, four Members elected at the AGM, two Delegates by and from the Forum and two Members appointed by the Board.</td>
<td>25.0 Nominating Committee</td>
</tr>
<tr>
<td></td>
<td>25.1 The committee shall be composed of the Immediate Past President, who shall be chair, <strong>the President</strong>, four Members elected at the AGM, two Delegates by and from the Forum and two Members appointed by the Board.</td>
</tr>
</tbody>
</table>

Dr. Peter C. Jamieson, Calgary

Dr. Tami L. Masterson, Edmonton
In accordance with the Alberta Medical Association Constitution and Bylaws, the Nominating Committee nominates candidates for office to be elected by the annual general meeting (AGM), to be elected by the Representative Forum (RF), and to be appointed by the Board of Directors of the association.

The Nominating Committee submits the following nominations for consideration during the AGM:

1. **Representatives to CMA General Council 2017**

   **NOTE:** The president attends General Council by virtue of the position and is not included in the number of Alberta representatives allowed to attend (30). The Nominating Committee recommends that the 2017 CMA General Council representatives be:
   - President-Elect
   - Immediate Past President
   - Speaker or Deputy Speaker
   - 10 representatives named by the board
   - 10 representatives named by the Nominating Committee
   - Two physician appointees of the CPSA, at least one of whom must be an elected member of the Council
   - One dean or designate from his office
   - Two student representatives
   - Two PARA representatives

2. **Speaker and Deputy Speaker 2016-17**
   a. **Speaker:** Dr. Fredrykka D. Rinaldi, General Practice, Medicine Hat
   b. **Deputy Speaker:** Dr. Daniel R. Ryan, General Practice, Edmonton

   In accordance with custom, brief profiles for these candidates follow on the next page.

3. **Nominating Committee 2016-17**

   The bylaws require that the AGM elect four members to the Nominating Committee. The members elected for 2015-16 were:
   - Dr. John E. Bromley, General Practice, Red Deer
   - Dr. Dianne E. Brox, General Practice, Edmonton
   - Dr. Tobias N.M. Gelber, General Practice, Pincher Creek
   - Dr. Tami L. Masterson, Pediatrics, Edmonton

   The Fall Nominating Committee meeting is Thursday, October 27.

   **NOTE:** The board recently approved a policy whereby Nominating Committee members cannot be the Nominating Committee’s nominees for any elected office. As well, to generate a balance between continuity/corporate memory and new ideas, members elected to the Nominating Committee by the AGM will serve a two-year term, renewable once, with initial terms to be staggered for purposes of continuity.
PROFILES

Dr. Fredrykka D. Rinaldi
General Practice, Medicine Hat

2015-present
Speaker
Member, Governance Review Group

2014-present
Member, Section of General Practice Executive

2012-present
Member, Committee on Financial Audit, Council of Zonal Leaders
President, South Zone Medical Staff Association
Section of General Practice member-at-large

2014-15
Deputy Speaker, RF

2012-15
Member, RF Planning Group

2003-14
RF delegate

2000-14
AMA rep, AMA/CPSA/LSA Joint Medical-Legal Committee

2013-14
Member, Nominating Committee

2007-13
Member, IM/IT Coordinating Committee and Task Force

2011-12
Joint AMA/CPSA Executive

2009-12
Member, Executive Committee

2006-12
Member, Board of Directors

2004-08
Member, Section of General Practice Executive

2006-07
Member, Nominating Committee

1999-2004
Member, Health Issues Council

2002-03
Member, Negotiations 2003 Job Action Group

2001-02
Member, AMA/WCB Negotiating Committee

1996-97
RF delegate

AMA delegate, CMA General Council

Dr. Daniel R. Ryan
General Practice, Edmonton

2015-present
President-Elect, Section of Addiction Medicine
Member, Governance Review Group

2011-present
Member, Committee on Constitution and Bylaws

2004-present
RF delegate

2012-13
Member-at-large, Section of Addiction Medicine

2009-12
Deputy Speaker, RF

2005-12
Member, RF Planning Group

2009, 2011
AMA delegate, CMA General Council

2008-10
Past President, Section of Addiction Medicine

2007-08
President, Section of Addiction Medicine
Member, AADAC Projects

2005-07
President-Elect, Section of Addiction Medicine
ELECTIONS

EXECUTIVE DIRECTOR REPORT TO THE 2016 ANNUAL GENERAL MEETING

In accordance with the Alberta Medical Association (AMA) Constitution and Bylaws, a Call for Nominations for Speaker, Deputy Speaker and Representatives to Canadian Medical Association (CMA) General Council 2017 was sent to the membership on July 26, 2016.

In response to the call, no further nominations were received for the Speaker and Deputy Speaker positions. Two nominations were received for Representatives to CMA General Council 2017.

Representatives to CMA General Council 2017

In response to the Call for Nominations, Dr. Michal S. (Mike) Kalisiak, a dermatologist in Calgary, and Dr. Jillian M. Ratti, a family physician in Calgary, have been nominated to attend the 2017 CMA General Council as AMA delegates; brief profiles on both candidates, based on service as contained in AMA records, is provided below.

Dr. Michael S. (Mike) Kalisiak

2015-present  RF delegate (Region 3 representative)
2011-present  Member, Health Issues Council
2014-16  Member, Nominating Committee
2011, 2012  AMA delegate, CMA General Council
2009-12  RF delegate (Section of Dermatology and Dermatologic Surgery representative)
2006-07  PARA representative, Committee on Achievement Awards

Dr. Jillian M. Ratti

2009-10  PARA observer, Board of Directors
         PARA representative, RF, Nominating Committee
2009 (Oct-Nov)  PARA representative, Committee on Achievement Awards, Committee on Financial Audit, Committee on Constitution and Bylaws, Health Issues Council, Fees Advisory Committee

The Nominating Committee Report to the Fall 2016 AGM, included elsewhere in these reports, contains recommendations for AMA representatives to CMA General Council 2017. Direction will be sought regarding AMA representatives to CMA General Council 2017 at the AMA AGM on Saturday, September 24, starting at 10 a.m.
FINANCIAL STATEMENTS

Responsibility for the financial statements
The management of the Alberta Medical Association (the Association) is responsible for the integrity and fair presentation of the financial statements.

The Association has developed prudent financial controls that give management reasonable assurance that the assets are safeguarded and reliable financial records are maintained. These controls, which are reviewed by the Committee on Financial Audit, include written policies and procedures, technology controls and an organizational structure that segregates duties.

The Association’s independent auditors, PricewaterhouseCoopers LLP, Chartered Accountants, have been appointed to express an opinion as to whether these financial statements present fairly the Association’s financial position and operating results in accordance with Canadian generally accepted accounting principles. Their report follows.

The Board of Directors has reviewed and approved these financial statements. To assist the board in meeting its responsibility, it has established the Committee on Financial Audit. The committee meets with management and the independent auditor to review accounting principles and practices, financial controls and audit results.

Michael A. Gormley  Cameron N. Plitt
Executive Director  Chief Financial Officer

Report of the independent auditor on the summary financial statements
To the Members of Alberta Medical Association (C.M.A. Alberta Division)

The accompanying summary financial statements, which comprise the summary statement of financial position as at September 30, 2015, the summary statement of operations and net assets and the summary statement of cash flows for the year then ended, and the related notes, are derived from the audited consolidated financial statements of Alberta Medical Association (C.M.A. Alberta Division) for the year ended September 30, 2015. We expressed an unmodified audit opinion on those financial statements in our report dated February 5, 2016.

The summary financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organizations. Reading the summary financial statements, therefore, is not a substitute for reading the audited consolidated financial statements of the Alberta Medical Association (C.M.A. Alberta Division).

Management’s responsibility for the summary financial statements
Management is responsible for the preparation of a summary of the audited financial statements on the basis described in note 1.

Auditor’s responsibility
Our responsibility is to express an opinion on the summary financial statements based on our procedures which were conducted in accordance with Canadian Auditing Standard (CAS) 810 – Engagement to Report on Summary Financial Statements.

Opinion
In our opinion, the summary financial statements derived from the audited financial statements of Alberta Medical Association (C.M.A. Alberta Division) for the year ended September 30, 2015 are a fair summary of those financial statements, on the basis described in note 1.

PricewaterhouseCoopers LLP
Chartered Accountants
Edmonton, Canada
## SUMMARY STATEMENT OF FINANCIAL POSITION

For the year ended September 30, 2015

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>$11,550,077</td>
<td>$3,650,101</td>
</tr>
<tr>
<td>Funds held on deposit</td>
<td>$924,110</td>
<td>$1,115,652</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>$496,397</td>
<td>$1,170,832</td>
</tr>
<tr>
<td>Due from administered</td>
<td>$928,470</td>
<td>$2,926,090</td>
</tr>
<tr>
<td>Due from Alberta</td>
<td>$29,434</td>
<td>$107,598</td>
</tr>
<tr>
<td>Due from AMA Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Portfolio investments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(note 4)</td>
<td>$26,977,798</td>
<td>$26,309,365</td>
</tr>
<tr>
<td><strong>Employee future benefits</strong> (note 6)</td>
<td>$210,015</td>
<td>$277,693</td>
</tr>
<tr>
<td><strong>Property and equipment</strong> (note 5)</td>
<td>$7,824,384</td>
<td>$7,502,310</td>
</tr>
<tr>
<td><strong>Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable</td>
<td>$5,586,071</td>
<td>$4,714,435</td>
</tr>
<tr>
<td>Payable to Canadian</td>
<td>$1,048,898</td>
<td>$806,475</td>
</tr>
<tr>
<td>Deferred membership</td>
<td>$3,389,886</td>
<td>$2,504,226</td>
</tr>
<tr>
<td>Deferred leasehold</td>
<td>$163,625</td>
<td>$130,469</td>
</tr>
<tr>
<td>inducements and other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Deferred leasehold inducements and other</strong></td>
<td>$338,578</td>
<td>$456,096</td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td>$38,413,627</td>
<td>$34,448,660</td>
</tr>
</tbody>
</table>

![Table](image)
### SUMMARY STATEMENT OF OPERATIONS AND NET ASSETS

For the year ended September 30, 2015

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members’ dues</td>
<td>15,250,097</td>
<td>13,983,109</td>
</tr>
<tr>
<td>Fees and commissions</td>
<td>1,881,736</td>
<td>1,833,041</td>
</tr>
<tr>
<td>Investment income</td>
<td>829,714</td>
<td>1,879,908</td>
</tr>
<tr>
<td>Other</td>
<td>969,603</td>
<td>924,934</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>18,931,150</td>
<td>18,620,992</td>
</tr>
</tbody>
</table>

| **Expenditures**     |           |           |
| Corporate affairs    | 6,835,003 | 6,480,471 |
| Executive office     | 2,865,991 | 3,024,626 |
| Health policy and economics | 2,114,897 | 1,812,749 |
| Committees           | 2,080,727 | 2,161,506 |
| Public affairs       | 1,553,905 | 1,927,157 |
| Professional affairs | 899,364   | 857,039   |
| Southern Alberta Office | 477,727  | 466,502   |
| Priority projects    | 996,343   | 831,713   |
| **Total Expenditures** | 17,823,957| 17,561,763|

<table>
<thead>
<tr>
<th><strong>Revenue before undernoted items</strong></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,107,193</td>
<td>1,059,229</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Employee future benefit</strong></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(626,157)</td>
<td>(696,396)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Realization of insurance experience (note 7)</strong></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4,264,626</td>
<td>404,111</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Net assets – Beginning of year</strong></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>As previously reported</td>
<td>31,225,536</td>
<td>32,266,230</td>
</tr>
<tr>
<td>Change in accounting policy (note 2)</td>
<td>3,223,124</td>
<td>1,514,022</td>
</tr>
<tr>
<td><strong>Net assets for the year – restated</strong></td>
<td>34,448,660</td>
<td>33,780,252</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Remeasurement of employee future benefits</strong></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(780,695)</td>
<td>(98,536)</td>
</tr>
<tr>
<td><strong>Net assets – End of year</strong></td>
<td>38,413,627</td>
<td>34,448,660</td>
</tr>
</tbody>
</table>
### SUMMARY STATEMENT OF CASH FLOWS

For the year ended September 30, 2015

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

#### (restated – note 2)

**Cash provided by (used in)**

**Operating activities**

<table>
<thead>
<tr>
<th>Category</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net revenue for the year</td>
<td>4,745,662</td>
<td>766,944</td>
</tr>
<tr>
<td>Items not affecting cash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amortization (note 5)</td>
<td>829,081</td>
<td>883,136</td>
</tr>
<tr>
<td>Loss (gain) on portfolio investments</td>
<td>336,848</td>
<td>(564,363)</td>
</tr>
<tr>
<td>Gain on pension benefit</td>
<td>(713,017)</td>
<td>(907,315)</td>
</tr>
<tr>
<td>Net change in non-cash working capital items</td>
<td>4,857,838</td>
<td>(1,776,090)</td>
</tr>
<tr>
<td><strong>Total cash provided by (used in)</strong></td>
<td>10,056,412</td>
<td>(1,597,692)</td>
</tr>
</tbody>
</table>

**Investing Activities**

<table>
<thead>
<tr>
<th>Category</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additions to property and equipment</td>
<td>(1,151,155)</td>
<td>(1,879,648)</td>
</tr>
<tr>
<td>Purchase of portfolio investments</td>
<td>(1,412,829)</td>
<td>(2,282,575)</td>
</tr>
<tr>
<td>Proceeds from sale of portfolio investments</td>
<td>407,548</td>
<td>1,127,814</td>
</tr>
<tr>
<td><strong>Total decrease in cash</strong></td>
<td>(2,156,436)</td>
<td>(3,034,409)</td>
</tr>
</tbody>
</table>

**Increase (decrease) in cash during the year**

<table>
<thead>
<tr>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>7,899,976</td>
<td>(4,632,101)</td>
</tr>
</tbody>
</table>

**Cash – Beginning of year**

<table>
<thead>
<tr>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,650,101</td>
<td>8,282,202</td>
</tr>
</tbody>
</table>

**Cash – End of year**

<table>
<thead>
<tr>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>11,550,077</td>
<td>3,650,101</td>
</tr>
</tbody>
</table>
NOTES TO SUMMARIZED FINANCIAL STATEMENTS

For the year ended September 30, 2015

1. Basis of presentation

The summary financial statements are derived from the audited financial statements, prepared in accordance with Canadian accounting standards for not-for-profit organizations (ASNPO), as at September 30, 2015 and for the year then ended.

The preparation of these summary financial statements requires management to determine the information that needs to be reflected in them so that they are consistent in all material respects with, or represent a fair summary of, the audited financial statements.

Management prepared these summary financial statements using the following criteria:

• The summary financial statements include a statement for each included in the audited financial statements with the exception of the statement of changes in net assets, as this statement is readily available on request;
• Information in the summary financial statements agrees with the related information in the audited financial statements;
• Major subtotals, totals, and comparative information from the audited financial statements are included; and
• The summary financial statements contain the information from the audited financial statements dealing with matters having a pervasive or otherwise significant effect on the summarized financial statements.

The audited financial statements of the Alberta Medical Association (C.M.A. Alberta Division) are available upon request by contacting the Association.

2. Change in accounting policies

Effective October 1, 2014, the Association adopted Section 3463, Reporting Employee Future Benefits for Not-for-Profit Organizations, of the ASNPO as issued by the Canadian Accounting Standards Board. The accounting policy selected under this framework has been applied consistently and retrospectively as if this policy had always been in effect. The following adjustments were made by the Association on adoption and had the following effect on the consolidated financial statements:
### Summary statement of financial position

<table>
<thead>
<tr>
<th>Description</th>
<th>Reported amount</th>
<th>Adjustment</th>
<th>Restated amount as at September 30, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee future benefits</td>
<td>(2,945,431)</td>
<td>3,223,124</td>
<td>277,693</td>
</tr>
</tbody>
</table>

### Summary statement of operations and net assets

<table>
<thead>
<tr>
<th>Description</th>
<th>Reported amount</th>
<th>Adjustment</th>
<th>Restated amount as at September 30, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee future benefit gain (loss)</td>
<td>(1,699,128)</td>
<td>1,002,732</td>
<td>(696,396)</td>
</tr>
<tr>
<td>Corporate affairs expenditures</td>
<td>6,746,881</td>
<td>(266,410)</td>
<td>6,480,471</td>
</tr>
<tr>
<td>Executive office expenditures</td>
<td>3,185,768</td>
<td>(161,142)</td>
<td>3,024,626</td>
</tr>
<tr>
<td>Health policy and economics expenditures</td>
<td>1,969,517</td>
<td>(156,768)</td>
<td>1,812,749</td>
</tr>
<tr>
<td>Public affairs expenditures</td>
<td>2,015,373</td>
<td>(88,216)</td>
<td>1,927,157</td>
</tr>
<tr>
<td>Professional affairs expenditures</td>
<td>951,892</td>
<td>(94,853)</td>
<td>857,039</td>
</tr>
<tr>
<td>Southern Alberta Office expenditures</td>
<td>504,019</td>
<td>(37,517)</td>
<td>466,502</td>
</tr>
<tr>
<td>Remeasurement of employee future benefits</td>
<td>-</td>
<td>(98,536)</td>
<td>(98,536)</td>
</tr>
</tbody>
</table>

Under Section 3463 of ASNPO, the Association recognizes gains and losses arising from the remeasurement of employee future benefit obligations in net assets as they arise under the immediate recognition approach. Remeasurement and other items are not reclassified from net assets to the consolidated statement of operations in a subsequent period. Prior to adoption, all charges from remeasuring the employee future benefit obligation, past service costs, settlements, or curtailments were deferred and systematically amortized into income on the consolidated statement of operations.

The Association has further elected under Section 3463 of ASNPO to utilize the actuarial valuation prepared for funding purposes to measure the employee future benefit obligation for the period. Prior to this election, the Association utilized the actuarial valuation for accounting purposes to determine the measurement of the obligation. This election results in more reliable and relevant information about the valuation of the future obligation arising from employee services provided. The impact of this election has been applied retrospectively.

The change in accounting policy had no impact on cash flows generated by the Association.

### 3. Administered programs

In addition to its principal activities, by agreement between the Association, and Her Majesty the Queen in Right of Alberta (the government), the Association is the administrator of certain programs. These programs are audited separately and reported to the government. As the Association is an administrator of the programs, the assets, liabilities, revenues and expenses of these programs are not included in these summary financial statements. The costs recovered by the Association to administer these programs have been included in these summary financial statements.
A summary of the programs administered by the Association as at and for the year ended March 31, 2015, which is the most recent fiscal year of the programs, is as follows:

<table>
<thead>
<tr>
<th>Program</th>
<th>Revenue</th>
<th>Expenses</th>
<th>Net Change in reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Plans</td>
<td>118,329,392</td>
<td>118,329,392</td>
<td>-</td>
</tr>
<tr>
<td>Physician Locum Services</td>
<td>30,130,806</td>
<td>30,130,806</td>
<td>-</td>
</tr>
<tr>
<td>Electronic Medical Records Completion Project</td>
<td>11,048,407</td>
<td>11,060,656</td>
<td>(12,249)</td>
</tr>
<tr>
<td>Alternate Relationship Plan Program Management Office</td>
<td>1,649,475</td>
<td>1,649,475</td>
<td>-</td>
</tr>
<tr>
<td>Towards Optimized Practice – Phase One: Panel</td>
<td>994,085</td>
<td>994,085</td>
<td>-</td>
</tr>
<tr>
<td>C-Change Clinical Practice Guidelines for Cardiovascular</td>
<td>2,407,156</td>
<td>2,407,156</td>
<td>-</td>
</tr>
<tr>
<td>Primary Care Initiative Program Management Office</td>
<td>3,089,314</td>
<td>3,089,314</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td><strong>167,648,635</strong></td>
<td><strong>167,660,884</strong></td>
<td><strong>(12,249)</strong></td>
</tr>
</tbody>
</table>

4. Portfolio investments

<table>
<thead>
<tr>
<th>Fund</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emerald Canadian Short-Term Investment Fund</td>
<td>19,496,955</td>
<td>18,676,082</td>
</tr>
<tr>
<td>Emerald U.S. Market Hedged Fund</td>
<td>2,828,857</td>
<td>2,929,090</td>
</tr>
<tr>
<td>Emerald International Equity Fund</td>
<td>2,634,805</td>
<td>2,587,392</td>
</tr>
<tr>
<td>Emerald Canadian Equity Index Fund</td>
<td>1,493,688</td>
<td>1,579,022</td>
</tr>
<tr>
<td>Emerald Canadian Bond Index Fund</td>
<td>523,393</td>
<td>537,779</td>
</tr>
<tr>
<td>Total portfolio investments – at quoted market value</td>
<td>26,977,798</td>
<td>26,309,365</td>
</tr>
<tr>
<td>Total portfolio investments – at cost</td>
<td>26,293,301</td>
<td>25,284,439</td>
</tr>
</tbody>
</table>

The asset mix for the portfolio investments is determined by management, taking into consideration the purposed of the reserves as prescribed by board policy.
5. Property and equipment

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost</td>
<td>Accumulated amortization</td>
</tr>
<tr>
<td>Land</td>
<td>$550,000</td>
<td>-</td>
</tr>
<tr>
<td>Building</td>
<td>$5,270,000</td>
<td>$843,279</td>
</tr>
<tr>
<td>Fixtures and improvements</td>
<td>$1,609,260</td>
<td>$445,968</td>
</tr>
<tr>
<td>Computers</td>
<td>$3,657,325</td>
<td>$2,265,790</td>
</tr>
<tr>
<td>Office furniture and equipment</td>
<td>$1,165,275</td>
<td>$876,439</td>
</tr>
<tr>
<td></td>
<td>$12,255,860</td>
<td>$4,431,476</td>
</tr>
</tbody>
</table>

Amortization for administered programs is recognized in the administered programs. In the current year, amortization was recognized in the capital fund for a total expense of $829,081 (2014 – $883,136).

6. Employee future benefits

The Association has a defined benefit pension plan for all permanent employees. The benefits are based on years of service and employees’ final average earnings.

The Association accrues its obligations under the employee defined benefit plans as the employees render the services necessary to earn the pension.

The Association measures its accrued employee future benefit obligation and the fair value of plan assets using the valuation for funding purposes as at December 31 each year (note 4). The most recent actuarial valuation of the pension plan for funding purposes was as at December 31, 2013, and the next required valuation will be as at December 31, 2016.

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Fair value of plan assets</td>
<td>$21,738,650</td>
<td>$19,794,119</td>
</tr>
<tr>
<td>Accrued benefit obligation</td>
<td>$21,528,635</td>
<td>$19,516,426</td>
</tr>
<tr>
<td>Plan surplus</td>
<td>$210,015</td>
<td>$277,693</td>
</tr>
</tbody>
</table>

The net accrued benefit asset is included in the Association’s consolidated statement of financial position.
The significant actuarial assumptions adopted in measuring the Association's employee future benefit determination are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>5.00%</td>
<td>5.00%</td>
</tr>
<tr>
<td>Rate of compensation increase</td>
<td>2.75% + SMP</td>
<td>2.75 + SMP</td>
</tr>
<tr>
<td>Inflation</td>
<td>2.25%</td>
<td>2.25%</td>
</tr>
</tbody>
</table>

Total cash payments for employee future benefits for 2015, consisting of cash contributed by the Association to the registered pension plan was $1,791,813 (2014 – $2,287,033). Cash contributions received from administered programs and remitted to the pension plan were $746,201 (2014 – $933,241).

Employee future benefits as reported on the statement of financial position include the following:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee future benefit – opening balance</td>
<td>277,693</td>
<td>(531,090)</td>
</tr>
<tr>
<td>Net benefit plan expense</td>
<td>(1,078,796)</td>
<td>(1,379,714)</td>
</tr>
<tr>
<td>Remeasurements of employee future benefits</td>
<td>(780,695)</td>
<td>(98,536)</td>
</tr>
<tr>
<td>Gross employer contributions</td>
<td>1,791,813</td>
<td>2,287,033</td>
</tr>
<tr>
<td></td>
<td>210,015</td>
<td>277,693</td>
</tr>
</tbody>
</table>

7. Insurance experience

The Association maintains a group insurance policy for the benefit of the members and enters into an annual Financial letter of Understanding. It is the intention of the Association that insurance products operate on a break-even basis over the long term. Over the short term, the Association participates, out of reserves, in experience surpluses and losses as calculated at December 31 of each fiscal year. An experience gain of $4,264,626 (2014 – $404,111) was recognized during the year with $924,110 (2014 – $1,115,652) recorded as funds on deposit.

As a result of the positive experience, the Association has provided premium rate reductions of 15% to 25% for a number of years. The 2015 premium reduction of $2.2 million (2014 – $2.2 million) is funded from the premium reserve.