

2012 PHYSICIAN MASTER AGREEMENT

THIS AGREEMENT made as of the 1st day of April, 2012,

BETWEEN:

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE
OF BRITISH COLUMBIA**, as represented by the Minister of Health

(the “Government”)

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION

(the “BCMA”)

AND:

MEDICAL SERVICES COMMISSION

(the “MSC”)

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2012 PHYSICIAN MASTER AGREEMENT

THIS AGREEMENT made as of the 1st day of April, 2012,

BETWEEN:

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF
BRITISH COLUMBIA**, as represented by the Minister of Health

(the “**Government**”)

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION

(the “**BCMA**”)

AND:

MEDICAL SERVICES COMMISSION

(the “**MSC**”)

WITNESSES THAT WHEREAS:

- A. The BCMA, the MSC and the Government were parties to the 2007 PMA, the 2007 General Practitioners Subsidiary Agreement, the 2007 Specialists Subsidiary Agreement, the 2007 Rural Practice Subsidiary Agreement, the 2007 Alternative Payments Subsidiary Agreement, and the 2007 Benefits Subsidiary Agreement;
- B. The parties have agreed to renew and replace the 2007 PMA, the 2007 General Practitioners Subsidiary Agreement, the 2007 Specialists Subsidiary Agreement, the 2007 Rural Practice Subsidiary Agreement, the 2007 Alternative Payments Subsidiary Agreement, and the 2007 Benefits Subsidiary Agreement on the terms set out in this Agreement;
- C. The parties have agreed that this agreement will constitute the 2012 Physician Master Agreement, and to enter into the General Practitioners Subsidiary Agreement, the Specialists Subsidiary Agreement, the Rural Practice Subsidiary Agreement, the Alternative Payments Subsidiary Agreement, and the Benefits Subsidiary Agreement, in the forms attached hereto as Appendices A through E respectively;
- D. The parties wish to work collaboratively in the health care system and recognize their shared obligation and responsibility to meet population and patient medical needs through evidence-based, quality care provided through an integrated, sustainable, accountable, efficient and effective health care system; and

E. This Agreement:

- (a) defines a relationship between the parties built upon transparency, constructive collaboration and mutual respect;
- (b) recognizes that the Government has an obligation to maintain and improve the health status of the population; to create health legislation, regulation and policy; to determine service organization and enable that organization through Health Authorities; and to determine the allocation of provincial funding for health services;
- (c) recognizes that Health Authorities are responsible for regional service planning and operations and the allocation and management of their fiscal, human and capital resources to meet the health service needs of residents; and
- (d) recognizes the BCMA's goals of maximizing physicians' professional satisfaction and achieving fair economic compensation for the services rendered by physicians.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows

ARTICLE 1 - INTERPRETATION

1.1 Definitions

In this Agreement including the recitals and Appendices the following definitions shall apply:

“this Agreement” or **“2012 Physician Master Agreement”** means this document including the Appendices, as amended from time to time in accordance with section 1.7.

“Ad Hoc Advisory Panel” has the meaning given in section 6.6.

“Adjudication Committee” has the meaning given in section 21.2.

“Agency” means a Health Authority and any other public agency funded by the Government and, in the context of an Alternative Payment Arrangement where the Government is a party, includes the Government.

“Alternative Payment Arrangement” means compensation for “Physician Services” (as defined in the Alternative Payments Subsidiary Agreement) under a Salary Agreement, Service Contract or Sessional Contract.

“Alternative Payments Committee” means the committee referred to in section 4.1 of the Alternative Payments Subsidiary Agreement.

“**Alternative Payments Program**” means the Government program designed to fund “Physician Services” (as defined in the Alternative Payments Subsidiary Agreement) through Alternative Payment Arrangements.

“**Alternative Payments Subsidiary Agreement**” means the agreement titled “2012 Alternative Payments Subsidiary Agreement” entered into by the parties pursuant to section 2.5, as amended from time to time.

“**Audit and Inspection Committee**” means the panel of that name appointed by the MSC pursuant to section 6 of the *Medicare Protection Act*.

“**Available Amount**” in respect of any Fiscal Year means the amount of funding set by the MSC for allocation under section 25 of the *Medicare Protection Act* for the payment of Insured Medical Services provided by physicians on a fee for service basis during that Fiscal Year, “Percentage Fee Premiums” (as defined in the Rural Practice Subsidiary Agreement) for such Fiscal Year, and payments made pursuant to the “Northern and Isolation Travel Assistance Program” (as defined in the Rural Practice Subsidiary Agreement) for such Fiscal Year, but excluding any interest payments related to the late payment of Fee for Service Accounts.

“**Benefits Committee**” has the meaning given in section 4.1 of the Benefits Subsidiary Agreement.

“**Benefits Subsidiary Agreement**” means the agreement titled “2012 Benefits Subsidiary Agreement” entered into by the parties pursuant to section 2.5, as amended from time to time.

“**Canadian Medical Protective Association Rebate Program**” means the program referred to in section 2.4 of the Benefits Subsidiary Agreement.

“**Central Recommendations**” has the meaning given in section 27.5(a)(i).

“**Change in form of compensation**” means a change in the type of compensation for physician services from fee for service to a Service Contract or Salary Agreement.

“**CHARD**” has the meaning given in section 5.4.

“**Clinical Support Services Committee**” has the meaning given in section 8.5(a).

“**Consult**” means to provide a meaningful opportunity for advice to be provided and for an exchange of views or concerns prior to the making of a decision or the finalization of a policy initiative as the context may require, and “**Consultation**” and “**Consulted**” have similar meanings.

“**Continuing Medical Education Fund**” means the fund referred to in section 2.5 of the Benefits Subsidiary Agreement.

“**Contributory Professional Retirement Savings Plan**” means the plan referred to in section 2.6 of the Benefits Subsidiary Agreement.

“**Dispute**” means a Provincial Dispute, a Local Dispute, or a MOCAP Distribution Dispute.

“Doctor of the Day” means a General Practitioner designated by a Health Authority to be available for the care of a patient who is being or has been admitted to a hospital and/or while the patient remains an inpatient of the hospital, where the patient does not have a General Practitioner or has a General Practitioner who does not have privileges at that hospital.

“e-Health Strategy Council” means a council comprised of representatives of the Ministry, the Health Authorities, the BCMA and other health care provider groups, whose mission is to contribute expertise, oversight, guidance and support to the development of e-health strategy and initiatives in British Columbia.

“EMR” has the meaning given in section 1.1(b) of Appendix H.

“Fee for Service Accounts” means accounts submitted by physicians to the MSP for the provision of Insured Medical Services provided on a fee for service basis.

“Fees” means the fees set out in the Payment Schedule.

“Final Termination Date” has the meaning given in section 28.2(b).

“Fiscal Year” means the 12 month period commencing on April 1 of a calendar year and ending on March 31 of the following calendar year.

“Further Termination Notice” has the meaning given in section 28.2(b).

“Future Legislation” has the meaning given in section 25.1.

“General Practice Services Committee” means the committee referred to in section 4.2 of the General Practitioners Subsidiary Agreement.

“General Practitioner” means a physician who is not a Specialist Physician.

“General Practitioners Subsidiary Agreement” means the agreement titled “2012 General Practitioners Subsidiary Agreement” entered into by the parties pursuant to section 2.5, as amended from time to time.

“Guide to Fees” means the BCMA Guide to Fees as published by the BCMA from time to time.

“Guidelines and Protocols Advisory Committee” means the committee of that name established and existing under section 5(1)(o) of the *Medicare Protection Act* as an advisory committee to the MSC.

“Health Authority” means a board as defined in section 1 of the *Health Authorities Act* (British Columbia), and also the Provincial Health Services Authority.

“Hybrid Working Group” has the meaning given in section 6.7.

“Insured Medical Services” at any time means services that are benefits under the *Medicare Protection Act* at that time.

“Issue” means a Local Interest Issue or a Local Quality of Care Issue.

“Joint Agreement Administration Group” has the meaning given in section 7.1.

“Joint Clinical Committees” has the meaning given in section 8.1.

“Joint Standing Committee on Rural Issues” or **“JSC”** means the committee referred to in section 5.1 of the Rural Practice Subsidiary Agreement.

“Laboratory Medicine Fee Agreement” has the meaning given in section 2.8.

“Laboratory Services Fees” means the Fees billed for laboratory medicine services and provided on an out-patient basis but excluding Fees for ECG, Nuclear Medicine, consultations and visits (as of the date of this Agreement, fee codes 94005, 94006, 94007, 94008, 94009, 94010, 94012), telephone consultations (as of the date of this Agreement, fee codes 94070, 97072, 94076, 04077, 94078), and General Practitioner laboratory services (as of the date of this Agreement, fee codes 00012, 30015 and 15000 to 15143).

“Local Contract” means:

- (a) a Salary Agreement, Service Contract, Sessional Contract, a MOCAP Contract and any other contract that the Government and BCMA agree is a Local Contract; or
- (b) an agreement, existing as at May 10, 2007, made in writing by an Agency, on the one hand, and a physician or group of physicians, on the other, that was intended to create an enforceable commitment, and is sufficiently certain as to its terms and duration so as to be capable of enforcement.

“Local Contract Dispute” means a dispute between an Agency, on the one hand, and a physician or group of physicians, on the other, regarding the interpretation, application, operation or alleged breach of a Local Contract:

- (c) where there is no mechanism in the Local Contract to resolve the dispute; or
- (d) where the Local Contract mandates the use of any of the dispute resolution procedures in this Agreement to resolve the dispute; or
- (e) where the parties to the Local Contract otherwise agree to use the applicable dispute resolution procedures in this Agreement to resolve the dispute.

“Local Dispute” means a Local Contract Dispute or a Local Range Placement Dispute.

“Local Interest Issue” means any issue, disagreement, conflict or matter that arises between an Agency, on the one hand, and a physician or group of physicians, on the other, that is not a Dispute or a Local Quality of Care Issue.

“**Local Quality of Care Issue**” means an issue that arises between an Agency, on the one hand, and a physician or group of physicians, on the other, that relates to the quality of patient care, that is not a Dispute.

“**Local Range Placement Dispute**” has the meaning given in section 11.10 of the Alternative Payments Subsidiary Agreement.

“**MCRC**” has the meaning given in section 17.3(d).

“**Medicare Protection Act**” means the *Medicare Protection Act*, R.S.B.C. 1996, c.286.

“**Minister**” means the Minister of Health and includes the Deputy Minister or a person designated to act on the Minister’s behalf.

“**Ministry**” means the British Columbia Ministry of Health.

“**MOCAP**” means the medical on-call/availability program referred to in Article 17 and described in Appendix G.

“**MOCAP Adjudicator**” has the meaning given in section 22.3(b).

“**MOCAP Advisory Committee**” means the committee established by the Ministry to monitor the administration of MOCAP.

“**MOCAP Contract**” means a contract between an Agency and a physician or group of physicians for on call availability under MOCAP.

“**MOCAP Distribution Dispute**” has the meaning given in section 17.3(k).

“**MOCAP Objectives**” has the meaning given in section 17.3(a).

“**MOCAP Redesign Panel**” has the meaning given in section 17.4(a).

“**MSP**” means the division of the Ministry responsible for the administration and operation of the Medical Services Plan continued under the *Medicare Protection Act*.

“**Other Recommendations**” has the meaning given in section 27.5(a)(ii).

“**Parental Leave Program**” has the meaning given in section 2.7 of the Benefits Subsidiary Agreement.

“**Patterns of Practice Committee**” means the committee of that name established and existing under section 5(1)(o) of the *Medicare Protection Act* as an advisory committee to the MSC.

“**PHSA**” has the meaning given in section 17.3(d).

“**Payment Schedule**” means the payment schedule established under section 26 of the *Medicare Protection Act*.

“Physician Disability Insurance Program” means the program referred to in section 2.8 of the Benefits Subsidiary Agreement.

“Physician Health Program” means the program referred to in section 2.9 of the Benefits Subsidiary Agreement.

“Physician Master Subsidiary Agreements” means, collectively, the General Practitioners Subsidiary Agreement, the Specialists Subsidiary Agreement, the Rural Practice Subsidiary Agreement, the Alternative Payments Subsidiary Agreement and the Benefits Subsidiary Agreement.

“Physician Section” means a group of physicians recognized by the BCMA Board as a section pursuant to Bylaw 4 of the Constitution and By-Laws of the BCMA.

“Physician Services Committee” has the meaning given in section 6.1.

“PITO” has the meaning given in section 18.2.

“PITO Steering Committee” means the committee described in section 2.2 of Appendix H.

“Practice Support Program” means the program supported by the General Practice Services Committee, the Specialist Services Committee and the Shared Care Committee to improve care for patients in British Columbia and increase job satisfaction amongst physicians.

“Provincial Dispute” means a dispute between the Government and the BCMA regarding the interpretation, application, operation or alleged breach of this Agreement and/or any of the Physician Master Subsidiary Agreements.

“Reference Committee” means the committee of that name established or to be established under section 5(1) (o) of the *Medicare Protection Act* as an advisory committee to the MSC.

“Renegotiation Notice” has the meaning given in section 27.1.

“Reopener Central Recommendations” has the meaning given in section 26.5(a)(i).

“Reopener Notice” has the meaning given in section 26.1.

“Reopener Other Recommendations” has the meaning given in section 26.5(a)(ii).

“Roster” has the meaning given in section 21.1.

“Rural Practice Subsidiary Agreement” means the agreement titled “2012 Rural Practice Subsidiary Agreement” entered into by the parties pursuant to section 2.5, as amended from time to time.

“Salary Agreement” means an employment agreement between a physician and an Agency for the provision of “Physician Services” (as defined in the Alternative Payments Subsidiary Agreement).

“**Salary Agreement Ranges**” means the annual salary rate ranges as set out in Schedule A to the Alternative Payments Subsidiary Agreement, as amended from time to time.

“**Salary Agreement Rate**” means a rate within one of the Salary Agreement Ranges and a corresponding rate in an individual Salary Agreement.

“**Service Contract**” means a contract between a physician or a group of physicians organized as an association or partnership of physicians or a physician corporation, on the one hand, and an Agency, on the other hand, for the provision of “Physician Services” (as defined in the Alternative Payments Subsidiary Agreement), but does not include contracts for payment on a fee for service basis, Salary Agreements, Sessional Contracts or MOCAP Contracts.

“**Service Contract Ranges**” means the annual Service Contract rate ranges as set out in Schedule B to the Alternative Payments Subsidiary Agreement, as amended from time to time.

“**Service Contract Rate**” means a rate within one of the Service Contract Ranges and a corresponding rate in an individual Service Contract.

“**Sessional Contract**” means a contract between a physician or a group of physicians organized as an association or partnership of physicians or a physician corporation, on the one hand, and an Agency, on the other, for the provision of “Physician Services” (as defined in the Alternative Payments Subsidiary Agreement) provided on a sessional basis.

“**Sessional Contract Rate**” means a rate set out on Schedule C to the Alternative Payment Subsidiary Agreement, as such rates may be amended from time to time pursuant to Appendix F, and a corresponding rate in an individual Sessional Contract.

“**Shared Care Committee**” has the meaning given in section 8.6.

“**Specialist Section**” means a Physician Section for an area of Specialist Physician practice.

“**Specialist Physician**” means a physician who is a certificant or fellow of the Royal College of Physicians and Surgeons of Canada.

“**Specialist Services Committee**” means the committee referred to in section 5.1 of the Specialists Subsidiary Agreement.

“**Specialists Subsidiary Agreement**” means the agreement titled “2012 Specialists Subsidiary Agreement” entered into by the parties pursuant to section 2.5, as amended from time to time.

“**Tariff Committee**” means the BCMA Economics Committee as described in the Constitution and By-Laws of the BCMA in effect on the date of execution of this Agreement.

“**Termination Notice**” has the meaning given in section 28.1.

“**Total Claims Cost**” in respect of any Fiscal Year means the amount actually paid by the MSP for Insured Medical Services provided by physicians on a fee for service basis during that Fiscal Year, all “Percentage Fee Premiums” (as defined in the Rural Practice Subsidiary Agreement)

paid during that Fiscal Year, and all payments made under the “Northern and Isolation Travel Assistance Program” (as defined in the Rural Practice Subsidiary Agreement) during that Fiscal Year, but excluding any interest payments related to the late payment of Fee for Service Accounts.

“**Triple Aim Principles**” means the simultaneous pursuit of positively impacting the experience of the individual receiving healthcare services and the healthcare professional providing those services, the health of populations, and healthcare spending.

“**Trouble Shooter**” has the meaning given in section 21.3.

“**withdrawal of services**” means the withdrawal of any clinical or related teaching, research or clinical administrative services, or any services related to the participation on hospital committees, the participation on the active staff of hospitals, or other administrative, educational, management or related non-clinical services.

“**2007 Alternative Payments Subsidiary Agreement**” means the agreement titled “Alternative Payments Subsidiary Agreement” made as of November 1, 2007, among the Government, the BCMA and the MSC, as subsequently amended.

“**2007 Benefits Subsidiary Agreement**” means the agreement titled “Benefits Subsidiary Agreement” made as of November 1, 2007, among the Government, the BCMA and the MSC, as subsequently amended.

“**2007 General Practitioners Subsidiary Agreement**” means the agreement titled “General Practitioners Subsidiary Agreement” made as of November 1, 2007, among the Government, the BCMA and the MSC, as subsequently amended.

“**2007 PMA**” means the agreement titled “Physician Master Agreement” made as of November 1, 2007, among the Government, the BCMA and the MSC, as subsequently amended.

“**2007 Rural Practice Subsidiary Agreement**” means the agreement titled “Rural Practice Subsidiary Agreement” made as of November 1, 2007, among the Government, the BCMA and the MSC, as subsequently amended.

“**2007 Specialists Subsidiary Agreement**” means the agreement titled “Specialists Subsidiary Agreement” made as of November 1, 2007, among the Government, the BCMA and the MSC, as subsequently amended.

“**2012 Benefits Administration Agreement**” means the agreement referred to in section 7.1 of the Benefits Subsidiary Agreement.

1.2 Meaning of “Consensus Decision”

In this Agreement, a committee shall be deemed to have made a “**consensus decision**” if:

- (a) a resolution of the committee is passed by at least a majority of the members of the committee after the committee has gone through a reasonable process to reach unanimous approval of the resolution by the members of the committee;
- (b) for all committees other than the Physician Services Committee, a written copy of the passed resolution is submitted to the co-chairs of the Physician Services Committee; and
- (c) either:
 - (i) the Government and the BCMA both express in writing their support of the resolution by notice in writing to the other; or
 - (ii) for all committees other than the Physician Services Committee, the resolution is not objected to in writing by either the Government or the BCMA by notice in writing to the other within 45 days after the date the written copy of the resolution is submitted to the co-chairs of the Physician Services Committee, and for the Physician Services Committee the resolution is not objected to in writing by either the Government or the BCMA by notice in writing to the other within 45 days after the date such resolution is passed by the Physician Services Committee.

1.3 Successor to the MSC

The words “**the MSC, or its successor,**” do not include a public administrator appointed pursuant to section 3(13) of the *Medicare Protection Act*, and if such a public administrator is so appointed, the parties agree to amend this Agreement to provide for an alternate process for the determination of issues that under those sections are to be or may be referred to “**the MSC, or its successor,**” for determination.

1.4 Miscellaneous Interpretation

In this Agreement:

- (a) words in the singular include the plural and vice versa, and words in one gender include all genders;
- (b) the headings of Articles, sections and Appendices are for convenience of reference only and do not form part of this Agreement and shall not affect the construction or interpretation of this Agreement;
- (c) the words “**Article**” and “**section**” mean and refer to the specified Article or section of this Agreement unless reference is made to another agreement;

- (d) the words “**include**”, “**includes**” or “**including**” mean “include without limitation”, “includes without limitation” and “including without limitation” respectively, and the words following “include”, “includes” or “including” shall not be considered to set forth an exhaustive list;
- (e) all references to money or currency refer to lawful money of Canada and all amounts to be calculated or paid pursuant to this Agreement are to be calculated and paid in lawful money of Canada;
- (f) the words “**this Agreement**”, “**herein**”, “**hereof**” and “**hereunder**” and other words of similar import refer to this Agreement as a whole and not to any particular Article, section or Appendix of this Agreement; and
- (g) unless reference is made to a statute in effect at a particular time, each reference to a statute is deemed to be a reference to that statute and any successor statute, and to any regulations and rules made under that statute and any successor statute, each as amended or re-enacted from time to time.

1.5 Binding Effect

This Agreement shall enure to the benefit of and be binding upon the parties hereto and their respective successors and assigns.

1.6 Governing Law

This Agreement will be governed by, and construed in accordance with, the laws of the Province of British Columbia.

1.7 Amendment and Waiver

This Agreement may be amended at any time but only by written agreement of the parties. Any waiver of any provision of this Agreement shall only be effective if in writing signed by the waiving party, and no waiver shall be implied by indulgence, delay or other act, failure to act, omission or conduct. Any waiver shall only apply to the specific matter waived and only in the specific instance and for the specific purpose for which it is given.

1.8 Severability

The parties:

- (a) intend that this Agreement shall comply with all applicable laws; and
- (b) agree that if any part of any Article, section, subsection, clause or provision of this Agreement shall be determined by a court or arbitrator of competent jurisdiction to be invalid or unenforceable for any reason, it shall not impair or affect or be deemed to impair or affect the validity of the remaining parts of such Article, section, subsection, clause or provision or the remaining parts of this Agreement, and such remaining parts shall continue to have full force and effect,

and such invalid or unenforceable part shall be severable and severed from and deemed not to be part of this Agreement.

ARTICLE 2 - EFFECT OF AGREEMENT AND RELATED AGREEMENTS

2.1 Ratification

This Agreement and the Physician Master Subsidiary Agreements are not binding on the parties until this Agreement is ratified and executed by them, and the terms of this Agreement and the Physician Master Subsidiary Agreements, and all information, documents and other materials exchanged between the parties in the negotiation of this Agreement and the Physician Master Subsidiary Agreements, are without prejudice to any party if this Agreement is not ratified and executed by all of them within the time provided in section 2.2.

2.2 Failure to Ratify

If this Agreement is not ratified and executed by the parties in accordance with section 2.1 on or before August 31, 2012, this Agreement and the Physician Master Subsidiary Agreements will be null and void and will not be used by any party in any proceeding or in any other way.

2.3 Effective Date

This Agreement comes into force on April 1, 2012.

2.4 Further Assurances

The parties agree to execute and deliver all such further documents and do all such further things as may be reasonably required to carry out the purpose and intent of this Agreement.

2.5 Physician Master Subsidiary Agreements

Concurrently with execution and delivery of this Agreement, the parties shall execute and deliver the Physician Master Subsidiary Agreements in the forms attached hereto as Appendices A through E.

2.6 Conflicts

If there is any conflict or inconsistency between, on the one hand, any terms of this Agreement and, on the other hand, any terms of any of the Physician Master Subsidiary Agreements, the terms of this Agreement shall govern and take precedence.

2.7 Termination of Prior Agreements

If each of this Agreement and the Physician Master Subsidiary Agreements are executed, delivered and ratified as provided in sections 2.1 and 2.5, the following agreements shall terminate and be of no further force or effect:

- (a) the 2007 PMA;
- (b) the 2007 Alternative Payments Subsidiary Agreement;
- (c) the 2007 Benefits Subsidiary Agreement;
- (d) the 2007 General Practitioners Subsidiary Agreement;
- (e) the 2007 Rural Practice Subsidiary Agreement; and
- (f) the 2007 Specialists Subsidiary Agreement.

2.8 Laboratory Medicine Fee Agreement

The Government and the BCMA have agreed to certain terms and conditions related to expenditures on laboratory services and have recorded those terms and conditions in the Laboratory Medicine Fee Agreement dated as of April 1, 2012 (the “**Laboratory Medicine Fee Agreement**”), a copy of which is attached hereto as Appendix J. The Laboratory Medicine Fee Agreement is a separate and distinct agreement and its construction is not to be influenced or affected by the provisions of this Agreement (other than Appendix J itself). Further, the provisions of this Agreement (other than Appendix J itself) do not apply to the Laboratory Medicine Fee Agreement except to the extent that they would apply to it as a separate and distinct agreement. For greater certainty, and without limiting the generality of the forgoing, the following provisions have no application to the Laboratory Medicine Fee Agreement:

- (a) section 6.3;
- (b) Articles 20 through 23; and
- (c) Articles 25 through 28.

ARTICLE 3 - APPLICATION AND REPRESENTATION

3.1 Application

This Agreement applies to those physicians resident within the Province of British Columbia whose services are compensated by funds provided by the Government either directly or through Agencies.

3.2 BCMA Representation of Physicians

- (a) The Government hereby grants to the BCMA the sole and exclusive right, and the BCMA hereby undertakes the obligation, to represent the collective and individual interests of those physicians where the funding for their services is, in whole or in part, provided by the Government either directly or through Agencies.

- (b) The Government undertakes to include within funding contracts for physician services with Agencies, a clause requiring the Agency to advise physicians of their right to be represented by the BCMA, and to negotiate in good faith when establishing Local Contracts.
- (c) The Government further undertakes that it will require Agencies to recognize the BCMA's right to represent those physicians who request the assistance of the BCMA in negotiating contractual arrangements with those Agencies.
- (d) The BCMA undertakes that, in exercising its representation rights, it will advise physicians that all matters within the ambit of this Agreement and/or within the ambit of any of the Physician Master Subsidiary Agreements, must comply with the provisions of this Agreement and the Physician Master Subsidiary Agreements.

3.3 Health Authority Compliance

The Government will ensure that Health Authorities comply with this Agreement and the Physician Master Subsidiary Agreements.

ARTICLE 4 - COOPERATION AND CONSULTATION TO SUPPORT QUALITY ASSURANCE AND IMPROVEMENT

4.1 Obligation to Consult

- (a) The Government and the BCMA will Consult and collaborate with each other to ensure the provision of high quality medical services to the residents of British Columbia, and the Government will facilitate the participation of Health Authorities in that Consultation.
- (b) It is acknowledged and agreed that the partnership envisaged by this Agreement requires ongoing dialogue and Consultation on major issues of significance to the provision of medical care, including policy, whether such care is funded directly or indirectly by the Government.
- (c) In particular:
 - (i) the BCMA shall be Consulted prior to the adoption of policy initiatives by the Government that would affect the provision of medical care by physicians; and
 - (ii) the parties will Consult on strategies and measures to ensure that total expenditures on physician services do not exceed the annual funding.

4.2 Consultation Process

The primary vehicle for the Consultations referred to in this Article 4 will be the Physician Services Committee.

4.3 Consultation Does Not Constrain Change

Except as explicitly identified in this Agreement, nothing in this process of Consultation and collaboration constrains the Government or the Health Authorities from implementing change in the organization and delivery of services once the required Consultation has taken place.

ARTICLE 5 - SHARING INFORMATION

5.1 Need for Information Sharing

Each of the Government, the MSC and the BCMA acknowledges and agrees that the sharing of relevant information and data in a timely way is critically important to the achievement of the objectives established in this Agreement and to the administration of the *Medicare Protection Act*.

5.2 Agreement to Share Information

- (a) Subject to sections 5.2(c) and (d), each of the Government, the MSC and the BCMA agrees to provide relevant information that is requested by the others. Relevant historical and predictive data prepared by any party will be shared.
- (b) In particular, but subject to sections 5.2(c) and (d), the Government will provide to the BCMA:
 - (i) aggregate information on Total Claims Cost on a monthly basis and detailed information on fee for service claims semi-monthly, with physician and beneficiary identification encoded;
 - (ii) information including, at a minimum, the total paid amount, specialty and location for payments funded by Health Authorities and/or the Government on all Sessional Contracts, Service Contracts and Salary Agreements at the level of the individual physician, where available, on an annual basis, with physician identification encoded; and
 - (iii) information on MOCAP payments including, at a minimum, paid amount, on call level, specialty and location, at the level of the individual physician, where available, on an annual basis, with physician identification encoded.
- (c) The Government will provide information that contains the identification of physicians or beneficiaries to MSC advisory committees constituted under the *Medicare Protection Act*, but only for the purposes of the administration of the *Medicare Protection Act*.
- (d) Notwithstanding sections 5.2(a), (b) and (c), no party shall be obligated to share information with, or to disclose information to, any other party:

- (i) unless such sharing or disclosure would be in compliance with all applicable laws; or
- (ii) if such information is subject to any solicitor and client privilege, or other privilege to which the sharing or disclosing party is entitled at law.

5.3 Confidentiality

Each of the Government, the MSC and the BCMA agrees that it shall, and shall cause its representatives to, keep confidential all information identified as confidential by the disclosing party that is disclosed to it pursuant to this Agreement, not disclose such information to any other person, use such information solely in connection with this Agreement, and take precautions necessary to prevent unauthorized access to or use, disclosure or reproduction of such information, provided that the foregoing restrictions shall not apply to information that is in the public domain other than through a breach of this section, or that is or was obtained from sources other than a party to this Agreement, and shall not apply to disclosure required by applicable laws or made to a professional advisor on a strictly confidential basis.

5.4 Community Healthcare and Resource Directory

If the Government chooses to fund the Community Healthcare and Resource Directory, (the “**CHARD**”), the BCMA will continue to encourage physicians to update and maintain the information required for the CHARD.

ARTICLE 6 - PHYSICIAN SERVICES COMMITTEE

6.1 Physician Services Committee Composition

- (a) The **Physician Services Committee** shall continue as the senior body overseeing the relationship between the Government and the BCMA and the implementation and administration of this Agreement and the Physician Master Subsidiary Agreements.
- (b) The Physician Services Committee will be composed of six members, three of whom will be appointed by the Government and three of whom will be appointed by the BCMA. The members appointed by the Government will include an Assistant Deputy Minister of Health and at least one Health Authority Chief Executive Officer or Health Authority designate. The members appointed by the BCMA will include the Chief Executive Officer of the BCMA.
- (c) The Government and the BCMA will each name one of their respective appointees to act as co-chair of the Physician Services Committee, and the chair will alternate for successive meetings.

6.2 Costs of the Physician Services Committee

The Government and the BCMA will pay the costs of the participation in the Physician Services Committee of their respective appointees, and the Government will provide secretariat support for the Physician Services Committee.

6.3 Functions of the Physician Services Committee

The Physician Services Committee, as the senior body overseeing the relationship between the Government and the BCMA and the implementation and administration of this Agreement and the Physician Master Subsidiary Agreements, will, among other things:

- (a) monitor the activities of, and provide direction to, the other joint committees of the Government and the BCMA referred to in this Agreement or the Physician Master Subsidiary Agreements, including, among other things, overseeing the work of the General Practice Services Committee, the Specialist Services Committee, the Clinical Support Services Committee, the Shared Care Committee, the Joint Standing Committee on Rural Issues, and the Benefits Committee by engaging in the following process for each Fiscal Year:
 - (i) by March 1 of each year, the Physician Services Committee will convene a meeting with the co-chairs of each of the General Practice Services Committee, the Specialist Services Committee, the Clinical Support Services Committee, the Shared Care Committee, the Joint Standing Committee on Rural Issues, and the Benefits Committee during which the Government's priorities for the health care system for the next Fiscal Year and the possible initiatives of the committee in question for the next Fiscal Year will be identified and discussed, all in the context of the mandate established for the committee in question in this Agreement and/or in a Physician Master Subsidiary Agreement;
 - (ii) following the meeting referred to in section 6.3(a)(i), and before April 1 of the same year, the committee in question shall submit to the Physician Services Committee a detailed written plan outlining the committee's intentions for initiatives within its mandate to be undertaken by the committee during the Fiscal Year commencing on April 1 of the same year;
 - (iii) the Physician Services Committee will consider each plan submitted to it pursuant to section 6.3(a)(ii) by the General Practice Services Committee, the Specialist Services Committee, the Clinical Support Services Committee, the Shared Care Committee, and the Joint Standing Committee on Rural Issues, and will either approve the plan or advise the committee in question of why it is unable to approve the plan in which case the committee will, within 30 days of being advised by the Physician Services Committee that it is unable to approve the plan, reconsider the

plan and, if able, submit a revised plan to the Physician Services Committee for approval;

- (iv) where the Physician Services Committee receives a revised plan from a committee in accordance with section 6.3(a)(iii), the Physician Services Committee may approve the revised plan, in whole or in part, and if the Physician Services Committee does not approve the whole of the revised plan either the Government or the BCMA may refer the outstanding issues to the MSC and the MSC, or its successor, will determine the matter;
 - (v) where the Physician Services Committee is unable to approve a plan from a committee and the committee is unable to submit a revised plan to the Physician Services Committee either the Government or the BCMA may refer the outstanding issues to the MSC and the MSC, or its successor, will determine the matter;
 - (vi) following finalization of a committee's plan in accordance with either section 6.3(a)(iii), (iv) or (v), the Physician Services Committee will convene at least two additional meetings with the co-chairs of each committee specifically named in section 6.3(a)(iii), to take place prior to the end of the Fiscal Year in question, during which the plan of the committee in question will be reviewed, its progress assessed and any variances addressed; and
 - (vii) if, during any Fiscal Year, any of the committees specifically named in section 6.3(a)(i) proposes to reallocate funds between its programs in a manner not specifically contemplated by its plan for that Fiscal Year, it shall first provide the Physician Services Committee of advance written notice of its intentions;
- (b) approve any proposal to reallocate funding between any of the joint committees of the Government and the BCMA referred to in this Agreement or the Physician Master Subsidiary Agreements;
 - (c) oversee the development of and approve a joint communications protocol to be used by each of the joint committees of the Government and the BCMA referred to in this Agreement or the Physician Master Subsidiary Agreements, in respect of all decisions made by such committees, that shall include the requirement for prior approval of the co-chairs of the committee in question of any communication regarding the business and/or decisions of the committee;
 - (d) on an annual basis, review the joint committee structure reflected in this Agreement and the Physician Master Subsidiary Agreements, and make any changes to that committee structure that the Physician Services Committee considers desirable;
 - (e) provide a forum for Consultation on the matters specifically identified for Consultation in this Agreement;

- (f) provide a forum for the Government, the BCMA and the Health Authorities to discuss and agree on a joint vision framework for medical services that is aligned with the Ministry's agenda for innovation and change;
- (g) subject to the specific processes set out elsewhere in this Agreement, discuss and where possible attempt to resolve Issues;
- (h) provide general oversight of the dispute resolution processes in this Agreement and the Physician Master Subsidiary Agreements including, among other things,
 - (i) receive, from the Joint Agreement Administration Group, regular reports of the business of the Joint Agreement Administration Group by way of copies of the minutes of the meetings of the Joint Agreement Administration Group or otherwise as directed by the Physician Services Committee; and
 - (ii) receive, from the Joint Agreement Administration Group, and consider notices of all Disputes, and upon doing so, the Physician Services Committee may require the co-chairs of the Joint Agreement Administration Group to provide the Physician Services Committee with a without prejudice briefing about any Dispute;
- (i) enable communication between the Government, the BCMA and the Health Authorities;
- (j) engage in any other functions that the Government and BCMA may, by written agreement, assign to it; and
- (k) in addition to fulfilling its role in relation to Disputes and Issues as specified elsewhere in this Agreement, the Physician Services Committee will attempt to resolve any other matter that arises between the Government and the BCMA, and that is not a Dispute or Issue, in the following manner:
 - (i) the party raising the matter must notify the other party, in writing, with a copy of the notice to the Physician Services Committee;
 - (ii) the notice shall comprehensively outline the substance of the matter and include all data or other information relied on by the party raising the matter as well as a statement of the proposed remedy or proposed solution; and
 - (iii) upon receiving such a notice, the Physician Services Committee may, by consensus decision, issue recommendations with respect to the matter to the Government and the BCMA or may, by consensus decision, direct that the matter be referred to the Adjudication Committee for arbitration, at which time a chair will be appointed from the Roster.

6.4 Conduct of the Business of the Physician Services Committee

- (a) The Physician Services Committee will maintain terms of reference for the conduct of its business that will include a requirement for the use of formal agendas for its meetings, notice of meetings with agendas, formal resolutions and minutes of its meetings and decisions. Any changes to the terms of reference will be subject to adoption by consensus decision.
- (b) The Government and the BCMA will determine the frequency of meetings of the Physician Services Committee.
- (c) The Physician Services Committee will make all decisions and recommendations by consensus decision, whether or not a consensus decision is expressly called for by any other provision of this Agreement.

6.5 Local Quality of Care Issues

- (a) The parties agree that there is benefit to discussing significant Local Quality of Care Issues that are raised by physicians, groups of physicians or Agencies, when such Local Quality of Care Issues have not been resolved at the local or regional level.
- (b) Where a physician, group of physicians or Agency has a significant concern respecting a Local Quality of Care Issue related to hospital care, the physician, physician group or Agency must first attempt to resolve the matter through the appropriate medical advisory committee.
- (c) Where a physician, group of physicians or Agency has a significant concern respecting a Local Quality of Care Issue that is not related to hospital care, the physician, group of physicians or Agency must first attempt to resolve the matter through a direct meeting.
- (d) Where a Local Quality of Care Issue is not resolved pursuant to either of sections 6.5(b) and 6.5(c), the physician, group of physicians or Agency may refer the matter to the Physician Services Committee.
- (e) Any referral of a Local Quality of Care Issue to the Physician Services Committee pursuant to section 6.5(d) must be in writing and must include full particulars related to the matter, including relevant supporting data and any proposed solutions.
- (f) Upon receiving a referral pursuant to section 6.5(d), the Physician Services Committee may:
 - (i) appoint an Ad Hoc Advisory Panel to review the issue and provide recommendations to the Physician Services Committee;

- (ii) refer the matter to the Trouble Shooter for recommendations to the Physician Services Committee; or
 - (iii) take any other action the Physician Services Committee considers appropriate in the circumstances.
- (g) All recommendations of an Ad Hoc Advisory Panel or the Trouble Shooter, on any Local Quality of Care Issue, will be confidential unless directed otherwise by the Physician Services Committee.
- (h) Upon receiving recommendations from any of an Ad Hoc Advisory Panel or the Trouble Shooter pursuant to section 6.5(f), the Physician Services Committee will attempt to resolve the Local Quality of Care Issue through a recommendation. Failing such a recommendation of the Physician Services Committee, there are no further steps under this Agreement to address the Local Quality of Care Issue.

6.6 Ad Hoc Advisory Panel

- (a) An **Ad Hoc Advisory Panel** will be struck by the Physician Services Committee, as required, to assist in resolving Local Quality of Care Issues.
- (b) An Ad Hoc Advisory Panel will be selected by the Physician Services Committee so as to bring the necessary administrative and professional skills, experience and credentials to the examination of the Local Quality of Care Issue in question.
- (c) The Physician Services Committee will develop and maintain a roster of individuals who may be appointed to an Ad Hoc Advisory Panel, but the Physician Services Committee may appoint individuals who are not on that roster to any Ad Hoc Advisory Panel.
- (d) Recommendations of an Ad Hoc Advisory Panel will be unanimous or, failing unanimity, an Ad Hoc Advisory Panel may issue different sets of recommendations.
- (e) Upon releasing its recommendations to the Physician Services Committee, that Ad Hoc Advisory Panel will be dissolved.

6.7 Hybrid Compensation Model

- (a) The Government and the BCMA shall create an *ad hoc* working group (the “**Hybrid Working Group**”) to consider and make recommendations regarding a hybrid model of compensation that includes both a prospective and retrospective payment component.
- (b) The Hybrid Working Group will be composed of four members, two of whom will be appointed by the Government, two of whom will be appointed by the BCMA.

- (c) The Hybrid Working Group will commence its work by April 1, 2013, and will, on matters where all members of the Hybrid Working Group agree, submit a written report and recommendations to the Physician Services Committee by March 31, 2014. In preparing that report and recommendations, the Hybrid Working Group will, among other things, consider the following:
- (i) models of hybrid compensation that could more closely align compensation with service and quality outcomes than fee for service or purely fixed payment (such as a Service Contract or Salary Agreement) may do alone;
 - (ii) services that could be provided within the prospective component of compensation and services that could be incentivised within the retrospective component of compensation;
 - (iii) areas of practice that may be suited for application of hybrid compensation models;
 - (iv) areas of practice or physician groups for participation in a potential hybrid compensation pilot project; and
 - (v) input from both the General Practice Services Committee and the Specialist Services Committee.
- (d) The Physician Services Committee will consider any report and recommendations received from the Hybrid Working Group and make any decisions regarding such report and recommendations by consensus decision.

ARTICLE 7 - JOINT AGREEMENT ADMINISTRATION GROUP

7.1 Joint Agreement Administration Group Composition

- (a) The **Joint Agreement Administration Group** shall continue under this Agreement to provide oversight of the implementation and administration of this Agreement, the Physician Master Subsidiary Agreements and the 2012 Benefits Administration Agreement, and to manage the dispute resolution provisions of this Agreement, the Physician Master Subsidiary Agreements and Local Contracts, in accordance with the provisions of this Agreement.
- (b) The Joint Agreement Administration Group will be composed of six members, three of whom will be appointed by the Government and three of whom will be appointed by the BCMA. The members appointed by the Government will be staff members of the Government, a Health Authority, and/or the Health Employers Association of British Columbia, and the members appointed by the BCMA will be staff members of the BCMA.

- (c) The Government and the BCMA will each name one of their respective appointees as co-chair of the Joint Agreement Administration Group, and the chair will alternate for successive meetings.

7.2 Costs of the Joint Agreement Administration Group

The Government and the BCMA will pay the costs of the participation in the Joint Agreement Administration Group of their respective appointees.

7.3 Functions of the Joint Agreement Administration Group

The Joint Agreement Administration Group will, among other things:

- (a) report to the Physician Services Committee by:
 - (i) providing the Physician Services Committee with copies of all minutes of Joint Agreement Administration Group meetings,
 - (ii) providing the Physician Services Committee with copies of notices of all Disputes, and, if required by the Physician Services Committee, providing the Physician Services Committee with a without prejudice briefing about any Dispute, and
 - (iii) otherwise reporting as directed by the Physician Services Committee; and
- (b) oversee and manage the processes for the resolution of Disputes, in accordance with the provisions of this Agreement.

7.4 Conduct of the Business of the Joint Agreement Administration Group

- (a) The Joint Agreement Administration Group will maintain terms of reference for the conduct of its business that will include a requirement for the use of formal agendas for its meetings, notice of its meetings with agendas, formal resolutions and minutes of meetings and decisions. Any changes to the the terms of reference will be subject to approval by consensus decision of the Physician Services Committee.
- (b) The Joint Agreement Administration Group will make all decisions and recommendations by consensus decision, whether or not a consensus decision is expressly called for by any other provision of this Agreement.
- (c) The Joint Agreement Administration Group must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Joint Agreement Administration Group pre-approve any communication about the business and/or decisions of the Joint Agreement Administration Group.

ARTICLE 8 - JOINT CLINICAL COMMITTEES

8.1 Joint Clinical Committees

The Government and the BCMA will create or continue the following joint committees (the “**Joint Clinical Committees**”):

- (a) the Specialist Services Committee;
- (b) the General Practice Services Committee;
- (c) the Clinical Support Services Committee; and
- (d) the Shared Care Committee.

8.2 Core Mandate of the Joint Clinical Committees

In fulfilling each of their specific mandates, each of the Joint Clinical Committees will operate from a core mandate to:

- (a) identify changes in current physician service delivery that could result in improvements in patient care, more effective utilization of physician and other healthcare resources, and measurable savings in expenditures that could be reallocated for more optimal provision of healthcare services;
- (b) support the integration and alignment of physician services with other health service delivery;
- (c) strengthen the application of Triple Aim Principles in service design and delivery;
- (d) encourage appropriate collaborative practice with other physicians and integration of physicians with other healthcare professionals in the delivery of services;
- (e) identify gaps in care and address population health needs;
- (f) support the delivery of quality and evidence based care including promoting the adoption and effective implementation of appropriate clinical practice guidelines, where appropriate;
- (g) prior to making decisions, consider the unique issues arising from rural practice;
- (h) use total expenditure data for services as an aid to making decisions;
- (i) form temporary sub-committees (that may be allocated a specific budget) where required to address issues of patient care which engage the mandates of more than one Joint Clinical Committee;
- (j) make recommendations on appropriate shared care between physicians and other healthcare professionals; and

- (k) establish measures for accountability and achievement of outcomes.

8.3 Specialist Services Committee

In addition to the core mandate outlined in section 8.2, the Specialist Services Committee will fulfill the specific mandate outlined in the Specialists Subsidiary Agreement.

8.4 General Practice Services Committee

In addition to the core mandate outlined in section 8.2, the General Practice Services Committee will fulfill the specific mandate outlined in the General Practitioners Subsidiary Agreement.

8.5 Clinical Support Services Committee

- (a) The Government and the BCMA shall create a committee (the “**Clinical Support Services Committee**”) to improve the quality and efficient delivery of clinical support services.
- (b) The Clinical Support Services Committee will be composed of eight members, four of whom will be appointed by the Government and four of whom will be appointed by the BCMA.
- (c) The Clinical Support Services Committee will be co-chaired by one member appointed by the Government members and one member appointed by the BCMA members, and the chair will alternate for successive meetings.
- (d) The Clinical Support Services Committee will meet once in each quarter of each Fiscal Year, or more frequently as agreed by the co-chairs of the Clinical Support Services Committee.
- (e) The Clinical Support Services Committee will endeavor to make all recommendations by consensus decision, whether or not a consensus decision is expressly called for by any other provision of this Agreement. Failing a consensus decision the Clinical Support Services Committee may make more than one set of recommendations on a particular topic.
- (f) In addition to the core mandate outlined in section 8.2, the Clinical Support Services Committee will fulfill the specific mandate to:
 - (i) make recommendations on measures that would improve the quality and efficient delivery of clinical support services and on the appropriate utilization of clinical support services;
 - (ii) work with the General Practice Services Committee and the Specialist Services Committee on efforts to ensure appropriate utilization of clinical support services by physicians;

- (iii) monitor system level utilization of clinical support services;
 - (iv) advise on clinical support service delivery issues that arise among other Joint Clinical Committees; and
 - (v) monitor implementation of any agreements related to clinical support services as provided for in any such agreements.
- (g) On an annual basis, the Clinical Support Services Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a).
- (h) The Clinical Support Services Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Clinical Support Services Committee pre-approve any communication about the business and/or decisions of the Clinical Support Services Committee.

8.6 Shared Care Committee

- (a) The **Shared Care Committee** shall continue under this Agreement as a subcommittee of the General Practice Services Committee, the Specialist Services Committee, and the Clinical Support Services Committee to improve shared care between General Practitioners, Specialist Physicians and other healthcare professionals.
- (b) The Shared Care Committee will be composed of eight members, four of whom will be appointed by the Government and four of whom will be appointed by the BCMA. The members appointed by the Government will include at least one of the Government appointees to each of the General Practice Services Committee, the Specialist Services Committee, and the Clinical Support Services Committee. The members appointed by the BCMA will include at least one of the BCMA appointees to each of the General Practice Services Committee, the Specialist Services Committee, and the Clinical Support Services Committee.
- (c) The Shared Care Committee will be co-chaired by one member appointed by the Government members and one member appointed by the BCMA members, and the chair will alternate for successive meetings.
- (d) The Shared Care Committee will make all recommendations and decisions by consensus decision, whether or not a consensus decision is expressly called for by any other provision of this Agreement. Failing a consensus decision the Shared Care Committee may make more than one set of recommendations on a particular topic or, in the case of a decision that is required of the Shared Care Committee, the Government and/or the BCMA may make recommendations to the MSC and the MSC, or its successor, will determine the matter.

- (e) In addition to the core mandate outlined in section 8.2, the Shared Care Committee will fulfill the specific mandate to:
 - (i) develop recommendations for the General Practice Services Committee, the Specialist Services Committee, and the Clinical Support Services Committee including the creation of new fees (that is, fees to be added to the Payment Schedule) to enable shared care and appropriate scopes of practice between General Practitioners, Specialist Physicians and other healthcare professionals and, specifically, will develop recommendations regarding:
 - (A) changes to, or full use of, scopes of practice of General Practitioners to free up Specialist Physician time;
 - (B) refining and supporting the appropriate allocation of services between General Practitioners and Specialist Physicians to meet patients' medical needs;
 - (C) collaboration between General Practitioners, Specialist Physicians and other healthcare professionals to meet the medical needs of patients; and
 - (D) facilitating access to advice from Specialist Physicians by General Practitioners; and
 - (ii) allocate the funding identified in sections 8.6(f) in accordance with sections 8.6(f) and (g).
- (f) As at March 31, 2012, the annual funding level for the Shared Care Committee was \$6 million. Effective April 1, 2013, the Government will add new annual funding of \$500,000 for the Shared Care Committee. The funding for the Shared Care Committee will be allocated by the Shared Care Committee to support and increase collaboration between General Practitioners and Specialist Physicians in providing high quality, integrated medical care to British Columbians.
- (g) Any funds identified in section 8.6(f) that remain unexpended at the end of any Fiscal Year will be available to the Shared Care Committee for use as one time allocations to improve the quality of care.
- (h) Administrative and clerical support required for the work of the Shared Care Committee and physician (other than employees of the BCMA, the Government and the Health Authorities) participation in the Shared Care Committee will be paid from funds referred to in section 8.6(f).
- (i) On an annual basis, the Shared Care Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a).

- (j) The Shared Care Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Shared Care Committee pre-approve any communication about the business and/or decisions of the Shared Care Committee.

8.7 Practice Support Program

- (a) The Practice Support Program shall operate effective April 1, 2012 under the direction of a subcommittee of the General Practice Services Committee and the Specialist Services Committee.
- (b) The Practice Support Committee will assume the activities of the practice support program previously provided through the General Practice Services Committee, and will provide support to both General Practitioners and Specialist Physicians.
- (c) Effective April 1, 2014, with the termination of the PITO on March 31, 2014, the Practice Support Program will assume responsibility for providing physicians with change management support related to the adoption and use of EMRs by physicians.
- (d) The Practice Support Program will be funded by monies currently allocated by the General Practice Services Committee, the Specialist Services Committee and the Shared Care Committee.

ARTICLE 9 - MEDICAL SERVICES COMMISSION

9.1 MSC Membership

Subject to applicable laws:

- (a) the following process will be used to appoint the members to the MSC:
 - (i) the Minister will advise the BCMA of three individuals who will be recommended to the Lieutenant Governor in Council for appointment under the *Medicare Protection Act* as representatives of the Government;
 - (ii) the BCMA will advise the Minister of three individuals the BCMA nominates for membership on the MSC, and the Minister will recommend to the Lieutenant Governor in Council the appointment of those three individuals under the *Medicare Protection Act*;
 - (iii) the Minister and the BCMA will consult as to the names of three individuals who will be appointed under the *Medicare Protection Act* as representatives of beneficiaries under that Act, and the Minister and the BCMA must agree on a joint recommendation of the three individuals who will be recommended to the Lieutenant Government in Council for appointment, provided that if the parties are unable to agree, either the Minister or the BCMA may request the Chief Justice of the Supreme

Court of British Columbia to name the three individuals who will be jointly recommended by the Minister and the BCMA to be appointed as representatives of the beneficiaries;

- (b) members of the MSC will be appointed for a term of three years and may be re-appointed;
- (c) upon the expiry of the term of any member of the MSC or, in the event of death, disability, incapacity, or resignation during the term of appointment, the process outlined in section 9.1(a) that was applicable to the appointment of such member will be utilized to the extent necessary to replace such member;
- (d) the Ministry and the BCMA each retain the right to remove any member of the MSC appointed as its representative and the Government will pass any necessary order-in-council; and
- (e) an alternate member may be appointed to serve in the absence of a member as permitted by section 23 of the *Interpretation Act*.

9.2 Chair of the MSC

- (a) It is acknowledged that subsection 3(4) of the *Medicare Protection Act* requires the Lieutenant Governor in Council to designate a member of the MSC appointed to represent the Government as the Chair of the MSC. The Minister will Consult with the BCMA prior to the appointment or reappointment of the Chair of the MSC.
- (b) The Chair of the MSC must act in a manner that is consistent with the purpose of the *Medicare Protection Act* and in the spirit of this Agreement and shall not execute or initiate matters or changes not previously authorized or agreed to by the MSC in the period between meetings of the MSC.

9.3 Independence of the MSC

The parties agree that it is in the best interests of all parties and in the public interest for the MSC to exercise its full legal authority in an independent manner under the management of its members.

ARTICLE 10 - ADVISORY COMMITTEES TO THE MEDICAL SERVICES COMMISSION

10.1 Reference Committee

- (a) The Reference Committee may, as contemplated in this Agreement, make recommendations to the MSC.
- (b) The MSP shall inform physicians of their right to refer matters relating to their medical accounts to the Reference Committee where:

- (i) there is a disagreement between the physician and the MSP with respect to an account or accounts, that is not resolved within 60 days from the date that a written enquiry, from the physician, is received by the MSP; or
 - (ii) there is a disagreement between the physician and the MSP over payment for services or procedures for which no fee has been established and approved by the MSC, that is not resolved within 60 days from the date that a written enquiry, from the physician, is received by the MSP.
- (c) The Reference Committee shall promptly review all matters referred to it and shall forward its recommendations to the MSC within one month of its meeting or to the Tariff Committee or MSP as appropriate.
 - (d) When the MSC accepts the recommendation of the Reference Committee to pay a Fee for Service Account as submitted by a physician, the MSP shall pay the account with interest at the rate provided for in and in accordance with Regulation 215/83 of the *Financial Administration Act*.
 - (e) The Reference Committee shall meet to review matters referred to it at least three times per calendar year and the period between successive meetings is not to exceed six months. A recommendation by the Reference Committee is not binding on the MSC. However, the MSC will endeavour to follow the recommendations of the Reference Committee. This does not in any way circumscribe or fetter the duties, rights and discretions of the MSC under the *Medicare Protection Act*.
 - (f) The approved costs of the Reference Committee will be shared equally by the MSP and the BCMA.

10.2 Audit and Inspection Committee

- (a) In this section 10.2 and section 10.3, “medical practitioner” has the meaning given to that expression in section 1 of the *Medicare Protection Act*, as further defined by section 36(1) therein, and “panel” has the meaning given to that expression in section 6 of the *Medicare Protection Act*, as further described in this section 10.2.
- (b) The MSC has the right and responsibility to appoint inspectors to audit claims for payment by medical practitioners and the patterns of practice or billing followed by medical practitioners under the *Medicare Protection Act*.
- (c) The Audit and Inspection Committee is a panel appointed by the MSC pursuant to section 6 of the *Medicare Protection Act*.
- (d) The parties agree that the Audit and Inspection Committee shall be delegated the powers of the MSC under section 36(1) to (12) of the *Medicare Protection Act* to appoint inspectors to audit and inspect practitioners.

- (e) The Audit and Inspection Committee's responsibilities include random audits, other audits and inspections referred to it by the MSC, MSP or any practitioner review committee, including the Patterns of Practice Committee, and the submission of its recommendations to the MSC.
- (f) Inspectors are to be appointed from a list maintained by the Audit and Inspection Committee and proposed jointly by the BCMA and the Government after consultation with the College of Physicians and Surgeons of British Columbia.
- (g) Notice of inspection must be provided to the medical practitioner(s) in question. Except in extraordinary circumstances, which in no case would include a random audit, notice of inspection must be provided at least 14 days prior to the inspection.
- (h) Inspection guidelines are to be clearly laid out and communicated to the medical practitioner(s) prior to inspection.
- (i) The confidential nature of medical records will be protected. The identity of patients shall be protected except to the extent necessary for verification or as evidence for a hearing.
- (j) Prior to any decision being made by the MSC resulting from a recommendation of the Audit and Inspection Committee, it is understood that the medical practitioner(s) subject to the audit and inspection shall be entitled to be heard by the MSC and to have legal counsel present and may have one or more colleagues present to comment on the practice of the medical practitioner(s).
- (k) Prior to a hearing before the MSC, the MSC will communicate in writing to the medical practitioner(s) its concerns and provide copies of all relevant documents (except those over which a claim of privilege is advanced and, if challenged, upheld) to the medical practitioner(s) at least 21 days prior to the hearing.
- (l) The approved costs of the Audit and Inspection Committee shall be funded by the MSP.

10.3 Patterns of Practice Committee

- (a) The MSC has the right and responsibility to appoint inspectors to audit the patterns of practice of medical practitioners as part of a random review or in response to service verification irregularities.
- (b) The Patterns of Practice Committee shall continue to act as an advisory committee to the MSC under section 5(1)(o) of the *Medicare Protection Act*.
- (c) The approved costs of the Patterns of Practice Committee will be shared equally by the MSP and the BCMA.

10.4 Guidelines and Protocols Advisory Committee

- (a) The Guidelines and Protocols Advisory Committee is an advisory committee to the MSC.
- (b) The Guidelines and Protocols Advisory Committee will be composed of members appointed by the MSC on the advice of the Government and the BCMA.
- (c) The Guidelines and Protocols Advisory Committee will be co-chaired by a Government representative and a BCMA representative, and the chair will alternate for successive meetings.
- (d) The Government will provide administrative and clerical support required for the work of the Guidelines and Protocols Advisory Committee. The Government will provide up to \$320,000 annually to support the work of the Guidelines and Protocols Advisory Committee. The costs of physician (other than employees of the BCMA, Government or Health Authorities) participation in the Guidelines and Protocols Advisory Committee will be paid from the \$320,000 referred to in this section.
- (e) The Guidelines and Protocols Advisory Committee will, at the request of any of the Joint Clinical Committees or the Physician Services Committee from time to time, develop guidelines and protocols to support the effective utilization of medical services.
- (f) The Guidelines and Protocols Advisory Committee will develop strategies for the rapid adoption by all affected parties of guidelines and protocols once they are approved.

ARTICLE 11 - THE AVAILABLE AMOUNT

11.1 Establishment of the Available Amount

- (a) There will be one centrally administered Available Amount. This does not preclude segmenting components of the Available Amount for analysis of expenditures of the Available Amount for purposes of planning, evaluation and management.
- (b) The Government will Consult with the MSC and the BCMA prior to the tabling of the Ministry's spending estimates on the amount of annual funding for the provision of physician services to the residents of British Columbia in each year.
- (c) For each Fiscal Year, the Government will advise the BCMA through the MSC of the budget for the Available Amount within 15 days of the approval of the Ministry's spending estimates by the Legislature. Adjustments as a result of the negotiation of agreements will be disclosed following the resolution of those agreements.

11.2 Monitoring and Managing the Available Amount

- (a) The MSP will track Total Claims Cost against the Available Amount at the conclusion of each month and will make a forecast concerning the adequacy of the Available Amount. The results will be forwarded to the MSC, at or before the next meeting of the MSC.
- (b) If the MSC concludes on the basis of a reasonable forecast that the Total Claims Cost for a Fiscal Year is likely to exceed the Available Amount, the MSC will Consult with the BCMA and the Ministry on developing strategies and measures to prevent the overrun of the Available Amount. While the parties agree that there will be no pro-rationing of Fees for the term of this Agreement, the parties recognize that the MSC must exercise its statutory responsibility through the use of reasonable methods within its jurisdiction, subject to the specific provisions agreed to in this Agreement. An integral part of the exercise of that responsibility will be the development of protocols and billing guidelines by the MSC. The BCMA will participate in the development of those protocols and billing guidelines and the medical profession will make every effort to adhere to such protocols and billing guidelines once implemented by the MSC.
- (c) In recognition of the need for all parties to this Agreement to be satisfied that the MSC continues to be effective in managing the Available Amount, the Chair of the MSC will meet with the Physician Services Committee at regular intervals to assess the management process. The Physician Services Committee will report the results of these meetings to the Minister, the MSC and the Board of Directors of the BCMA on a timely basis.
- (d) Reconciliation of the Total Claims Cost with the Available Amount for each Fiscal Year shall take place and be concluded by October 31 of the following Fiscal Year.

ARTICLE 12 - REVISION AND MAINTENANCE OF THE GUIDE TO FEES

12.1 Revisions to Guide to Fees by BCMA

- (a) Funds made available in Appendix F for revisions to the Payment Schedule, will be allocated by the BCMA to fee items in the Guide to Fees in a manner consistent with this Agreement including Appendix F.
- (b) Except where otherwise expressly agreed in writing, revisions to the Guide to Fees allocating funds made available under Appendix F for any Fiscal Year will be effective April 1 of that Fiscal Year.
- (c) When the Tariff Committee has prepared recommendations for revisions to the Guide to Fees for consideration by the Board of Directors of the BCMA, prior to transmission of its recommendations to the Board of Directors of the BCMA the Tariff Committee will:

- (i) inform the MSC and the Physician Services Committee of the recommendations in writing;
 - (ii) consult with the MSC and the Physician Services Committee to identify any comments or concerns they may have respecting such recommendations in order that the Tariff Committee may have such comments or concerns before them at the time of finally recommending a revision of the Guide to Fees to the BCMA's Board of Directors; and
 - (iii) attempt to achieve agreement in writing between the BCMA and the Government on the recommended changes, and if such agreement is reached, section 13.1 shall apply.
- (d) If agreement is not reached between the BCMA and the Government pursuant to section 12.1(c)(iii) within 90 days, or such additional time as may be agreed, of written notification from the BCMA to the Government of a proposed revision pursuant to this section 12.1, the BCMA may refer the matter to the MSC for a decision under section 13.2.
- (e) No change to the Payment Schedule shall result from a change to the Guide to Fees under this section 12.1, except in accordance with Article 13.

12.2 Revisions to Guide to Fees on Government's Recommendation

- (a) When the Government wishes to recommend the creation of a new fee item or any revisions to existing fee items in the Guide to Fees, it will:
 - (i) consult with the Tariff Committee and with the Health Authorities to identify any comments or concerns they may have respecting such recommendations; and
 - (ii) attempt to achieve agreement in writing with the BCMA through the Tariff Committee on the recommended changes, and if such agreement is reached, section 13.1 shall apply.
- (b) If agreement is not reached between the Government and the BCMA pursuant to section 12.2(a)(ii) within 90 days, or such additional time as may be agreed, of written notification from the Government to the BCMA of a proposed revision pursuant to this section 12.2, the Government may advise the BCMA that it intends to refer the matter to an ad hoc joint review panel as provided in section 12.2(c).
- (c) The joint review panel must be appointed within 60 days of the Government advising the BCMA that it intends to refer the matter to an ad hoc joint review panel. The composition of the joint review panel shall be three members, with one member appointed by the BCMA, one member appointed by the Government, and the third member who shall be the Chair, selected from a roster of individuals agreed upon by the Government and the BCMA. The members appointed shall be

chosen so as to avoid conflicts of interest. If the Government and the BCMA have not agreed upon the roster, the MSC will appoint the Chair.

- (d) The joint review panel must render a majority recommendation to the parties and the MSC within three months of its appointment.
- (e) If the Government and the BCMA support in writing the recommendation of the joint review panel, the BCMA shall change the Guide to Fees accordingly and section 13.1 shall apply.
- (f) If either the Government or the BCMA does not support in writing the recommendation of the joint review panel, the MSC will decide the matter in accordance with section 13.2, and if the MSC decides that a change to the Guide to Fees should be made, the BCMA will implement the change to the Guide to Fees.

ARTICLE 13 - REVISIONS TO THE PAYMENT SCHEDULE

13.1 Revisions By Agreement

The MSC shall adopt as part of the Payment Schedule additions to, deletions from or other modifications of the Guide to Fees, provided that:

- (a) either:
 - (i) the BCMA and the Government agree in writing to the additions, deletions or other modifications; or
 - (ii) the Government and the BCMA support in writing the recommendations of the joint review panel as contemplated by section 12.2(e);
- (b) the MSC agrees that such modifications are consistent with the requirements of the *Medicare Protection Act* and Regulations;
- (c) the MSC agrees that the services covered by a given fee item are medically necessary; and
- (d) the MSC agrees to the estimated projected net cost effect on the Total Claims Cost which would result from such recommended changes.

13.2 Revisions in the Absence of Agreement

Where there is no agreement between the BCMA and the Government on recommended changes to the Payment Schedule, the BCMA and the Government may make separate recommendations to the MSC and the MSC will determine the changes, if any, to the Payment Schedule.

13.3 Changes to Insured Medical Services

If the MSC introduces any change to the medical services that are benefits under the *Medicare Protection Act*, it will provide at least 30 days' notice of such change to all physicians enrolled in the MSP.

ARTICLE 14 - PAYMENT OF FEE FOR SERVICE ACCOUNTS

14.1 Payment Process

- (a) It is acknowledged and agreed that there exists a common interest in ensuring that Fee for Service Accounts are processed and paid promptly.
- (b) On behalf of beneficiaries, the MSP will pay Fee for Service Accounts promptly, in accordance with the Payment Schedule, subject to the provisions of the *Medicare Protection Act* and this Agreement.
- (c) Normally, the MSC makes general remittances for Fee for Service Accounts on a regular cycle that is at least semi-monthly. If the MSC is unable to make a general remittance within five working days of the end of a payment cycle, an advance against Fee for Service Accounts payable will be paid. This will be limited to the physician's average regular cycle payment, measured over the previous 12 months or over the length of time the physician has participated in the MSP, whichever is the lesser period of time.
- (d) By September 1, 2012, the Government and the BCMA will create a joint working group to review the time within which Fee for Service Accounts are typically paid, evaluate the effectiveness of current MSP initiatives to pay Fee for Service Accounts promptly, and recommend strategies directed at ensuring that Fee for Service Accounts are paid within 90 days of submission to the MSP.
- (e) If, by April 1, 2013, a system has not been implemented by the MSP to ensure that Fee for Service Accounts are paid within 90 days of submission to the MSP, then the MSC will cause the MSP to implement a payment system that requires payment of 50% of the amount claimed in each Fee for Service Account within 90 days of submission of same to the MSP. If such payment system is implemented by the MSP, it shall remain in place until the MSP has implemented a system that ensures that each Fee for Service Account is processed and paid within 90 days of submission to the MSP.

14.2 Advances

The MSP may, on an individual physician basis, provide an advance to a physician encountering temporary difficulty submitting his or her Fee for Service Accounts or having those Fee for Service Accounts processed by the MSP. Requests for advances will be submitted to the MSP, which will determine whether or not the advance will be granted. If the MSP denies a request for an advance, the requesting physician may refer the matter to the Physician Services Committee for a final decision on the matter. Such advances will be set off against subsequent

remittances to the physician by the MSP until the advance is fully repaid. Interest at the rate provided for in and in accordance with Regulation 214/83 of the *Financial Administration Act* (British Columbia) shall apply to and be paid by the physician on all such advances.

14.3 Overdue Accounts

Interest shall apply to and be paid by the MSP on overdue Fee for Service Accounts at the rate provided for in and in accordance with Regulation 215/83 of the *Financial Administration Act* (British Columbia). Interest will only apply on the amount of the outstanding Fee for Service Account that exceeds the amount of any outstanding advance.

14.4 Changes to Payment Process

- (a) Should a need arise to review the routine data requirements, submission formats and/or transmission protocols for processing Fee for Service Accounts, the review must consider, among other things, the efficacy of the modification and the cost to physicians of implementing such a change.
- (b) When there are modifications to the routine data requirements, submission formats and/or transmission protocols for processing Fee for Service Accounts, the parties will attempt to reach agreement on the net average cost of implementing these modifications and, if they fail to do so, then the matter shall be determined by the Adjudication Committee and appropriate compensation (including retroactivity) if any, will be provided to the affected physicians.

ARTICLE 15 - FEES, SERVICE CONTRACT RANGES, SESSIONAL CONTRACT RATES AND SALARY AGREEMENT RANGES

15.1 Compensation Changes to March 31, 2014

Changes to Fees, Service Contract Ranges, Sessional Contract Rates, Salary Agreement Ranges and other fees over the term of this Agreement are set out or provided for in Appendix F.

15.2 Interprovincial Physician Compensation Report

- (a) The parties recognize that the compensation of physicians and physician groups in British Columbia should, at least in part, be based upon the need to be competitive with other provinces for the recruitment and retention of physicians.
- (b) Pursuant to the 2007 Physician Master Agreement, a panel was assembled to produce a report on interprovincial comparisons and the panel produced such a report dated December 31, 2010.

15.3 WorkSafe BC Services and ICBC Services

Effective April 1, 2011, an in office assessment of an unrelated condition in association with a WorkSafeBC service and/or an ICBC service shall be compensated in accordance with the Payment Schedule.

ARTICLE 16 - FUNDING NEW FEE ITEMS

16.1 Allocation for New Fee Items

In each of the Fiscal Years from April 1, 2012 to March 31, 2014, the Government will make an additional annual allocation of \$1 million for new fee items (that is, fee items to be added to the Payment Schedule). These funds will be allocated to new fee items pursuant to Articles 12 and 13. Any such monies that are unused in one Fiscal Year (including the Fiscal Year ending on March 31, 2014) shall be carried forward to the next Fiscal Year. The funding obligation to provide the \$1 million additional annual allocation for new fee items under this section ends on March 31, 2014.

ARTICLE 17 - THE MEDICAL ON-CALL/AVAILABILITY PROGRAM

17.1 Budget for MOCAP

Funding for Doctor of the Day is allocated from the annual MOCAP budget.

17.2 MOCAP Terms and Conditions

- (a) The MOCAP shall be operated in accordance with the terms attached hereto as Appendix G.
- (b) Physicians who provide MOCAP coverage will do so in accordance with the provisions of the MOCAP Contract attached hereto as Schedule 1 to Appendix G.

17.3 Distribution of MOCAP Funds by Health Authorities

- (a) The Health Authorities will distribute MOCAP funds that have been allocated to them by the Government in a manner that supports the following objectives (the “**MOCAP Objectives**”), in the following order of priority:
 - (i) first, to provide life and limb support in acute care hospitals, diagnostic and treatment centres, and specified emergency rooms;
 - (ii) second, where required for the operational efficiency of hospitals; and
 - (iii) third, to support General Practitioner care of complex patients in the community.
- (b) The MOCAP Advisory Committee has Consulted with the BCMA through the Physician Services Committee and has developed evaluation criteria that support the MOCAP Objectives and their prioritization as required by section 17.3(a).
- (c) Notwithstanding section 2.3, sections 17.3(d) through (n) will not take effect as of April 1, 2012 but rather will come into force on July 1, 2013 for application to the Fiscal Year 2014/15 and thereafter unless the Physician Services Committee accepts the recommendations of the MOCAP Redesign Panel in accordance with

section 17.4(g) in which case sections 17.3(d) through (n) will be of no force or effect.

- (d) By July 1 of each year, each Health Authority will form a MOCAP Contract Review Committee (the "**MCRC**"). The MCRC of each Health Authority except the Provincial Health Services Authority ("**PHSA**") will include Health Authority representatives, one representative of the Health Authority's medical advisory committee and at least three representatives of emergency medicine physicians within the Health Authority. The MCRC of PHSA will be composed of two emergency physicians representative of emergency medicine at BC Children's Hospital, one physician who is peer selected from each of the PHSA agencies and one member appointed by the PHSA.
- (e) Each MCRC will review and Consult on the Health Authority's requirements for MOCAP coverage within its MOCAP funding allocation for the next Fiscal Year. This review will include Consultations with non-physician service providers who have expertise and experience that would assist the MCRC in recommending annual MOCAP coverage needs to the Health Authority, on the most urgent priority needs for on-call availability. Each MCRC will apply the evaluation criteria referred to in section 17.3(b), as amended and published by the MOCAP Advisory Committee from time to time, in making recommendations to its Health Authority with respect to the distribution of the Health Authority's MOCAP funding allocation.
- (f) After having received recommendations pursuant to section 17.3(e) and prior to finalizing a plan for the distribution of its annual MOCAP funding allocation, each Health Authority except the PHSA will review its proposed plan with its medical advisory committee and may make changes in response to any concerns identified by the Health Authority's medical advisory committee.
- (g) After having received recommendations pursuant to section 17.3(e) and prior to finalizing a plan for the distribution of its annual MOCAP funding allocation, the PHSA will review its proposed plan with a committee composed of the members of its Physician Leaders Council and one peer selected physician chosen from each of the Children's & Women's Health Centre of British Columbia, the BC Cancer Agency and Riverview Hospital-Forensic Psychiatric Services and may make changes in response to any concerns identified by that committee.
- (h) Following the Consultations referred to in section 17.3(e) and either section 17.3(f) or section 17.3(g) as applicable, each Health Authority will finalize a plan for the distribution of its annual MOCAP funding allocation for the next Fiscal Year through renewal, modification or new MOCAP Contracts.
- (i) By November 1 of each year, each Health Authority will publish to all affected physicians the plan for the distribution of its annual MOCAP funding allocation for the next Fiscal Year.

- (j) Upon request received by November 15 of any year from any physician or physician group affected by a Health Authority's plan for the distribution of its annual MOCAP funding allocation for the next Fiscal Year, the Health Authority will conduct a debriefing with the affected physician or physician group. Any member of that Health Authority's MCRC may attend such debriefing.
- (k) Following a debriefing as contemplated in section 17.3(j), any physician or physician group may challenge a Health Authority's plan for the distribution of its annual MOCAP funding allocation for the next Fiscal Year (a "**MOCAP Distribution Dispute**") in accordance with section 22.3 on the following grounds:
 - (i) the process set out in sections 17.3(d) through 17.3(i) was not followed;
 - (ii) the proposed distribution is inconsistent with the MOCAP Objectives and their prioritization as required by section 17.3(a); or
 - (iii) in finalizing its distribution plan the Health Authority relied upon considerations other than those that are relevant to the MOCAP Objectives and their prioritization as required by section 17.3(a).
- (l) Where no MOCAP Distribution Dispute arises within the deadline in section 22.3(c), the Health Authority's MOCAP distribution plan for the subsequent Fiscal Year will be final.
- (m) Notwithstanding any MOCAP Distribution Dispute regarding the distribution of a Health Authority's annual MOCAP funding allocation for a particular Fiscal Year, the Health Authority may implement its plan for the distribution of its annual MOCAP funding allocation for that Fiscal Year, subject to section 17.3(n).
- (n) If, as a result of any MOCAP Distribution Dispute in respect of a Fiscal Year, a modification to a Health Authority's plan for the distribution of its annual MOCAP funding allocation is required by an award of the MOCAP Adjudicator made pursuant to section 22.3(f), the Health Authority may terminate or amend MOCAP Contracts entered into for that Fiscal Year as may reasonably be required to carry out or comply with such award.

17.4 MOCAP Redesign

- (a) The Government and the BCMA shall create a panel (the "**MOCAP Redesign Panel**") to redesign MOCAP, in accordance with the provisions of this section 17.4.
- (b) The MOCAP Redesign Panel will be composed of five members, two of whom will be appointed by the Government, two of whom will be appointed by the BCMA, and Eric Harris, QC who shall serve as chair. The Government appointees and the BCMA appointees will have experience and expertise in the healthcare system.

- (c) The MOCAP Redesign Panel will commence its work by September 1, 2012, and will prepare a written report and recommendations for the redesign of MOCAP. In preparing that report and recommendations, the MOCAP Redesign Panel will, among other things, consider the following:
 - (i) compensation for on site on call availability that is different in structure and/or amount from compensation for off site on call availability;
 - (ii) a single base compensation rate for all off site on call availability;
 - (iii) in addition to the single base compensation rate referred to in section 17.4(c)(ii), additional compensation based on factors including but not limited to:
 - (A) the extent to which being on call disrupts the physician's personal and/or professional life including the number of calls the physician receives and/or the nature of the work arising when the physician is called; and
 - (B) the particular challenges associated with rural practice;
 - (iv) the requirement that response times will always be determined by patient clinical needs;
 - (v) administrative, reporting and billing rules required to ensure adequate data collection and ongoing review and assessment of the redesigned MOCAP; and
 - (vi) the funding constraints reflected by the Health Authorities' annual MOCAP allocations.
- (d) The written report and recommendations of the MOCAP Redesign Panel must:
 - (i) address the resolution of disputes between physicians and Health Authorities over the distribution of MOCAP funds;
 - (ii) distinguish between issues relating to a physician's obligation to provide on call coverage and issues relating to payment for providing on call availability; and
 - (iii) ensure physician input into the Health Authorities' MOCAP funding distribution decisions.
- (e) By March 31, 2013, or such later date as may be agreed upon by the Physician Services Committee, the MOCAP Redesign Panel will conclude its work and will present its written report and recommendations for the redesign of MOCAP to the Physician Services Committee. The report and recommendations will be endorsed unanimously by all members of the MOCAP Redesign Panel or, failing

unanimity, will reflect the views of the majority of the members of the MOCAP Redesign Panel.

- (f) The Physician Services Committee will have until May 31, 2013, or such later date as may be agreed upon by the Physician Services Committee, to accept by consensus decision the recommendations of the MOCAP Redesign Panel.
- (g) If the Physician Services Committee accepts the recommendations of the MOCAP Redesign Panel:
 - (i) the Government, the Health Authorities and the BCMA will jointly develop a plan for the implementation of the redesigned MOCAP that will ensure the continued delivery of required services, which shall include the continuation of existing MOCAP Contracts until October 1, 2013;
 - (ii) this Agreement will be amended as required to implement the redesigned MOCAP;
 - (iii) the redesigned MOCAP will take effect on October 1, 2013; and
 - (iv) during and following the implementation of the redesigned MOCAP, the Government, the Health Authorities and the BCMA will closely monitor the performance of the redesigned MOCAP and will ensure that any unintended consequences are mitigated.
- (h) If the Physician Services Committee does not accept the recommendations of the MOCAP Redesign Panel then the MOCAP as described in sections 17.1, 17.2, 17.3, Appendix G, and Schedules 1 and 2 to Appendix G will continue in force.

ARTICLE 18 - INFORMATION TECHNOLOGY

18.1 BCMA Participation in e-Health

The BCMA will participate in the leadership structure for e-Health in British Columbia. It will appoint one senior representative to the e-Health Strategy Council and will participate on the e-Health Strategy Council's subcommittees.

18.2 Physician Information Technology Office (PITO)

Pursuant to the 2007 Physician Master Agreement, the Government established a physician information technology office for British Columbia (the "PITO") to operate between April 1, 2006 and March 31, 2012. Notwithstanding the original termination date of March 31, 2012 for the PITO, the PITO shall continue to operate for physicians adopting EMRs, on a transitional basis, until March 31, 2014 on the terms set out in this Article 18 and in Appendix H to this Agreement. For greater certainty, notwithstanding anything else in this Agreement, this Article 18 and Appendix H to this Agreement will be of no further force or effect after March 31, 2014, and all PITO programs, services, activities and funding will end on March 31, 2014, subject to the outcome of the reopener process in Article 26.

18.3 PITO Structure and Functions

The structure, purpose and activities of the PITO are detailed in Appendix H to this Agreement.

ARTICLE 19 - CHANGE IN FORM OF COMPENSATION FOR PHYSICIAN SERVICES

19.1 Change in Form of Compensation

- (a) No change in form of compensation for physician services will be required of any physician.
- (b) An Agency has the right to determine the form of compensation for physician services for any new service model it introduces.

ARTICLE 20 - DISPUTE RESOLUTION AND ISSUE MANAGEMENT GENERAL PROVISIONS

20.1 Government and BCMA will Work to Prevent Withdrawals of Services

It is agreed that the Government and the BCMA will work together through the Physician Services Committee to prevent withdrawals of services as a result of Disputes and Issues arising between physicians and/or the BCMA, on the one hand, and the Government and/or Agencies, on the other.

20.2 Dispute Resolution and Issue Management may not alter Agreements

- (a) Any resolution of a Dispute or Issue must be consistent with the terms of this Agreement and the Physician Master Subsidiary Agreements unless otherwise recommended by the Physician Services Committee and agreed to by the parties to this Agreement.
- (b) No term or provision of this Agreement or any Physician Master Subsidiary Agreement may be amended except by agreement of the parties to this Agreement in accordance with section 1.7.
- (c) The Adjudication Committee does not have the authority to alter, modify or enlarge upon any provisions of this Agreement, the Physician Master Subsidiary Agreements, or any other agreement.

20.3 Voluntary Settlements are Without Prejudice

Any voluntary resolution of a Dispute or Issue achieved outside of any binding resolution process under this Agreement is without prejudice or precedent in any other Dispute or Issue and is inadmissible in any other proceeding relating to any other Dispute or Issue unless the Joint Agreement Administration Group decides otherwise.

20.4 Process, Time Limits and Procedural Requirements to be Strictly Complied With

- (a) Subject to a decision of the Joint Agreement Administration Group, or a direction of the Adjudication Committee, in either case to relieve against breaches of time limits for equitable reasons, and subject to the right of a party to elect to proceed to the next step in a process despite the other party's non-compliance with the time limits or procedural requirements, the time limits and procedural requirements established in this Agreement are mandatory, and where a Dispute or Issue is not advanced within these time limits or procedural requirements, the Dispute or Issue will be barred for all purposes and may not be reasserted in any proceeding or any forum.
- (b) Disputes and Issues will be resolved in accordance with the processes set out in this Agreement and only in accordance with the processes set out in this Agreement.

20.5 Distinguishing Disputes from Issues

- (a) The Joint Agreement Administration Group will resolve any disagreement as to whether:
 - (i) a matter is a Dispute, an Issue, or neither;
 - (ii) a Dispute is a Provincial Dispute, a Local Dispute, or a MOCAP Distribution Dispute;
 - (iii) a Local Dispute is a Local Contract Dispute or Local Range Placement Dispute; and
 - (iv) an Issue is a Local Interest Issue or a Local Quality of Care Issue.
- (b) If the Joint Agreement Administration Group cannot resolve a disagreement referred to in section 20.5(a), the Government or the BCMA may refer the question to the Adjudication Committee for a final and binding decision.

20.6 Costs of Dispute Resolution and Issue Management

The Government and the BCMA will bear the costs of their own respective participation in any of the Dispute and Issue management processes set out in this Agreement and will share the costs of the Trouble Shooter, any MOCAP Adjudicator and any third party appointed to the Adjudication Committee or an Ad Hoc Advisory Panel, other than representatives of the BCMA or the Government, and employees of the Health Authorities or parties.

ARTICLE 21 - DISPUTE RESOLUTION AND ISSUE MANAGEMENT TOOLS

21.1 Adjudication Roster

- (a) An Adjudication Roster (the “**Roster**”) will be maintained from which a chair for the Adjudication Committee will be appointed, on an as needed basis. The Roster will be composed of at least three individuals agreed upon in writing by the Government and the BCMA.
- (b) Individuals named to the Roster will have experience in conflict resolution, mediation and adjudication.
- (c) The Roster will be renewed every four years and members may only be appointed or reappointed by written agreement of the BCMA and the Government.
- (d) Members of the Roster may be removed or replaced at any time by written agreement of the BCMA and the Government.
- (e) The current members of the Roster are listed in Appendix I .

21.2 Adjudication Committee

- (a) The Government and the BCMA will maintain an adjudication committee (the “**Adjudication Committee**”) to resolve Provincial Disputes, Local Disputes, Local Interest Issues and other issues in accordance with this Agreement. The Adjudication Committee will be composed of one BCMA representative and one Government representative. In addition, a chair will be appointed from the Roster, on a rotating basis in the order in which the members of the Roster are listed in Appendix I starting with the first member listed (unless the Government and the BCMA otherwise agree in writing), at the time a reference is made to the Adjudication Committee. If any member of the Roster to be appointed to the Adjudication Committee is not able to hear the matter within a reasonable time the next named member who is able to do so will be appointed, and the rotation will continue from the member actually appointed. The Government and the BCMA will each be entitled to appoint one alternate representative to the Adjudication Committee.
- (b) All arbitrations conducted by the Adjudication Committee will be conducted pursuant to the *Commercial Arbitration Act*. The Rules of the British Columbia International Arbitration Centre for the Conduct of Domestic Commercial Arbitrations will apply unless modified by this Agreement or any other agreement between the Government and the BCMA from time to time.
- (c) In resolving any matter referred to it, the chair of the Adjudication Committee will work with the other members of the Adjudication Committee in an attempt to achieve a unanimous decision, which will be binding. If, after a reasonable time, a unanimous decision is not achieved, the majority decision of the Adjudication Committee will be binding. If there is no majority decision of the Adjudication

Committee, the chair of the Adjudication Committee will not decide the matter and the arbitration will terminate.

21.3 Trouble Shooter

- (a) A Trouble Shooter (the “**Trouble Shooter**”) will be appointed by agreement of the BCMA and the Government to facilitate the early and voluntary settlement of certain Disputes and Issues in accordance with this Agreement, without withdrawals of services.
- (b) Subject to section 21.3(c), the Trouble Shooter will be appointed for a three year term and may only be reappointed by agreement of the BCMA and the Government.
- (c) The Trouble Shooter may be removed and replaced at any time by agreement of the BCMA and the Government. In the event that the Trouble Shooter resigns or becomes unable to fulfill his or her role during the term of his or her appointment, a replacement will be appointed by agreement of the BCMA and the Government.
- (d) In the event that a matter referred to the Trouble Shooter raises an aspect of quality of care, the Joint Agreement Administration Group may request one or more additional people with relevant expertise to provide informed advice to the Trouble Shooter. Such additional people will not directly contribute to the Trouble Shooter’s findings or recommendations.
- (e) The Trouble Shooter will consider only those matters referred to him or her in accordance with this Agreement and will at all times act in a manner consistent with this Agreement.
- (f) The Trouble Shooter may:
 - (i) assist in attempting to effect a voluntary resolution of the matter referred to it;
 - (ii) conduct fact finding in relation to the matter referred to it; and
 - (iii) issue recommendations regarding the matter referred to it.
- (g) Any facts found and/or recommendations made by the Trouble Shooter will be treated as confidential by the parties unless otherwise agreed by the Joint Agreement Administration Group.

ARTICLE 22 - DISPUTE RESOLUTION PROCESS

22.1 Provincial Disputes

- (a) In the event that a Provincial Dispute is initially raised by an Agency, the Agency will refer the matter in writing to the Government, with a copy of the reference to

the Joint Agreement Administration Group. In the event that a Provincial Dispute is initially raised by a physician or group of physicians, the physician or group of physicians will refer the matter in writing to the BCMA, with a copy of the reference to the Joint Agreement Administration Group.

- (b) If the Government or the BCMA raises a Provincial Dispute or has a Provincial Dispute referred to it as contemplated by section 22.1(a), that party must notify the designated representative of the other party. The notice must be in writing, with a copy to the Joint Agreement Administration Group, and must include the following information:
 - (i) the provisions of the agreement(s) in issue;
 - (ii) the facts upon which the complaining party relies;
 - (iii) an outline of argument demonstrating how the facts and law support the complaining party's position; and
 - (iv) the remedy sought by the complaining party.
- (c) Within 15 days of the receipt of the notice referred to in section 22.1(b) by the other party, the designated representatives of the parties will meet informally in an attempt to resolve the matter or to narrow the issues.
- (d) If there is no resolution of the matter within 15 days of the meeting referred to in section 22.1(c), or longer period as agreed by the parties, either the Government or the BCMA may refer the matter to the Adjudication Committee with notice to the Joint Agreement Administration Group, at which time a chair will be appointed from the Roster in accordance with section 21.2(a). The Adjudication Committee will attempt to assist the parties to resolve the matter on a voluntary basis through a mediation process which will be conducted by the chair of the Adjudication Committee, or, if either the BCMA or the Government stipulates so in writing within five business days of the referral to the Adjudication Committee, by the full Adjudication Committee.
- (e) Where no voluntary resolution is achieved pursuant to section 22.1(d) within 45 days of the first date the parties meet to mediate the matter as contemplated in section 22.1(d), or such longer period as may be directed by the Joint Agreement Administration Group upon the recommendation of the mediator, the Adjudication Committee will arbitrate the matter in accordance with section 21.2.

22.2 Local Disputes

- (a) A party to a Local Dispute must notify the designated representative of the other party to the Local Dispute. The notice must be in writing, with a copy to the Joint Agreement Administration Group, and must include the following information:
 - (i) the provisions of any Local Contract in issue;

- (ii) the facts upon which the complaining party relies;
 - (iii) an outline of argument demonstrating how the facts and law support the complaining party's position; and
 - (iv) the remedy sought by the complaining party.
- (b) Within 15 days of receipt of the notice referred to in section 22.2(a) by the other party to the Local Dispute, the designated representatives of the parties to the Local Dispute will meet informally in an attempt to resolve the matter or to narrow the issues.
- (c) In the event that the meeting referred to in section 22.2(b) results in a proposed agreement between the parties to the Local Dispute to settle the Local Dispute, they will jointly submit the proposed agreement to the Joint Agreement Administration Group. Within 15 days of receiving a proposed agreement, the Joint Agreement Administration Group will advise the parties to the Local Dispute of whether or not the proposed agreement is consistent with this Agreement and the Physician Master Subsidiary Agreements. If the Joint Agreement Administration Group advises that:
- (i) the proposed agreement is so consistent, the proposed agreement will be binding on the parties to the Local Dispute;
 - (ii) the proposed agreement is not so consistent, the proposed agreement will not be implemented and section 22.2(e) will apply; and
 - (iii) the Joint Agreement Administration Group cannot reach a consensus decision with respect to the consistency of the proposed agreement with this Agreement and the Physician Master Subsidiary Agreements, then, within 30 days of the Joint Agreement Administration Group advising that it cannot reach a consensus decision, either the Government or the BCMA may refer the question of the consistency of the proposed agreement with this Agreement and the Physician Master Subsidiary Agreements to the Adjudication Committee with notice to the Joint Agreement Administration Group; the Adjudication Committee will arbitrate that question in accordance with section 21.2; if the Adjudication Committee decides that the proposed agreement is so consistent, it will be binding on the parties to the Local Dispute; and if the Adjudication Committee decides that the proposed agreement is not so consistent, the proposed agreement will not be implemented and section 22.2(e) will apply.
- (d) If the Joint Agreement Administration Group does not provide a response within the time limit referred to in section 22.2(c), the proposed agreement will be deemed to be consistent with this Agreement and the Physician Master Subsidiary Agreements.

- (e) If the meeting referred to in section 22.2(b) does not result in a proposed agreement between the parties to the Local Dispute to settle the Local Dispute within 15 days of the meeting or a longer period agreed to by the local parties; or if the Joint Agreement Administration Group advises, in accordance with section 22.2(c)(ii), that the proposed agreement is not consistent with this Agreement and/or the Physician Master Subsidiary Agreements; or if the Adjudication Committee decides, in accordance with section 22.2(c)(iii), that the proposed agreement is not consistent with this Agreement and/or the Physician Master Subsidiary Agreements, then:
 - (i) the parties to the Local Dispute will submit the Local Dispute to the Government and the BCMA, and will agree to be bound by the resolution of the Local Dispute pursuant to this Agreement;
 - (ii) either the Government or the BCMA may refer the Local Dispute in writing to the Joint Agreement Administration Group; and
 - (iii) the parties to the Local Dispute may agree to be bound by recommendations from the Trouble Shooter with respect to the Local Dispute in the event that the Joint Agreement Administration Group refers the Local Dispute to the Trouble Shooter.
- (f) In the event that the Government or the BCMA refers the Local Dispute to the Joint Agreement Administration Group under section 22.2(e), the Government and the BCMA will thereafter have exclusive carriage of the Local Dispute.
- (g) Upon a Local Dispute being referred to the Joint Agreement Administration Group under section 22.2(e), the Joint Agreement Administration Group may direct the Trouble Shooter to attempt to facilitate a settlement of the Local Dispute.
- (h) If the parties to the Local Dispute agree to be bound by recommendations from the Trouble Shooter with respect to the Local Dispute, the Trouble Shooter will make recommendations and will provide a copy of such recommendations to the Joint Agreement Administration Group. Within 15 days of receiving such recommendations, the Joint Agreement Administration Group will advise the parties to the Local Dispute of whether or not the recommendations are consistent with this Agreement and the Physician Master Subsidiary Agreements. If the Joint Agreement Administration Group advises that:
 - (i) the recommendations are so consistent, they will be binding on the parties to the Local Dispute;
 - (ii) the recommendations are not so consistent, they will not be implemented and section 22.2(j) will apply; and
 - (iii) the Joint Agreement Administration Group cannot reach a consensus decision with respect to the consistency of the recommendations with this

Agreement and the Physician Master Subsidiary Agreements, then, within 30 days of the Joint Agreement Administration Group advising that it cannot reach a consensus decision, either the Government or the BCMA may refer the question of the consistency of the recommendations with this Agreement and the Physician Master Subsidiary Agreements to the Adjudication Committee with notice to the Joint Agreement Administration Group; the Adjudication Committee will arbitrate that question in accordance with section 21.2; if the Adjudication Committee decides that the recommendations are so consistent, they will be binding on the parties to the Local Dispute; and if the Adjudication Committee decides that the recommendations are not so consistent, they will not be implemented and section 22.2(j) will apply.

- (i) If the parties to the Local Dispute do not agree to be bound by recommendations from the Trouble Shooter, the Trouble Shooter will attempt to facilitate a voluntary settlement of the matter. Failing settlement within 30 days of the Trouble Shooter being directed to attempt to facilitate a settlement, the Trouble Shooter will make recommendations with respect to the Local Dispute to the Joint Agreement Administration Group. If the Trouble Shooter's efforts result in a proposed agreement between the parties to the Local Dispute, the proposed agreement must be submitted to the Joint Agreement Administration Group. Within 15 days of receiving a proposed agreement, the Joint Agreement Administration Group will advise the parties to the Local Dispute of whether or not the proposed agreement is consistent with this Agreement and the Physician Master Subsidiary Agreements and the procedure outlined in section 22.2(h)(i) through (iii) will apply.
- (j) If resolution of the Local Dispute is not achieved under one of sections 22.2(c), (h) or (i), the Joint Agreement Administration Group will notify the parties to the Local Dispute that the Joint Agreement Administration Group is proceeding under this section, will consider the recommendations of the Trouble Shooter, if any, and will attempt to resolve the Local Dispute. If the Local Dispute is not resolved within 30 days of the issuance of the notification to the parties under this section (or any longer period agreed to by the Government and the BCMA), either the Government or the BCMA may, within a further 30 days, refer the Local Dispute to the Adjudication Committee with notice to the Joint Agreement Administration Group.
- (k) Upon a referral of a Local Dispute to the Adjudication Committee pursuant to section 22.2(j) a chair for the Adjudication Committee will be appointed from the Roster.
- (l) Where a Local Contract Dispute is referred to the Adjudication Committee pursuant to section 22.2(j), the Adjudication Committee will arbitrate the matter in accordance with section 21.2.

- (m) Where a Local Range Placement Dispute is referred to the Adjudication Committee pursuant to section 22.2(j), the Adjudication Committee's jurisdiction will be restricted to deciding the placement of the specific physician or physician group in issue on the applicable "Service Contract Range" (as defined in the Alternative Payments Subsidiary Agreement).

22.3 MOCAP Distribution Disputes

- (a) Notwithstanding section 2.3, sections 22.3(b) through (g) will not take effect as of April 1, 2012 but rather will come into force on July 1, 2013 for application to the Fiscal Year 2014/15 and thereafter unless the Physician Services Committee accepts the recommendations of the MOCAP Redesign Panel in accordance with section 17.4(g) in which case sections 22.3(b) through (g) will be of no force or effect.
- (b) The Joint Agreement Administration Group will appoint one member of the Roster to act as an adjudicator (the "**MOCAP Adjudicator**") for the term of this Agreement. The MOCAP Adjudicator may be changed at any time by a decision of the Joint Agreement Administration Group.
- (c) To initiate a MOCAP Distribution Dispute a physician or physician group must provide notice to the applicable Health Authority and to the Joint Agreement Administration Group within 15 days of the debriefing conducted pursuant to section 17.3(j). The notice must be in writing and must include the facts upon which the physician or physician group relies, an outline of argument supporting the physician position and the remedy sought.
- (d) The Joint Agreement Administration Group will meet within 15 days of the expiration of the latest deadline specified in section 22.3(c) for the receipt of all notices of MOCAP Distribution Disputes for all Health Authorities, and at that meeting the Joint Agreement Administration Group will compile a consolidated list of all MOCAP Distribution Disputes that have been initiated in accordance with section 22.3(c). The Joint Agreement Administration Group will submit the consolidated list for independent review by the Government and the BCMA.
- (e) Any MOCAP Distribution Disputes from the consolidated list may be referred to the MOCAP Adjudicator by either the Government or the BCMA within 30 days of the meeting of the Joint Agreement Administration Group referred to in section 22.3(d).
- (f) The MOCAP Adjudicator will consider, as a group, all MOCAP Distribution Disputes referred to him or her for a particular Health Authority. The MOCAP Adjudicator will attempt to achieve a voluntary settlement of each such group of MOCAP Distribution Disputes. If such a voluntary settlement is achieved with respect to any such group, the MOCAP Adjudicator will reflect the settlement in a final and binding award. Any group of MOCAP Distribution Disputes that is not voluntarily resolved within 45 days of the first meeting between the MOCAP

Adjudicator, the affected Health Authority and the physicians (or any longer period agreed to by the Joint Agreement Administration Group), will be the subject of a final and binding award by the MOCAP Adjudicator following any further process stipulated by the MOCAP Adjudicator.

- (g) In resolving MOCAP Distribution Disputes pursuant to section 22.3(f), the MOCAP Adjudicator:
 - (i) must provide all interested parties with the opportunity to be heard;
 - (ii) must ensure that the resolution will not result in expenditures for MOCAP that exceed the amount allocated to the Health Authority in issue for MOCAP in the applicable Fiscal Year; and
 - (iii) has no jurisdiction to decide on the extent of the allocation of MOCAP funding to the Health Authority and the MOCAP Adjudicator's jurisdiction is restricted to confirming the Health Authority's plan for the distribution of its annual MOCAP funding allocation as published in accordance with section 17.3(i) or modifying that plan but only in a manner that ensures that the Health Authority's annual MOCAP funding allocation is not exceeded and in a manner that is consistent with the application of the MOCAP Objectives and their prioritization as required by section 17.3(a).

ARTICLE 23 - ISSUE MANAGEMENT PROCESS

23.1 Local Interest Issue Resolution

- (a) A physician, group of physicians or Agency raising a Local Interest Issue must notify, in writing, all other interested parties of the Local Interest Issue, with a copy of the notice to the Physician Services Committee.
- (b) The notice shall comprehensively outline the substance of the Local Interest Issue and include all data or other information relied on by the person raising the Local Interest Issue as well as a statement of the proposed remedy or proposed solution.
- (c) Upon receipt of the notice referred to in section 23.1(b), parties interested in the Local Interest Issue will meet to discuss the Local Interest Issue and attempt to achieve a voluntary resolution of it.
- (d) If, as a result of the meeting referred to in section 23.1(c), the parties interested in the Local Interest Issue achieve a proposed resolution of the Local Interest Issue, they shall submit the proposed resolution, in writing, to the Physician Services Committee. Within 15 days of receiving a proposed resolution, the Physician Services Committee will advise the parties to the Local Interest Issue of whether or not the proposed resolution is consistent with this Agreement and the Physician Master Subsidiary Agreements. If the Physician Services Committee advises that:

- (i) the proposed resolution is so consistent, it may be implemented; and
 - (ii) the proposed resolution is not so consistent, or the Physician Services Committee cannot reach a consensus decision with respect to the consistency of the proposed resolution with this Agreement and the Physician Master Subsidiary Agreements, it may not be implemented.
- (e) If the Physician Services Committee does not provide a response within the time limit referred to in section 23.1(d), the proposed resolution will be deemed to be consistent with this Agreement and the Physician Master Subsidiary Agreements.
- (f) If the Local Interest Issue is not resolved in accordance with section 23.1(d) within 45 days of the first meeting contemplated by section 23.1 (c), or any longer period agreed to by the parties to the Local Interest Issue, either the affected Health Authority or the affected physician(s) may, within a further 30 days, request the Government or the BCMA respectively, to refer the Local Interest Issue to the Physician Services Committee. If, during the 45 days, or longer period if agreed, either party to the Local Interest Issue concludes that the process to resolve the Local Interest Issue has failed, it may so advise the other party in writing and the time limits for referral to the Physician Services Committee will commence from the date of that notice.
- (g) Upon a Local Interest Issue being referred to the Physician Services Committee in accordance with section 23.1(f), the Government and the BCMA shall assume exclusive carriage of it.
- (h) Upon receiving a referral of a Local Interest Issue in accordance with section 23.1(f), the Physician Services Committee may, by consensus decision:
- (i) issue recommendations with respect to the Local Interest Issue to the parties interested in the Local Interest Issue; or
 - (ii) direct that the Local Interest Issue be referred to the Adjudication Committee for arbitration, at which time a chair will be appointed from the Roster.
- (i) Failing acceptance by the parties interested in the Local Interest Issue of recommendations from the Physician Services Committee in accordance with section 23.1(h)(i) or failing a decision of the Adjudication Committee pursuant to section 23.1(h)(ii), there are no further steps under this Agreement to address the Local Interest Issue.

ARTICLE 24 - SERVICE CONTINUITY

24.1 No Withdrawal of Services or Threat of Withdrawal of Services

All Disputes and Issues will be resolved or addressed through the processes set out in this Agreement. Without limiting obligations of any party or person under any law, agreement or

contract, where a process exists, in this Agreement or otherwise, for binding resolution of a Dispute or Issue between physicians and/or the BCMA, on the one hand, and the Government and/or Agencies, on the other, there shall be no withdrawal of services or threat of withdrawal of services by any physician or group of physicians in connection with such Dispute or Issue.

24.2 Notice of Withdrawal of Services Required

- (a) Without limiting obligations of any party or person under any law, agreement or contract, where there is no binding resolution of any Dispute or Issue, or any matter between physicians and/or the BCMA, on the one hand, and the Government and/or Agencies, on the other, after any applicable process has been utilized, a physician or group of physicians may carry out a withdrawal of services but must first provide a minimum of 90 days written notice of the withdrawal of clinical and related services to the applicable Health Authority, the College of Physicians and Surgeons of British Columbia, and the Physician Services Committee. In the event that notice of a withdrawal of services is given, the matter will be referred by the Physician Services Committee to the Trouble Shooter. The Trouble Shooter will define the issues in dispute and make recommendations to the Physician Services Committee to facilitate a resolution consistent with the provisions of this Agreement.
- (b) Any withdrawal of clinical and related services during a notice period or without providing notice is contrary to this Agreement and the BCMA will so advise physicians.

24.3 No Withdrawal of Services to Pressure Government to Change Existing Agreements

The BCMA agrees that once an agreement is entered into, physicians who are covered by it should not carry out a withdrawal of services for the purpose of pressuring the Government or an Agency to change the terms and conditions of the agreement. The BCMA will take all appropriate measures to encourage physicians to comply with existing agreements.

24.4 BCMA Will Not Condone Withdrawals of Service

As long as there is no pro-rationing in effect the BCMA will not sponsor, support or condone withdrawals of services by physicians and shall take the necessary steps that are available to prevent such initiatives.

ARTICLE 25 - REPLACEMENT OF PROVISIONS AFFECTED BY LEGISLATION

25.1 Replacement by Agreement

Subject to section 25.3, in the event that any future legislation (the “**Future Legislation**”) renders null and void or materially alters any provision of this Agreement, the remaining provisions will remain in force and effect during the currency of this Agreement and the parties will negotiate a mutually agreeable provision to be substituted for the provision that has been rendered null and void or materially altered by the Future Legislation.

25.2 Replacement by Arbitration

- (a) If the parties are unable to reach agreement on replacement provisions pursuant to section 25.1, any of them may refer the issues in dispute to arbitration in accordance with this section 25.2.
- (b) If any party makes a referral to arbitration under this section 25.2, the parties will agree upon a single arbitrator within fifteen days of the date of the referral. If such agreement is not reached any of them may ask the Chief Justice of the Supreme Court of British Columbia to make the appointment and the person so appointed will be the arbitrator.
- (c) The arbitration will be conducted in accordance with the *Commercial Arbitration Act*, using the Rules of the British Columbia International Arbitration Centre for the Conduct of Domestic Commercial Arbitrations, except to the extent such rules are modified by this Agreement or any other agreement between the Government and the BCMA.
- (d) Subject to section 25.3, the arbitrator will issue a final and binding award on all of the outstanding issues.

25.3 No Conflict with Legislation

No replacement provision, whether the subject of agreement pursuant to section 25.1 or arbitration pursuant to section 25.2, may conflict with the provisions of the Future Legislation or any other applicable laws. Specifically, an arbitrator acting pursuant to section 25.2 does not have the jurisdiction to order any replacement provision which is inconsistent with or in conflict with or would cause any reading down of the Future Legislation or any other applicable laws.

ARTICLE 26 - REOPENER

26.1 Reopener Notice

On or after April 1, 2013, but no later than April 30, 2013, either the Government or the BCMA may give notice to the other (the “**Reopener Notice**”) of its wish to reopen negotiation, for the Fiscal Years 2014/15 and 2015/16, of aspects of this Agreement and/or any of the Physician Master Subsidiary Agreements that concern any of the following issues:

- (a) compensation;
- (b) Benefit Plans (as defined in the Benefits Subsidiary Agreement);
- (c) MOCAP;
- (d) funding for information technology;
- (e) any of the matters referred to in section 4.5(d) of the Alternative Payments Subsidiary Agreement that remain unresolved;

- (f) any matter of general application that does not have the effect of causing the termination of this Agreement or any of the Physician Master Subsidiary Agreements; and
- (g) any other matters the Government and the BCMA have agreed in writing to submit to the reopener process contemplated by this Article 26.

26.2 Initial Reopener Meeting

If a Reopener Notice is given, the BCMA and the Government will meet, no later than June 1, 2013, and commence negotiations to reopen, for the Fiscal Years 2014/15 and 2015/16, the aspects of this Agreement and/or any of the Physician Master Subsidiary Agreements that are identified in any Reopener Notice and that concern any of the issues listed in section 26.1.

26.3 Reopener Conciliation Panel Chair

- (a) If a Reopener Notice is given, the Government and the BCMA will appoint, by no later than June 1, 2013, an individual to act as chair of a conciliation panel for the reopener negotiations. If the Government and the BCMA are unable to agree upon the chair of the conciliation panel either of them may request the Chief Justice of the Supreme Court of British Columbia to make the appointment and the individual so appointed will be the chair of the conciliation panel.
- (b) If, by September 30, 2013, the Government and the BCMA do not reach agreement on all amendments (if any) to this Agreement and/or the Physician Master Subsidiary Agreements, to be applicable during the Fiscal Years 2014/15 and 2015/16, that concern any of the issues listed in section 26.1, either the Government or the BCMA may request the intervention of the chair of the conciliation panel.
- (c) Once either the Government or the BCMA has requested the intervention of the chair of the conciliation panel, he or she will work with the BCMA and Government negotiators in an attempt to mediate an agreement on all amendments (if any) to this Agreement and/or the Physician Master Subsidiary Agreements, to be applicable during the Fiscal Years 2014/15 and 2015/16, that concern any of the issues listed in section 26.1.

26.4 Intervention by Reopener Conciliation Panel

- (a) After December 31, 2013, either the Government or the BCMA may request the chair of the conciliation panel to discontinue the mediation and to assemble a conciliation panel. The Government and the BCMA will each name one representative to the conciliation panel, and those two representatives plus the chair appointed pursuant to section 26.3(a) will comprise the conciliation panel.
- (b) The conciliation panel will conduct a conciliation in accordance with procedures agreed to by the Government and the BCMA, which may include formal hearings, to review the issues in dispute.

- (c) The conciliation panel must retain an independent expert to assist it in determining costing issues and verifying comparators.
- (d) The terms of reference of the conciliation panel will include:
 - (i) the need to be consistent with the law;
 - (ii) reflecting the Government's fiscal situation, including its ability to pay;
 - (iii) the need to provide reasonable compensation to physicians for the services rendered; and
 - (iv) the operational and medical resource needs of the Health Authorities.

26.5 Report of the Reopener Conciliation Panel

- (a) The conciliation panel will publish a report containing the recommended terms of settlement regarding amendments to this Agreement and/or the Physician Master Subsidiary Agreements, to be applicable during the Fiscal Years 2014/15 and 2015/16, that concern any of the issues listed in section 26.1, such report to be in two parts:
 - (i) the first part to contain the recommended terms of settlement on those issues of compensation, on-call payment issues, physician benefit plans consisting of the Continuing Medical Education Fund, Physician Disability Insurance Program, Physician Health Program, Canadian Medical Protective Association Rebate Program, Contributory Professional Retirement Savings Plan, and Parental Leave Program, and any other matters the parties have agreed in writing to submit to binding conciliation for the purpose of this section 26.5(a)(i) (collectively, the "**Reopener Central Recommendations**"); and
 - (ii) the second part to contain all recommended terms of settlement other than the Reopener Central Recommendations (collectively, the "**Reopener Other Recommendations**").
- (b) The report of the conciliation panel must also set out reasons and the estimated costs of implementing both the Reopener Central Recommendations and the Reopener Other Recommendations.

26.6 Effect of Reopener Conciliation Panel's Report

- (a) The Reopener Central Recommendations will be binding on the parties unless, within 10 days of its receipt of the conciliation panel's report, the Government rejects the Reopener Central Recommendations in their entirety and, upon such rejection, the Reopener Central Recommendations will not be binding upon the parties. All Reopener Other Recommendations will not be binding on the parties unless agreed to by the parties in writing.

- (b) If the Government rejects the Reopener Central Recommendations, the Government and the BCMA will resume negotiations on the areas in dispute with respect to the Reopener Central Recommendations and the BCMA will be relieved of its obligations under sections 24.3 and 24.4 of this Agreement, subject to section 26.6(c) below, until all amendments (if any) to this Agreement and/or the Physician Master Subsidiary Agreements to be applicable during the Fiscal Years 2014/15 and 2015/16, that concern any of the issues listed in section 26.1, are agreed upon by the BCMA and the Government.
- (c) Prior to the commencement of any service disruptions by physicians following any rejection of the Reopener Central Recommendations by the Government, the Government and the BCMA will seek guidance from the College of Physicians and Surgeons of British Columbia with respect to the services that should be maintained to ensure that the safety of British Columbians is protected. The BCMA will not condone or support a withdrawal of services contrary to the guidance provided by the College of Physicians and Surgeons of British Columbia.

ARTICLE 27 - RENEGOTIATION

27.1 Renegotiation Notice

On or after April 1, 2015, but no later than April 30, 2015, either the Government or the BCMA may give notice to the other (the “**Renegotiation Notice**”) of its wish to renegotiate and amend all or any of the provisions of this Agreement and the Physician Master Subsidiary Agreements.

27.2 Initial Meeting

If a Renegotiation Notice is given, the BCMA and the Government will meet, no later than June 1, 2015, and commence negotiations to renegotiate all or any of the provisions of this Agreement and the Physician Master Subsidiary Agreements.

27.3 Conciliation Panel Chair

- (a) If a Renegotiation Notice is given, the Government and the BCMA will appoint, by no later than June 1, 2015, an individual to act as chair of a conciliation panel for the negotiations. If the Government and the BCMA are unable to agree upon the chair of the conciliation panel either of them may request the Chief Justice of the Supreme Court of British Columbia to make the appointment and the individual so appointed will be the chair of the conciliation panel.
- (b) If the Government and the BCMA do not reach agreement on all amendments (if any) to this Agreement and/or the Physician Master Subsidiary Agreements, by September 30, 2015, either the Government or the BCMA may request the intervention of the chair of the conciliation panel.

- (c) Once either the Government or the BCMA has requested the intervention of the chair of the conciliation panel, he or she will work with the BCMA and Government negotiators in an attempt to mediate an agreement on all amendments (if any) to this Agreement and/or the Physician Master Subsidiary Agreements.

27.4 Intervention by Conciliation Panel

- (a) After December 31, 2015, either the Government or the BCMA may request the chair of the conciliation panel to discontinue the mediation and to assemble a conciliation panel. The Government and the BCMA will each name one representative to the conciliation panel, and those two representatives plus the chair appointed pursuant to section 27.3(a) will comprise the conciliation panel.
- (b) The conciliation panel will conduct a conciliation in accordance with procedures agreed to by the Government and the BCMA, which may include formal hearings, to review the issues in dispute.
- (c) The conciliation panel must retain an independent expert to assist it in determining costing issues and verifying comparators.
- (d) The terms of reference of the conciliation panel will include:
 - (i) the need to be consistent with the law;
 - (ii) reflecting the Government's fiscal situation, including its ability to pay;
 - (iii) the need to provide reasonable compensation to physicians for the services rendered; and
 - (iv) the operational and medical resource needs of the Health Authorities.

27.5 Report of the Conciliation Panel

- (a) The conciliation panel will publish a report containing the recommended terms of settlement on all of the outstanding issues, such report to be in two parts:
 - (i) the first part to contain the recommended terms of settlement on those issues of compensation, on-call payment issues, physician benefit plans consisting of the Continuing Medical Education Fund, Physician Disability Insurance Program, Physician Health Program, Canadian Medical Protective Association Rebate Program, Contributory Professional Retirement Savings Plan, and Parental Leave Program, and any other matters the parties have agreed in writing to submit to binding conciliation for the purpose of this section 27.5(a)(i) (collectively, the "**Central Recommendations**"); and

- (ii) the second part to contain all recommended terms of settlement other than the Central Recommendations (collectively, the “**Other Recommendations**”).
- (b) The report of the conciliation panel must also set out reasons and the estimated costs of implementing both the Central Recommendations and the Other Recommendations.

27.6 Effect of Conciliation Panel’s Report

- (a) The Central Recommendations will be binding on the parties unless, within 10 days of its receipt of the conciliation panel’s report, the Government rejects the Central Recommendations in their entirety and, upon such rejection, the Central Recommendations will not be binding upon the parties. All Other Recommendations will not be binding on the parties unless agreed to by the parties in writing.
- (b) If the Government rejects the Central Recommendations, the Government and the BCMA will resume negotiations on the areas in dispute with respect to the Central Recommendations and the BCMA will be relieved of its obligations under sections 24.3 and 24.4 of this Agreement, subject to section 27.6(c) below, until all amendments (if any) to this Agreement and/or the Physician Master Subsidiary Agreements are agreed upon by the BCMA and the Government.
- (c) Prior to the commencement of any service disruptions by physicians following any rejection of the Central Recommendations by the Government, the Government and the BCMA will seek guidance from the College of Physicians and Surgeons of British Columbia with respect to the services that should be maintained to ensure that the safety of British Columbians is protected. The BCMA will not condone or support a withdrawal of services contrary to the guidance provided by the College of Physicians and Surgeons of British Columbia.

ARTICLE 28 - TERMINATION

28.1 Termination Notice

Notwithstanding Article 27, either the Government or the BCMA may give notice (the “**Termination Notice**”) to the other, on or after January 1, 2016, of termination of this Agreement and the Physician Master Subsidiary Agreements, in which case this Agreement and Physician Master Subsidiary Agreements will terminate on March 31, 2016, subject to section 28.2.

28.2 Effect of Termination Notice

- (a) If one of the parties gives the Termination Notice in accordance with section 28.1, then the provisions of this Agreement and the Physician Master Subsidiary Agreements providing for those matters referred to in section 27.5(a)(i) will

continue in effect notwithstanding the termination of this Agreement and the Physician Master Subsidiary Agreements pursuant to section 28.1, subject however to the further rights to terminate those continuing provisions under section 28.2(b).

- (b) If a Termination Notice is given in accordance with section 28.1, either the Government or the BCMA may give notice (the “**Further Termination Notice**”) to the other, on or after April 1, 2016, of termination of those provisions of this Agreement and the Physician Master Subsidiary Agreements that have continued in effect pursuant to section 28.2(a), such termination to be effective on the date (the “**Final Termination Date**”) that is one year after the date the Further Termination Notice is given, and on the Final Termination Date all such continuing provisions shall terminate and be of no further force or effect.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2012.

SIGNED, SEALED & DELIVERED on)
behalf of HER MAJESTY THE QUEEN)
IN RIGHT OF THE PROVINCE OF)
BRITISH COLUMBIA, by the Minister)
of Health or his/her duly authorized)
representative, in the presence of:)

Signature of Witness)

Name)

Address)

THE CORPORATE SEAL of the)
BRITISH COLUMBIA MEDICAL)
ASSOCIATION was hereunto affixed in)
the presence of:)

C/S

Signature of Authorized Signatory)

Name)

Position)

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

Name

Position

APPENDIX A

2012 GENERAL PRACTITIONERS SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of April, 2012,

BETWEEN:

**HER MAJESTY THE QUEEN IN RIGHT OF THE
PROVINCE OF BRITISH COLUMBIA**, as represented by the
Minister of Health

(the “**Government**”)

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION

(the “**BCMA**”)

AND:

MEDICAL SERVICES COMMISSION

(the “**MSC**”)

WITNESSES THAT WHEREAS:

- A. The BCMA, the MSC and the Government have agreed to renew and replace the 2007 PMA, the 2007 General Practitioners Subsidiary Agreement, the 2007 Specialists Subsidiary Agreement, the 2007 Rural Practice Subsidiary Agreement, the 2007 Alternative Payments Subsidiary Agreement and the 2007 Benefits Subsidiary Agreement;
- B. The parties have agreed that this Agreement will constitute the new General Practitioners Subsidiary Agreement, to take effect as of April 1, 2012; and
- C. The parties intend this Agreement to address those matters of unique interest and applicability to General Practitioners.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 1 - RELATIONSHIP TO THE 2012 PHYSICIAN MASTER AGREEMENT

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2012 Physician Master Agreement and is subject to its terms and conditions.

ARTICLE 2 - DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the 2012 Physician Master Agreement have the same meaning as in the 2012 Physician Master Agreement unless otherwise defined in this Agreement.

2.2 “**this Agreement**” means this document, as amended from time to time as provided herein.

2.3 “**Attachment**” means the initiative aimed at ensuring that British Columbians have access to a family physician.

2.4 “**Divisions of Family Practice**” means the initiative created and supported by the General Practice Services Committee to organize physicians at the local or regional level in order to address common health care goals in their communities.

2.5 “**2012 Physician Master Agreement**” means the agreement titled “2012 Physician Master Agreement” between the Government, the BCMA and the MSC, dated April 1, 2012.

2.6 The provisions of sections 1.2 to 1.8 inclusive of the 2012 Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to “this Agreement” shall herein be construed to mean this Agreement.

ARTICLE 3 - TERM

3.1 This Agreement comes into force on April 1, 2012.

3.2 This Agreement shall be for the same term as the 2012 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the 2012 Physician Master Agreement.

ARTICLE 4 - GENERAL PRACTICE SERVICES COMMITTEE

4.1 The parties agree that full service family practice must be encouraged and supported.

4.2 The **General Practice Services Committee** shall continue under this Agreement as a vehicle for representatives of the Government, the BCMA and the Society of General Practitioners to work together on matters affecting the provision of services by General Practitioners in British Columbia, including ways of providing incentives for General Practitioners to provide full service family practice and benefit patients. In addition to the core mandate outlined in section 8.2 of the 2012 Physician Master Agreement, the General Practice Services Committee will fulfill the specific mandate set out in this Agreement.

4.3 The General Practice Services Committee shall be composed of six members appointed by the Government and six members appointed by the BCMA.

4.4 The General Practice Services Committee shall be co-chaired by a member chosen by the Government members and a member chosen by the BCMA members and shall appoint two of its members as vice chairs, one who shall be chosen by the Government from among the

Government members and one who shall be chosen by the BCMA from among the BCMA members

4.5 Decisions of the General Practice Services Committee shall be by consensus decision.

4.6 If the General Practice Services Committee cannot reach a consensus decision on any matter it is required to determine, the Government and/or the BCMA may make recommendations to the MSC and the MSC, or its successor, will determine the matter.

4.7 On an annual basis, the General Practice Services Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the 2012 Physician Master Agreement.

4.8 The General Practice Services Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the General Practice Services Committee pre-approve any communication about the business and/or decisions of the General Practice Services Committee.

4.9 The costs of administrative and clerical support required for the work of the General Practice Services Committee and physician (other than employees of the Government, BCMA and Health Authorities) participation in the General Practice Services Committee, will be paid from the funds to be allocated by the General Practice Services Committee pursuant to this Agreement.

ARTICLE 5 - FULL SERVICE FAMILY PRACTICE FUNDING

5.1 The General Practice Services Committee will be used to further collaborate with General Practitioners to encourage and enhance full service family practice and benefit patients through increases to the existing \$190.5 million annual funding level for full service family practitioners, as follows:

- (a) \$10 million made available effective April 1, 2012;
- (b) an additional \$8 million made available effective April 1, 2013.

The funds identified in this section 5.1 are to be allocated by the General Practice Services Committee to support its work in maintaining, enhancing and expanding the programs that support the delivery of primary care services to British Columbians by, among other things, supporting integrated and collaborative initiatives including change management, identifying and treating patients and communities with unmet needs, providing incentives for General Practitioners to provide full service family practice, enhancing risk assessment and reduction, improving capacity in primary care, enhancing comprehensive and continuous care and improving coordination and quality of care to family practice patients in British Columbia, with allocations to include, but not be limited to, the areas identified in section 5.2.

5.2 The General Practice Services Committee will use the funds available to it pursuant to section 5.1 for the following purposes, among others:

- (a) to fund financial incentive programs for the support of full service family practice, including:
 - (i) improved identification and management of:
 - (A) mental health conditions;
 - (B) chronic disease;
 - (C) complex co-morbidities;
 - (D) maternity care;
 - (E) the frail elderly;
 - (F) the co-ordination of care of patients in hospital or residential care; and
 - (G) patients requiring end of life care; and
 - (ii) increased multi-disciplinary care between General Practitioners and other healthcare providers;
- (c) to fund, in whole or in part, full service family practice support programs such as Divisions of Family Practice and the Practice Support Program; and
- (d) to improve disease prevention.

5.4 Any funds identified in sections 5.1 that remain unexpended at the end of any Fiscal Year will be available to the General Practice Services Committee for use as one time allocations to improve the quality of care.

5.5 The General Practice Services Committee will continue to review and recommend approaches that support General Practitioners' continued role in providing hospital care, including the relationship between that role and the role of hospitalists. The General Practice Services Committee will determine the key elements or models of care with indicators that demonstrate and support optimum patient outcomes. The recommendations will propose how best to utilize existing allocations for primary care support of hospitalized patients.

ARTICLE 6 - ATTACHMENT

6.1 If the General Practice Services Committee agrees, the Government may, at its discretion, make funds available to the General Practice Services Committee to be used to support non-physician related costs of Attachment. Any such additional funds will be identified specifically for this purpose and any such funds not so expended by the General Practice Services Committee will be returned to the Government.

6.2 Funds previously approved by the General Practice Services Committee to support Attachment will be available for the direct physician compensation associated with Attachment unless otherwise decided by the General Practice Services Committee.

ARTICLE 7 - DOCTOR OF THE DAY

- 7.1 The need for a Doctor of the Day will be determined by the Health Authorities.
- 7.2 A Doctor of the Day will be compensated at the rate of \$400 per twenty-four hours of coverage.
- 7.3 Where there is a requirement for less than twenty-four hours of coverage, an appropriate rate based upon the twenty-four hour rate shall be determined at the local level.
- 7.4 Funding for Doctor of the Day will be allocated from the annual MOCAP budget.

ARTICLE 8 - DISPUTE RESOLUTION

8.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the 2012 Physician Master Agreement applicable to Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2012.

SIGNED, SEALED & DELIVERED on)
behalf of HER MAJESTY THE QUEEN)
IN RIGHT OF THE PROVINCE OF)
BRITISH COLUMBIA, by the Minister)
of Health or his/her duly authorized)
representative, in the presence of:)

Signature of Witness)

Name)

Address)

)

THE CORPORATE SEAL of the)
BRITISH COLUMBIA MEDICAL)
ASSOCIATION was hereunto affixed in)
the presence of:)

C/S

Signature of Authorized Signatory)

Name)

Position)

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

Name

Position

APPENDIX B

2012 SPECIALISTS SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of April, 2012,

BETWEEN:

**HER MAJESTY THE QUEEN IN RIGHT OF THE
PROVINCE OF BRITISH COLUMBIA**, as represented by the
Minister of Health

(the “**Government**”)

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION

(the “**BCMA**”)

AND:

MEDICAL SERVICES COMMISSION

(the “**MSC**”)

WITNESSES THAT WHEREAS:

- A. The BCMA, the MSC and the Government have agreed to renew and replace the 2007 PMA, the 2007 General Practitioners Subsidiary Agreement, the 2007 Specialists Subsidiary Agreement, the 2007 Rural Practice Subsidiary Agreement, the 2007 Alternative Payments Subsidiary Agreement and the 2007 Benefits Subsidiary Agreement;
- B. The parties have agreed that this Agreement will constitute the new Specialists Subsidiary Agreement, to take effect as of April 1, 2012; and
- C. The parties intend this Agreement to address those matters of unique interest and applicability to Specialist Physicians.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 1 - RELATIONSHIP TO THE 2012 PHYSICIAN MASTER AGREEMENT

- 1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2012 Physician Master Agreement and is subject to its terms and conditions.

ARTICLE 2 – DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the 2012 Physician Master Agreement have the same meaning as in the 2012 Physician Master Agreement unless otherwise defined in this Agreement.

2.2 “**this Agreement**” means this document as amended from time to time as provided herein.

2.3 “**2012 Physician Master Agreement**” means the agreement titled “Physician Master Agreement” between the Government, the BCMA and the MSC, dated April 1, 2012.

2.4 The provisions of sections 1.2 to 1.8 inclusive of the 2012 Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to “this Agreement” shall herein be construed to mean this Agreement.

ARTICLE 3 - TERM

3.1 This Agreement comes into force on April 1, 2012.

3.2 This Agreement shall be for the same term as the 2012 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the 2012 Physician Master Agreement.

ARTICLE 4 - COLLABORATION WITH SPECIALIST PHYSICIANS

4.1 The Government and the BCMA agree to collaborate with Specialist Physicians to improve access to needed, evidence-based, quality services to meet patients’ medical needs for optimum health outcomes. This approach will be built on understanding population health needs, linked to optimizing the mix of service delivery options, technology options and health human resource options.

ARTICLE 5 - SPECIALIST SERVICES COMMITTEE

5.1 A **Specialist Services Committee** shall continue under this Agreement to facilitate collaboration between the Government, the BCMA and the Health Authorities on the delivery of the services of Specialist Physicians to British Columbians and to support the improvement of the specialist care system. In addition to the core mandate outlined in section 8.2 of the 2012 Physician Master Agreement, the Specialist Services Committee will fulfill the specific mandate as set out in this Agreement.

5.2 The Government and the BCMA shall each appoint an equal number (not to exceed four each) of members to the Specialist Services Committee.

5.3 The Specialist Services Committee will be co-chaired by a member chosen by the Government members and a member chosen by the BCMA members.

5.4 Decisions of the Specialist Services Committee shall be by consensus decision.

5.5 If the Specialist Services Committee cannot reach a consensus decision on any matter that it is required to determine under section 5.6(a), the BCMA and/or the Government may make recommendations to the MSC and the MSC, or its successor, will determine the matter. If the Specialist Services Committee cannot reach a consensus decision with respect to any matter that is referred to it under section 5.6(d) and that requires a determination, the Physician Services Committee will determine a process for resolving the dispute, which may include referral to the Adjudication Committee or the MSC.

5.6 The Specialist Services Committee will have the following responsibilities:

- (a) allocating funds referred to in Article 6;
- (b) identifying possible time limited projects that have measurable patient-centred goals focused on the following areas:
 - (i) system redesign; and
 - (ii) expediting access;
- (c) consulting with representatives of allied health professionals as necessary in the completion of its mandate; and
- (d) other matters that may be referred to it by the Physician Services Committee.

5.7 On an annual basis, the Specialist Services Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the 2012 Physician Master Agreement.

5.8 The Specialist Services Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Specialist Services Committee pre-approve any communication about the business and/or decisions of the Specialist Services Committee.

5.9 The costs of administrative and clerical support required for the work of the Specialist Services Committee and physician (other than employees of the Government, BCMA and Health Authorities) participation in the Specialist Services Committee, will be paid from the funds referred to in Article 6 of this Agreement.

ARTICLE 6 - FUNDING TO IMPROVE ACCESS TO SPECIALTY SERVICES BY BRITISH COLUMBIANS

6.1 The Government previously provided \$49 million in annual funding to support the work of the Specialist Services Committee, of which \$2,159,372 has been transferred to the Alternative Payments Program and \$10 million has been made available for allocation to Fees in accordance with section 1.1(b) of Appendix F to the 2012 Physician Master Agreement. The

Government will continue to provide the remaining \$36,840,628 in annual funding to be allocated by the Specialist Services Committee to support the work of the Specialist Services Committee in enhancing and expanding the programs that support the delivery of high quality specialty services to British Columbians.

6.2 The Government will provide an additional \$10 million in annual funding to be made available effective April 1, 2012, with such funding to be allocated by the Specialist Services Committee to, amongst other things, offset utilization pressures on its programs.

6.3 The Government will provide an additional \$8 million in annual funding to be made available effective April 1, 2013, with such funding to be allocated by the Specialist Services Committee to, amongst other things, offset utilization pressures on its programs.

6.4 Any funds identified in this Article 6 that remain unexpended at the end of any Fiscal Year will be available to the Specialist Services Committee for use as one time allocations to improve the quality of care.

ARTICLE 7 – SPECIALIST SERVICES COMMITTEE REPORTING

7.1 The Specialist Services Committee will submit a semi-annual written report to the Government and the BCMA, as of March 31 and September 30 of each year, on the use of the funds referred to in section 6.4, with each such report to include the following information:

- (a) the total amount of such funds available at the beginning of the reporting period in issue (October 1 for reports as of March 31 and April 1 for reports as of September 30);
- (b) an itemized account, by initiative, of all funds spent since the prior report including a description of each initiative, an explanation of how each initiative meets the objective of improving the quality of care, and the total amount of the funds spent on each initiative;
- (c) an itemized account, by initiative, of all funds committed, but not spent, since the prior report including a description of each initiative, an explanation of how each initiative meets the objective of improving the quality of care, and the total amount of the funds committed to each initiative;
- (d) the amount of any funds identified in any previous report as having been committed, but not spent, that the Specialist Services Committee has determined will not be spent, identified by initiative, with an explanation of why the funds were not spent as initially contemplated; and
- (e) the balance of the funds remaining available at the end of the reporting period in issue.

ARTICLE 8 - DISPUTE RESOLUTION

8.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the 2012 Physician Master Agreement applicable to Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2012.

SIGNED, SEALED & DELIVERED on)
behalf of HER MAJESTY THE QUEEN)
IN RIGHT OF THE PROVINCE OF)
BRITISH COLUMBIA, by the Minister)
of Health or his/her duly authorized)
representative, in the presence of:)

Signature of Witness)

Name)

Address)

THE CORPORATE SEAL of the)
BRITISH COLUMBIA MEDICAL)
ASSOCIATION was hereunto affixed in)
the presence of:)

C/S

Signature of Authorized Signatory)

Name)

Position)

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

Name

Position

APPENDIX C

2012 RURAL PRACTICE SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of April, 2012,

BETWEEN:

**HER MAJESTY THE QUEEN IN RIGHT OF THE
PROVINCE OF BRITISH COLUMBIA**, as represented by the
Minister of Health

(the “**Government**”)

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION

(the “**BCMA**”)

AND:

MEDICAL SERVICES COMMISSION

(the “**MSC**”)

WITNESSES THAT WHEREAS:

A. The BCMA, the MSC and the Government have agreed to renew and replace the 2007 PMA, the 2007 General Practitioners Subsidiary Agreement, the 2007 Specialists Subsidiary Agreement, the 2007 Rural Practice Subsidiary Agreement, the 2007 Alternative Payments Subsidiary Agreement and the 2007 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new Rural Practice Subsidiary Agreement, to take effect as of April 1, 2012; and

C. The parties intend this Agreement to enhance the availability and stability of services provided by physicians in smaller urban, rural and remote areas of British Columbia by addressing some of the uniquely demanding and difficult circumstances attendant upon the provision of those services by physicians.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 1 - RELATIONSHIP TO THE 2012 PHYSICIAN MASTER AGREEMENT

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2012 Physician Master Agreement and is subject to its terms and conditions.

ARTICLE 2 - DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the 2012 Physician Master Agreement have the same meaning as in the 2012 Physician Master Agreement unless otherwise defined in this Agreement.

2.2 “**this Agreement**” means this document including the Appendices, as amended from time to time as provided herein.

2.3 “**Flat Premium**” means an annual payment in an amount determined by the JSC from time to time and paid in one or more instalments that is available through the RRP to eligible physicians in RRP Communities.

2.4 “**Isolation Points**” means points allocated by the JSC to a community in accordance with Appendix “C”.

2.5 “**IAF**” means the Isolation Allowance Fund referred to in section 14.1.

2.6 “**NITAOP**” means the two-component Northern and Isolation Travel Assistance Outreach Program consisting of the Physician Outreach Program and the Northern and Isolation Travel Assistance Program, and referred to in section 11.1.

2.7 “**Northern and Isolation Travel Assistance Program**” means the component of the NITAOP that is funded through the Available Amount, and that provides funding for travel expenses incurred by approved Specialist Physicians for travel to the communities listed in Appendix B for the purpose of such Specialist Physicians providing medical services to residents of such communities.

2.8 “**Percentage Fee Premium**” means a premium, expressed as a percentage, in an amount determined by the JSC from time to time for each RRP Community in accordance with this Agreement, that is added to Fees, Service Contract, Salary Agreement and Sessional Contract payments and made available through the RRP to eligible Physicians in RRP Communities.

2.9 “**2012 Physician Master Agreement**” means the agreement titled “2012 Physician Master Agreement” between the Government, the MSC and the BCMA, dated April 1, 2012.

2.10 “**Physician Outreach Program**” means the component of the NITAOP that provides funding for travel honorariums for Specialist Physicians and General Practitioners, and travel expenses for General Practitioners, for approved travel to the communities listed in Appendix B for the purpose of such Specialist Physicians and General Practitioners providing medical services to residents of such communities.

2.11 “**Physician Supply Plan**” has the meaning given in Appendix “D”.

2.12 “**RCF**” means the Recruitment Contingency Fund referred to in section 10.5.

2.13 “**RCME**” means the Rural Continuing Medical Education program referred to in section 8.1.

- 2.14 “**REAP**” means the Rural Education Action Plan referred to in section 9.1.
- 2.15 “**RGPLP**” means the Rural General Practitioner Locum Program referred to in section 7.1.
- 2.16 “**RIF**” means the Recruitment Incentive Fund referred to in section 10.1.
- 2.17 “**RRP**” means the Rural Retention Program referred to in section 6.1.
- 2.18 “**Rural Community**” means a community listed on Appendix A.
- 2.19 “**RRP Community**” means a Rural Community which has at least 6 Isolation Points.
- 2.20 “**RSLP**” means the Rural Specialist Locum Program referred to in section 7.5.
- 2.21 “**Rural Programs**” means the RRP, the RGPLP, the RSLP, the RCME, the REAP, the RIF, the RCF, the NITAOP, and the IAF.
- 2.22 Subject to section 2.23, this Agreement may be amended at any time but only by written agreement of the parties. Any waiver of any provision of this Agreement shall only be effective if in writing signed by the waiving party, and no waiver shall be implied by indulgence, delay or other act, failure to act, omission or conduct. Any waiver shall only apply to the specific matter waived and only in the specific instance and for the specific purpose for which it is given.
- 2.23 Notwithstanding section 2.22, Appendix A, Appendix B and Appendix C of this Agreement may be amended by the JSC, by consensus decision, as provided herein.
- 2.24 The provisions of sections 1.2 to 1.6 and 1.8 of the 2012 Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to “this Agreement” shall herein be construed to mean this Agreement.

ARTICLE 3 - TERM

- 3.1 This Agreement comes into force on April 1, 2012.
- 3.2 This Agreement shall be for the same term as the 2012 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the 2012 Physician Master Agreement.

ARTICLE 4 - SCOPE

- 4.1 Subject to section 4.2, this Agreement applies to physicians practising in British Columbia except those whose practice is in Greater Vancouver, greater Victoria, Nanaimo, Kelowna, Kamloops, Vernon, Penticton, and the Fraser Valley west of Agassiz/Harrison Lake.
- 4.2 This Agreement applies to all physicians who practice in Rural Communities and are required by a Physician Supply Plan, subject to the specific terms, conditions, rules and

eligibility criteria approved or established by the JSC for each of the Rural Programs from time to time.

4.3 For purposes of the NITAOP, this Agreement applies to the communities listed in Appendix B, subject to the specific terms, conditions, rules and eligibility criteria established by the JSC for the NITAOP from time to time.

4.4 A Health Authority, the Government, or the BCMA may apply to the JSC to add a community, except those referred to in section 4.1, to Appendix A if a physician is (or physicians are) needed in the community as agreed upon by a consensus decision of the JSC or as reflected in a Physician Supply Plan. The criteria for including any community in Appendix A are set out in Appendix C. To be included in Appendix A, a community must receive at least 0.5 Isolation Points as a result of the application of Appendix C. The JSC will review and amend Appendix A at least annually in accordance with sections 5.7 and 5.8.

4.5 A Health Authority, the Government or the BCMA may apply to the JSC to add a community to Appendix B if the community is listed in Appendix A, and the community will be added to Appendix B if the JSC agrees, by consensus decision, that the community requires itinerant services.

ARTICLE 5 - THE JOINT STANDING COMMITTEE ON RURAL ISSUES

5.1 The **Joint Standing Committee on Rural Issues** (the “JSC”) will continue under this Agreement and will continue to work to enhance the delivery of rural healthcare in accordance with the duties imposed and the powers conferred by this Agreement. In addition to administering the Rural Programs as described in this Agreement, the JSC may consider and make recommendations on matters that support the following objectives:

- (a) increasing relativities between Rural Communities;
- (b) supporting hospital based core services;
- (c) supporting new physicians moving into Rural Communities;
- (d) enhancing support for rural emergency departments;
- (e) developing a response to Rural Communities in crisis; and
- (f) supporting the use of physician extenders in Rural Communities.

5.2 The JSC is composed of five members appointed by the BCMA and five members appointed by the Government. In addition, each party may designate up to three alternates. Each party pays for the expenses of its own members.

5.3 The JSC must meet a minimum of six days per year and will be co-chaired by a member chosen by the Government members and a member chosen by the BCMA members. The JSC must establish, before March 31 each year, a schedule of meetings for the next 12 months.

5.4 The time for any JSC meeting may be changed but only by mutual agreement of the co-chairs. Either co-chair may call additional meetings. Any such additional meetings must take place within two weeks of the call, unless otherwise agreed.

5.5 The JSC must adopt appropriate procedural rules to ensure the fair and timely resolution of matters before it. The JSC will make all decisions by consensus decision, whether or not a consensus decision is expressly called for by any other provisions of this Agreement.

5.6 The JSC may make recommendations to the Physician Services Committee on the use of innovative and emerging technologies.

5.7 The JSC must review Appendix A annually in accordance with section 5.8. In addition to amendments made to Appendix A as a result of that annual review, Appendix A may be amended periodically to reflect any changes determined by the JSC to be appropriate and consistent with this Agreement, provided however that any community listed on Appendix A must have at least 0.5 Isolation Points.

5.8 Commencing in December of each year, the JSC must review the Isolation Points assigned to each community in Appendix A by applying Appendix C to each such community. This annual review must be completed by the end of February of the subsequent calendar year. By no later than April 1 of the same year, the JSC must amend the Isolation Points assigned to each of the communities in Appendix A, to reflect the results of the annual review.

5.9 Where, as a result of a review pursuant to section 5.7 or section 5.8, the JSC assigns a community:

- (a) less than 6 Isolation Points then, in the year to which that assignment applies,
 - (i) eligible physicians, who received a Flat Premium the immediately preceding year, will be entitled to receive a Flat Premium in the amount of 50% of their Flat Premium entitlement from the immediately preceding year.
 - (ii) eligible physicians who received a Percentage Fee Premium for medical services performed in such community in the immediately preceding year will be entitled to receive a Percentage Fee Premium on medical services performed in such community in the amount of 50% of their Percentage Fee Premium for such community from the immediately preceding year.
- (b) between 0.5 and 5.99 Isolation Points, it will be deemed to be a “D” community and physicians residing and practising in such community will only be eligible for the RCME, the RGPLP, the RIF, the RCF and the REAP, all in accordance with the specific terms, conditions, rules and eligibility criteria applicable to each of those programs as established by the JSC from time to time; and
- (c) less than 0.5 Isolation Points, it will be deleted from Appendix “A” and, if prior to such review it was listed in Appendix B, it will be deleted from Appendix B and

physicians residing and/or providing services in such community will be ineligible for Rural Programs.

5.10 Where a community has been recommended for inclusion in Appendix A in accordance with section 4.4, the JSC must evaluate the community by application of Appendix C. If the evaluation results in a rating for the community of at least 0.5 Isolation Points, the JSC must add the community to Appendix A.

5.11 The JSC will periodically review Appendix B and may, by consensus decision, add or delete communities to it if the JSC determines such changes are required to reflect the criteria set out in section 4.5.

5.12 The JSC will periodically review Appendix C and may, by consensus decision, make any changes determined by the JSC to be appropriate.

5.13 In the event the JSC is unable to reach a consensus decision with regard to any matter that it is required by this Agreement to decide, the Government and/or the BCMA may refer the matter in dispute for adjudication by the Adjudication Committee in accordance with section 21.2 of the Physician Master Agreement.

5.14 The JSC must establish practices and procedures appropriate to decisions with respect to the disbursement of public funds, including conflict of interest guidelines. The practices and procedures adopted by the JSC must include provisions that promote accountability, transparency and, consistent with section 5.3 of the Physician Master Agreement, confidentiality.

5.15 On an annual basis, the JSC will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the 2012 Physician Master Agreement.

5.16 The JSC must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the JSC pre-approve any communication about the business and/or affairs of the JSC.

ARTICLE 6 - RURAL RETENTION PROGRAM

6.1 The Rural Retention Program (the “**RRP**”) is a program that makes available, to eligible physicians in RRP Communities, a Percentage Fee Premium and an annual Flat Premium, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

6.2 Responsibility for the governance and oversight of the RRP resides with the JSC, with day to day administration of the RRP provided by the Ministry.

6.3 To be eligible for a Percentage Fee Premium, a physician must meet all eligibility criteria approved or established by the JSC from time to time and must provide medical services in an RRP Community.

6.4 To be eligible for a Flat Premium, a physician must meet all eligibility criteria approved or established by the JSC from time to time.

6.5 The value of the Percentage Fee Premium and the value of the Flat Premium, each as applicable to each RRP Community, will be based on the Isolation Points allocated by the JSC to such community at least annually in accordance with sections 5.7 and 5.8, and the value of the Percentage Fee Premium and Flat Premium resulting therefrom shall be determined by the JSC.

6.6 Percentage Fee Premiums apply to the professional component of radiologists' and pathologists' in-patient and emergency services.

6.7 Between April 1, 2012 and March 31, 2016, the Government will fund the RRP at a level sufficient to maintain Percentage Fee Premium and Flat Premium values that reflect the implementation of the at least annual application of Appendix C and the amendments to the Isolation Points for each RRP Community that result therefrom, on the following basis;

- (a) for RRP Communities without a resident physician and without a vacancy, a Percentage Fee Premium will be available in an amount equal to the total Isolation Points for the RRP Community in question but to a maximum Percentage Fee Premium of 30%;
- (b) for RRP Communities with at least one resident physician or at least one vacancy, a Percentage Fee Premium will be available in an amount equal to 70% of the Isolation Points for the RRP Community in question but to a maximum Percentage Fee Premium of 30%;
- (c) for RRP Communities with at least one resident physician, a Flat Premium will be available in an amount equal to 30% of the Isolation Points for the RRP Community in question multiplied by \$2,040;
- (d) if the JSC chooses not to implement reductions in Isolation Points for RRP Communities as a result of the application of Appendix C, the cost of maintaining the Percentage Fee Premium and Flat Premium values will be paid out of funds provided in Article 12; and
- (e) if the JSC changes the application of the terms, conditions, rules and eligibility criteria for the RRP, any increased cost associated with such changes will be paid out of funds provided in Article 12.

ARTICLE 7 - RURAL LOCUM PROGRAMS

7.1 The Rural General Practice Locum Program (the "RGPLP") is a program that provides support to enable eligible General Practitioners to have reasonable periods of leave from their practices for such purposes as continuing medical education, maternity leave, vacation and health needs, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

7.2 Responsibility for the governance and oversight of the RGPLP resides with the JSC, with day to day administration of the RGPLP provided by the Ministry.

7.3 Preference for locum support through the RGPLP will be given to the most isolated/vulnerable communities.

7.4 The Government will provide annual funding of \$1,850,000 for the RGPLP.

7.5 The Rural Specialist Locum Program (the “RSLP”) is a program that provides support to enable eligible Specialist Physicians practising in certain designated specialities and in certain rural communities to have reasonable periods of leave from their practices for such purposes as continuing medical education, parental leave, vacation, health needs and to assist in the provision of continuous specialist coverage as designated by the applicable Health Authority, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

7.6 Responsibility for the governance and oversight of the RSLP resides with the JSC, with day to day administration of the RSLP provided by the Ministry.

7.7 The Government will provide annual funding of \$600,000 for the RSLP.

ARTICLE 8 - RURAL CONTINUING MEDICAL EDUCATION

8.1 The Rural Continuing Medical Education program (the “RCME”) is a program that makes funds available to eligible physicians, to assist them with eligible educational expenses, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

8.2 Responsibility for the governance and oversight of the RCME resides with the JSC, with day to day administration of the RCME provided by the Ministry.

8.3 When a physician has practised in a Rural Community for the number of years set out below, the physician is eligible for reimbursement of eligible educational expenses up to the annual amounts set out below, according to the degree of isolation of his or her community:

	Up to 2 years	in the 3rd & 4th year	Over 4 yrs
“A” communities	\$1,200	\$3,200	\$5,200
“B” communities	\$400	\$2,400	\$4,400
“C” communities	\$0	\$2,000	\$4,000
“D” communities	\$0	\$1,000	\$2,000

where:

- (a) an “A” community is a Rural Community that received 20 or more Isolation Points as a result of the most recent application by the JSC of Appendix C to that community;
- (b) a “B” community is a Rural Community that received between 15 and 19.99 Isolation Points as a result of the most recent application by the JSC of Appendix C to that community;

- (c) a “C” community is a Rural Community that received between 6 and 14.99 Isolation Points as a result of the most recent application by the JSC of Appendix C to that community; and
- (d) a “D” community is a Rural Community that received between 0.5 and 5.99 Isolation Points as a result of the most recent application by the JSC of Appendix C to that community.

8.4 RCME is provided in addition to CME. Physicians who are eligible for RCME are also eligible for CME (as defined in the Benefits Subsidiary Agreement) so long as they meet the terms, conditions, rules and eligibility criteria applicable to the CME as approved and published by the Benefits Committee (as defined in the Benefits Subsidiary Agreement) from time to time.

8.5 A physician who is eligible for RCME in accordance with section 8.3 and moves to another Rural Community, continues to get credit for the time in the previous Rural Community but is eligible to receive the RCME amount applicable to the new community.

8.6 A physician who is eligible for RCME in accordance with section 8.3 and who does not practice in a Rural Community for the entire 12 months in any given calendar year is eligible for a proportionate amount of the RCME amount set out in section 8.3, for that calendar year. If the physician uses the entire annual entitlement and subsequently ceases practising in a Rural Community before the end of the 12-month period, the physician is only eligible for a proportionate amount of the amount set out in section 8.3 for that calendar year and must reimburse the appropriate Health Authority for any amount that was received by him or her in excess of that proportionate amount.

8.7 A physician may “bank” RCME entitlements, except that the eligibility for RCME for any calendar year expires at the end of two subsequent calendar years. For greater clarity, a physician’s RCME “bank” can contain up to three calendar years of RCME entitlement. Upon expiry of eligibility, or upon the physician ceasing to practice in a Rural Community, any sum remaining from that set aside for that physician transfers to the appropriate Health Authority.

8.8 Health Authorities must, in agreement with the Health Authority medical advisory committee, use any RCME amounts transferred to them pursuant to section 8.6 or section 8.7, for continuing medical education purposes within one or more of the Rural Communities, in addition to the payment of amounts set out in section 8.3.

8.9 The eligibility of particular educational expenses for reimbursement pursuant to the RCME will be as determined by the JSC provided however that expenses related to the acquisition of new technology or to support technology upgrades which are reasonably necessary for a physician to participate in distance continuing medical education will be eligible expenses.

ARTICLE 9 - RURAL EDUCATION ACTION PLAN

9.1 The Rural Education Action Plan (the “**REAP**”) is a program that provides funds to support and facilitate the training of physicians in rural practice including the enhanced skills program for rural physicians; a re-entry program, and increasing the rural training programs for

physicians, in accordance with the specific terms, conditions, rules and eligibility criteria as approved or established by the JSC from time to time.

9.2 Responsibility for the governance and oversight of the REAP resides with the JSC, with day to day administration of the REAP provided by the Ministry.

9.3 The JSC may provide advice and recommendations to the Government and the BCMA respecting rural undergraduate, post graduate and specialty training programs.

9.4 The Government will provide annual funding of \$2,250,000 for the REAP. This funding obligation is in addition to the obligation to fund training programs existing as of November 4, 2002.

9.5 The JSC must determine how to allocate the REAP budget, ensure that expenditures for any program are independently evaluated for their cost effectiveness, and make further allocation decisions taking into account the results of the evaluation.

ARTICLE 10 - RECRUITMENT INCENTIVES

10.1 The Recruitment Incentive Fund (the “**RIF**”) is a program that, subject to section 10.3, makes financial benefits available to eligible physicians recruited to fill:

- (a) vacancies identified in a Physician Supply Plan; or
- (b) pending vacancies identified in a Physician Supply Plan,

in any Rural Community, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

10.2 Responsibility for the governance and oversight of the RIF resides with the JSC, with day to day administration of the RIF provided by the Ministry.

10.3 Physicians recruited from any community (other than those listed as exceptions in section 4.1) where a recruitment and retention initiative funded by the Government is in place, are not eligible for RIF. In exceptional circumstances the JSC may waive this restriction.

10.4 The maximum benefit available under the RIF is \$20,000, which is pro-rated in the case of physicians who are recruited to work less than full-time. Payment of the benefit is subject to the physician’s agreement to repay the benefit in full if he/she leaves the community to which he or she was recruited within one year from the date of commencement of practice in that community.

10.5 The Recruitment Contingency Fund (the “**RCF**”) is a program that makes payments available to Health Authorities to assist in the recruitment of physicians to Rural Communities, where the difficulty in filling a vacancy is, or is expected to be, especially severe and where the failure to fill the vacancy in a timely manner would have a significant impact on the delivery of medical care as required by the applicable Health Authority’s Physician Supply Plan; such payments are to be used to pay expenses associated with recruiting activities or to supplement

the benefit available to a recruited physician under the RIF, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

10.6 Responsibility for the governance and oversight of the RCF resides with the JSC, with day to day administration of the RCF provided by the Ministry.

10.7 Health Authorities may apply to the JSC for a grant from the RCF and must include with such application an explanation of why RCF funds are needed and how they are proposed to be spent.

10.8 The Government will provide annual funding of \$300,000 for the RCF.

ARTICLE 11 - NORTHERN AND ISOLATION TRAVEL ASSISTANCE OUTREACH PROGRAM

11.1 The Northern and Isolation Travel Assistance Outreach Program (the “NITAOP”) is a two-component program consisting of the Northern and Isolation Travel Assistance Program and the Physician Outreach Program, that makes funding available to provide approved physicians with a travel time honorarium and reimbursement of travel expenses, for approved travel to the communities listed in Appendix B for the purpose of providing medical services to the residents of such communities, in accordance with the specific terms, conditions, rules and eligibility criteria approved or established by the JSC from time to time.

11.2 Responsibility for the governance and oversight of the NITAOP resides with the JSC, with day to day administration of the NITAOP provided by the Ministry.

11.3 The Government will provide annual funding of \$1.5 million for the Physician Outreach Program.

ARTICLE 12 - ADDITIONAL FUNDING

12.1 The Government will continue to provide \$3.2 million in annual funding identified in the 2007 Rural Subsidiary Agreement which was and continues to be allocated by the JSC among the REAP, the RGPLP, the Physician Outreach Program, the RSLP, and the RCME programs.

12.2 The Government will continue to provide \$20 million annual funding identified in the 2007 Rural Subsidiary Agreement for allocation by the JSC to support its work enhancing and expanding the programs that support the delivery of physician services to British Columbians who reside in rural areas by, among other things, stabilizing the payments resulting from the application of isolation points, supporting the provision of physician services during periods of manpower transition and strengthening the emergency care system in the rural communities.

12.3 Effective April 1, 2013, the Government will increase annual funding by \$10 million to be allocated by the JSC to, amongst other things, offset utilization pressures on the Rural Programs excluding the RIF, RCME and RRP.

12.4 Any funds identified in section 12.2 and 12.3 that remain unexpended at the end of any Fiscal Year will be available to the JSC for use as one time allocations to improve the quality of care.

ARTICLE 13 - EXPENSES WHILE ACCOMPANYING A PATIENT

13.1 Physicians who accompany a patient who is being transferred from a Rural Community will, upon application to the Health Authority, be reimbursed for expenses reasonably incurred during, and necessitated by, the transfer.

ARTICLE 14 - ISOLATION ALLOWANCE FUND

14.1 The Isolation Allowance Fund (the “IAF”) is a program that makes payments available to physicians providing necessary medical services in Rural Communities with fewer than four physicians and no hospital, who are not receiving benefits under MOCAP (including call back and/or Doctor of the Day payments), for services provided in that Community, subject to the specific terms, conditions, rules and eligibility criteria as approved or established by the JSC from time to time.

14.2 Responsibility for the governance and oversight of the IAF resides with the JSC, with day to day administration of the IAF provided by the Ministry.

14.3 The Government will provide annual funding of \$600,000 for the IAF.

ARTICLE 15 - DISPUTE RESOLUTION

15.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the 2012 Physician Master Agreement applicable to Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2012.

SIGNED, SEALED & DELIVERED on)
behalf of HER MAJESTY THE QUEEN)
IN RIGHT OF THE PROVINCE OF)
BRITISH COLUMBIA, by the Minister)
of Health or his/her duly authorized)
representative, in the presence of:)

Signature of Witness)

Name)

Address)

THE CORPORATE SEAL of the)
BRITISH COLUMBIA MEDICAL)
ASSOCIATION was hereunto affixed in)
the presence of:)

C/S

Signature of Authorized Signatory)

Name)

Position)

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

Name

Position

Appendix A

COMMUNITIES WITH AT LEAST 0.5 ISOLATION POINTS (As of April 1, 2012)

Physicians in communities listed in this Appendix may be entitled to receive RRP, RCME, REAP, RGPLP, RSLP, IAF, RCF and RIF subject to the community meeting the applicable Isolation Point requirements and the physician meeting the applicable eligibility criteria.

100 Mile House	Doig River Duncan/N. Cowichan	Kitwanga Klemtu Kootenay Bay/Riondel Kyuquot
Agassiz/Harrison		
Ahousat	Edgewood	
Alert Bay	Elkford	
Alexis Creek	Enderby	Ladysmith/Chemainus
Anahim Lake		Lake Cowichan
Armstrong/Spallumcheen	Fernie	Lillooet
Ashcroft	Fort Nelson	Logan Lake
Atlin	Fort St. James	Lower Post
	Fort St. John/Taylor	Lumby
	Fort Ware	Lytton
Bamfield	Fraser Lake	
Barriere		
Bella Bella		Mackenzie
Bella Coola	Gabriola Island	Madeira Park
Big White	Galiano Island	Masset
Blind Bay	Gold Bridge/Bralorne	Mayne Island
Blue River	Gold River	McBride
Blueberry River	Golden	Merritt
Bowen Island	Granisle	Mill Bay
Bridge Lake	Greenwood/Midway/Rock Creek	Miocene
Burns Lake		Mount Currie
	Halfway River	
Campbell River	Hartley Bay	Nakusp
Canal Flats	Hazelton	Nelson
Castlegar	Holberg	New Aiyansh
Chase	Hope	New Denver
Chemainus	Hornby Island	Nitinat
Chetwynd	Hot Springs Cove	
Christina Lk/Grand Forks	Houston	
Clearwater	Hudson's Hope	Ocean Falls
Clinton		Osoyoos/Oliver
Cobble Hill		
Cortes Island	Invermere	Parksville/Qualicum
Courtenay/Comox/Cumberland		Pemberton
Cranbrook	Kaslo	Pender Island
Crescent Valley	Keremeos	Port Alberni
Creston	Kimberley	Port Alice
	Kincolith	Port Clements
	Kingcome	Port Hardy
Dawson Creek	Kitimat	Port McNeill
Dease Lake	Kitkatla	Port Renfrew
Denman Island	Kitsault	Port Simpson

Powell River
Prince George
Prince Rupert
Princeton

Quadra Island
Quatsino
Queen Charlotte
Quesnel

Revelstoke
Rivers Inlet

Salmo
Salmon Arm/Sicamous
Saltspring Island
Samahquam
Saturna Island
Savary Island
Sayward
Sechelt/Gibsons

Seton Portage
Shawnigan Lake
Sirdar
Skatin
Slocan Park
Smithers
Sointula
Sooke
Sorrento
Sparwood
Spences Bridge
Squamish
Stewart

Tahsis
Takla Landing
Tatla Lake
Tatlayoko Lake
Telegraph Creek
Tepella
Terrace
Texada Island

Tofino
Trail/Rossland/Fruitvale
Tsay Keh Dene
Tumbler Ridge

Ucluelet

Valemount
Vanderhoof
Wardner
Whistler
Williams Lake
Winlaw
Woss

Zeballos

Appendix B

NITAOP COMMUNITIES (As of April 1, 2012)

Subject to meeting eligibility criteria per specialty

100 Mile House	Hazelton	
	Holberg	
Ahousat	Houston	Salmon Arm
Alert Bay	Hudson's Hope	Saltspring Island
Alexis Creek		Samaqham
Anahim Lake		Saturna Island
Atlin	Invermere	Sechelt/Gibsons
		Seton Portage
		Skatin
Bamfield	Kingcome	Smithers
	Kitimat	Sointula
	Kitkatla	Sparwood
	Klemtu	Stewart
Bella Bella	Kyuquot	
Bella Coola	Lillooet	
Blueberry River		Tahsis
Burns Lake		Tepella
	Mackenzie	Terrace
Campbell River	Masset	Tofino
	Mayne Island	Trail
	McBride	Tsay Keh Dene
Castlegar	Merritt	Tumbler Ridge
Chetwynd		
Clearwater		
Clinton	Nakusp	Ucluelet
Cortes Island	Nelson	
Courtenay/Comox	New Aiyansh	Valemount
Cranbrook	New Denver	Vanderhoof
Crawford Bay	Nitinat	
Creston		
	Ocean Falls	Whistler
Dawson Creek		Williams Lake
Dease Lake		Woss
Doig River	Pender Island	
	Port Alberni	Zeballos
	Port Hardy	
Edgewood	Port McNeill	
	Port Renfrew	
	Port Simpson	
Fernie	Powell River	
Fort Nelson	Prince George	
Fort St. James	Prince Rupert	
Fort St. John	Princeton	
	Quatsino	
Galiano Island	Queen Charlotte	
Gold Bridge/Bralorne	Quesnel	
Gold River		
Golden		
Grand Forks/Midway/ Rock Creek	Revelstoke	
	Riondel	
Halfway River	Rivers Inlet	
Hartley Bay	Salmo	

Appendix C

ISOLATION POINT CRITERIA

Medical Isolation and Living Factors	Points	Max Points
Number of Designated Specialties within 70 km		
0 Specialties within 70 km	60	
1 Specialty within 70 km	50	
2 Specialties within 70 km	40	
3 Specialties within 70 km	20	
4 Specialties within 70 km	0	60
Number of General Practitioners within 35 km		
over 20 Practitioners	0	
11-20 Practitioners	20	
4 to 10 Practitioners	40	
0 to 3 Practitioners	60	60
Community Size (If larger community within 35 km then larger population is considered)		
30,000+	0	
10,000 to 30,000	10	
Between 5,000 and 9,999	15	
Up to 5,000	25	25
Distance from Major Medical Community (Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford, Prince George)		
first 70 km road distance	4	
for each 35 km over 70 km	2	
to a maximum of	30	30
Note: ferry dependent communities will have a multiplier added to sea distance		
Degree of Latitude		
Communities between 52 to 53 degrees latitude	20	
Communities above 53 degrees latitude	30	30
Specialist Centre		
- 3 or 4 Designated Specialties in Health Authority Physician Supply Plans	30	
- 5 to 7 Designated Specialties in Health Authority Physician Supply Plans	50	
- 8 Designated Specialties and more than one specialist in each specialty in Health Authority Physician Supply Plans	60	60
Location Arc		
- communities in Arc A (within 100 km air distance from Vancouver)	0.10	
- communities in Arc B (between 100 and 300 km air distance from Vancouver)	0.15	
- communities in Arc C (between 300 and 750 km air distance from Vancouver)	0.20	
- communities in Arc D (over 750 km air distance from Vancouver)	0.25	

Appendix D

PHYSICIAN SUPPLY PLANS

- 1.1 A Physician Supply Plan is a plan created by a Health Authority further to the Ministry's Health Human Resource Strategy, in consultation with the Health Authority's medical advisory committee, and approved by the Ministry, which addresses issues related to access to physician services within the geographic jurisdiction of the Health Authority.
- 1.2 For purposes of this Agreement, the key elements of a Physician Supply Plan are:
 - The number of General Practitioners and Specialists required to provide the physician services identified in the Physician Supply Plan; and
 - The on-call requirements necessary to ensure coverage.
- 1.3 In some cases, Health Authorities do not yet have approved Physician Supply Plans. Pending development and approval of a Physician Supply Plan covering a community within the jurisdiction of a Health Authority without a Physician Supply Plan, a reference to "Physician Supply Plan" in this Agreement means, with respect to that community:
 - The number of General Practitioners and Specialists in the community as of December 31, 2007, plus any vacancies identified by the Health Authority as of that date where active recruitment was underway; and
 - On-call requirements as determined by the Health Authority.
- 1.4 Despite any provision to the contrary, all physicians working in any Rural Community as of December 31, 2007 are deemed to be included in the Physician Supply Plan for the term of this Agreement.

APPENDIX D

2012 ALTERNATIVE PAYMENTS SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of April, 2012,

BETWEEN:

**HER MAJESTY THE QUEEN IN RIGHT OF THE
PROVINCE OF BRITISH COLUMBIA**, as represented by the
Minister of Health

(the “**Government**”)

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION

(the “**BCMA**”)

AND:

MEDICAL SERVICES COMMISSION

(the “**MSC**”)

WITNESSES THAT WHEREAS:

A. The BCMA, the MSC and the Government have agreed to renew and replace the 2007 PMA, the 2007 General Practitioners Subsidiary Agreement, the 2007 Specialists Subsidiary Agreement, the 2007 Rural Practice Subsidiary Agreement, the 2007 Alternative Payments Subsidiary Agreement, and the 2007 Benefits Subsidiary Agreement;

B. The parties have agreed that this Agreement will constitute the new Alternative Payments Subsidiary Agreement, to take effect as of April 1, 2012; and

C. The parties intend this Agreement to define compensation and the general terms and conditions that will apply to all Salary Agreements, Service Contracts and Sessional Contracts between Physicians and Agencies for Physician Services.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

PART 1 – GENERAL MATTERS

ARTICLE 1 - RELATIONSHIP TO THE 2012 PHYSICIAN MASTER AGREEMENT

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2012 Physician Master Agreement and is subject to its terms and conditions.

ARTICLE 2 - DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the 2012 Physician Master Agreement have the same meaning as in the 2012 Physician Master Agreement unless otherwise defined in this Agreement.

2.2 “**this Agreement**” means this document including the Schedules, as amended from time to time as provided herein.

2.3 “**General Practice Services**” means Physician Services generally recognized as being within the practice scope of a General Practitioner.

2.4 “**Physician**” means a medical practitioner who is and remains a member in good standing of the College of Physicians and Surgeons of British Columbia, whose services require him or her to have a medical degree and who is not providing exclusively administrative services, but does not include any member who is an undergraduate or an intern, resident, clinical fellow or clinical trainee in a postgraduate training program.

2.5 “**2012 Physician Master Agreement**” means the agreement titled “2012 Physician Master Agreement” between the Government, the BCMA, and the MSC, dated April 1, 2012.

2.6 “**Physician Placement System**” has the meaning given in section 11.6.

2.7 “**Physician Services**” means clinical and related teaching, research and clinical administrative services provided by Physicians.

2.8 “**Salary Agreement Full Time Equivalent**” means 1957.5 paid hours of employment per year for a Physician employed under a Salary Agreement.

2.9 “**Specialist Services**” means Physician Services generally recognized as requiring Specialist Physician expertise.

2.10 “**Template Service Contract**” means a contract in the form attached as Schedule E to this Agreement.

2.11 “**Template Sessional Contract**” means a contract in the form attached as Schedule F to this Agreement.

2.12 The provisions of sections 1.2 to 1.8 inclusive of the 2012 Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this

Agreement, except those references in such sections to “this Agreement” shall herein be construed to mean this Agreement.

ARTICLE 3 - TERM

3.1 This Agreement comes into force on April 1, 2012.

3.2 This Agreement shall be for the same term as the 2012 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the 2012 Physician Master Agreement.

ARTICLE 4 - ALTERNATIVE PAYMENTS COMMITTEE

4.1 The **Alternative Payments Committee** will continue under this Agreement until the earlier of the date on which it fulfills all of its responsibilities referred to in section 4.5 and September 30, 2013.

4.2 The membership of the Alternative Payments Committee will be composed of three members appointed by the BCMA and three members appointed by the Government.

4.3 The Alternative Payments Committee will be co-chaired by one member chosen by the BCMA appointees to the Alternative Payments Committee and one member chosen by the Government appointees to the Alternative Payments Committee.

4.4 Decisions of the Alternative Payments Committee will be by consensus decision.

4.5 The Alternative Payments Committee will:

- (a) complete the implementation of the adjustments to Service Contract Ranges and Salary Agreement Ranges contemplated by the Consensus Decision of the Alternative Payments Committee dated December 9, 2010;
- (b) within the funding identified in section 1.1(c) of Appendix F of the 2012 Physician Master Agreement, determining changes to the Service Contract Ranges and Salary Agreement Ranges in response to physician recruitment and retention challenges;
- (c) subject to section 4.10, within the funding identified in section 1.2(b) of Appendix F of the 2012 Physician Master Agreement, determining changes to the Service Contract Ranges and Salary Agreement Ranges in response to physician recruitment and retention challenges;
- (d) in accordance with section 4.6:
 - (i) develop an integrated approach to the pricing of a Service Contract within the appropriate Service Contract Range which may include among other things:

- (A) the level of time and service commitment by providers along a continuum;
 - (B) a definition of enhanced skills;
 - (C) a consideration of how enhanced skills, where such enhanced skills are required by the Agency that is party to the Service Contract in question, might be recognised; and
 - (D) other factors reflected in the Physician Placement System;
- (ii) absent agreement on an integrated approach to the pricing of a Service Contract as contemplated by section 4.5(d)(i), develop a revised definition of a full time equivalent for application to Service Contracts (other than Service Contracts for Emergency Medicine) that provides reasonable and competitive levels of productivity and output consistent with a professional workforce;
 - (iii) determine the conditions, if any, under which the Service Contract Ranges and the Salary Agreement Ranges may be exceeded; and
 - (iv) make changes to the Template Service Contract and Template Sessional Contract to improve clarity and operational efficiency.

4.6 Mr. Eric Harris, QC will serve as a facilitator and mediator to assist the Alternative Payments Committee to fulfill the responsibilities referred to in section 4.5(d), and in this role he will meet with the members of the Alternative Payments Committee for up to 15 days, or longer by agreement of the Physician Services Committee, provided however that no more than one day may be allocated to addressing the matters referred to in section 4.5(d)(iv).

4.7 If the Alternative Payments Committee reaches consensus decision(s) on any matter(s) referred to in section 4.5, such consensus decision(s) shall be implemented.

4.8 If the Alternative Payments Committee cannot reach a consensus decision on the matters referred to in section 4.5(b) or section 4.5(c), the Government and/or the BCMA may make recommendations to the MSC regarding such matters and the MSC, or its successor, will determine the matter.

4.9 If the Alternative Payments Committee cannot reach a consensus decision on any matters referred to in section 4.5(d) by June 30, 2013, Mr. Eric Harris, QC shall issue recommendations regarding any such matter(s) to the Physician Services Committee by July 31 2013.

4.10 All costs associated with the implementation of any consensus decision or agreement on any matters referred to in section 4.5(d) will be funded from the monies referred to in section 1.2(b) of Appendix F to the 2012 Physician Master Agreement.

4.11 The Alternative Payments Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the plan, and report to the Physician Services Committee annually on progress.

4.12 The Government previously provided one time funding of \$400,000 to support the work of the Alternative Payments Committee.

4.13 The costs of:

- (a) administrative and clerical support required for the work of the Alternative Payments Committee;
- (b) Physician (other than employees of the parties or Health Authorities) participation in the Alternative Payments Committee; and
- (c) the costs of the mediator/facilitator referred to in sections 4.6 and 4.9.

will be paid from the funds referred to in section 4.12.

ARTICLE 5 - COMPENSATION ENTITLEMENT

5.1 Subject to sections 5.2 and 5.3 of this Agreement, Physicians providing Physician Services under the terms of a Salary Agreement or Service Contract or during the time for which they are paid in accordance with a Sessional Contract, are not entitled to any additional compensation for those Physician Services and may not be paid Fees or any other fees for those Physician Services.

5.2 Physicians paid pursuant to a Salary Agreement, a Service Contract or a Sessional Contract will be entitled to receive:

- (a) additional compensation under the Rural Practice Subsidiary Agreement; and
- (b) additional compensation under the 2012 Physician Master Agreement, the General Practitioners Subsidiary Agreement or the Specialists Subsidiary Agreement;

where eligible under those agreements and all applicable eligibility criteria.

5.3 Physicians on Service Contracts or Sessional Contracts are entitled to participate in the Benefit Plans as defined and described in the Benefits Subsidiary Agreement, subject to the terms of the Benefits Subsidiary Agreement and the Benefit Plans.

ARTICLE 6 - COMPENSATION ADMINISTRATION

6.1 Physicians providing Specialist Services who are registered to provide Specialist Services with the College of Physicians and Surgeons of British Columbia but who do not hold certification or fellowship with the Royal College of Physicians and Surgeons of Canada, will, subject to agreement of the Physician Services Committee, be paid at the appropriate Sessional

Contract Rate or on the appropriate Salary Agreement Range or Service Contract Range for the practice category for such Specialist Services. Pending that agreement of the Physician Services Committee, the Physician may be so paid for a period of up to six months. A Physician being paid under a Service Contract or a Salary Agreement pursuant to this section 6.1 will normally be placed at the minimum rate on the appropriate range unless the Physician Services Committee approves placement elsewhere on the range.

6.2 The Medical Health Officer 1 and Medical Health Officer 2 practice categories in Schedules A and B include Physicians who practice Community Medicine and are not classified in another medical group, including Medical Health Officers, Community Medicine Consultants and First Nations Medical/Public Health Advisors. Physicians will be assigned to the Medical Health Officer 1 practice category or the Medical Health Officer 2 practice category on Schedule A and Schedule B in accordance with Schedule G.

6.3 Physicians who are currently being paid under a Salary Agreement or a Service Contract at an annual rate that is above the range maximum on the Salary Agreement Range or Service Contract Range for their practice category will not have their annual rate decreased as a result of the application of Schedule A or Schedule B, whichever is applicable, but will only receive the compensation increases that are identified in sections 1.1(a), 1.1(b), and 1.2(a) of Appendix F to the Physician Master Agreement to the extent that their resulting compensation is within the then current applicable Salary Agreement Range or Service Contract Range.

6.4 Where Schedule A or Schedule B does not list a Salary Agreement Range or a Service Contract Range for a particular practice category, the Physician Services Committee will determine an appropriate range.

ARTICLE 7 - RELATIONSHIP WITH CONTRACTING AGENCIES

7.1 All Salary Agreements, Service Contracts and Sessional Contracts must be signed by the Physician or group of Physicians and the Agency, and the parties to such contracts shall exchange executed copies.

7.2 Subject to this Agreement, the Agency retains authority to negotiate with Physicians how Physician Services are to be delivered and what compensation is to be provided under a Salary Agreement, a Service Contract or Sessional Contract.

7.3 Except for the indemnity at section 3.5 of the Template Service Contract and section 3.4 of the Template Sessional Contract, Alternative Payment Arrangements must not contain provisions requiring either the Physician or the Agency to indemnify the other in the event of a claim by a third party. For greater clarity, this clause is not intended to abrogate the common law rights of parties to an Alternative Payment Arrangement to claim indemnification from any other party.

7.4 Subject to sections 7.5 and 7.6, all Service Contracts and Sessional Contracts must be in the forms for each set out in Schedules E and F to this Agreement.

7.5 The parties to a Service Contract or a Sessional Contract may agree to contractual provisions that are in addition to those found in Schedules E and F to this Agreement provided that these additional provisions are not inconsistent with the spirit and intent of this Agreement.

7.6 The Template Service Contract and the Template Sessional Contract may be amended to reflect the legal status of the Physician(s) who will be parties and the number of parties to the contract.

PART 2- PHYSICIANS EMPLOYED UNDER SALARY AGREEMENTS

ARTICLE 8 - COMPENSATION AND HOURS OF WORK

8.1 Physicians employed under Salary Agreements will be compensated within the Salary Agreement Range for the applicable practice category.

8.2 Physicians working less than a Salary Agreement Full Time Equivalent will receive a proportionate amount of compensation.

8.3 Annual salaries of Physicians under Salary Agreements include payment for time spent providing ongoing responsibility for patients and any necessary referred emergency and non-elective services.

8.4 When a Physician is initially employed by an Agency under a Salary Agreement, the Physician's annual salary on the Salary Agreement Range for the applicable practice category will be the subject of an agreement between the Agency and the Physician and reflected in the offer of employment. Thereafter, annual in-range movement on the Salary Agreement Range will be on the same basis as senior management employees of the Agency, provided that no such movement shall result in any Physician's annual salary exceeding the range maximum on the Salary Agreement Range for the applicable practice category.

ARTICLE 9 - STANDARD TERMS AND CONDITIONS OF EMPLOYMENT UNDER SALARY AGREEMENTS

9.1 All Salary Agreements include and shall be deemed to include the standard terms and conditions of employment set out in Schedule D except in the case of Salary Agreements entered into before November 4, 2002 that reflect comparable practices. The Agency must provide the Physician with a copy of the applicable terms and conditions of employment.

9.2 The Agency retains full authority to direct the operations of its services, subject to this Agreement and the Physician's right to professional autonomy.

9.3 Notwithstanding section 9.1, terms regarding severance and current levels of support, office space, supplies and professional development entitlement and support in agreements between Physicians and Agencies in place on November 4, 2002 shall be maintained for twelve months from the date of written notice of a change to such term(s) being provided to the Physician.

9.4 Severance entitlements under all Salary Agreements must conform to the Employment Termination Standards established for the purposes of section 14.4 of the *Public Sector Employers Act* and amendments thereto.

ARTICLE 10 - BENEFITS, VACATION AND EXPENSES

10.1 Physicians employed under Salary Agreements will receive their benefits through the Agency that is their employer and, with the exception of the Physician Health Program, are not entitled to participate in the Benefit Plans as defined and described in the Benefits Subsidiary Agreement, unless otherwise specified in the Benefits Subsidiary Agreement.

10.2 Physicians employed under Salary Agreements are entitled to benefits and vacation at the same level and under the same terms as those provided to the senior management employees of the Agency that is their employer. In addition, the following will apply to Physicians employed under Salary Agreements:

- (a) reimbursement for the cost of annual dues of the College of Physicians and Surgeons of British Columbia and, where such membership is a requirement of employment, the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada;
- (b) reimbursement for other approved professional fees to the maximum permitted by existing employer policies;
- (c) reimbursement for the annual dues or premiums, as applicable, for membership in the Canadian Medical Protective Association or coverage under a comparable professional/malpractice liability insurance plan;
- (d) a minimum of five days each year with pay for participation in Continuing Medical Education; and
- (e) reimbursement for Continuing Medical Education expenditures which, at a minimum, will be equivalent to that available under the Benefits Subsidiary Agreement.

10.3 In no case will a Physician's vacation, benefits, Continuing Medical Education, professional costs and fees, under an existing Salary Agreement be diminished as result of this Agreement.

10.4 Notwithstanding the employer's vacation policy, if a Physician employed under a Salary Agreement is not permitted by his or her employer to take any or all of his/her vacation entitlement, then the Physician may:

- (a) be paid out for the unused vacation days in the form of a lump sum cash payment in the employment year immediately following the employment year to which the unused vacation days are attributable;

- (b) carry forward the unused vacation days and use them for vacation leave in the employment year immediately following the employment year to which the unused vacation days are attributable; or
- (c) in the employment year immediately following the employment year to which the unused vacation leave is attributable, choose in part, to be paid out under section 10.4(a) and, in part, to use them for vacation leave under section 10.4(b).

PART 3 – PHYSICIAN SERVICES PROVIDED UNDER A SERVICE CONTRACT

ARTICLE 11 - COMPENSATION AND HOURS OF SERVICE

11.1 Physicians providing Physician Services under Service Contracts will be compensated within the Service Contract Range for the applicable practice category.

11.2 Subject to section 11.7, Physicians shall provide a minimum of 1680 hours to a maximum of 2400 hours of Physician Services per year in order to receive an annual rate on the Service Contract Range, and such number of hours will constitute one full time equivalent for the purposes of this Article 11. The parties recognize that many Physicians must work hours in addition to their contract hours, providing ongoing responsibility for patients and any necessary referred emergency and non-elective services.

11.3 Parties to intended Service Contracts must attempt to reach agreement on the number of hours per year, between 1680 and 2400 hours, that will constitute a full time equivalent under the Service Contracts, and the following shall apply:

- (a) if the parties are unable to reach agreement on the number of hours per year, between 1680 and 2400 hours, that will constitute a full time equivalent under the Service Contract to meet the deliverables required by the Agency, the parties may request, through the BCMA and the Government, the use of the Trouble Shooter;
- (b) where either the BCMA or the Government requests the Trouble Shooter to assist in resolving the disagreement, the Trouble Shooter will conduct a fact finding review and issue recommendations, consistent with section 11.2, to the Joint Agreement Administration Group and the local parties, and such recommendations will be treated by the BCMA, the Government, and the local parties as confidential unless otherwise agreed by the Joint Agreement Administrative Group;
- (c) in arriving at a recommendation, the Trouble Shooter will consider the annual hours of work reported in the 2004 National Physician Survey, the conditions under which the Physician Services have been provided previously, and the hours of work for Physician Services under Service Contracts, Sessional Contracts and fee for service arrangements in British Columbia and other jurisdictions; and
- (d) the local parties may agree at any time to be bound by recommendations made by the Trouble Shooter, subject to section 20.2 of the 2012 Physician Master Agreement.

11.4 Physicians providing less than the hours of service per year required for a full time equivalent under any Service Contract will receive a proportionate amount of the compensation required for a full time equivalent under such Service Contract.

11.5 The Service Contract Range for emergency medicine is based on a maximum of 1680 hours of emergency medicine Physician Services per year including time spent providing indirect patient care at the beginning and end of each scheduled shift.

11.6 The BCMA and the Government have developed criteria for range placement (the “**Physician Placement System**”), to be applied in determining Service Contract Range placement for Physicians providing Physician Services under Service Contracts.

11.7 Subject to section 11.9, in the case of a Service Contract for a group of Physicians, the rate for determining the financial value of the Service Contract shall be either:

- (a) the composite rate on the Service Contract Range for the applicable practice category derived from the application of the Physician Placement System to each Physician in the group; or
- (b) the rate equal to 95% of the maximum rate on the Service Contract Range for the applicable practice category;

as selected by the Physician group. The Physician group is bound by the option it selects.

11.8 In the case of any Service Contract for a group of Physicians, the Physician group will, within the total financial value of the Service Contract, determine rates of compensation for the individual Physicians in the group that the group deems appropriate (e.g. time of day, weekends, amount of time worked by an individual Physician).

11.9 A Physician or Physician group providing Physician Services under a Service Contract in existence as at November 1, 2007 may, upon renewals of that Service Contract, for the purposes of establishing a rate for determining the financial value of a renewal of the Service Contract, instead of selecting a rate as provided in section 11.7, select a rate equal to the lesser of:

- (a) the maximum rate on the Service Contract Range for the applicable practice category; and
- (b) the rate determined according to the following formula:

$$x = [(A \div B) \div C] \times D$$

where:

x = the rate;

A = the financial value of the expiring Service Contract;

- B = the number of full time equivalents for the expiring Service Contract;
- C = the maximum rate on the Service Contract Range for the applicable practice category at the time the expiring Service Contract was entered into; and
- D = the maximum rate on the Service Contract Range for the applicable practice category at the time of renewal of the Service Contract.

11.10 Any dispute between an Agency and a Physician or group of Physicians as to the proper application of the Physician Placement System to the Physician or group of Physicians (a “**Local Range Placement Dispute**”) will be resolved pursuant to the provisions of Articles 20, 21 and 22 of the Physician Master Agreement applicable to Local Range Placement Disputes.

11.11 If, during the term of this Agreement, the parties agree to any of the following, they will include in that agreement any necessary changes to this Article 11:

- (a) restructuring of the Service Contract Ranges;
- (b) an integrated approach to pricing of a Service Contract; and
- (c) a revised definition of a full time equivalent for application to Service Contracts.

11.12 All Service Contracts must include clear and specific provisions that identify the respective responsibilities of the Agency and the Physician or Physician group regarding the provision of support, technology, materials and supplies.

11.13 All Service Contracts must contain a comprehensive description of the Physician Services to be provided to the Agency.

PART 4- PHYSICIAN SERVICES PROVIDED UNDER A SESSIONAL CONTRACT

ARTICLE 12 - COMPENSATION

12.1 Compensation for Physicians (including forensic practitioners) providing Physician Services under Sessional Contracts will be based on the applicable rate set out in Schedule C.

12.2 A session, for the purposes of a Sessional Contract, is 3.5 hours of Physician Services. A session may be an accumulation of lesser time intervals adding up to 3.5 hours. Smaller amounts of time not adding up to a full session will be recognized provided, however, that payment will not be made until such smaller amounts of time have accumulated to at least a quarter of an hour.

12.3 The hourly rate of payment for sessional time will be determined by dividing the appropriate sessional rate set out in Schedule C by 3.5 hours.

12.4 A Physician who is a party to a Sessional Contract with an Agency and who is called in by the Agency to provide a Physician Service will be compensated for the Physician Service

provided at the Physician's hourly rate under the Sessional Contract, which payment will be for a minimum of one hour; such payment to be in addition to any payment the Physician is entitled to under a MOCAP Contract.

12.5 Travel expenses related to Physician Services performed by forensic practitioners under a Sessional Contract will be in accordance with the rates established for “Group 2” (public service) employees.

12.6 Required travel rates and related billing guidelines for forensic practitioners will be in accordance with the Medical Expert Witness Billing Fees and Guidelines, as amended from time to time.

ARTICLE 13 - DISPUTE RESOLUTION

13.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the 2012 Physician Master Agreement applicable to Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2012.

SIGNED, SEALED & DELIVERED on)
behalf of HER MAJESTY THE QUEEN)
IN RIGHT OF THE PROVINCE OF)
BRITISH COLUMBIA, by the Minister)
of Health or his/her duly authorized)
representative, in the presence of:)

Signature of Witness)

Name)

Address)
_____)
)

THE CORPORATE SEAL of the)
BRITISH COLUMBIA MEDICAL)
ASSOCIATION was hereunto affixed in)
the presence of:)

C/S

Signature of Authorized Signatory)

Name)

Position)
)

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

Name

Position

Schedule “A” to the Alternative Payments Subsidiary Agreement

2011/12 Salary Agreement Ranges as Reflected in the December 9, 2010 Consensus Decision of the Alternative Payments Committee, subject to change as contemplated in that Consensus Decision and in Appendix F to the 2012 Physician Master Agreement

PRACTICE CATEGORY	Minimum	Maximum
General Practice - Defined Scope B	\$150,491	\$188,114
General Practice - Defined Scope A	\$163,517	\$204,396
General Practice - Full Scope B	\$163,517	\$204,396
General Practice - Full Scope A	\$174,468	\$218,085
Hospitalists	\$163,517	\$204,396
MHO Area A	\$158,714	\$181,253
MHO Area B	\$181,253	\$198,393
MHO Area C	\$188,102	\$219,743
MHO Area D	\$219,743	\$235,127
General Paediatrics (Defined Scope)	\$166,519	\$208,149
General Paediatrics	\$191,682	\$239,602
Psychiatry	\$195,620	\$244,525
Forensic Psychiatry	\$209,314	\$261,642
Physical Medicine	\$191,682	\$239,602
Neurology	\$200,652	\$250,815
Dermatology	\$200,652	\$250,815
Internal Medicine	\$200,657	\$250,821
Medical Genetics	\$205,641	\$257,051
Sub-specialty Paediatrics	\$205,641	\$257,051
Sub-specialty Internal Medicine B	\$205,641	\$257,051
Sub-specialty Internal Medicine A	\$219,962	\$274,953
Anaesthesia	\$248,751	\$310,939
Critical Care	\$241,597	\$301,996
Haematology/Oncology	\$265,372	\$331,715
Medical Oncology	\$265,372	\$331,715
Radiation Oncology	\$265,372	\$331,715
Pathology	\$240,434	\$300,543
Radiology	\$244,819	\$306,024
Pediatric Radiology	TBD	TBD
Otolaryngology	\$252,004	\$315,005
Orthopaedic Surgery	\$252,004	\$315,005
Urology	\$252,004	\$315,005
Ophthalmology	\$252,004	\$315,005
Plastic Surgery	\$252,004	\$315,005
Obstetrics/Gynecology	\$252,004	\$315,005
General Surgery	\$252,004	\$315,005
Gynecological Oncology	\$276,478	\$345,597
Maternal Fetal Medicine	\$258,576	\$323,220
General Surgical Oncology	\$276,478	\$345,597
Sub-specialty Orthopaedics	\$333,038	\$416,297
Neurosurgery	\$333,038	\$416,297
Vascular Surgery	\$333,038	\$416,297
Cardiac Surgery	\$333,038	\$416,297
Thoracic Surgery	\$333,038	\$416,297
Emergency Medicine (Non-Hospital Based)	\$170,971	\$213,714
Emergency Medicine Area A	\$208,513	\$229,922
Emergency Medicine Area B	\$229,922	\$260,641

For specific and representative assignment to Practice Categories, see the Consensus Decision of the Alternative Payments Committee dated December 9, 2010, and any subsequent Consensus Decision of the Alternative Payments Committee related to the assignment to Practice Categories.

Schedule “B” to the Alternative Payments Subsidiary Agreement

2011/12 Service Contract Ranges as Reflected in the December 9, 2010 Consensus Decision of the Alternative Payments Committee, subject to change as contemplated in that Consensus Decision and in Appendix F to the 2012 Physician Master Agreement

These ranges include 12% for benefits. These rates may also be increased by reasonable overhead expenses projected to be incurred by the Physician.

PRACTICE CATEGORY	Minimum	Maximum
General Practice - Defined Scope B	\$168,550	\$210,687
General Practice - Defined Scope A	\$183,138	\$228,923
General Practice - Full Scope B	\$183,138	\$228,923
General Practice - Full Scope A	\$195,404	\$244,255
Hospitalists	\$183,138	\$228,923
MHO Area A	\$177,760	\$203,003
MHO Area B	\$203,003	\$222,200
MHO Area C	\$210,674	\$246,112
MHO Area D	\$246,112	\$263,342
General Paediatrics (Defined Scope)	\$186,502	\$233,127
General Paediatrics	\$214,683	\$268,354
Psychiatry	\$219,094	\$273,868
Forensic Psychiatry	\$234,431	\$293,039
Physical Medicine	\$214,683	\$268,354
Neurology	\$224,730	\$280,913
Dermatology	\$224,730	\$280,913
Internal Medicine	\$224,736	\$280,920
Medical Genetics	\$230,318	\$287,897
Sub-specialty Paediatrics	\$230,318	\$287,897
Sub-specialty Internal Medicine B	\$230,318	\$287,897
Sub-specialty Internal Medicine A	\$246,358	\$307,947
Anaesthesia	\$278,602	\$348,252
Critical Care	\$270,589	\$338,236
Haematology/Oncology	\$297,217	\$371,521
Medical Oncology	\$297,217	\$371,521
Radiation Oncology	\$297,217	\$371,521
Pathology	\$269,286	\$336,608
Radiology	\$274,197	\$342,746
Pediatric Radiology	TBD	TBD
Otolaryngology	\$282,246	\$352,807
Orthopaedic Surgery	\$282,246	\$352,807
Urology	\$282,246	\$352,807
Ophthalmology	\$282,246	\$352,807
Plastic Surgery	\$282,246	\$352,807
Obstetrics/Gynecology	\$282,246	\$352,807
General Surgery	\$282,246	\$352,807
Gynecological Oncology	\$309,655	\$387,069
Maternal Fetal Medicine	\$289,605	\$362,006
General Surgical Oncology	\$309,655	\$387,069
Sub-specialty Orthopaedics	\$373,002	\$466,253
Neurosurgery	\$373,002	\$466,253
Vascular Surgery	\$373,002	\$466,253
Cardiac Surgery	\$373,002	\$466,253
Thoracic Surgery	\$373,002	\$466,253
Emergency Medicine (Non-Hospital Based)	\$191,453	\$239,316
Emergency Medicine Area A	\$233,534	\$257,513
Emergency Medicine Area B	\$257,513	\$291,918

For specific and representative assignment to Practice Categories, see the Consensus Decision of the Alternative Payments Committee dated December 9, 2010, and any subsequent Consensus Decision of the Alternative Payments Committee related to the assignment to Practice Categories.

Schedule "C" to the Alternative Payments Subsidiary Agreement

PROVINCIAL SESSIONAL RATES, EFFECTIVE APRIL 1, 2012

The sessional rates effective April 1, 2012 are as follows:

General Practitioners	Specialists
\$409.85	\$483.46

The sessional rates for practitioners providing services to the Forensic Psychiatric Services Commission (and the Maples Adolescent Treatment Centre and Youth Forensic Services, now a part of the Ministry of Children and Family Development) are as follows:

General Practitioners	Specialists
\$444.56	\$525.15

Schedule “D” to the Alternative Payments Subsidiary Agreement

**STANDARD TERMS AND CONDITIONS OF EMPLOYMENT
UNDER SALARY AGREEMENTS**

1. British Columbia Medical Association

- (a) The Physician is entitled, at his or her option, to representation by the British Columbia Medical Association (the “BCMA”) in the discussion or resolution of any issue arising under this Salary Agreement, including without limitation the re-negotiation or termination of this Salary Agreement.

2. Responsibilities and Workload

- (a) The Physician’s responsibilities will be defined and communicated to him/her by his/her supervisor. There will be ongoing communication between the Physician and his/her supervisors regarding the performance of the services, including issues relating to workload and distribution of clinical, academic and administrative responsibilities. If they are unable to reach agreement on an approach to resolve the concerns in these areas, either the Government or the BCMA may refer the matter to the Physician Services Committee as a Local Interest Issue.
- (b) The nature of the Physician’s position requires him/her to be flexible about hours of work. The Physician is required to be adaptable to a work situation, which may result in working hours other than those considered to be the normal hours of work. The annual salary of the Physician includes payment for additional hours spent providing ongoing responsibility for patients and any necessary referred emergency and non-elective services.

3. Probation and Termination

- (a) The Physician shall be subject to the Employer’s probation policy applicable to senior management employees, unless the Employer and Physician agree otherwise.
- (b) The Employer may, at any time, terminate the Physician’s employment without notice or pay in lieu of notice if the Employer has just cause for termination.
- (c) The Employer may, at any time, terminate the Physician’s employment on notice or by making payment in lieu of notice. The amount of notice or payment in lieu of notice afforded by the Employer to the Physician terminated under this provision shall be calculated in accordance with common law and statutory standards, including the Public Sector Employers Act and any applicable regulations.

- (d) Termination of employment by the Physician will require three months' notice, or a shorter period as may be agreed to by the parties.
- (e) On termination of the Physician's employment, the Employer must provide the Physician with the necessary support to abide by all applicable patient notification requirements of the College of Physicians and Surgeons of BC.

4. Fee for Service and Third Party Billings

- (a) Unless specified otherwise, the Physician will not retain fee-for-service billings or receive any other form of remuneration for the services or procedures covered by this Salary Agreement.
- (b) Where the Available Amount is not a source of funding for this Salary Agreement, the Physician will sign a waiver in the form attached hereto as Appendix 1.
- (c) Where the Available Amount is a source of funding for this Salary Agreement, the Physician assigns to the Agency any and all rights he or she may have to receive fee-for-service payments from the Available Amount for any of the services covered by this Salary Agreement, and will sign an assignment in the form attached hereto as Appendix 2.
- (d) The Physician shall retain one hundred per cent (100%) of third party billings provided they are not included within the services or procedures covered by, and do not conflict with the Physician's obligations under, this Salary Agreement. For the purposes of this clause, third party billings include but are not limited to WCB, ICBC, RCMP, Armed Forces, disability insurers, non-insured services and services provided to non-beneficiaries.

5. Autonomy

- (a) The Physician will provide the services under this Salary Agreement in accordance with applicable standards of law, professional ethics and medical practice and any Agency policies, by-laws or rules and regulations that are not inconsistent with, and do not represent a material change to, the terms of this Salary Agreement.
- (b) Subject to section (5)(a), the Physician is entitled to professional autonomy in the provision of the services covered by this Salary Agreement.

6. Locum Coverage

- (a) The Employer, at its sole discretion, shall be responsible for securing the services of a locum in consultation with the Physician.

7. Dispute Resolution

- (a) This Salary Agreement shall be governed by and construed in accordance with the laws of British Columbia.
- (b) All disputes arising out of or in connection with this Salary Agreement that the parties are unable to resolve at the local level, may be referred to mediation on notice by either party to the other, with the assistance of a neutral mediator jointly selected by the parties. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the parties in writing, the dispute will be referred to arbitration administered pursuant to the Commercial Arbitration Act.
- (c) Should the parties be unable to agree on the selection of the mediator or arbitrator within seven (7) days after notice is served by any party seeking the appointment of a mediator or arbitrator, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the mediator or arbitrator.
- (d) Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration.
- (e) The Employer and the Physician must advise the Ministry of Health and the BCMA respectively prior to referring any dispute to arbitration. The Ministry of Health and the BCMA shall have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.
- (f) Any dispute settlement achieved by the parties, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

8. Licenses & Qualifications

- (a) The Physician is and shall remain a registered member in good standing with the College of Physicians and Surgeons of British Columbia and conduct his/her practice of medicine consistent with the conditions of such registration.
- (b) The Physician is and shall remain enrolled in the Medical Services Plan.
- (c) If all or some of the services provided under this Agreement are Specialist Services, then the Physician must be and remain registered by the College of Physicians and Surgeons of British Columbia to provide these Specialist Services.
- (d) Where the Employer is subject to the Hospital Act, all Physicians performing Services on behalf of the Employer must first be credentialed and granted privileges by the Employer, and no physician who has not been credentialed or

obtained and maintained such privileges, shall be permitted by the Employer to perform the Services.

- (e) All medical services under this Agreement will be provided either directly by the Physician, or by an intern or resident under the supervision and responsibility of the Physician in accordance with the “Guidelines for Payment for Services by Residents and/or Interns” published by the Medical Services Commission, or a clinical fellow under the supervision and responsibility of the Physician.

9. Third Party Claims

- (a) Each party will provide the other with prompt notice of any action against either or both of them arising out of this Salary Agreement.

10. Medical Liability Protection

- (a) The Physician will obtain and maintain professional malpractice liability protection, at the expense of the Employer, through the Canadian Medical Protective Association or a comparable plan of insurance and will be required to provide the Employer with evidence of the required protection on request.

11. Confidentiality

- (a) The Physician and the Employer shall maintain as confidential and not disclose any patient information, except as required or permitted by law.
- (b) The Physician must not, without the prior written consent of the Employer, publish, release or disclose or permit to be published, released, or disclosed before, during the term of this Salary Agreement, or otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Salary Agreement unless the publication, release or disclosure is:
 - (i) necessary for the Physician to fulfill his/her obligations under this Salary Agreement;
 - (ii) required or expressly permitted by an order of the court;
 - (iii) required when giving or when validly compelled to give evidence in a proceeding;
 - (iv) required or expressly permitted by an enactment of British Columbia or of Canada;
 - (v) made in accordance with any other applicable law or rule of law;
 - (vi) made in accordance with the Physician’s professional obligations as identified by the College of Physicians and Surgeons of B.C.; or

(vii) in reference to the Physician's Salary Agreement.

The Physician will notify the employer prior to the publication, release, or disclosure of information under (i) – (vi), above.

- (c) For the purposes of section 11(b), information shall be deemed to be confidential where all of the following criteria are met:
- (i) the information is not found in the public domain;
 - (ii) the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgment to be confidential; and
 - (iii) the Employer has maintained adequate internal control to ensure information remained confidential.

12. Conflict of Interest

- (a) During the term of this Salary Agreement, absent the written consent of the Employer, the Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest.
- (b) The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach section 12(a). Should they not be able to resolve the issue, the matter will be dealt with in accordance with section 7 above.

13. Notices

- (a) Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:
 - if mailed by prepaid double registered mail to the addressee's address listed below, on date of confirmation of delivery; or
 - if delivered by hand to the addressee's address listed below on the date of such personal delivery.

Either party may give notice to the other of a change of address.

Address of the Employer

-
-

- Address of the Physician

-
-
-

14. Headings

- (a) The headings in this Salary Agreement have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Salary Agreement.

15. Enforceability and Severability

- (a) If any provision of this Salary Agreement is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

16. 2012 Physician Master Agreement and Physician Master Subsidiary Agreements

- (a) This Salary Agreement is subject to the 2012 Physician Master Agreement and the Physician Master Subsidiary Agreements (as defined in the Physician Master Agreement), and amendments thereto.
- (b) In the event that during the Physician's employment a new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s) come into effect, the parties agree to meet on notice by one party to the other, to re-negotiate and amend the terms of this Salary Agreement to ensure it complies with the new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s).

17. Work Environment:

- (a) The Employer, at its discretion, shall provide the Physician with the facilities, equipment, support and supplies that are reasonably required for the Physician to provide the services covered by this Salary Agreement. If the Physician disagrees with the Employer's decision on these matters he/she may address them with the Physician Services Committee as a Local Interest Issue.

APPENDIX 1

FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER

Physician Name _____

MSP Practitioner Number _____

I acknowledge that the payments paid to me by _____ (the Agency) for the services provided under the terms of the Salary Agreement between us dated _____ are payments in full for the services covered by the Salary Agreement and provided to the Agency and I will make no other claim for these services.

Note: If any services covered by this Salary Agreement are billable on a fee-for-service basis, they must be specifically excluded here.

Physician's Signature

Date

APPENDIX 2

FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT

Physician Name _____

MSP Practitioner Number _____

I acknowledge that the payments paid to me by _____ (the Agency) for the services provided under the terms of the Salary Agreement between us dated _____ are payments in full for the services covered by the Salary Agreement and provided to the Agency and I will make no other claim for these services. I hereby assign to _____ (the Agency) any and all rights I have to receive fee for service payments for any of the services provided under the terms of that Salary Agreement.

Note: If any services covered by this Salary Agreement are billable on a fee-for-service basis, they must be specifically excluded here.

Physician's Signature

Date

Schedule “E” to the Alternative Payments Subsidiary Agreement

TEMPLATE SERVICE CONTRACT

BETWEEN:

(the “Physician”)

or

(the “Physician Association”)

or

(the “Partnership”)

or

(the “Corporation”)

AND:

(the “Agency”)

WHEREAS the Physician wishes to contract with the Agency and the Agency wishes to contract with the Physician to provide clinical and related teaching, research and clinical administrative services (the “Services”) on the terms, conditions and understandings set out in this Service Contract (the “Contract”);

THEREFORE in consideration of the mutual promises contained in this Contract, the Physician and the Agency agree as follows:

DEFINITIONS

“Material” means findings, data, reports, documents and records, whether complete or otherwise, that have been produced or developed by the Physician, or provided to the Physician by the Agency, as part of the Services under this Contract.

“2012 Physician Master Agreement” means the agreement titled “2012 Physician Master Agreement” and entered into as of April 1, 2012, among the Government, the Medical Services Commission and the BCMA.

“Physician Master Subsidiary Agreements” has the meaning given in the 2012 Physician Master Agreement.

Article 1: Term & Renewal

- 1.1 This Contract will be in effect from _____ to _____ notwithstanding the date of its execution (the “Term”).
- 1.2 This Contract may be renewed for such period of time and on such terms as the parties may mutually agree to in writing. If either party wishes to renew this Contract, it must provide written notice to the other party no later than ninety (90) days prior to the end of the Term and, as soon as practical thereafter, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.
- 1.3 Subject to clause 1.4, if both parties agree to renew the Contract the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.
- 1.4 In the event that notice is given by either party in accordance with clause 1.2 above and if a new contract is not completed within six (6) months following the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

Article 2: Termination

- 2.1 Subject to clause 2.2, either party may terminate this Contract without cause upon six (6) months written notice to the other party.
- 2.2 Either party may terminate this Contract without notice if the other party breaches a fundamental term of this Contract.

Article 3: Relationship of Parties

- 3.1 The Physician is an independent contractor and not the servant, employee, or agent of the Agency. No employment relationship is created by this Contract, or by the provision of the Services to the Agency by the Physician.
- 3.2 Neither the Physician nor the Agency will in any manner commit or purport to commit the other to the payment of any monies or to the performance of any other duties or responsibilities except as provided for in this Contract, or as otherwise agreed to in writing between the parties.
- 3.3 The Physician must pay any and all payments and/or deductions required to be paid by him/her, including those required for income tax, Employment Insurance premiums, Workers Compensations premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that he/she is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to this Contract.

- 3.4 The liability of Physician Association members for payments referred to in clause 3.3 are several and not joint.
- 3.5 The Physician agrees to indemnify the Agency from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from the Physician's failure to make payments referred to in clause 3.3.
- 3.6 The indemnity in clause 3.5 survives the expiry or earlier termination of this Contract.

Article 4: Unincorporated Associations

To be included only where the physician group is an unincorporated association.

- 4.1 If Services are provided under this Contract by Physicians who are part of a Physician Association, each of the Physicians in the Physician Association will be party to, and bound by, this Contract.
- 4.2 The Physician Association must develop a process to govern their intra-association relationship.
- 4.3 Each member of the Physician Association has the right to terminate his/her relationship with the Agency without affecting the rights and obligations of the remaining members of the Physician Association and must do so in accordance with the termination provisions of this Contract.
- 4.4 The Agency may terminate this Contract with respect to individual members of the Physician Association in accordance with the termination provisions herein.
- 4.5 In the event of the departure of a member of the Physician Association pursuant to clause 4.3 or 4.4, the parties will meet to discuss whether amendments to Appendices "1" or "2" are required and to make agreed changes.
- 4.6 The Physician Association must use reasonable efforts to replace departing members.
- 4.7 Any replacement or new physicians that the Physician Association members propose to add as a member are subject to the approval by the Agency in accordance with its normal policies. Such approval will not be unreasonably withheld.
- 4.8 Subject to clause 4.7, a Physician who is a member of a Physician Association will sign a copy of this Contract and become a party to it. The Agency will provide a copy of the Contract bearing the signature of the new Physician to the Physician Association.

Article 5: Assignment

- 5.1 Unless specified otherwise, the Physician must not retain fee-for-service billings for the Services covered by this Contract. The Physician may bill fee-for-service or directly for any and all services delivered outside the scope of this Contract.

- 5.2 Where the Available Amount is not a source of funding for this Contract, the Physician will sign a waiver in the form attached hereto as Appendix 3.
- 5.3 Where the Available Amount is a source of funding for this Contract, the Physician assigns to the Agency any and all rights he or she has to receive fee-for-service payments from the Available Amount for any of the Services covered by this Contract, and will sign an assignment in the form attached hereto as Appendix 4.

Article 6: Autonomy

- 6.1 The Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice and any Agency policies, by-laws or rules and regulations that are not inconsistent with, and do not represent a material change to, the terms of this Contract.
- 6.2 Subject to clause 6.1, the Physician is entitled to professional autonomy in the provision of the Services.

Article 7: British Columbia Medical Association

- 7.1 The Physician is entitled, at his or her option, to representation by the British Columbia Medical Association (the "BCMA") in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

Article 8: Dispute Resolution

- 8.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.
- 8.2 All disputes with respect to the interpretation, application, or alleged breach of this Contract that the parties are unable to resolve informally at the local level, may be referred to mediation on notice by either party to the others, with the assistance of a neutral mediator jointly selected by the parties. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the parties in writing, the dispute will be referred to arbitration administered pursuant to the Commercial Arbitration Act.
- 8.3 Should the parties be unable to agree on the selection of the mediator or arbitrator within seven (7) days after notice is served by any party seeking the appointment of a mediator or arbitrator, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the mediator or arbitrator.
- 8.4 Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration.
- 8.5 The Agency and the Physician must advise the Ministry of Health and the BCMA respectively prior to referring any dispute to arbitration. The Ministry of Health and the

BCMA shall have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.

- 8.6 Any dispute settlement achieved by the parties, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

Article 9: Service Requirements

- 9.1 The Physician will provide the Services set out in Appendix “1” and will schedule his/her availability to reasonably ensure the provision of the Services.
- 9.2 Hours are as agreed upon by the parties at Appendix “1”. It is understood that many circumstances require flexibility of hours and the Physician will respond to these needs.
- 9.3 If the Physician is unable to provide the Services under the terms of this Contract on a persistent basis due to significant unanticipated increases in volume or the departure of one or more Physicians, then the parties will meet to discuss and develop an approach to attempt to resolve the concern. If they are unable to reach an agreement either the BCMA or the Government may refer the matter to the Physician Services Committee as a Local Interest Issue.

Article 10: Licenses & Qualifications

- 10.1 The Physician is and shall remain a registered member in good standing with the College of Physicians and Surgeons of British Columbia and conduct his/her practice of medicine consistent with the conditions of such registration.
- 10.2 The Physician is and shall remain enrolled in the Medical Services Plan.
- 10.3 If all or some of the Services provided under this Contract are Specialist Services, as defined in the Alternative Payments Subsidiary Agreement, then the Physician must be and must remain registered by the College of Physicians and Surgeons of BC to provide these Specialist Services.
- 10.4 All medical services under this Contract will be provided either directly by the Physician, or by an intern or resident under the supervision and responsibility of the Physician in accordance with the “Guidelines for Payment for Services by Residents and/or Interns” published by the Medical Services Commission, or by a clinical fellow under the supervision and responsibility of the Physician.
- 10.5 Where the facility where the Services are provided is subject to the Hospital Act, all Physicians performing services on behalf of the Agency at the facility must first be credentialed and granted privileges at the facility, and no physician who has not been credentialed or obtained and maintained such privileges, shall be permitted by the Agency to perform the Services.

Article 11: Third Party Billing

11.1 The Physician shall retain one hundred per cent (100%) of fees received for third party services provided they are not included within the Services and do not conflict with the Physician's obligations under this Contract. For the purposes of this Article, third party billings include but are not limited to WCB, ICBC, RCMP, Armed Forces, disability insurers, non-insured services and services provided to non-beneficiaries.

Article 12: General Leave & Locum Coverage

12.1 The Physician and the Agency will work together in recruiting and retaining qualified locum physicians when necessary. Locum physicians are subject to the approval of the Agency, whose approval will not be unreasonably withheld.

12.2 In the event a locum is not available, the Agency and the Physician may agree that the Physician will provide hours of service in excess of the annual hours of service specified at Appendix "1". In this event the parties must agree upon appropriate compensation for the additional hours of service.

Article 13: Subcontracting

13.1 The Physician may, with the written consent of the Agency, subcontract or assign any of the Services. The consent of the Agency will not be unreasonably withheld.

Article 14: Compensation

14.1 The Physician will invoice the Agency for all the Services provided in a form acceptable to the Agency.

14.2 The Agency will pay the Physician pursuant to Appendix "2" upon receipt of an invoice for the Services provided.

14.3 Physicians on Service Contracts shall be entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician Master Agreement).

14.4 The Agency must forward the necessary information to the BCMA Benefits Department, at the address set out below, prior to March 31 of each year in which this Contract is in effect.

Benefits Manager
British Columbia Medical Association
115 – 1665 West Broadway
Vancouver, BC V6J 5A4

Article 15: Reporting

- 15.1 The parties acknowledge that the Agency has a responsibility to transmit the details of the Services to the Ministry of Health the same as required for physicians billing fee-for-service, including:
 - 15.1.1 the name and identity number of the patient;
 - 15.1.2 the practitioner number of the practitioner who personally rendered or was responsible for the service; and
 - 15.1.3 the details of the service, including the location where the service was rendered, the date and time the service was rendered, the length of time spent rendering the service, the diagnosis and the equivalent fee item or encounter record code.
- 15.2 The Physician will co-operate with the Agency and make all reasonable efforts to provide it with the information it requires in order to meet its obligation referred to in clause 15.1, by providing the information listed at Appendix “5”.
- 15.3 The Physician will also report to the Agency all work done by him/her in connection with the provision of the Services.
- 15.4 The Physician is responsible for the accuracy of all information and reports submitted by him/her to the Agency.
- 15.5 The Physician is required to complete and submit to the Agency all reports reasonably required by the Agency within 30 days of the Agency’s written request.

Article 16: Records

- 16.1 Where the Agency has procedures in place, the Physician will create Clinical Records in the clinical charts which are established by and owned by the Agency and used by the facility where the Services are provided.
- 16.2 Where the Agency does not have procedures in place, the Physician will create and maintain Clinical Records in the manner provided for in the Bylaws of the College of Physicians and Surgeons of British Columbia under the *Health Professions Act*.
- 16.3 The Physician will keep business accounts, including records of expenses incurred in connection with the Services and invoices, receipts and vouchers for the expenses.
- 16.4 For the purposes of this Article 16, “Clinical Record” means a clinical record maintained in accordance with the Bylaws of the College of Physicians and Surgeons of British Columbia under the *Health Professions Act* and an adequate medical record in accordance with the Medical Services Commission Payment Schedule.
- 16.5 The Physician will promptly return to the Agency all Materials in his/her possession or control if requested to do so by the Agency.

Article 17: Third Party Claims

- 17.1 Each party will provide the other with prompt notice of any action against either or both of them arising out of this Contract.

Article 18: Liability Protection

- 18.1 The Physician will without limiting his or her obligations or liabilities herein purchase, maintain, and cause any sub-contractors to maintain, throughout the Term of this Contract:

18.1.1 Where the Physician owns or rents the premises where the Services are provided, he/she shall maintain comprehensive or commercial general liability insurance with a limit of not less than \$2,000,000. The Agency will be added as an additional insured and the policy(s) will contain a cross liability clause. It is understood by the parties that this comprehensive or commercial general liability insurance is a reasonable overhead expense.

18.1.2 Professional/malpractice liability coverage with the Canadian Medical Protective Association or a comparable plan of insurance.

- 18.2 All of the insurance required under clause 18.1.1 will be primary and not require the sharing of any loss by any insurer of the Agency and must be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change.

- 18.3 The Physician agrees to provide the Agency with evidence of the insurance/coverage required under this Article 18 at the time of execution of this Contract and otherwise from time to time as requested.

Article 19: Confidentiality

- 19.1 The Physician and the Agency shall maintain as confidential and not disclose any patient information, except as required or permitted by law.

- 19.2 The Physician must not, without the prior written consent of the Agency, publish, release or disclose or permit to be published, released, or disclosed before, during the term of this Contract, or otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Contract unless the publication, release or disclosure is:

19.2.1 necessary for the Physician to fulfill his/her obligations under this Contract;

19.2.2 required or expressly permitted by an order of the court;

19.2.3 required when giving or when validly compelled to give evidence in a proceeding;

- 19.2.4 required or expressly permitted by an enactment of British Columbia or of Canada;
 - 19.2.5 made in accordance with any other applicable law or rule of law;
 - 19.2.6 made in accordance with the Physician's professional obligations as identified by the College of Physicians and Surgeons of BC; or
 - 19.2.7 in reference to this Contract.
- 19.3 For the purposes of clause 19.2, information shall be deemed to be confidential where all of the following criteria are met:
- 19.3.1 the information is not found in the public domain;
 - 19.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgment to be confidential; and
 - 19.3.3 the Agency has maintained adequate internal control to ensure information remained confidential.

Article 20: Conflict of Interest

- 20.1 During the term of this Contract, absent the written consent of the Agency, the Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest.
- 20.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 20.1. Should they not be able to resolve the issue, the question will be dealt with in accordance with Article 8 above.

Article 21: Ownership

- 21.1 The parties acknowledge that in the course of providing the Services intellectual or like property may be developed. The Physician or each member of a Physician group agrees to be bound by and observe the relevant patent and licensing policies of the Agency in effect from time to time.

Article 22: Audit, Evaluation and Assessment

- 22.1 The Physician acknowledges the auditing authority of the Medical Services Commission under the Medicare Protection Act.

Article 23: Notices

- 23.1 Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered

by mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:

23.1.1 if mailed by prepaid double registered mail to the addressee's address listed below, on date of confirmation of delivery; or

23.1.2 if delivered by hand to the addressee's address listed below on the date of such personal delivery.

23.2 Either party may give notice to the other of a change of address.

23.3 Address of the Agency

-
-
-

Address of the Physician

-
-
-

Article 24: Amendments

24.1 This Contract must not be amended except by written agreement of both parties

Article 25: Entire Contract

25.1 This Contract, the 2012 Physician Master Agreement and the Physician Master Subsidiary Agreements embody the entire understanding and agreement between the parties relating to the Services and there are no covenants, representations, warranties or agreements other than those contained or specifically preserved under the terms of this Contract, the 2012 Physician Master Agreement and the Physician Master Subsidiary Agreements.

Article 26: No Waiver Unless in Writing

26.1 No provision of this Contract and no breach by either party of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other party. The written waiver of a party of any breach of any provision of this Contract by the other party must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

Article 27: Headings

27.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

Article 28: Enforceability and Severability

28.1 If any provision of this Contract is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

Article 29: 2012 Physician Master Agreement and Physician Master Subsidiary Agreements

29.1 This Contract is subject to the 2012 Physician Master Agreement and the Physician Master Subsidiary Agreements, and amendments thereto.

29.2 In the event that during the term of this Contract, a new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s) come into effect the parties agree to meet, on notice by one party, to re-negotiate and amend the terms of this Contract to ensure compliance with the new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s).

Dated at _____, British Columbia this ____ day of _____ 20__.

IN WITNESS WHEREOF THE PARTIES to this Contract have duly executed this Contract as of the date written above.

Authorized Signatory

Dr.

APPENDIX 2

PAYMENT

The Agency will pay the Physician bi-weekly/monthly at a rate of \$_____ per day/month/year that the Physician provides Services under the terms of this Contract, upon receipt of an invoice for the Services provided.

APPENDIX 3

FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER

Physician Name _____

MSP Practitioner Number _____

I acknowledge that the payments paid to me by _____ (the Agency) for the Services provided under the terms of the Contract between us dated _____ are payments in full for Services covered by the Contract and provided to the Agency and I will make no other claim for these Services.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

Physician's Signature

Date

APPENDIX 4

FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT

Physician Name _____

MSP Practitioner Number _____

I acknowledge that the payments paid to me by _____ (the Agency) for the Services provided under the terms of the Contract between us dated _____ are payments in full for Services covered by the Contract and provided to the Agency and I will make no other claim for these Services. I hereby assign to _____ (the Agency) any and all rights I have to receive fee for service payments for any of the Services provided under the terms of that Contract.

Note: If any Services are billable on a fee-for-service basis, they must be specifically excluded here and in the Contract.

Physician's Signature

Date

APPENDIX 5
REPORTING

The following information must be provided by the Physician to the Agency on the last day of each month:

Schedule “F” to the Alternative Payments Subsidiary Agreement

**TEMPLATE SESSIONAL CONTRACT
FOR PHYSICIAN SERVICES**

BETWEEN:

(the “Physician”)

AND:

(the “Agency”)

WHEREAS the Physician wishes to contract with the Agency and the Agency wishes to contract with the Physician to provide clinical and related teaching, research and clinical administrative services (the “Services”) on the terms, conditions and understandings set out in this Sessional Contract (the “Contract”);

THEREFORE in consideration of the mutual promises contained in this Contract, the Physician and the Agency agree as follows:

DEFINITIONS

“Material” means findings, data, reports, documents and records, whether complete or otherwise, that have been produced or developed by the Physician, or provided to the Physician by the Agency, as part of the Services under this Contract.

“2012 Physician Master Agreement” means the agreement titled “2012 Physician Master Agreement” and entered into as of April 1, 2012, among the Government, the Medical Services Commission and the BCMA.

“Physician Master Subsidiary Agreement” has the meaning given in the 2012 Physician Master Agreement.

Article 1: Term & Renewal

1.2 This Contract will be in effect from _____ to _____ notwithstanding the date of its execution (the “Term”).

- 1.3 This Contract may be renewed for such period of time and on such terms as the parties may mutually agree to in writing. If either party wishes to renew this Contract, it must provide written notice to the other party no later than ninety (90) days prior to the end of the Term and, as soon as practical thereafter, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.
- 1.4 Subject to clause 1.5, if both parties agree to renew the terms and conditions of this Contract, it shall remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.
- 1.5 In the event that notice is given by either party in accordance with clause 1.3 above and if a new contract is not completed within six (6) months following the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

Article 2: Termination

- 2.1 Subject to clause 2.2, either party may terminate this Contract without cause upon six (6) months written notice to the other party.
- 2.2 Either party may terminate this Contract without notice if the other party breaches one or more of its fundamental terms.

Article 3: Relationship of Parties

- 3.1 The Physician is an independent contractor and not the servant, employee, or agent of the Agency. No employment relationship is created by this Contract, or by the provision of the Services to the Agency by the Physician.
- 3.2 Neither the Physician nor the Agency will in any manner commit or purport to commit the other to the payment of any monies or to the performance of any other duties or responsibilities except as provided for in this Contract, or as otherwise agreed to in writing between the parties.
- 3.3 The Physician must pay any and all payments and/or deductions required to be paid by him/her, including those required for income tax, Employment Insurance premiums, Workers Compensations premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that he or she is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to the Contract.
- 3.4 The Physician agrees to indemnify the Agency from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from the Physician's failure to make payments referred to in clause 3.3.
- 3.5 The indemnity in clause 3.4 survives the expiry or earlier termination of this Contract.

Article 4: Assignment

- 4.1 Unless specified otherwise, the Physician must not bill fee-for-service for the Services covered by this Contract. The Physician may bill fee-for-service or directly for any and all services delivered outside the scope of this Contract.
- 4.2 Where the Available Amount is not a source of funding for this Contract, the Physician will sign a waiver in the form attached hereto as Appendix 3.
- 4.3 Where the Available Amount is a source of funding for this Contract, the Physician assigns to the Agency any and all rights he or she has to receive fee-for-service payments from the Available Amount for any of the Services covered by this Contract, and will sign an assignment in the form attached hereto as Appendix 4.

Article 5: Autonomy

- 5.1 The Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice and any Agency policies, by-laws or rules and regulations that are not inconsistent with, and do not represent a material change to, the terms of this Contract.
- 5.2 Subject to clause 5.1, the Physician is entitled to professional autonomy in the provision of the Services.

Article 6: British Columbia Medical Association

- 6.1 The Physician is entitled, at his or her option, to representation by the British Columbia Medical Association (the "BCMA") in the discussion or resolution of any issue arising under this Contract, including without limitation the re-negotiation or termination of this Contract.

Article 7: Dispute Resolution

- 7.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.
- 7.2 All disputes with respect to the interpretation, application, operation or alleged breach of this Contract that the parties are unable to resolve informally at the local level, may be referred to mediation on notice by either party to the others, with the assistance of a neutral mediator jointly selected by the parties. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the parties in writing, the dispute will be referred to arbitration administered pursuant to the Commercial Arbitration Act.
- 7.3 Should the parties be unable to agree on the selection of the mediator or arbitrator within seven (7) days after notice is served by any party seeking the appointment of a mediator or arbitrator, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the mediator or arbitrator.

- 7.4 Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration.
- 7.5 The Agency and the Physician must advise the Ministry of Health and the BCMA respectively prior to referring any dispute to arbitration. The Ministry of Health and the BCMA shall have the right to apply to intervene in the arbitration and such application will rely on the common-law test for granting intervenor status. All intervenors are responsible for their own costs and any other costs the arbitrator may order them to pay.
- 7.6 Any dispute settlement achieved by the parties, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

Article 8: Service Requirements

- 8.1 The Physician will provide the Services and the number of sessions set out at Appendix “1”.
- 8.2 The Agency and the Physician will provide the support, technology, material and supplies as set out at Appendix “1”.

Article 9: Licenses & Qualifications

- 9.1 The Physician is and shall remain a registered member in good standing with the College of Physicians and Surgeons of British Columbia and conduct his/her practice of medicine consistent with the conditions of such registration.
- 9.2 The Physician is and shall remain enrolled in the Medical Services Plan.
- 9.3 All medical services under this Contract will be provided either directly by the Physician, or by an intern or resident under the supervision and responsibility of the Physician in accordance with the “Guidelines for Payment for Services by Residents and/or Interns” published by the Medical Services Commission, or by a clinical fellow under the supervision and responsibility of the Physician.
- 9.4 Where the facility where the Services are provided is subject to the Hospital Act, all Physicians performing Services on behalf of the Agency at the facility must first be credentialed and granted privileges at the facility, and no physician who has not been credentialed or obtained and maintained such privileges, shall be permitted by the Agency to perform the Services.

Article 10: Third Party Claims

- 10.1 Each party will provide the other with prompt notice of any action against either or both of them arising out of this Contract.

Article 11: Subcontracting

- 11.1 The Physician may, with the written consent of the Agency, subcontract or assign any of the Services. The consent of the Agency will not be unreasonably withheld.

Article 12: Compensation

- 12.1 The Physician will invoice the Agency for all the Services provided in a form acceptable to the Agency.
- 12.2 The Agency will pay the Physician pursuant to Appendix “2” upon receipt of an invoice for the Services provided.
- 12.3 Physicians on Sessional Contracts shall be entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician Master Agreement).
- 12.4 The Agency must forward the necessary information to the BCMA Benefits Department, at the address set out below, prior to March 31 of each year in which this Contract is in effect.

Benefits Manager
British Columbia Medical Association
115 – 1665 West Broadway
Vancouver, BC V6J 5A4

Article 13: Reporting

- 13.1 The parties acknowledge that the Agency has a responsibility to transmit the details of the Services to the Ministry of Health the same as required for physicians billing fee-for-service, including:
- 13.1.1 the name and identity number of the patient;
 - 13.1.2 the practitioner number of the practitioner who personally rendered or was responsible for the service; and
 - 13.1.3 the details of the service, including the location where the service was rendered, the date and time the service was rendered, the length of time spent rendering the service, the diagnosis and the equivalent fee item or encounter record code.
- 13.2 The Physician will co-operate with the Agency and make all reasonable efforts to provide it with the information it requires in order to meet its obligation referred to in article 13.1, by providing the information listed at Appendix 5.
- 13.3 The Physician will also report to the Agency all work done by him/her in connection with the provision of the Services.

- 13.4 The Physician is responsible for the accuracy of all information and reports submitted by him/her to the Agency.
- 13.5 The Physician is required to complete and submit to the Agency all reports reasonably required by the Agency within 30 days of the Agency's written request.

Article 14: Records

- 14.1 Where the Agency has procedures in place, the Physician will create Clinical Records in the clinical charts, which are established by and owned by the Agency and used by the facility where the Services are provided.
- 14.2 Where the Agency does not have procedures in place, the Physician will create and maintain Clinical Records in the manner provided for in the Bylaws of the College of Physicians and Surgeons of British Columbia under the *Health Professions Act*.
- 14.3 The Physician will keep business accounts, including records of expenses incurred in connection with the Services and invoices, receipts and vouchers for the expenses.
- 14.4 For the purposes of this Article 14, "Clinical Record" means a clinical record maintained in accordance with the Bylaws of the College of Physicians and Surgeons of British Columbia under the *Health Professions Act* and an adequate medical record in accordance with the Medical Services Commission Payment Schedule.
- 14.5 The Physician will promptly return to the Agency all Materials in his/her possession or control if requested to do so by the Agency.

Article 15: Liability Protection

- 15.1 The Physician will without limiting his/her obligations or liabilities herein purchase, maintain, and cause any sub-contractors to maintain, throughout the Term of this Contract:
 - 15.1.1 Where the Physician owns or rents the premises where the Services are provided, he/she shall maintain comprehensive or commercial general liability insurance with a limit of not less than \$2,000,000. The Agency will be added as an additional insured and the policy(s) will contain a cross liability clause. It is understood by the parties that this comprehensive or commercial general liability insurance is a reasonable overhead expense.
 - 15.1.2 Professional/malpractice liability coverage with the Canadian Medical Protective Association or a comparable plan of insurance.
- 15.2 All of the insurance required under clause 15.1.1 will be primary and not require the sharing of any loss by any insurer of the Agency and must be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change.

- 15.3 The Physician agrees to provide the Agency with evidence of the insurance/coverage required under this Article 15 at the time of execution of this Contract and otherwise from time to time as requested.

Article 16: Confidentiality

- 16.1 The Physician and the Agency shall maintain as confidential and not disclose any patient information, except as required or permitted by law.
- 16.2 The Physician must not, without the prior written consent of the Agency, publish, release or disclose or permit to be published, released, or disclosed before, during the term of this Contract, or otherwise, any other confidential information supplied to, obtained by, or which comes to the knowledge of the Physician as a result of this Contract unless the publication, release or disclosure is:
- 16.2.1 necessary for the Physician to fulfill his/her obligations under this Contract;
 - 16.2.2 required or expressly permitted by an order of the court;
 - 16.2.3 required when giving or when validly compelled to give evidence in a proceeding;
 - 16.2.4 required or expressly permitted by an enactment of British Columbia or of Canada;
 - 16.2.5 made in accordance with any other applicable law or rule of law;
 - 16.2.6 made in accordance with the Physician's professional obligations as identified by the College of Physician's and Surgeons of B.C.; or
 - 16.2.7 in reference to this Contract.
- 16.3 For the purposes of clause 16.2, information shall be deemed to be confidential where all of the following criteria are met:
- 16.3.1 the information is not found in the public domain;
 - 16.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgment to be confidential; and
 - 16.3.3 the Agency has maintained adequate internal control to ensure information remained confidential.

Article 17: Conflict of Interest

- 17.1 During the Term of this Contract, absent the written consent of the Agency, the Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest.

17.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 17.1. Should they not be able to resolve the issue, the question will be dealt with in accordance with Article 7 above.

Article 18: Ownership

18.1 The parties acknowledge that in the course of providing the Services intellectual or like property may be developed. The Physician agrees to be bound by and observe the relevant patent and licensing policies of the Agency in effect from time to time.

Article 19: Audit, Evaluation and Assessment

19.1 The Physician acknowledges the auditing authority of the Medical Services Commission under the Medicare Protection Act.

Article 20: Notices

20.1 Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:

20.1.1 if mailed by prepaid double registered mail to the addressee's address listed below, on date of confirmation of delivery; or

20.1.2 if delivered by hand to the addressee's address listed below on the date of such personal delivery.

20.2 Either party may give notice to the other of a change of address.

20.3 Address of the Agency

-
-
-

Address of the Physician

-
-
-

Article 21: Amendments

21.1 This Contract must not be amended except by written agreement of both parties.

Article 22: Entire Contract

22.1 This Contract, the 2012 Physician Master Agreement and the Physician Master Subsidiary Agreements embody the entire understanding and agreement between the parties relating to the Services and there are no covenants, representations, warranties or agreements other than those contained or specifically preserved under the terms of this Contract, the 2012 Physician Master Agreement and the Physician Master Subsidiary Agreements.

Article 23: No Waiver Unless in Writing

23.1 No provision of this Contract and no breach by either party of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other party. The written waiver of a party of any breach of any provision of this Contract by the other party must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

Article 24: Headings

24.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

Article 25: Enforceability and Severability

25.1 If any provision of this Contract is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.

Article 26: 2012 Physician Master Agreement and Subsidiary Agreements

26.1 This Contract is subject to the 2012 Physician Master Agreement and the Physician Master Subsidiary Agreements, and amendments thereto.

26.2 In the event that during the term of this Contract, a new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s) come into effect the parties agree to meet, on notice by one party, to re-negotiate and amend the terms of this Contract to ensure compliance with the new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s).

Dated for reference this ____ day of _____ 20__.

IN WITNESS WHEREOF THE PARTIES to this Contract have duly executed this Contract as of the date written above.

Authorized Signatory

Dr.

APPENDIX 1

SERVICES/DELIVERABLES

1. The Physician shall provide a minimum of _____ and a maximum of _____ sessions during the term of this Contract, according to the following schedule:

2. The Physician will provide the following services:

-
-
-

It is understood and agreed that more detailed descriptions of the Services will be included in this Appendix, as negotiated at the local level between the Physician and the Agency, but must include the following.

- (a) Participation in the evaluation of the efficiency, quality and delivery of the Services, including and without limiting the generality of the foregoing, participation in medical audits, peer and interdisciplinary reviews, chart reviews, and incident report reviews.
- (b) Submission to the Agency all reports reasonably required by the Agency within 30 days of the Agency's written request.

3. The Physician will supply the following support, technology, material and supplies:

4. The Agency will provide the following support, technology, material and supplies:

APPENDIX 2

PAYMENT

The Agency will pay the Physician at a rate of \$_____ per session that the Physician provides Services under the terms of this Contract, upon receipt of an invoice for the Services provided.

APPENDIX 3

FEE FOR SERVICE AND THIRD PARTY BILLING WAIVER

Physician Name _____

MSP Practitioner Number _____

I acknowledge that the payments paid to me by the _____ (the Agency) for the Services provided under the terms of the Contract between us dated _____ are payments in full for the Services covered by the Contract and provided to the Agency and I will make no other claim for these Services.

Physician's Signature

Date

APPENDIX 4

FEE FOR SERVICE AND THIRD PARTY BILLING ASSIGNMENT

Physician Name _____

MSP Practitioner Number _____

I acknowledge that the payments paid to me by the _____ (the Agency) for the Services provided under the terms of the Contract between us dated _____ are payments in full for the Services covered by the Contract and provided to the Agency and I will make no other claim for these Services. I hereby assign to _____ (the Agency) any and all rights I have to receive fee for service payments for any of the Services covered by that Contract.

Physician's Signature

Date

APPENDIX 5
REPORTING

The following information must be provided by the Physician to the Agency on the last day of each month:

Schedule “G” to the Alternative Payments Subsidiary Agreement
CLASSIFICATION CRITERIA FOR MEDICAL HEALTH OFFICER 1
AND MEDICAL HEALTH OFFICER 2 PRACTICE CATEGORIES –
Salary Agreements and Service Contracts

Subject to amendment by the Alternative Payments Committee
under section 4.5

General Principles

5. *Community Medicine/Public Health (CMPH) Physician* shall be the title of the job group used to classify physician positions that require the practice of Public Health or Community Medicine. This includes, for example, Medical Health Officers (MHOs), Public Health Epidemiologists, Community Medicine Consultants, and First Nations Medical/Public Health Advisors.
6. Physician positions that are matched to the CMPH classification require graduation from a medical school of recognized standing with a degree of Doctor of Medicine and membership in good standing with the College of Physicians and Surgeons of British Columbia.
7. Physician positions that are matched to the CMPH classification and are compensated through a Salary Agreement or Service Contract shall be paid in accordance with the Salary Agreement Range or Service Contract Range, as applicable, for either the Medical Health Officer 1 practice category or Medical Health Officer 2 practice category in accordance with the Application section below.

Application

Range Minimum (Annually)	Area A	Area A Maximum/Area B Minimum (Annually)	Area B	Range Maximum (Annually)
Medical Health Officer 1 Practice Category				

Range Minimum (Annually)	Area C	Area C Maximum/Area D Minimum (Annually)	Area D	Range Maximum (Annually)
Medical Health Officer 2 Practice Category				

1. Area A is reserved for physician positions that require the practice of Public Health or Community Medicine, that do not include the administrative roles of supervising other physicians and establishing program policy, and where the physician is not certified by the Royal College of Physicians and Surgeons of Canada as a specialist in Community Medicine or a related specialty and does not have a Master's degree in Public Health (e.g., a GP working in the job of MHO) or where such specialty or degree is not relevant to the duties of the job.
2. Area B is reserved for physician positions that require the practice of Public Health or Community Medicine, that do not include the administrative roles of supervising other physicians and establishing program policy, and where the physician has the additional training of a Master's degree in Public Health or the equivalent Master's degree, provided that the degree is relevant to the duties of the job.
3. Area C is reserved for physician positions that require the practice of Public Health or Community Medicine, that do not include the administrative roles of supervising other physicians and establishing program policy, and where the physician is certified by the Royal College of Physicians and Surgeons of Canada as a specialist in Community Medicine or a related specialty, provided that the specialty is relevant to the duties of the job.
4. Physician positions that include the administrative roles of supervising other physicians and establishing program policy (e.g., Chief Medical Health Officer, Director Epidemiology) move to the next higher Area (e.g., a Chief MHO who is a GP would fall within Area B; a Chief MHO who has a relevant Master's degree would fall within Area C; a Chief MHO who has a relevant Specialist certification would fall within Area D).
5. Area D is reserved for physician positions that include the administrative roles of supervising other physicians and establishing program policy AND where the physician is certified by the Royal College of Physicians and Surgeons of Canada as a specialist in Community Medicine or a related specialty, provided that the specialty is relevant to the duties of the job (i.e., all criteria must be met).

APPENDIX E

2012 BENEFITS SUBSIDIARY AGREEMENT

THIS AGREEMENT made as of the 1st day of April, 2012,

BETWEEN:

**HER MAJESTY THE QUEEN IN RIGHT OF THE
PROVINCE OF BRITISH COLUMBIA**, as represented by the
Minister of Health

(the “**Government**”)

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION

(the “**BCMA**”)

AND:

MEDICAL SERVICES COMMISSION

(the “**MSC**”)

WITNESSES THAT WHEREAS:

- A. The BCMA, the MSC and the Government have agreed to renew and replace the 2007 PMA, the 2007 General Practitioners Subsidiary Agreement, the 2007 Specialists Subsidiary Agreement, the 2007 Rural Practice Subsidiary Agreement, the 2007 Alternative Payments Subsidiary Agreement and the 2007 Benefits Subsidiary Agreement;
- B. The parties have agreed that this Agreement will constitute the new Benefits Subsidiary Agreement, to take effect as of April 1, 2012; and
- C. The parties intend this Agreement to:
- (a) identify the benefits that are available to physicians through agreements between the parties;
 - (b) describe threshold eligibility for participation in the Benefit Plans, subject to the specific terms, conditions, rules and eligibility criteria applicable to each Benefit Plan;
 - (c) assign responsibility for the oversight and administration of the Benefit Plans; and

- (d) identify the funding for the Benefit Plans.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 1 - RELATIONSHIP TO THE 2012 PHYSICIAN MASTER AGREEMENT

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2012 Physician Master Agreement and is subject to its terms and conditions.

ARTICLE 2 – DEFINITIONS AND INTERPRETATION

2.1 Words used in this Agreement that are defined in the 2012 Physician Master Agreement have the same meaning as in the 2012 Physician Master Agreement unless otherwise defined in this Agreement.

2.2 “**this Agreement**” means this document including the Schedules, as amended from time to time as provided herein.

2.3 “**Benefit Plans**” means the CME, the PDI, the CMPA Rebate Program, the CPRSP, the PHP, and the Parental Leave Program.

2.4 “**CMPA Rebate Program**” means the Canadian Medical Protective Association Rebate Program referred to in Schedule “C” to this Agreement.

2.5 “**CME**” means the Continuing Medical Education Fund referred to in Schedule “B” to this Agreement.

2.6 “**CPRSP**” means the Contributory Professional Retirement Savings Plan referred to in Schedule “D” to this Agreement.

2.7 “**Parental Leave Program**” means the program referred to in Schedule “E” to this Agreement.

2.8 “**PDI**” means the Physician Disability Insurance Program referred to in Schedule “A” to this Agreement.

2.9 “**PHP**” means the Physician Health Program operated by the Physician Health Program Society of British Columbia to provide advocacy and support for physicians, including those in training, and their families, who are experiencing problems related to personal and family emotional health issues, the inappropriate use of alcohol and/or drugs or coping with physical illness.

2.10 “**2012 Physician Master Agreement**” means the agreement titled “2012 Physician Master Agreement” between the Government, the BCMA, and the MSC, dated April 1, 2012.

2.11 The provisions of sections 1.2 to 1.8 inclusive of the 2012 Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this

Agreement, except those references in such sections to “this Agreement” shall herein be construed to mean this Agreement.

ARTICLE 3 - TERM

3.1 This Agreement comes into force on April 1, 2012.

3.2 This Agreement shall be for the same term as the 2012 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the 2012 Physician Master Agreement.

ARTICLE 4 - PHYSICIAN BENEFITS COMMITTEE

4.1 The Government and the BCMA will continue the **Benefits Committee** which provides oversight of the Benefit Plans and the administration of them.

4.2 The Benefits Committee will be composed of up to three members appointed by the BCMA and up to three members appointed by the Government, and will be co-chaired by one member chosen by the BCMA appointees and one member chosen by the Government appointees.

4.3 The Benefits Committee must meet a minimum of two times per year, unless the members of the Benefits Committee agree to additional meetings or the Physician Services Committee directs additional meetings, in which case the Benefits Committee must hold such additional meetings.

4.4 The terms of reference of the Benefits Committee will include:

- (a) providing general oversight of the Benefit Plans within the available funding, consistent with the terms of this Agreement and the 2012 Benefits Administration Agreement;
- (b) determining when there is a surplus in funding for any of the Benefit Plans and allocating any such surplus in accordance with this Agreement;
- (c) identifying and making changes to the specific terms, conditions, rules, eligibility criteria and benefits associated with each of the Benefit Plans, except the PHP, to maximize the benefits realized within the budget for each Benefit Plan; and
- (d) discovering whether or not physicians who are compensated by Salary Agreements are entitled to make any contribution to an RRSP and, if so, considering whether to provide a partial CPRSP benefit to such physicians.

4.5 The Benefits Committee will make decisions by consensus decision.

4.6 If the Benefits Committee cannot reach a consensus decision on any matter that it is required to determine pursuant to sections 4.4(a) or (b), the Government and/or the BCMA may make recommendations to the Adjudication Committee regarding such matter and the

Adjudication Committee will determine the matter. If the Benefits Committee cannot reach a consensus decision on any matter that it is required to determine pursuant to section 4.4(c) or section 4.4(d), the Government and/or the BCMA may refer the matter to the Physician Services Committee and the Physician Services Committee will attempt to resolve the matter, failing which there will be no change to the Benefit Plan(s) in issue.

4.7 On an annual basis, the Benefits Committee will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report to the Physician Services Committee in the manner outlined in section 6.3(a) of the 2012 Physician Master Agreement.

4.8 The Benefits Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the Benefits Committee pre-approve any communication about the business and/or decisions of the Benefits Committee.

ARTICLE 5 – IDENTIFICATION OF BENEFIT PLANS

5.1 Subject to section 5.2, the following Benefit Plans will be available to physicians who have not made an election under Section 14 of the *Medicare Protection Act* and who are not subject to an order made under Section 15(2)(a) or (b) of the *Medicare Protection Act*, under the terms and conditions that are described in the 2012 Physician Master Agreement, this Agreement and any of the other Physician Master Subsidiary Agreements:

- (a) the CME;
- (b) the PDI;
- (c) the CMPA Rebate Program;
- (d) the CPRSP;
- (e) the PHP; and
- (f) the Parental Leave Program.

5.2 The Benefit Plans, other than the PHP, are generally described in Schedules A through E. The specific terms, conditions, rules, eligibility criteria and benefits associated with each Benefit Plan, other than the PHP, are as approved and published by the Benefits Committee from time to time.

ARTICLE 6 - FUNDING

6.1 The annual base funding for the Benefit Plans is as follows:

- (a) \$11,700,000 for the PDI;
- (b) \$9,725,000 for the CME;

- (c) the amount required to reimburse eligible physicians 100% of CMPA membership dues above the 1985 CMPA dues, to a maximum of \$22,000,000, for the CMPA Rebate Program;
- (d) \$52,370,000 for the CPRSP;
- (e) \$4,300,000 for the Parental Leave Program; and
- (f) \$4,690,000 to be allocated on an annual basis by the Benefits Committee among the PDI, CME, CPRSP, and Parental Leave Program.

6.2 For each Fiscal Year during the term of this Agreement, the annual base funding for each of the Benefit Plans will be as set out in section 6.1.

6.3 For each of the Fiscal Years 2012/2013 and 2013/2014, the level of the Benefit Plans in existence as of March 31, 2012 will be maintained by:

- (a) use of surplus funds in any of the Benefit Plans, other than the CMPA Rebate Program; and
- (b) if the funds referred to in section 6.3(a) are inadequate to maintain the level of the Benefit Plans as described in this section 6.3, use of surplus from the CMPA Rebate Program;

subject to the terms, conditions, rules and eligibility criteria applicable to each of the Benefit Plans.

6.4 If in any Fiscal Year during the term of this Agreement, after any surplus funds in the Benefit Plans are applied to maintaining the level of the Benefit Plans as described in section 6.3, there remain surplus funds in any of the Benefit Plans, other than CMPA Rebate Program, such surplus funds will be allocated by the Benefits Committee.

6.5 In each Fiscal Year from April 1, 2012 to March 31, 2016, the Government will provide to the PHP the sum of \$600,000, provided that in each such Fiscal Year the BCMA and the College of Physicians and Surgeons of British Columbia, together, contribute an equal amount, so that \$1,200,000 is available to the PHP each year.

ARTICLE 7 - ADMINISTRATION OF THE BENEFITS PLANS

7.1 Concurrently with the execution and delivery of this Agreement, the Government and the BCMA will renew and amend the contract between them for administration of the Benefit Plans, except the PHP (the “**2012 Benefits Administration Agreement**”). The 2012 Benefits Administration Agreement shall include the following:

- (a) The responsibilities of the BCMA include the verification that public funds have been properly used for the purposes intended, including such audit and inspection procedures as may be necessary and required.

- (b) The BCMA acknowledges and accepts its responsibility to administer the Benefit Plans available to all eligible physicians who have not made an election under Section 14 of the *Medicare Protection Act* and who are not subject to an order made under Section 15(2)(a) or (b) of the *Medicare Protection Act*, and acknowledges and accepts its responsibility to provide the same standard of administration to both members and non-members of the BCMA.
- (c) It is understood and agreed that the BCMA may charge physicians who are not members of the BCMA an administrative fee when such non-members apply for any benefits available to them under the Benefit Plans. It is further understood and agreed that non-members will not be charged administrative fees that exceed the equivalent of dues and levies charged to BCMA members in the calendar year in which the non-member applies for a benefit or benefits.
- (d) To facilitate the Government and the MSC in meeting their statutory obligations to account for the use of public money, the BCMA will report annually to the Government on its expenditures related to the administration of the Benefit Plans, such report to also include audited financial statements for each Benefit Plan.
- (e) A clause permitting either party to terminate without cause upon 6 months written notice to the other party, such clause not to be operable prior to April 1, 2015.

7.2 The costs associated with administering the Benefit Plans that are the subject of the 2012 Benefits Administration Agreement will be paid from the annual funding made available for those Benefit Plans.

7.3 During the term of this Agreement, either the Government or the BCMA may, at its own expense, initiate a review of the Benefit Plans. The other party will be fully reimbursed for the costs of its participation in the review. Where one party initiates a review under this section the other party will fully cooperate.

7.4 Information that contains the identification of physicians will be provided to the BCMA Benefits Department for the administration of the Benefits Plans only. Such information will be kept confidential in compliance with relevant legislation.

7.5 The Benefits Committee will review the current information needs of the BCMA Benefits Department with the aims of improving the quality of the information collected and reducing the administrative burden on the Health Authorities, the Government, and the BCMA associated with collecting the information.

7.6 The BCMA Benefits Department will report to the MSC the value of the benefits (excluding PDI and PHP) at the level of the individual physician on an annual basis. This information will be treated as confidential by the MSC and, subject to any statutory requirements to the contrary, will not be published or otherwise publicly reported.

7.7 The BCMA Benefits Department will report to the Benefits Committee the value of administrative fees charged to non-members for each Benefit Plan on an annual basis.

ARTICLE 8 - ELIGIBILITY TO PARTICIPATE IN THE BENEFIT PLANS

8.1 Subject to any specific provision of the 2012 Physician Master Agreement and any of the Physician Master Subsidiary Agreements, including this Agreement, and subject to the specific terms, conditions, rules and eligibility criteria applicable to each of the Benefit Plans, physicians who are compensated by Fees, Sessional Contracts or Service Contracts are eligible to participate in all of the Benefit Plans. Income from each compensation source shall be totalled and combined in determining eligibility/coverage.

8.2 Physicians who are compensated by Salary Agreements are not eligible to participate in the Benefit Plans (except for the PHP), with the exception of:

- (a) certain physicians who are compensated under part-time Salary Agreements and are entitled to participate in Benefit Plans as per current policy;
- (b) any physicians who the Benefits Committee determines, in accordance with section 4.4(d), will be provided with a partial CPRSP benefit,

provided however that no physician, as a result of working under more than one mode of compensation, may receive more than the full annual value of the benefits available under any of the Benefit Plans. Should a physician transfer to or from a Salary Agreement position during a year, the benefits available under each compensation arrangement will be pro-rated to match the time served by the physician under each compensation arrangement during that year.

8.3 A physician who elects to be paid directly by a beneficiary pursuant to Section 14 of the *Medicare Protection Act* is not entitled to participate in the Benefit Plans.

8.4 Where the MSC has, for cause, made an order under Section 15 (2) (a) or (b) of the *Medicare Protection Act* that physician is no longer entitled to participate in the Benefit Plans.

ARTICLE 9 - QUARANTINE INCOME REPLACEMENT

9.1 The Government will compensate physicians required by the Provincial Health Officer to undergo a period of quarantine as a result of exposure to a communicable disease while providing Insured Medical Services in British Columbia. Such compensation will be paid at a rate equal to the maximum benefit available under the PDI, for a period of up to two weeks.

ARTICLE 10 - DISPUTE RESOLUTION

10.1 Disputes as to the interpretation, application, operation or alleged breach of this Agreement are Provincial Disputes and will be resolved in accordance with the provisions of Articles 20, 21 and 22 of the 2012 Physician Master Agreement applicable to Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2012.

SIGNED, SEALED & DELIVERED on)
behalf of HER MAJESTY THE QUEEN)
IN RIGHT OF THE PROVINCE OF)
BRITISH COLUMBIA, by the Minister)
of Health or his/her duly authorized)
representative, in the presence of:)

Signature of Witness)

Name)

Address)

THE CORPORATE SEAL of the)
BRITISH COLUMBIA MEDICAL)
ASSOCIATION was hereunto affixed in)
the presence of:)

C/S

Signature of Authorized Signatory)

Name)

Position)

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

Name

Position

SCHEDULE A

PHYSICIAN DISABILITY INSURANCE PROGRAM

Funding for the PDI will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The PDI funds will be payable by the MSC to, and on the date required by, the insurance company which is providing the PDI coverage.

The PDI provides income replacement to eligible physicians who become totally disabled. Coverage is not automatic and each physician must apply for coverage and provide medical evidence of insurability. The specific terms, conditions, rules and eligibility criteria applicable to, and the benefits available from, the PDI are as approved and published by the Benefits Committee from time to time.

SCHEDULE B

CONTINUING MEDICAL EDUCATION FUND

Funding for the CME will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The annual funds will be payable to the BCMA on May 1st of each Fiscal Year.

The CME fund is a yearly allotment of monies used to assist physicians with eligible educational expenses. The specific terms, conditions, rules and eligibility criteria applicable to, and the benefits available from, the CME are as approved and published by the Benefits Committee from time to time.

SCHEDULE C

CANADIAN MEDICAL PROTECTIVE ASSOCIATION REBATE PROGRAM

The maximum funding available for the CMPA Rebate Program will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The Government will make contributions to maintain the CMPA Rebate Program such that 100% of CMPA membership dues above the 1985 CMPA dues are reimbursed to physicians who are practising under the MSP, subject to the maximum funding obligations as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The CMPA Rebate Program provides eligible physicians with partial reimbursement of their CMPA dues. The specific terms, conditions, rules and eligibility criteria applicable to, and the benefits available from, the CMPA Rebate Program are as approved and published by the Benefits Committee from time to time.

SCHEDULE D

CONTRIBUTORY PROFESSIONAL RETIREMENT SAVINGS PLAN

Funding for the CPRSP will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The CPRSP is a retirement savings program that provides funds for eligible physicians to contribute to their retirement savings plan, subject to the available CPRSP funding, and subject to the specific terms, conditions, rules and eligibility criteria approved and published by the Benefits Committee.

SCHEDULE E

PARENTAL LEAVE PROGRAM

Funding for the Parental Leave Program will be as set out in the applicable provisions of Article 6 of the Benefits Subsidiary Agreement.

The Parental Leave Program will provide up to \$1,000 per week for up to 17 weeks within one year of the date an eligible male or female physician becomes a parent of a newborn or newly adopted child or of a newborn through a surrogate mother. The 17 weeks need not be consecutive if it is necessary for the physician to return to work for one or more periods within the qualifying year.

The specific terms, conditions, rules and eligibility criteria applicable to the Parental Leave Program will be as approved and published by the Benefits Committee from time to time.

APPENDIX F

ADJUSTMENTS TO FEES, SERVICE CONTRACT RANGES AND SERVICE CONTRACT RATES, SALARY AGREEMENT RANGES AND SALARY AGREEMENT RATES, AND SESSIONAL CONTRACT RATES

1.1 Compensation Changes in 2012/13

- (a) Effective April 1, 2012,
 - (i) Fees (excluding Laboratory Services Fees) will be increased by an average of 0.5% to fund the increases in the cost of providing services, with such increase to be allocated pursuant to Articles 12 and 13 of the 2012 Physician Master Agreement.
 - (ii) Sessional Contract Rates will be increased by 0.5% over the Sessional Contract Rates in effect on March 31, 2012 to fund the increases in the cost of providing services;
 - (iii) Service Contract Ranges and Service Contract Rates, and Salary Agreement Ranges and Salary Agreement Rates will be increased by 0.5% over those in effect on March 31, 2012 to fund the increases in the cost of providing services;
 - (iv) the reading fee for a screening mammogram will be increased by 0.5% over that in effect on March 31, 2012 to fund the increases in the cost of providing services; and
 - (v) the MRI fee will be increased by 0.5% over that in effect on March 31, 2012 to fund the increases in the cost of providing services.
- (b) \$20 million (composed of \$10 million of new funding and \$10 million of pre-existing Specialist Services Committee funding as noted in section 6.1 of the Specialists Subsidiary Agreement) will be made available for allocation to Fees paid to those Specialist Sections (as defined in the Specialists Subsidiary Agreement) that have difficulty recruiting and retaining Specialist Physicians in British Columbia, the gross allocation of which among Specialist Sections (as defined in the Specialists Subsidiary Agreement) will be adjudicated by Eric J. Harris, Q.C., who will consider the effect of both intersectional and interprovincial disparities in compensation. This adjudication before Mr. Harris will be conducted in accordance with procedures as determined by him and will include an opportunity for the Government and the BCMA to make submissions. Once the gross allocation of this \$20 million has been determined by Eric J. Harris, Q.C., the resulting changes to the Payment Schedule will be determined in accordance with Articles 12 and 13 of the 2012 Physician Master Agreement, and will be effective as of April 1, 2012. Any financial impact to any Physician

Section resulting from the allocation of this funding to a specific Specialist Section, will be paid out of the Specialist Section allocation that produces such a cross-sectional impact.

- (c) Effective April 1, 2012, \$4 million will be made available to fund adjustments to be made by the Alternative Payments Committee to the Salary Agreement Ranges and the Service Contract Ranges in response to physician recruitment and retention challenges. Affected physicians under existing Service Contracts and Salary Agreements will be placed within the applicable amended Service Contract Range or Salary Agreement Range at the same level as their current placement (e.g. range minimum, mid-range, or range maximum). In no event shall the total cost to the Government under this section 1.1(c) exceed \$4 million in any one Fiscal Year.

1.2 Compensation Changes in 2013/14

- (a) Effective April 1, 2013,
 - (i) Fees (excluding Laboratory Services Fees) will be increased by an average of 0.5% to fund the increases in the cost of providing services, with such increase to be allocated pursuant to Articles 12 and 13 of the 2012 Physician Master Agreement.
 - (ii) Sessional Contract Rates will be increased by 0.5% over the Sessional Contract Rates in effect on March 31, 2013 to fund the increases in the cost of providing services;
 - (iii) Service Contract Ranges and Service Contract Rates, and Salary Agreement Ranges and Salary Agreement Rates will be increased by 0.5% over those in effect on March 31, 2013 to fund the increases in the cost of providing services;
 - (iv) the reading fee for a screening mammogram will be increased by 0.5% over that in effect on March 31, 2013 to fund the increases in the cost of providing services; and
 - (v) the MRI fee will be increased by 0.5% over that in effect on March 31, 2013 to fund the increases in the cost of providing services.
- (b) Effective April 1, 2013, \$10 million will be made available to fund
 - (i) adjustments to be made by the Alternative Payments Committee to the Salary Agreement Ranges and the Service Contract Ranges in response to physician recruitment and retention challenges, and/or
 - (ii) the implementation of consensus decisions and/or agreements regarding any of the matters referred to in section 4.5(d) of the Alternative Payments Subsidiary Agreement.

Physicians working under existing Service Contracts and Salary Agreements, who are affected by changes resulting from section 1.2(b)(i), will be placed within the applicable amended Service Contract Range or Salary Agreement Range at the same level as their current placement (e.g. range minimum, mid-range, or range maximum). In no event shall the total cost to the Government under this section 1.2(b) exceed \$10 million in any one Fiscal Year.

1.3 General

- (a) A physician who is compensated through a Salary Agreement or Service Contract, and who is paid an annual rate that is above the range maximum for the applicable practice category on Schedule A or Schedule B to the Alternative Payments Subsidiary Agreement, will only be entitled to compensation increases to the extent that the resulting rate is within the Salary Agreement Range or Service Contract Range applicable to that physician.
- (b) The increases identified in sections 1.1(a) and 1.2(a) do not apply to targeted funds including, but not limited to, new targeted funds which have been reflected in sections 1.1(b), 1.1(c) and 1.2(b) of this Appendix F and in Article 5 of the General Practitioners Subsidiary Agreement, Article 6 of the Specialists Subsidiary Agreement, and Article 12 of the Rural Practice Subsidiary Agreement. In particular, and without limiting the generality of the forgoing, in the event that any targeted funds are used for increases to Fees, Service Contract Ranges, Service Contract Rates, Salary Agreement Ranges, Salary Agreement Rates, Sessional Contract Rates, the reading fee for a screening mammogram and/or the MRI fee (collectively "Targeted Increase"):
 - (i) the base years for the application of any such Targeted Increase will be the Fiscal Year commencing April 1, 2011 for any Targeted Increase made effective April 1, 2012 and the Fiscal year commencing April 1, 2012 for any Targeted Increase made effective April 1, 2013; and
 - (ii) the increases identified in sections 1.1(a) and/or 1.2(a) will be applied prior to the application of any Targeted Increase.

In other words, no Targeted Increase will attract any increase identified in sections 1.1(a) and/or 1.2(a) in the year in which such Targeted Increase is introduced.

APPENDIX G

MEDICAL ON-CALL/AVAILABILITY PROGRAM (MOCAP)

- 1.1 MOCAP will provide payment to physician(s) and physician groups who provide coverage for patients, other than their own or their call groups', as required and approved by Health Authorities.
- 1.2 The MOCAP funding described in section 17.1 of the 2012 Physician Master Agreement includes funding for Doctor of the Day payments. This provides greater flexibility for Health Authorities in purchasing MOCAP coverage and Doctor of the Day services.
- 1.3 Where MOCAP availability coverage is required it is in the best interests of the population served that it be provided on a 24/7/52 basis. It is recognized that, in some circumstances, a Health Authority may decide to provide MOCAP availability coverage on some other basis.
- 1.4 Physicians will provide MOCAP availability coverage in accordance with the provisions of the template MOCAP Contract attached as Schedule 1 to this Appendix.
- 1.5 MOCAP availability payments will be determined on the basis of annual rates.
- 1.6 The annual rates for the MOCAP availability will be as follows:
 - (a) Level 1- Coverage designated by a Health Authority to require availability by telephone within 10 minutes, and available to be on-site urgently but no later than within 45 minutes. The annual rate for 24/7/52 Level 1 coverage is \$225,000 per call group.
 - (b) Level 2 - Coverage designated by a Health Authority to require availability by telephone within 15 minutes, and available to be on-site within 2 hours. The annual rate for 24/7/52 Level 2 coverage is \$165,000 per call group.
 - (c) Level 3 - Coverage designated by a Health Authority to require availability by telephone within 15 minutes, and available on-site within 16 hours of receiving the call. The annual rate for 24/7/52 Level 3 coverage is \$70,000 per call group.
 - (d) On Site On-Call - Where a physician is designated by a Health Authority to be on-call on site. Physician groups in this category predominately include tertiary obstetrics, anesthesia, and neonatology. The annual rate for 24/7/52 on site on-call coverage is \$325,000 per call group.
- 1.7 Where a physician is not on-call but is called in by the Health Authority to provide a service, the physician will be compensated at the rate of \$250 per call back provided the Call Back Criteria attached as Schedule 2 are met.

- 1.8 MOCAP arrangements should be sustainable and therefore must not contribute to physician burnout.
- 1.9 If, during the term of this Agreement, the parties agree to a MOCAP redesign, the parties will include in that agreement any changes to this Appendix G.

**SCHEDULE 1 TO APPENDIX G
TEMPLATE MOCAP CONTRACT**

BETWEEN:

(collectively called the “Call Group”
and individually referred to as a
“Member”)

AND:

(the “Health Authority”)

WHEREAS the Call Group and its Members wish to contract with the Health Authority and the Health Authority wishes to contract with the Call Group and its Members to provide On-Call/Availability on the terms, conditions and understandings set out in this contract (the “Contract”);

THEREFORE in consideration of the mutual premises contained in this Contract, the Call Group, its Members and the Health Authority agree as follows:

DEFINITIONS

“**On-Call/Availability**” means being available to provide care to patients, other than a Member’s or Call Group’s own patients, and being available to provide advice to other health care providers and other professionals involved in the care of those patients.

“**Call Group**” means a physician or group of physicians who have agreed to share responsibility to provide On-Call/Availability on contract to a Health Authority.

“**Physician Master Agreement**” means the agreement titled “2012 Physician Master Agreement” and entered into as of April 1, 2012 among the Government of British Columbia, the Medical Services Commission (MSC) and the British Columbia Medical Association (BCMA), as amended from time to time.

“**Physician Master Subsidiary Agreements**” has the meaning given in the Physician Master Agreement.

ARTICLE 1 - TERM & RENEWAL

- 1.1 This Contract will be in effect from _____ to _____ notwithstanding the date of its execution (the "Term").
- 1.2 This Contract may be renewed for such period of time and on such terms as the parties may mutually agree to in writing. If either party wishes to renew this Contract, it must provide written notice to the other party no later than ninety (90) days prior to the end of the Term and, as soon as practical thereafter, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.
- 1.3 Subject to section 1.4 herein, if both parties agree to renew the Contract, the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.
- 1.4 In the event that a new contract is not completed within ninety (90) days following the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

ARTICLE 2 - TERMINATION

- 2.1 Either party may terminate this Contract without cause upon ninety (90) days written notice to the other party.
- 2.2 Either party may terminate this Contract without notice if the other party breaches a fundamental term of the Contract.
- 2.3 Upon 10 days written notice to the other party, the Health Authority may terminate or amend this Contract as may reasonably be required for the Health Authority to carry out or comply with any award of the MOCAP Adjudicator (as defined in the Physician Master Agreement) made pursuant to section 22.3(f) of the Physician Master Agreement. If the Call Group or any of its Members does not agree to any amendment proposed by the Health Authority pursuant to this section, either party may terminate this Contract upon 10 days written notice to the other party.

ARTICLE 3 - PAYMENTS BY CALL GROUPS

- 3.1 The Members of the Call Group must pay any and all payments and/or deductions required to be paid by him/her, including those required for income tax, Employment Insurance premiums, Workers Compensation premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that he/she is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Members of the Call Group pursuant to this Contract.
- 3.2 The liability of Members of the Call Group for payments referred to in section 3.1 herein is severable and not joint.

- 3.3 Each Member of the Call Group agrees to indemnify the Health Authority from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from any Member of the Call Group's failure to make payments referred to in section 3.1 herein.
- 3.4 The indemnity clause in section 3.3 herein survives the expiry or earlier termination of this Contract.

ARTICLE 4 - UNINCORPORATED CALL GROUPS

- 4.1 Each Member has the right to terminate his/her relationship with the Health Authority without affecting the rights and obligations of the remaining Members and must do so in accordance with the termination provisions of this Contract.
- 4.2 The Health Authority may terminate the Contract with respect to an individual Member in accordance with the termination provisions herein.
- 4.3 In the event of the departure of a Member by resignation or termination, the parties will meet to discuss whether amendments are required and to make agreed changes.
- 4.4 Each Member will sign a copy of this Contract and become party to it. If a new Member is added to the Contract the Health Authority will provide a copy of the Contract bearing the signature of the new Member to the Members of the Call Group.

ARTICLE 5 - AUTONOMY

- 5.1 Each Member will provide the On-Call/Availability coverage under this Contract in accordance with applicable standards of law, professional ethics and medical practice and any Health Authority policies, by-laws or rules and regulations that are not inconsistent with or represent a material change to the terms of this Contract.

ARTICLE 6 - DISPUTE RESOLUTION

- 6.1 This Contract is governed by, and is to be construed in accordance with, the laws of British Columbia.
- 6.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that the parties are unable to resolve at the local level may be referred to mediation on notice by either party to the other. The neutral mediator shall be jointly selected by the parties. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the parties in writing, the dispute will be referred to arbitration administered pursuant to the *Commercial Arbitration Act*.
- 6.3 If an arbitrator or mediator cannot be agreed upon within fifteen (15) working days after notice is served by either party seeking appointment of an arbitrator or mediator under section 6.2 herein, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the arbitrator or mediator.

ARTICLE 7 - ON-CALL REQUIREMENTS

7.1 The Call Group will provide:

Level 1

Availability by telephone within 10 minutes and available to be on-site urgently but no later than within 45 minutes – The annual rate for 24/7/52 Level 1 coverage is \$225,000 per call group.

- Continuous coverage
- Non-continuous coverage (Details – e.g. hours, days)

Level 2

Availability by telephone within 15 minutes, and available to be on-site within 2 hours. The annual rate for 24/7/52 Level 2 coverage is \$165,000 per call group.

- Continuous coverage
- Non-continuous coverage (Details)

Level 3

Availability by telephone within 15 minutes and available on-site within 16 hours of receiving the call. The annual rate for 24/7/52 Level 3 coverage is \$70,000 per call group.

- Continuous coverage
- Non-continuous coverage (Details)

On site On-call

Availability on-site. The annual rate for 24/7/52 on site on-call coverage is \$325,000 per call group.

- Continuous coverage
- Non-continuous coverage (Details)

As per the following:

Nature of On-Call/Availability: _____ (e.g. general surgery, hours)

Location: _____ (e.g. St Paul's Hospital)

7.2 Notwithstanding section 7.1 herein, response times will be dictated by patient need.

7.3 The Call Group will notify the Health Authority of the call rota, which includes the Member covering each shift, in a timely fashion.

ARTICLE 8 - SUBCONTRACTING

- 8.1 Each Member may, with the written consent of the Health Authority, subcontract or assign any of the On-Call/Availability coverage. The consent of the Health Authority will not be unreasonably withheld.

ARTICLE 9 - COMPENSATION

- 9.1 The Health Authority will pay the Call Group or individual Members (time period – biweekly, etc.) upon receipt of an invoice for On-Call/Availability coverage provided based on a rate of _____ per year.
- 9.2 In no event will the aggregate amount paid under this Contract exceed the sum of _____ per year.

ARTICLE 10 - REPORTING

- 10.1 Each Call Group will report to the Health Authority payment received by each physician in the group for the provision of On-Call/Availability, thirty (30) days after the end of every quarter.

ARTICLE 11 - NOTICES

- 11.1 Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by mail or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:
- 11.1.1 If mailed by prepaid double-registered mail to the addressee's address listed below, on date of confirmation of delivery.
- 11.1.2 If delivered by hand to the addressee's address listed below on the date of such personal delivery; or
- 11.1.3 If sent by fax to the addressee's fax number listed below, at the time of successful transmission.
- 11.2 Either party may give notice to the other of a change of address or fax number.
- 11.3 Address of Health Authority:

Address of each Member of Call Group:

ARTICLE 12 - AMENDMENTS

- 12.1 This Contract may be amended by written agreement of both parties.

ARTICLE 13 - ENTIRE CONTRACT

13.1 This Contract, the Physician Master Agreement and the Physician Master Subsidiary Agreements embody the entire understanding and agreement between the parties relating to On-Call/Availability and there are no covenants, representations, warranties or agreements other than those contained or specifically preserved under the terms of these agreements.

ARTICLE 14 - NO WAIVER UNLESS IN WRITING

14.1 No provision of this Contract and no breach by either party of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other party. The written waiver of a party of any breach of any provision of this Contract by the other party must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Contract.

ARTICLE 15 - HEADINGS

15.1 The headings in this Contract have been inserted for reference only and in no way define, limit or enlarge the scope of any provision of this Contract.

ARTICLE 16 - ENFORCEABILITY AND SEVERABILITY

16.1 If any provision of this Contract is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, illegality or unenforceability will attach only to such provision or part of such provision.

Dated this ____ day of _____ 20__.

IN WITNESS WHEREOF THE PARTIES have duly executed this Contract as of the date written above.

Authorized Signatory

Dr. (Name of Member of Call Group)

SCHEDULE 2 TO APPENDIX G

CALL BACK CRITERIA

Part A: Call Back Payment Eligibility

All the following Criteria must be met for a physician to be eligible for the \$250 MOCAP call back payment.

1. Criteria related to the person making the decision to call.

The decision to initiate the call back is made by one of the following:

- a) A physician with privileges at the facility in issue who has responsibility for the care of the patient in question, including but not limited to the Most Responsible Physician.
- b) Any other member of the medical or nursing staff of the facility in issue who has been specifically authorized by the Health Authority to initiate call backs eligible under these Criteria.

2. Criteria related to the person who is called.

The call is made to a physician who meets all of the following:

- a) Has been designated for call back payments by the Health Authority in accordance with Part B below or falls within a category or group that has been so designated, and meets all the terms of such designation or, alternatively, has had the specific call back in issue approved for payment after-the-fact on an exception basis in accordance with Part C below.
- b) Is a member of the medical staff at the facility in issue with privileges to provide the required services.
- c) Is not on call or being paid to be on site, on shift, or otherwise available at the time of the call back.
- d) Is not:
 - i) at the time of the call back, on site at the facility at which the patient is present in accordance with Part A3(b) below;
 - ii) at the time of the call back, scheduled to be on site at the facility at which the patient is present in accordance with Part A3(b) below; or
 - iii) scheduled to be next on site at the facility at which the patient is present in accordance with Part A3(b) below at a time when the patient's needs could be adequately met.
- e) Is not receiving isolation allowance under the Rural Subsidiary Agreement.

3. Criteria related to the clinical circumstances.

All of the following circumstances are present:

- a) The call is for an identified patient who is not a patient of the physician being called or of a colleague for whose patients the physician has accepted responsibility.
- b) The patient is present in:
 - i) an acute care hospital, or
 - ii) a diagnostic and treatment centre or specified emergency treatment room that has been approved as a call back payment eligible facility by the MOCAP Advisory Committee.
- c) The patient requires medical services on an emergency basis as assessed by the person deciding to initiate the call at the time the call is made.
- d) Reasonable steps are taken to determine that the medical services required by the patient could not be provided (due to issues of competence or availability) by a physician who has ongoing responsibility for the care of the patient (either directly or by virtue of his/her call group), by a physician who is on-call, or by a physician who is being paid to be on site, on shift, or otherwise available.
- e) The physician being called personally attends the patient at the site contemplated by Part A3(b) above within the time dictated by the patient's needs but in any event no later than within 3 hours of being called.

4. Administrative Criteria

All of the following administrative rules are complied with:

- a) Only one \$250 payment is available per call back, regardless of the number of patients seen.
- b) Only one \$250 payment is available per patient per physician (i.e. for each episode of illness/injury).
- c) Within 30 days of the call back, an invoice in the form attached must be submitted to the Health Authority by the physician claiming the call back payment.
- d) Within 30 days of the call back, a verification, in the form attached must be submitted to the Health Authority by the person who made the decision to initiate the call back (that is the person referred to in Part A1 above).

Part B: Designation

1. Each Health Authority may designate physicians and/or services for call back payments.

2. The Health Authorities may designate individual physicians by name, groups of individual physicians by name, or practice categories/services without naming specific physicians (in which case any physician who is a member of the medical staff of the facility in issue with the privileges and qualifications required to provide the services and who meets all other terms of the designation will be deemed to be designated).
3. The Health Authorities may specify additional terms as being applicable to any designation so long as such additional terms are not inconsistent with these Criteria. Permissible additional terms include, but are not limited to:
 - a) Specific sites;
 - b) Specific services;
 - c) Specific times (e.g. hours in a day, days in a week);
 - d) Maximum dollar amounts for call back payments in a given time period (e.g. monthly, annually); and
 - e) Maximum number of call backs in a given time period (e.g. monthly, annually).
4. If the designation is in respect of a specific physician or group of specific physicians, then each such physician or group, respectively, will be provided with a standardized Call Back Designation Letter that expresses the names of the physicians that are the subject of the designation, expresses all additional terms applicable to the designation, and encloses a copy of these Criteria and a copy of the form of invoice to be used to submit claims for payment, and in the event the designation is cancelled or altered will be provided with a letter advising of same.

Part C: Approving Payments on an Exception Basis

1. Approval for call back payment on an exception basis may be sought for specific call backs by physicians who are not designated in accordance with Part B above and by physicians who are designated in accordance with Part B above but in circumstances where all terms applicable to the designation have not been met (e.g. the call back was to a non-designated site, for non-designated services, and/or at a non-designated time of day; or if paid, the maximum dollar amount would be exceeded and/or the maximum number of call backs would be exceeded).
2. To seek approval on an exception basis, a physician must submit an invoice in accordance with Part A4(c) above which clearly and expressly indicates that payment is sought on an exception basis.
3. Each Health Authority will specify an individual by name or position/title with authority to approve call back payments on an exception basis.
4. The individual specified in accordance with Part C3 above will approve exceptional claims for payment if all criteria for call back payment eligibility as set out in Part A above (except that set out in Part A2(a)) have been met.

Part D: Appeal of Denied Call Back Claims

1. In the event that a physician's claim for call back payment is denied the physician may, within 30 days of being advised by the Health Authority of the denial of the claim, request the BCMA to initiate a Call Back Dispute on his/her behalf. If the BCMA agrees to do so, the BCMA must provide notice of same to the applicable Health Authority and to the Joint Agreement Administration Group within 30 days of being requested by the physician to initiate a Call Back Dispute. The notice must be in writing and must include the facts upon which the physician relies including a copy of the invoice submitted in association with the claim as required by Part A4(c) above but with the name(s) and personal health number(s) of the patient(s) expunged, the identification of the ground upon which the Call Back Dispute is advanced, an outline of argument supporting the physician position, and a written consent to release information signed by the physician, in the form attached.
2. Upon receipt by the Ministry of Health Services of a consent to release information in the form attached, the Ministry will forward to the Joint Agreement Administration Group and to the applicable Health Authority a list of the information that the Ministry proposes to release. After providing the applicable Health Authority and the physician with the opportunity to comment on the list, the Joint Agreement Administration Group will request the Ministry to release some or all of the information on the list. The Ministry will then release the information as requested by the Joint Agreement Administration Group.
3. The only ground upon which a Call Back Dispute may be advanced is that all the criteria for call back payment eligibility as set out in Part A above have been met (except where the Call Back Dispute relates to a physician not designated in accordance with Part B above or a claim that does not fall within the terms of such a designation, in which case the only ground upon which such a Call Back Dispute may be advanced is that all the criteria for call back payment eligibility as set out in Part A above, except that in Part A2(a), have been met).
4. The Joint Agreement Administration Group will consider each Call Back Dispute referred to it and, after providing the physician and the applicable Health Authority with the opportunity to be heard, may decide the merits of the Call Back Dispute, following any further process stipulated by it, by consensus decision (as that term is defined in section 1.2 of the Physician Master Agreement), in which case the decision of the Joint Agreement Administration Group will be final and binding on the physician and the Health Authority.
5. In the event that the Joint Agreement Administration Group is unable to reach a consensus decision with respect to the resolution of any Call Back Dispute within 60 days of receipt of the associated notice, or any longer period agreed to by the Joint Agreement Administration Group, the BCMA or the Government may, within a further 30 days, refer the Call Back Dispute to Rod Germaine or any other person agreed to by the BCMA and the Government (the "Call Back Adjudicator")
6. Where, within the time limits in Part D5 above, the Joint Agreement Administration Group has not reached a consensus decision with respect to the resolution of any Call Back Dispute and the Call Back Dispute is not referred to the Call Back Adjudicator, then there will be no further

process under these Criteria or otherwise for the physician to advance his/her claim for call back payment, and the Health Authority's denial of such claim will be final and binding on the physician.

7. Where a Call Back Dispute is referred to the Call Back Adjudicator pursuant to Part D5, the Call Back Adjudicator will determine whether the criteria set out in Part A above have been met, following any further process stipulated by him/her. If the Call Back Adjudicator determines that the criteria set out in Part A have not been met then he/she will render a final and binding award confirming the Health Authority's denial of the claim for call back payment. If the Call Back Adjudicator determines that the criteria set out in Part A have been met then he/she will render a final and binding award allowing the claim for call back payment following which the applicable Health Authority will make the payment.

8. The Government and the BCMA will share the costs associated with the referral of Call Back Disputes to the Call Back Adjudicator.

Call Back Invoice

Name of physician making the claim: _____

Name of Health Authority: _____

MSP Billing # of physician making the claim: _____

Physician has been designated by the Health Authority for call back payments:

Yes No

If Yes, name of designated group/category: _____

Personal information on this form is collected under the *Freedom of Information and Protection of Privacy Act*. The information submitted will be used to assess this claim. All information provided will be used in a manner that complies with the terms of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, use, or disclosure of this information, please contact Physician Human Resources Management at 250 952-3146.

If No, or if any of the call backs on this invoice do not fall with in the terms of the designation, indicate, in the last column below, that approval is sought for payment on an exception basis.

Date & time call back received	Name of person initiating call back	Date & time physician physically attended the patient	Name of Patient	PHN # of Patient	Facility where patient was attended	Indicate with a \checkmark if approval is sought on exception basis

With respect to each of the above noted call backs:

1. The patient was not my patient or the patient of a colleague for whose patients I had accepted responsibility; and
2. At the time of the call back I was not on site at the Facility noted in the sixth column above, or scheduled to be on site, or scheduled to be next on site at a time when the patient's needs could be adequately met; nor was I on call or being paid to be on site, on shift or otherwise available.

I am not receiving Isolation Allowance Fund payments and was not receiving such payments at the time of any of the call backs above noted.

I authorize the Ministry of Health Services to release to the Health Authority named above any information related to the claims reflected on this invoice, excluding patient personal information (i.e. the name and personal health number of the patient), that, in the reasonable opinion of the Ministry, is relevant to assessing this claim, and if necessary, resolving any dispute over this claim through arbitration or otherwise. Such information will include, but not be limited to compensation/billing information (excluding patient personal information).

I certify all the information on this form to be correct.

Date

Physician Signature

Call Back Verification Form

Name of person initiating call back: _____

Name of Health Authority: _____

Title of person initiating call back: _____

Date & time call back was initiated	Name of physician who was called back	Indicate with a ✓ if the physician was designated for this call back	Name of patient	PHN # of Patient	Facility where patient was attended	Symptoms indicating emergency care was required	Associated Call Back Invoice Number (this column to be filled in by the Health Authority)

With respect to each of the above noted call backs:

- 3. I assessed the patient as requiring medical services on an emergency basis; and
- 4. Reasonable steps were taken to determine that the emergency medical services required by the patient could not have been provided (due to issues of competence or availability) by a physician who had on-going responsibility for the care of the patient (either directly or by virtue of his or her call group); by a physician who was on-call or by a physician who was being paid to be on site, on shift or otherwise available.

I certify all the information on this form to be correct.

_____ Date

_____ Signature of person initiating call back

Consent to Release Information
In Relation to a Call Back Dispute

Personal information on this form is collected under the Freedom of Information and Protection of Privacy Act. The information submitted will be used to assess this claim. All information provided will be used in a manner that complies with the terms of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, use, or disclosure of this information, please contact Physician Human Resources Management at 250 952-1849.

To: The Ministry of Health Services

Attention: Hlth.MOCAPCallBack@gov.bc.ca

From: Dr. _____ [name of physician initiating a Call Back Dispute]

I have requested the BCMA to initiate a Call Back Dispute on my behalf. The BCMA has agreed to do so. A copy of the associated notice to the _____ Health Authority and the Joint Agreement Administration Group (the “JAAG”) is attached.

I authorize the Ministry of Health Services to disclose to the _____ Health Authority, the JAAG and/or to any arbitrator any of my information, including but not limited to compensation/billing information but excluding patient personal information (i.e. name or personal health number of the patient) which, in the reasonable opinion of the Ministry, is relevant to resolving the Call Back Dispute.

Date: _____

Signature of Claiming Physician

APPENDIX H

PHYSICIAN INFORMATION TECHNOLOGY OFFICE

ARTICLE 1 – INTERPRETATION

1.1 Definitions

In this Appendix the following words and expressions have the following meanings:

- (a) “**ASP**” or “**Application Service Provider**” means a securely managed non-government and accredited third party application software hosting service connected to a secure British Columbia physician network, in which individual practices have a secure, private and separate database or virtual database for their data;
- (b) “**EMR**” means a standardized system of electronic medical records as further defined by section 3.3 of this Appendix.
- (c) “**Existing PITO Programs and Services**” means the programs and services maintained by the PITO as they existed on March 31, 2012 and consisting of the:
 - Implementation & Transition Support Program,
 - Technical Support Program and Service Desk,
 - Peer-2-Peer Program,
 - Post Implementation Support Program (prototypes) and Field Resources,
 - Physician Reimbursement Program, and
 - Special Projects (EMR-2-EMR Data Transfer Specification, Program Evaluation, and Joint PITO-PSP projects).
- (d) “**2012 Physician Master Agreement**” means the agreement titled “2012 Physician Master Agreement” and entered into as of April 1, 2012, among the Government, the MSC and the BCMA.
- (e) “**PITO Program Director**” has the meaning given in section 2.3 of this Appendix.
- (f) “**PITO Steering Committee**” has the meaning given in section 2.2 of this Appendix.
- (g) “**Remaining PITO Funding**” has the meaning given in section 2.4(a) of this Appendix.
- (h) “**Term**” has the meaning given in section 2.1 of this Appendix.

ARTICLE 2 - FORMATION AND STRUCTURE OF PITO

2.1 Continuation of PITO

The PITO shall continue to operate as described in Article 18 of the 2012 Physician Master Agreement and this Appendix during the term commencing on April 1, 2012 and ending on March 31, 2014 (the “**Term**”).

2.2 PITO Steering Committee

- (a) Management of the business and affairs of the PITO shall be governed by a steering committee (the “**PITO Steering Committee**”) comprised of six members, three of whom shall be appointed by the Government, and three of whom shall be practising physicians appointed by the BCMA. The PITO Steering Committee may add additional non-voting members and additional structures as it deems appropriate to assist it in aligning its work with that of the General Practice Services Committee, the Specialist Services Committee and the Shared Care Committee. The PITO Steering Committee shall be responsible for the carrying out of the mandate of the PITO as provided in this Appendix. The PITO Steering Committee shall act by consensus decision. If the PITO Steering Committee cannot reach a consensus decision on any matter requiring a decision by it, the matter shall be referred to the MSC, or its successor, which shall determine the matter.
- (b) The PITO Steering Committee must follow any communication protocol developed by the Physician Services Committee, and in any event must ensure that the co-chairs of the PITO Steering Committee pre-approve any communication about the business and/or decisions of the PITO Steering Committee.

2.3 PITO Program Director

The business and affairs of the PITO shall continue to be managed by a program director (the “**PITO Program Director**”) who will report to the PITO Steering Committee. The PITO Program Director shall be jointly selected by the BCMA and the Government. The responsibilities of the PITO Program Director shall include:

- (a) overseeing the office for the PITO in Vancouver, British Columbia, and hiring staff, within budgets established by the PITO Steering Committee in accordance with sections 2.5 and 3.5;
- (b) providing progress reports on the work of the PITO to the PITO Steering Committee, and the BCMA Board of Directors;
- (c) providing monthly expenditure reporting and forecasting to the BCMA and the Government against the annual program budget established pursuant to section 3.5; and

- (d) carrying out the purpose of the PITO and other duties as may be assigned by the PITO Steering Committee.

2.4 PITO Funding

- (a) As at April 1, 2012, approximately \$53.5 million (consisting of \$6.123 million held by the Government and approximately \$47.5 million held by the BCMA) remains unexpended from funding provided for PITO pursuant to the 2007 Physician Master Agreement (the “**Remaining PITO Funding**”). The actual amount of Remaining PITO Funding held by the BCMA will be determined by the PITO Steering Committee by September 30, 2012.
- (b) The PITO will be funded from the Remaining PITO Funding, provided however that if the Remaining PITO Funding is insufficient for this purpose, the Government will provide the additional funding that is required to fund the Existing PITO Programs and Services until March 31, 2014.

2.5 PITO Administrative Budgets

For each Fiscal Year of the Term the PITO Steering Committee shall establish a budget for the administrative costs of the PITO, which shall be paid out of the Remaining PITO Funding. The administrative costs of the PITO for the purposes of such budget shall include:

- (a) office costs;
- (b) PITO Program Director and administrative staff salaries, benefits and expenses;
- (c) costs of BCMA physician appointees’ participation (other than employees of the BCMA) on the PITO Steering Committee and the e-Health Strategy Council; and
- (d) costs of administrative and clerical support required for the work of the PITO Steering Committee.

If the PITO Steering Committee cannot reach a consensus decision on the budget for administrative costs for any Fiscal Year of the Term, the matter shall be referred to the MSC, or its successor, which shall determine the matter.

ARTICLE 3 – PURPOSE AND ACTIVITIES OF PITO

3.1 Purpose

The Government and the BCMA agree that the purpose and role of the PITO is to continue to offer the Existing PITO Programs and Services, and in doing so:

- (a) to promote the use by physicians in British Columbia of an EMR as their principal method of record keeping for patient/clinical records in their offices;

- (b) to maintain a program to advise, assist and support physicians in connection with such physicians subscribing to and effectively adopting an EMR as their principal method of record keeping for patient/clinical records;
- (c) to maintain the current focus and organizational capacity on matters related to the general functionality of EMRs and related technology as pertains to physician offices;
- (d) to facilitate the adoption by physicians of an EMR and other information technology solutions for their practices by supporting interested physicians in expanding their use of information technology and providing technical support and advice to physicians with respect to:
 - (i) information technology training services and information technology change management services, for physicians and their staff;
 - (ii) the purchase by physicians of suitable hardware and software packages;
 - (iii) the implementation of secure, high speed network and email service for their offices;
 - (iv) access by physicians to approved EMR applications with built in chronic disease management functionality, including licensing and maintenance; and
 - (v) access by physicians to e-prescribing of pharmaceuticals and to lab test results, if and when these services become available;
- (e) to consult with other jurisdictions on approaches to expanding the use of information technology by physicians;
- (f) to facilitate the sharing of best practices and experiences among physicians and physician groups;
- (g) to facilitate the development of change management strategies and educational strategies to assist physicians in adopting the EMR and other information technology solutions in their practices;
- (h) to adapt Existing PITO Programs and Services as necessary in order to more effectively achieve PITO purposes, provided this can be done within the Remaining PITO Funding and without increasing the Government's exposure to provide additional funding pursuant to section 2.4(b) of this Appendix; and
- (i) to participate in regular evaluation of the effectiveness of the PITO and the adoption by physicians of the EMR and other information technology solutions, such evaluations to be:

- (i) prepared jointly by the Ministry, the BCMA and the Health Authorities; and
- (ii) provided by PITO to the PITO Steering Committee and the BCMA Board of Directors when completed.

3.2 Product Packages for the EMR

- (a) The PITO will continue to work with third party suppliers to make available packages of hardware, software and other products and services (including high speed network and email services) that will facilitate the adoption by physicians of an EMR as their principal method of record keeping for patient/clinical records, and to make such packages (as they may exist or be altered from time to time) available to physicians on a standing offer basis. Physicians will then be free to choose their EMR solution from those standing offers.
- (b) PITO will continue to provide market update information on third party suppliers to physicians who are contemplating implementing or changing an existing EMR.

3.3 EMR Products

The EMR products referred to in section 3.2 must:

- (a) be hosted on an ASP basis, or such basis as approved by the PITO Steering Committee;
- (b) allow the entry of discrete patient data including demographics, medical problems, medications, allergies/alerts, immunizations, family/medical surgical history and observations;
- (c) provide a high degree of functionality to support practise management and quality improvement;
- (d) enable the exchange of discrete patient data as described in section 3.3 (b) using BC EMR-2-EMR Data Transfer Specification, or similar provincial standards, to support the continuity of care and the aggregation of de-identified data for population health analysis;
- (e) support a high level of integration into regional and provincial systems as interfaces to these systems are developed; and
- (f) meet provincial standards for EMR products.

3.4 Custody and Access to EMR Information

The principal responsibility for custodianship of the EMR data of a physician shall reside with the physician, in compliance with all applicable freedom of information and privacy legislation and any other relevant legislation.

3.5 Program and Budget for Implementation of PITO Purposes

During the Term, the PITO Steering Committee shall develop a program, strategy and timetable for delivery of the purpose described in section 3.1, and for each Fiscal Year of the Term the PITO Steering Committee shall establish a budget therefore within the funding described at section 2.4 of this Appendix H. If the PITO Steering Committee cannot reach a consensus decision on such a budget for any Fiscal Year of the Term, the matter shall be referred to the MSC, or its successor, which shall determine the matter.

3.6 Voluntary Implementation of the EMR by Physicians

Physicians shall adopt an EMR as their principal method of record keeping for patient/clinical records on a voluntary basis.

3.7 Financial Assistance to Physicians Adopting the EMR

As part of the program for implementation of an EMR by physicians in British Columbia, the PITO Steering Committee shall continue to provide a program and policies for providing financial assistance to physicians adopting and using an EMR as their principal method of record keeping for patient/clinical records, within the budgets determined pursuant to section 3.5. This includes reimbursement for approximately 70% of the cost paid by physicians for product packages made available to them pursuant to section 3.2 and other costs as determined by the PITO Steering Committee.

ARTICLE 4 – ROLE OF MINISTRY OF HEALTH

4.1 Responsibilities of Ministry

(a) The Ministry of Health recognizes that the EMR will continue to play a critical role in the integrated delivery of quality medical services during the term of the Physician Master Agreement and will maintain responsibility for:

- (i) health sector information management, technology and standards; and
- (ii) the determination of the requirements, architecture and strategy required for delivering provincial e-Referrals and patient portal solutions.

(b) The Ministry of Health will maintain existing and new PITO registration agreements between physicians and the Ministry until March 31, 2014.

APPENDIX I

MEMBERS OF THE ROSTER (AS OF APRIL 1, 2012)

Rod Germaine

Stan Lanyon

Robin McFee

APPENDIX J

LABORATORY MEDICINE FEE AGREEMENT

THIS AGREEMENT made as of the 1st day of April, 2012,

BETWEEN:

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF
BRITISH COLUMBIA**, as represented by the Minister of Health

(the “Government”)

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION

(the “BCMA”)

WITNESSES THAT WHEREAS:

- A. The Government and the BCMA wish to provide stability and structured improvement in the British Columbia laboratory system; and
- B. The Government and the BCMA have agreed to continue with a process to manage laboratory expenditures until March 31, 2014 as contemplated by this Agreement.

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

ARTICLE 1 – INTERPRETATION

- 1.1 **“this Agreement”** means this document, including the Schedules.
- 1.2 **“CUSIC”** has the meaning given in section 4.1 of this Agreement.
- 1.3 **“Expenditure Targets”** has the meaning given in section 3.1 of this Agreement.
- 1.4 **“Fiscal Year”** means the 12 month period commencing on April 1 of a calendar year and ending on March 31 of the following calendar year.

1.5 “**Laboratory Medicine Out-Patient Fee Items**” means the fee items in the Medical Services Commission Payment Schedule billed for laboratory medicine services and provided on an out-patient basis but excluding fee items for:

- (a) ECG, Nuclear Medicine, consultations and visits (as of the date of this Agreement, fee codes 94005, 94006, 94007, 94008, 94009, 94010, 94012), and telephone consultations (as of the date of this Agreement, fee codes 94070, 94072, 94076, 94077 and 94078), and
- (b) laboratory medicine services performed and billed by physicians in their office (as of the date of this Agreement, fee codes 00012, 30015, and 15000 to 15143).

1.6 “**Schedule 1 Fee Items**” means the Laboratory Medicine Out-Patient Fee Items listed at Schedule 1 to this Agreement.

1.7 “**Term**” has the meaning given in section 2.1 of this Agreement.

ARTICLE 2 – TERM AND EFFECT

2.1 This Agreement will be in effect for the period from April 1, 2012 to March 31, 2014 (the “Term”).

2.2 Upon execution of this Agreement, the agreement between the BCMA and the Government titled “Second Renewed Laboratory Medicine Agreement between the British Columbia Medical Association and the Government of British Columbia” made as of the 12th day of October, 2010 (as continued by subsequent agreement of the BCMA and the Government) shall terminate and be of no further force or effect.

ARTICLE 3 - EXPENDITURE TARGETS AND VOLUME DISCOUNT MECHANISM

3.1 The Government and the BCMA agree to the following annual targets for expenditures on Laboratory Medicine Out-Patient Fee Items referred by medical practitioners (the “**Expenditure Targets**”):

- (a) \$324.2 million for the Fiscal Year 2012/2013; and
- (b) \$328.3 million for the Fiscal Year 2013/2014.

3.2 Claims made by medical practitioners for Laboratory Medicine Out-Patient Fee Items that go beyond the Expenditure Targets will continue to be paid, subject to the specific provisions contained in this Agreement.

3.3 In order to meet the Expenditure Targets, the fees for the Schedule 1 Fee Items will be subject to volume discounting as contemplated by this Agreement. The fees for Laboratory Medicine Out-Patient Fee Items which are not listed in Schedule 1 will be paid at 100% of the Payment Schedule rate regardless of volume.

3.4 Subject to sections 3.5, 3.6 and 3.7 of this Agreement, the fees for the Schedule 1 Fee Items will be subject to annual volume discounting, which will be applied as follows:

- (a) in the Fiscal Year 2012/2013, for the first two quarters of the Fiscal Year (April 1, 2012 to September 31, 2012, inclusive), 97% of the 2006/07 volumes of Schedule 1 Fee Items will be paid at 100% with volumes greater than 97% discounted by 50%;
- (b) in the Fiscal Year 2012/2013, for the second two quarters of the Fiscal Year (October 1, 2012 to March 31, 2013, inclusive) 81 % of the 2006/07 volumes of Schedule 1 Fee Items will be paid at 100% with volumes greater than 81% discounted by 50%;
- (c) in the Fiscal Year 2013/2014, 64% of the 2011/12 volumes of Schedule 1 Fee Items will be paid at 100% with volumes greater than 64% discounted by 50%.

3.5 Prior to November 30, 2012, the parties will assess the expenditures on Laboratory Medicine Out-Patient Fee Items referred by medical practitioners to date for the Fiscal Year 2012/2013 and if it is projected that the Expenditure Target in section 3.1(a) of this Agreement will be exceeded, the fees for the Schedule 1 Fee Items will be discounted beyond the discounts reflected in section 3.4(b) of this Agreement for the balance of the Fiscal Year 2012/2013 as required to meet the Expenditure Target in section 3.1(a) of this Agreement.

3.6 Prior to November 30, 2013, the parties will assess the expenditures on Laboratory Medicine Out-Patient Fee Items referred by medical practitioners to date for the Fiscal Year 2013/2014 and if it is projected that the Expenditure Target in section 3.1(b) of this Agreement will be exceeded, the fees for the Schedule 1 Fee Items will be discounted beyond the discounts reflected in section 3.4(c) of this Agreement for the balance of the Fiscal Year 2013/2014 as required to meet the Expenditure Target in section 3.1(b) of this Agreement.

3.7 In the event that actual annual expenditures on Laboratory Medicine Out-Patient Fee Items referred by medical practitioners deviate by a margin of greater than +/- 1% of the Expenditure Targets, and subject to sections 3.10 and 3.11 of this Agreement, the parties will take corrective action.

3.8 The volume discounts contemplated by this Agreement will be applied at the individual laboratory provider level for private laboratories and at the Health Authority level for public laboratories.

3.9 For greater certainty, the volume discounts contemplated by this Agreement will apply to all Schedule 1 Fee Items referred by medical practitioners and other health care practitioners.

3.10 Considerable increases in the volume of Laboratory Medicine Out-Patient Fee Items being billed as a result of one-off epidemics or as a result of new strategies approved by the Government in the interests of improved patient care will result in corresponding increases to the Expenditure Targets.

3.11 Transfers from the portion of the Available Amount (as defined in the 2012 Physician Master Agreement) related to laboratory medicine to a Health Authority budget will result in corresponding decreases to the Expenditure Targets. Funds may only be transferred for selective laboratory services and by agreement of the parties.

3.12 The volume discounts contemplated in this Agreement will be implemented on a go forward basis. For greater clarity, there will be no related retroactive payments or adjustments.

3.13 During the Term, all new Laboratory Medicine Out-Patient Fee Items approved by the Medical Services Commission will be funded within the Expenditure Targets.

ARTICLE 4 – COLLABORATIVE UTILIZATION AND SYSTEM IMPROVEMENT COMMITTEE

4.1 The Collaborative Utilization and System Improvement Committee shall continue to facilitate collaboration between the Government and the BCMA on the delivery of laboratory services in British Columbia (the “CUSIC”).

4.2 The CUSIC shall continue to be composed of five members appointed by the BCMA and five members appointed by the Government and will be co-chaired by a member chosen from the BCMA from amongst its members and a member chosen from the Government from amongst its members.

4.3 The CUSIC will meet a minimum of four times per year.

4.4 Decisions of the CUSIC shall be by consensus decision as that term is defined in the 2012 Physician Master Agreement.

4.5 The Government shall provide secretariat support to the CUSIC. The costs for physician (other than employees of the Government, BCMA and Health Authorities) participation on the CUSIC shall be covered by the Government, such costs not to exceed \$30,000 thousand annually.

4.6 The role and tasks of CUSIC shall include, amongst other things, the following:

- (a) monitor and report on utilization of clinical laboratory services;
- (b) develop utilization measures for recommendation to the Government and the BCMA;
- (c) monitor implementation of this Agreement;
- (d) investigate and advise on initiatives that may optimize the efficiency of various aspects of laboratory medicine;
- (e) liaise with the General Practice Services Committee and the Specialist Services Committee;
- (f) make recommendations to the parties on a simplified approach to meeting the MSC requirements for requisition standards, within the Term;
- (g) liaise on Clinical Care Management activities, including the Guidelines and Protocols Advisory Committee, in order to understand the cost impact to laboratories as a result of new guidelines and protocols prior to their implementation; and

(h) any other matter which the members of the CUSIC agree upon.

ARTICLE 5 – PHYSICIAN COMPENSATION

5.1 The Government and the BCMA agree that the terms of this Agreement are not intended and cannot be used as a vehicle to affect pathologist contracts with Health Authorities or their affiliates in a way that would reduce laboratory medicine physician compensation. Specifically, the volume discounts contemplated by this Appendix will not be applied to the remuneration of hospital based laboratory medicine physicians whose compensation mechanism includes a fixed percentage of the Medical Services Plan fees.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2012.

SIGNED, SEALED & DELIVERED on)
behalf of HER MAJESTY THE QUEEN)
IN RIGHT OF THE PROVINCE OF)
BRITISH COLUMBIA, by the Minister)
of Health or his/her duly authorized)
representative, in the presence of:)
_____)

Signature of Witness)

Name)

Address)

THE CORPORATE SEAL of the)
BRITISH COLUMBIA MEDICAL)
ASSOCIATION was hereunto affixed in)
the presence of:)
_____)

C/S

Signature of Authorized Signatory)

Name)

Position)

Schedule 1

Fee Items Subject to Volume Discounting April 1, 2012 to March 31, 2014

Fee Code	Description
90205	Hematology profile
90315	Latex test (Rheumatoid factor)
90370	Thromboplastin test, partial
90440	Prothrombin time / INR
90490	Reticulocyte and Heinz bodies
90651	Chlamydia trachomatis using NAT - urine
90652	Chlamydia trachomatis using NAT - urogenital swab
90700	Hepatitis B surface antibody (anti-HBs)
90710	Prostatic specific antigen (PSA)
91000	Primary base fee
91040	Albumin, serum/plasma
91065	Alanine aminotransferase
91070	Alkaline phosphatase
91095	Alpha fetoprotein
91126	Amylase, serum/plasma
91210	Aspartate aminotransferase
91235	Bicarbonate, serum/plasma
91245	Bilirubin total, serum/plasma
91300	C - Reactive Protein
91326	Calcium Total, serum/plasma
91366	Chloride, serum/plasma
91375	Cholesterol, total
91415	Creatine kinase
91421	Creatinine, serum/plasma
91610	Estradiol
91645	Ferritin, serum
91660	Follicle stimulating hormone (FSH)
91707	Glucose, quantitative serum/plasma
91725	Glutamyl transpeptidase (GTP)
91745	Haemoglobin, A1C
91765	Hepatitis B surface antigen
91780	HDL Cholesterol
91865	Iron, total and binding capacity, protein
91901	Lactate Dehydrogenase, serum/plasma
91950	Luteinizing hormone (LH)
91957	Magnesium, serum/plasma
92030	Parathyroid hormone (intact)
92071	Phosphates, serum/plasma

92100	Potassium, serum/plasma
92135	Prolactin
92148	Protein total, serum or plasma
92160	Quantitative beta Hcg
92165	Quantitative Hcg (intact)
92231	Sodium, serum/plasma
92311	T3 - free
92325	Thyroid stimulating hormone, TSH
92330	Free T4
92350	Triglycerides, serum/plasma
92355	Troponin
92368	Urea, serum/plasma
92376	Uric acid, serum/plasma
92450	Vitamin B12
90690	Hepatitis B core antibody (anti-HBc)
91310	CA 125
91985	Micro albumin
92130	Progesterone, serum/plasma