

## **2014 PHYSICIAN MASTER AGREEMENT**

**THIS AGREEMENT** made as of the 1<sup>st</sup> day of April, 2014,

**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 “Doctors of BC”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “MSC”)

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## **2014 PHYSICIAN MASTER AGREEMENT**

**THIS AGREEMENT** made as of the 1<sup>st</sup> day of April, 2014,

**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 “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

**WITNESSES THAT WHEREAS:**

- A. The Doctors of BC, the MSC and the Government were parties to the 2012 PMA, the 2012 General Practitioners Subsidiary Agreement, the 2012 Specialists Subsidiary Agreement, the 2012 Rural Practice Subsidiary Agreement, the 2012 Alternative Payments Subsidiary Agreement, and the 2012 Benefits Subsidiary Agreement;
- B. The parties have agreed to renew and replace the 2012 PMA, the 2012 General Practitioners Subsidiary Agreement, the 2012 Specialists Subsidiary Agreement, the 2012 Rural Practice Subsidiary Agreement, the 2012 Alternative Payments Subsidiary Agreement, and the 2012 Benefits Subsidiary Agreement on the terms set out in this Agreement;
- C. The parties have agreed that this agreement will constitute the 2014 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 Doctors of BC'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 “2014 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.

**“Adjudicator”** 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.

**“Allocation Committee”** means the committee referred to in section 5.1 of the Alternative Payments Subsidiary Agreement.

**“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 “2014 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 “2014 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.



**“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.

**“CMPA Fee Schedule”** means the Canadian Medical Protective Association (CMPA) membership fees applicable to British Columbia physicians as determined by the CMPA.

**“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 or a Local 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.

**“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 Physician (non-FRCP) with a Focused Practice”** are those General Practitioners with a commitment to one or more specific clinical areas as major part-time or full-time components of their practices.

**“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 “2014 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 Doctors of BC Guide to Fees as published by the Doctors of BC 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 Clinical Committee Administrative Agreement”** means the agreement titled “Joint Clinical Committee Administrative Agreement” between the Government and the Doctors of BC dated April 1, 2014.

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

**“Limited Renegotiation Notice”** has the meaning given in section 26.1.

**“Local Contract”** means:

- (a) a Salary Agreement, Service Contract, Sessional Contract, a MOCAP Contract and any other contract that the Government and Doctors of BC 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:

- (a) where there is no mechanism in the Local Contract to resolve the dispute; or
- (b) where the Local Contract mandates the use of any of the dispute resolution procedures in this Agreement to resolve the dispute; or

- (c) 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 12.10 of the Alternative Payments Subsidiary Agreement.

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

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

**“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 Doctors of BC Board as a section pursuant to Bylaw 4 of the Constitution and By-Laws of the Doctors of BC.

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

**“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 Doctors of BC regarding the interpretation, application, operation or alleged breach of this Agreement and/or any of the Physician Master Subsidiary Agreements.

**“Provincial MOCAP Review Committee”** has the meaning given in section 17.4.

**“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.

**“Roster”** has the meaning given in section 21.1.

**“Rural Practice Subsidiary Agreement”** means the agreement titled “2014 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 8.5.

**“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 “2014 Specialists Subsidiary Agreement” entered into by the parties pursuant to section 2.5, as amended from time to time.

**“Tariff Committee”** means the Doctors of BC Economics Committee as described in the Constitution and By-Laws of the Doctors of BC 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.

**“2012 Alternative Payments Subsidiary Agreement”** means the agreement titled “Alternative Payments Subsidiary Agreement” made as of April 1, 2012, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2012 Benefits Subsidiary Agreement”** means the agreement titled “Benefits Subsidiary Agreement” made as of April 1, 2012, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2012 General Practitioners Subsidiary Agreement”** means the agreement titled “General Practitioners Subsidiary Agreement” made as of April 1, 2012, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2012 PMA”** means the agreement titled “Physician Master Agreement” made as of April 1, 2012, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2012 Rural Practice Subsidiary Agreement”** means the agreement titled “Rural Practice Subsidiary Agreement” made as of April 1, 2012, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2012 Specialists Subsidiary Agreement”** means the agreement titled “Specialists Subsidiary Agreement” made as of April 1, 2012, among the Government, the Doctors of BC and the MSC, as subsequently amended.

**“2014 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 December 31, 2014, 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, 2014.

## **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 2012 PMA;
- (b) the 2012 Alternative Payments Subsidiary Agreement;
- (c) the 2012 Benefits Subsidiary Agreement;
- (d) the 2012 General Practitioners Subsidiary Agreement;
- (e) the 2012 Rural Practice Subsidiary Agreement; and
- (f) the 2012 Specialists Subsidiary Agreement.

## **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 Doctors of BC Representation of Physicians**

- (a) The Government hereby grants to the Doctors of BC the sole and exclusive right, and the Doctors of BC 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 Doctors of BC, and to negotiate in good faith when establishing Local Contracts.
- (c) The Government further undertakes that it will require Agencies to recognize the Doctors of BC's right to represent those physicians who request the assistance of the Doctors of BC in negotiating contractual arrangements with those Agencies.
- (d) The Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC:
  - (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 Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC, or such greater, equal number of members as agreed to by the parties and will also include the Chair of the Medical Services Commission as a non-voting member. The members appointed by the Government will consist of at least one Senior Executive from the Ministry of Health (Assistant Deputy Minister of Health or above) and at least one Senior Executive from a Health Authority (Vice-President or above). The members appointed by the Doctors of BC will include the Chief Executive Officer of the Doctors of BC.
- (c) The Government and the Doctors of BC 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, the Medical Services Commission and the Doctors of BC 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 Doctors of BC and the implementation and administration of this Agreement and the Physician Master Subsidiary Agreements, will, among other things:

- (a) provide direction to, and monitor the activities of, the other joint committees of the Government and the Doctors of BC 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 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 February 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 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 Strategic Plans of both the Ministry of Health and the Doctors of BC will be discussed and the possible initiatives being considered by the committee in question for the next three Fiscal Years will be identified by the co-chairs of the relevant committee, all in the context of the mandate established for the committee in question in this Agreement and/or in a Physician Master Subsidiary Agreement. After such discussion, the Physician Services Committee will provide the co-chairs with direction on the content of the written plan referenced in (ii) below which will inform priority initiatives to be addressed by the committee in the upcoming Fiscal Year, including direction on the committee's budget for the Fiscal Year;

- (ii) following the meeting referred to in section 6.3(a)(i), and before March 1 of the same year, the committee in question shall submit to the Physician Services Committee a detailed written plan including a proposed budget by program and initiative and an administrative budget by program and initiative (which, for those committees covered by the Joint Clinical Committee Administration Agreement will be the budget for Administrative Costs approved under Article 5 of that Agreement) outlining the committee's intentions to address the initiatives within its mandate to be undertaken by the committee during the Fiscal Year commencing on April 1 of the same year. The written plan will account for the distribution of all funds which have been allocated to the committee in question, both ongoing funds and funding available for one-time allocations;
- (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 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 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, unless agreed otherwise by the Government and Doctors of BC, either the Government or the Doctors of BC 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, unless agreed otherwise by the Government and Doctors of

BC either the Government or the Doctors of BC 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, including directions from the Physician Services Committee on dealing with such variances;
  - (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 a minimum of two (2) weeks of advance written notice of its intentions and the Physician Services Committee may provide direction to the committee in question on the proposed reallocation; and
  - (viii) by June 30 of each year, each committee specifically named in section 6.3(a)(i) will provide the Physician Services Committee with a report for the previous Fiscal Year on the degree to which the committee achieved the expectations outlined in the approved written plan and how funding was utilized by program and initiatives in comparison to the approved budget. The Physician Services Committee may provide direction on that report to the committees.
- (b) approve any proposal to reallocate funding between any of the joint committees of the Government and the Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC and the Health Authorities;
- (j) engage in any other functions that the Government and Doctors of BC 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 Doctors of BC, 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 Doctors of BC 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 Physician Services Committee will meet within one month following the signing of this Agreement, at which time the Physician Services Committee will determine its annual meeting schedule and advise the Joint Clinical Committee co-chairs of this schedule.
- (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 Doctors of BC 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 Doctors of BC.

- (c) The Hybrid Working Group will, on matters where all members of the Hybrid Working Group agree, submit a written report and recommendations to the Physician Services Committee by a date to be determined. 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 2014 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 Doctors of BC. 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 Doctors of BC will be staff members of the Doctors of BC.

- (c) The Government and the Doctors of BC 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 Doctors of BC 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; and
- (c) 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 the use of quality improvement methodologies and promoting the adoption and effective implementation of appropriate clinical practice guidelines, where appropriate in order to address unwarranted variations in care;
- (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 Shared Care Committee**

- (a) The **Shared Care Committee** shall continue under this Agreement as a subcommittee of the General Practice Services Committee and the Specialist 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 Doctors of BC. The members appointed by the Government will include at least one of the Government appointees to each of the General Practice Services Committee and the Specialist Services Committee. The members appointed by the Doctors of BC will include at least one of the Doctors of BC appointees to each of the General Practice Services Committee, the Specialist Services Committee, and one General Practice Physician (non-FRCP) with a Focused Practice.
- (c) The Shared Care Committee will be co-chaired by one member appointed by the Government members and one member appointed by the Doctors of BC 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 Doctors of BC 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 and the Specialist 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 8.5(f) and 8.5(g) in accordance with sections 8.5(f),(g) and (h).
- (f) As at March 31, 2014, the annual funding level for the Shared Care Committee was \$6.5 million. 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) The Government will add the following new annual funding for the Shared Care Committee:
- (i) Effective April 1, 2016, an additional \$1.0 million to be used for new initiatives;
  - (ii) Effective April 1, 2017:
    - (A) an additional \$1.0 million to be used for new initiatives; and
    - (B) an additional \$2.0 million to be used to support the participation of General Practice Physicians (Non-FRCP) with Focused Practices in system improvement initiatives.
  - (iii) Effective April 1, 2018:
    - (A) an additional \$1.0 million to be used for new initiatives; and
    - (B) an additional \$2.0 million to be used to support the participation of General Practice Physicians (Non-FRCP) with Focused Practices in system improvement initiatives.

- (h) Any funds identified in sections 8.5(f) and (g) 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.
- (i) The costs of administrative and clerical support required for the work of the Shared Care Committee will be provided in accordance with the Joint Clinical Committee Administration Agreement and will be paid from the funds referred to in sections 8.5(f) and (g) including the cost of physician participation other than physicians who are employees of the Doctors of BC, the Government and the Health Authorities, unless such Health Authority employed physicians are participating on behalf of Doctors of BC.
- (j) 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).
- (k) 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.

## **8.6 Practice Support Program**

- (a) The Practice Support Program shall operate under the direction of a subcommittee of the General Practice Services Committee and the Specialist Services Committee.
- (b) The Practice Support Committee will provide support to both General Practitioners and Specialist Physicians.
- (c) Effective April 1, 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 Doctors of BC 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 Doctors of BC will advise the Minister of three individuals the Doctors of BC 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 Doctors of BC 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 Doctors of BC must agree on a joint recommendation of the three individuals who will be recommended to the Lieutenant Governor in Council for appointment, provided that if the parties are unable to agree, either the Minister or the Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC.

## **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 Doctors of BC 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 Doctors of BC.

### **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 Doctors of BC.
- (c) The Guidelines and Protocols Advisory Committee will be co-chaired by a Government representative and a Doctors of BC 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 participation in the Guidelines and Protocols Committee, other than physicians who are employed by the Doctors of BC, Government or Health Authorities, unless such Health Authority employed physicians are participating on behalf of the Doctors of BC, 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 be a non-voting member of the Physician Services Committee and will advise 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 Doctors of BC 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 Doctors of BC**

- (a) Funds made available in Appendix F for revisions to the Payment Schedule, will be allocated by the Doctors of BC 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 Doctors of BC, prior to transmission of its recommendations to the Board of Directors of the Doctors of BC 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 Doctors of BC's Board of Directors; and
  - (iii) attempt to achieve agreement in writing between the Doctors of BC 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 Doctors of BC 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 Doctors of BC to the Government of a proposed revision pursuant to this section 12.1, the Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC of a proposed revision pursuant to this section 12.2, the Government may advise the Doctors of BC 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 Doctors of BC 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 Doctors of BC, 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 Doctors of BC. The members appointed shall be chosen so as to avoid conflicts of interest. If the Government and the Doctors of BC 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 Doctors of BC support in writing the recommendation of the joint review panel, the Doctors of BC shall change the Guide to Fees accordingly and section 13.1 shall apply.
- (f) If either the Government or the Doctors of BC 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 Doctors of BC 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 Doctors of BC and the Government agree in writing to the additions, deletions or other modifications; or
  - (ii) the Government and the Doctors of BC 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 Doctors of BC and the Government on recommended changes to the Payment Schedule, the Doctors of BC 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.

## **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**

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 WorkSafeBC 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, 2016 to March 31, 2019, the Government will make an additional annual allocation of \$1 million for new fee items for Specialist Physicians (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 new fee item funds described in this section 16.1 and in the 2012 Physician Master Agreement that are unused in one Fiscal Year (including the Fiscal Year ending on March 31, 2019) 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, 2019.

## **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 Doctors of BC 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).

#### **17.4 Provincial MOCAP Review Committee**

- (a) The Government and the Doctors of BC will create a committee (the “**Provincial MOCAP Review Committee**”). The Provincial MOCAP Review Committee shall be composed of three representatives appointed by the Government (including any representatives of Health Authorities) and three physician representatives appointed by the Doctors of BC. The Government and the Doctors of BC will select an independent Chair for the Provincial MOCAP Review Committee. If the parties are unable to agree on an independent Chair, either of them may request the Chief Justice of the Supreme Court of British Columbia make the appointment and the individual so appointed will be the Chair of the Provincial MOCAP Review Committee.
- (b) The Provincial MOCAP Review Committee will make decisions by majority vote. In this case, a majority vote must consist of all of the representatives of either party and the Chair of the MOCAP Review Committee.
- (c) The Provincial MOCAP Review Committee will have the following responsibilities during the transition to and implementation of the redesigned MOCAP program:
  - (i) overseeing and guiding the MOCAP redesign and implementation process as set out in the Report of the MOCAP Redesign Panel dated May 14, 2013 (“**MOCAP Report**”) including:
    - (A) overseeing the work of a technical and clinical committee related to data collection, points allocation and the determination of payment levels for the redesigned MOCAP program in accordance with the MOCAP Report;
    - (B) providing either:
      - (1) final approval of the work of the technical and clinical committee, or

- (2) a report to the PSC that the technical and clinical committee has been unable to achieve the objectives of the MOCAP Report. In such a case, the PSC will determine the next steps and clause 17.5 below will not apply.
- (ii) a overseeing the transition to the redesigned MOCAP program in accordance with section 17.4(d);
- (iii) determining the process for implementation including the implementation date for the redesigned MOCAP program.
- (d) In order to assist in the orderly implementation of the MOCAP Report, the parties agree to the following:
  - (i) subject to section 17.4 (d)(ii), current on-call arrangements will continue in effect until those arrangements are modified through the redesigned MOCAP program;
  - (ii) during the period necessary to implement the redesigned MOCAP program, only minimal changes to call groups will be made;
  - (iii) the Provincial MOCAP Review Committee will approve all changes to call groups during the transition period;
  - (iv) the Provincial MOCAP Review Committee will resolve any disputes between physicians and Health Authorities with respect to on-call arrangements during the transition period;
  - (v) once the new process is finalized on a continuous basis either a call group or Health Authority may provide notice to the other party of their wish to review the existing arrangements; and
  - (vi) any changes in the payment level for call groups arising from such a review will be effective after 90 days' written notice is provided to physicians in accordance with the terms of existing MOCAP contracts.

## **17.5 PMA Amendments**

- (a) Following the determination of the implementation date for the redesigned MOCAP program by the Provincial MOCAP Review Committee in accordance with section 17.4(c)(iii), the Government and Doctors of BC will meet to amend this Agreement to reflect the MOCAP Report and the work of the Provincial MOCAP Review Committee under clause 17.4(c). Specifically, the parties will:
  - (i) amend this Agreement to explicitly adopt the principles for MOCAP found in recommendation "1" of the MOCAP Report;

- (ii) amend existing provisions in this Agreement related to MOCAP so that they reflect the principles and recommendations of the MOCAP Report and the work of the Provincial MOCAP Review Committee under clause 17.4(c);
  - (iii) add a new provision to this Agreement that sets out the responsibilities of the Provincial MOCAP Review Committee after implementation of the redesigned MOCAP program and reflects the principles and recommendations of the MOCAP Report;
  - (iv) add a new consultation/engagement process to this Agreement that reflects the principles and recommendations of the MOCAP Report and the work of the Provincial MOCAP Review Committee under clause 17.4(c); and
  - (v) add a new dispute resolution process to this Agreement that reflects the principles and recommendations of the MOCAP Report and the work of the Provincial MOCAP Review Committee under clause 17.4(c).
- (b) If the parties are unable to reach agreement on amendments to this Agreement within 4 months of the first meeting of the Government and Doctors of BC under 17.5(a), either party may request the intervention of Eric Harris, QC.
  - (c) Once either party has requested the intervention of Eric Harris, he will work with the parties to assist in the resolution of outstanding issues.
  - (d) If the parties are unable to reach an agreement on the outstanding issues within two months of the request in section 17.5(b), Eric Harris will make a final and binding determination on the outstanding issues consistent with section 17.5(a).

## **ARTICLE 18 - INFORMATION TECHNOLOGY**

### **18.1 Doctors of BC Participation in e-Health**

The Doctors of BC will participate in the leadership of e-Health in British Columbia through the appointment of one senior executive representative to the senior Government committee responsible for developing and overseeing the implementation of the Government's IT strategy and relevant subcommittees.

## **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 Doctors of BC will Work to Prevent Withdrawals of Services**

It is agreed that the Government and the Doctors of BC 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 Doctors of BC, 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) An Adjudicator or 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 Adjudicator or 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 or a Local 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 Doctors of BC may refer the question to the Adjudicator or, at one party's election, the Adjudication Committee for a final and binding decision.

## **20.6 Costs of Dispute Resolution and Issue Management**

The Government and the Doctors of BC 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 Adjudicator and any third party appointed to the Adjudication Committee or an Ad Hoc Advisory Panel, other than representatives of the Doctors of BC 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 the Adjudicator or the 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 Doctors of BC.
- (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 Doctors of BC and the Government.
- (d) Members of the Roster may be removed or replaced at any time by written agreement of the Doctors of BC and the Government.
- (e) The current members of the Roster are listed in Appendix H.

## 21.2 The Adjudicator and the Adjudication Committee

- (a) The Government and the Doctors of BC will refer Provincial Disputes, Local Disputes, Local Interest Issues and other issues in accordance with this Agreement to a single arbitrator, appointed from the Roster, on a rotating basis in the order in which the members of the Roster are listed in Appendix H starting with the first member listed (unless the Government and the Doctors of BC otherwise agree in writing) at the time a reference is made to adjudication (the “**Adjudicator**”). If any member of the Roster to be appointed as the Adjudicator 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. Either the Government or the Doctors of BC may elect to have Provincial Disputes, Local Disputes, Local Interest Issues and other issues in accordance with this Agreement heard by an Adjudication Committee as described in section 21.2(b).
- (b) Notwithstanding section 21.2 (a), the Government and the Doctors of BC 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 if either the Government or the Doctors of BC so elect to use the Adjudication Committee as an alternative to a single Adjudicator as provided in this Agreement. The Adjudication Committee will be composed of one Doctors of BC 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 H starting with the first member listed (unless the Government and the Doctors of BC otherwise agree in writing), at the time a reference is made to adjudication. 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 Doctors of BC will each be entitled to appoint one alternate representative to the Adjudication Committee.
- (c) All arbitrations conducted by the Adjudicator or 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 Doctors of BC from time to time.
- (d) 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 Doctors of BC 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 Doctors of BC and the Government.
- (c) The Trouble Shooter may be removed and replaced at any time by agreement of the Doctors of BC 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 Doctors of BC 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 Doctors of BC, with a copy of the reference to the Joint Agreement Administration Group.

- (b) If the Government or the Doctors of BC 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 Doctors of BC may refer the matter to the Adjudicator, or to the Adjudication Committee with notice to the Joint Agreement Administration Group.
- (e) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.1(d), the opposing party may, at their election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.
- (f) Upon receipt of the notice in section 22.1(d), the Joint Agreement Administration Group will appoint the Adjudicator or a chair of the Adjudication Committee, as the case may be, from the Roster in accordance with sections 21.2(a) and (b). The Adjudicator or 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 Adjudicator or the chair of the Adjudication Committee, or, if either the Doctors of BC or the Government stipulates so in writing within five business days of the referral to the Adjudication Committee, by the full Adjudication Committee.
- (g) Where no voluntary resolution is achieved pursuant to section 22.1(f) within 45 days of the first date the parties meet to mediate the matter as contemplated in section 22.1(f), or such longer period as may be directed by the Joint Agreement

Administration Group upon the recommendation of the mediator, the Adjudicator or 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;
  - (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 Doctors of BC may refer the question of the consistency of the proposed agreement with this Agreement and the Physician Master Subsidiary Agreements to the Adjudicator or the Adjudication Committee with notice to the Joint Agreement Administration Group;

- (iv) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.2(c)(iii), the opposing party may, at their election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.
- (v) The Adjudicator or the Adjudication Committee will arbitrate the question of whether the proposed agreement is consistent with this Agreement and the Physician Master Subsidiary Agreements in accordance with section 21.2; and if the Adjudicator or 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 Adjudicator or 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 Adjudicator or the Adjudication Committee decides, in accordance with section 22.2(c)(v), 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 Doctors of BC, and will agree to be bound by the resolution of the Local Dispute pursuant to this Agreement;
  - (ii) either the Government or the Doctors of BC 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 Doctors of BC refers the Local Dispute to the Joint Agreement Administration Group under section 22.2(e), the Government

and the Doctors of BC 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 Doctors of BC may refer the question of the consistency of the recommendations with this Agreement and the Physician Master Subsidiary Agreements to the Adjudicator or the Adjudication Committee with notice to the Joint Agreement Administration Group;
  - (iv) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.2(h)(iii), the opposing party may, at their election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.
  - (v) The Adjudicator or the Adjudication Committee will arbitrate the question of whether the recommendations are consistent with this Agreement and the Physician Master Subsidiary Agreements in accordance with section 21.2; and if the Adjudicator or the Adjudication Committee decides that the recommendations are so consistent, they will be binding on the parties to the Local Dispute; and if the Adjudicator or 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 (v) 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 Doctors of BC), either the Government or the Doctors of BC may, within a further 30 days, refer the Local Dispute to the Adjudicator or to the Adjudication Committee with notice to the Joint Agreement Administration Group.
- (k) If the Government or the Doctors of BC initially refers the matter to an Adjudicator under section 22.2(j), the opposing party may, at their election and within 10 days of the receipt of the notice by the Joint Agreement Committee, advise the Joint Agreement Administration Group that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator and in such case the matter will be dealt with by the Adjudication Committee.
- (l) Upon a referral of a Local Dispute to the Adjudicator or the Adjudication Committee pursuant to section 22.2(j) the Adjudicator or a chair for the Adjudication Committee will be appointed from the Roster.
- (m) Where a Local Contract Dispute is referred to the Adjudicator or the Adjudication Committee pursuant to section 22.2(j), the Adjudicator or the Adjudication Committee will arbitrate the matter in accordance with section 21.2.
- (n) Where a Local Range Placement Dispute is referred to the Adjudicator or the Adjudication Committee pursuant to section 22.2(j), their 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).

## **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 Doctors of BC 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 Doctors of BC 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 an Adjudicator or, if one party so elects, to the Adjudication Committee for arbitration, at which time the Adjudicator or a chair of the Adjudication Committee 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 Adjudicator or 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 Doctors of BC, 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 Doctors of BC, 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 Doctors of BC will so advise physicians.

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

The Doctors of BC 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 Doctors of BC will take all appropriate measures to encourage physicians to comply with existing agreements.

#### **24.4 Doctors of BC Will Not Condone Withdrawals of Service**

As long as there is no pro-rationing in effect the Doctors of BC 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 - LIMITED RENEGOTIATION**

### **26.1 Limited Renegotiation Notice**

On or after June 1, 2015, but no later than December 1, 2015, either the Government or the Doctors of BC may give notice to the other (the “**Limited Renegotiation Notice**”) of its wish to open discussions, regarding language changes to this Agreement and/or any of the Physician Master Subsidiary Agreements in order to address the following issues:

- (a) amendments necessary to reflect the parties’ joint interests following the results of an alternative payments review; and
- (b) amendments to non-monetary terms of this Agreement and/or any of the Physician Master Subsidiary Agreements that reflect the parties’ joint interests following the results of public and physician consultation on a provincial health human resources strategy.

### **26.2 Initial Meeting and Discussions**

If a Limited Renegotiation Notice is given, the Doctors of BC and the Government will meet, no later than February 1, 2016, and commence such discussions. The parties will endeavour to complete these discussions and agree on appropriate amendments to this Agreement and/or any of the Physician Master Subsidiary Agreements by December 31, 2016. These discussions are not subject to conciliation or any other dispute resolution mechanism under this Agreement.

## **ARTICLE 27 - RENEGOTIATION**

### **27.1 Renegotiation Notice**

On or after April 1, 2018, but no later than April 30, 2018, either the Government or the Doctors of BC 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 Doctors of BC and the Government will meet, no later than June 1, 2018, 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 Doctors of BC will appoint, by no later than June 1, 2018, an individual to act as chair of a conciliation panel for the negotiations. If the Government and the Doctors of BC 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 Doctors of BC do not reach agreement on all amendments (if any) to this Agreement and/or the Physician Master Subsidiary Agreements, by September 30, 2018, either the Government or the Doctors of BC may request the intervention of the chair of the conciliation panel.
- (c) Once either the Government or the Doctors of BC has requested the intervention of the chair of the conciliation panel, he or she will work with the Doctors of BC 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, 2018, either the Government or the Doctors of BC may request the chair of the conciliation panel to discontinue the mediation and to assemble a conciliation panel. The Government and the Doctors of BC 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 Doctors of BC, 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 Doctors of BC will resume negotiations on the areas in dispute with respect to the Central Recommendations and the Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC 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**

- (a) Notwithstanding Article 27, either the Government or the Doctors of BC may give notice (the “**Termination Notice**”) to the other, on or after January 1, 2019, 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, 2019, subject to section 28.2.

### **28.2 Effect of Termination Notice**

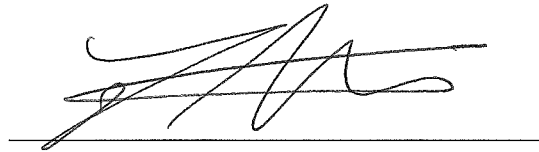
- (a) If one of the parties gives the Termination Notice in accordance with section 28.1, then the provisions of this Agreement and the Physician Master Subsidiary Agreements providing for those matters referred to in section 27.5(a)(i) will continue in effect notwithstanding the termination of this 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 Doctors of BC may give notice (the "**Further Termination Notice**") to the other, on or after April 1, 2019, 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 1<sup>st</sup> day of April, 2014.

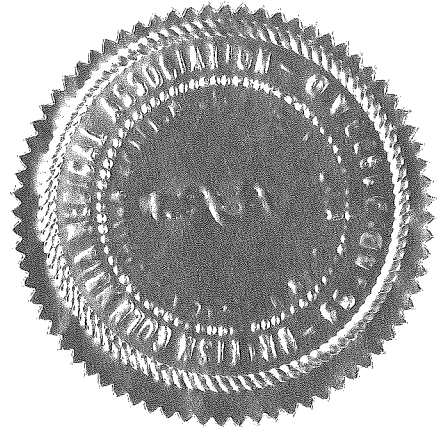
SIGNED, SEALED & DELIVERED on )  
behalf of HER MAJESTY THE QUEEN IN )  
RIGHT OF THE PROVINCE OF BRITISH )  
COLUMBIA, by the Minister of Health or )  
his/her duly authorized representative, in the )  
presence of: )

H. Murray )  
Signature of Witness )  
Heather Murray )  
Name )  
3-1, 1515 Blonhard St. )  
Address )  
Victoria, BC )



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

[Signature] )  
Signature of Authorized Signatory )  
DR WILLIAM T. R. CANERIS )  
Name )  
PRESIDENT )  
Position )



MEDICAL SERVICES COMMISSION

Per: [Signature]  
Authorized Signatory  
Tom Vincent  
Name  
Chair  
Position

**APPENDIX A**

**2014 GENERAL PRACTITIONERS SUBSIDIARY AGREEMENT**

**THIS AGREEMENT** made as of the 1<sup>st</sup> day of April, 2014,

**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 “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

**WITNESSES THAT WHEREAS:**

A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the 2012 PMA, the 2012 General Practitioners Subsidiary Agreement, the 2012 Specialists Subsidiary Agreement, the 2012 Rural Practice Subsidiary Agreement, the 2012 Alternative Payments Subsidiary Agreement and the 2012 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, 2014; 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 2014 PHYSICIAN MASTER AGREEMENT**

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2014 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 2014 Physician Master Agreement have the same meaning as in the 2014 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 “**CMPA Rebate Program**” means the Canadian Medical Protective Association Rebate Program defined in the 2014 Benefits Subsidiary Agreement.

2.5 “**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.

2.6 “**2014 Physician Master Agreement**” means the agreement titled “2014 Physician Master Agreement” among the Government, the Doctors of BC and the MSC, dated April 1, 2014.

2.7 “**2014 Regional and Local Engagement Memorandum of Agreement**” means the memorandum of agreement titled “2014 Regional and Local Engagement Memorandum of Agreement” between the Government and the Doctors of BC.

2.8 The provisions of sections 1.2 to 1.8 inclusive of the 2014 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, 2014.

3.2 This Agreement shall be for the same term as the 2014 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the 2014 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 Doctors of BC 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 2014 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 Doctors of BC.
- 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 Doctors of BC 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 Doctors of BC from among the Doctors of BC 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 Doctors of BC 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 2014 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 will be paid from the funds to be allocated by the General Practice Services Committee pursuant to this Agreement, including the cost of physician participation other than physicians who are employees of the Government, Doctors of BC and Health Authorities, unless such Health Authority employed physicians are participating on behalf of the Doctors of BC.

## **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 \$208.5 million annual funding level for full service family practitioners, as follows:

- (a) an additional \$5.5 million per year effective April 1, 2016;
- (b) an additional \$9.1 million per year effective April 1, 2017; and
- (c) an additional \$7.5 million per year effective April 1, 2018.

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, offsetting utilization pressures on its programs, 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;
- (b) 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
- (c) to improve disease prevention.

5.3 In addition to the funds identified in section 5.1, the Government will provide the following funding 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:

- (a) an additional \$15.3 million per year effective April 1, 2016;
- (b) an additional \$14.0 million per year effective April 1, 2017; and
- (c) an additional \$16.0 million per year effective April 1, 2018.

5.4 The following funds will be available to the General Practice Services Committee to support its Residential Care Initiative:

- (a) up to \$12 million in each of Fiscal Years 2016/2017, 2017/2018 and 2018/2019 from any existing unexpended General Practice Services Committee funds from the 2012 General Practice Subsidiary Agreement, to be applied on a one time basis in each of those Fiscal Years; and
- (b) an additional \$12 million per year to be added by the Government to the annual funding for the General Practice Services Committee, effective April 1, 2019.

5.5 The following funding will be made available on a one time basis for the CMPA Rebate Program from existing unexpended General Practice Services Committee funds from the 2012 General Practitioners Subsidiary Agreement and from existing unexpended Specialist Services Committee funds from the 2012 Specialists Subsidiary Agreement, or, if existing unexpended funds are not sufficient for this purpose, from General Practice Services Committee funding described in section 5.1 and from Specialist Services Committee funding described in the 2014 Specialist Services Subsidiary Agreement:

- (a) up to \$7.3 million for Fiscal Year 2014/2015 as required to mitigate CMPA costs increases to physicians; and
- (b) up to \$24.3 million for Fiscal Year 2015/2016 as required to mitigate CMPA costs increases to physicians.

For each of Fiscal Years 2014/2015 and 2015/2016 the contribution of these funds shall be apportioned between the General Practices Services Committee funds and the Specialist Services Committee funds based on the increased CMPA costs distribution between General Practitioners and Specialists in accordance with the applicable CMPA Fee Schedule for those years.

5.6 In Fiscal Year 2016/2017, the Government will transfer on a one time basis to the Doctors of BC \$3 million from unexpended funds available to the General Practice Service Committee to be allocated by the Specialist Services Committee per Article 8 of the Specialist Services Subsidiary Agreement to support the engagement of facility-based General Practitioners with Health Authorities in accordance with the objectives described in the 2014 Regional and Local Engagement Memorandum of Agreement.

5.7 Any funds described in sections 5.1, 5.3 and 5.4 (b) 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.

5.8 If the General Practice Services Committee needs to reduce expenditures in order to meet its budget targets, the General Practice Service Committee will first address such budget

pressures through a reduction of expenditures on its programs that do not have accompanying fees before considering adjustments to any of its established fees. Any such fee adjustments will be by mutual agreement. For clarity, this section 5.8 does not restrict the General Practice Service Committee from adjusting its fees in order to meet its mandate.

5.9 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 2014 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, 2014.

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: )

\_\_\_\_\_  
Signature of Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

C/S

MEDICAL SERVICES COMMISSION:

Per: \_\_\_\_\_

Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

**APPENDIX B**

**2014 SPECIALISTS SUBSIDIARY AGREEMENT**

**THIS AGREEMENT** made as of the 1<sup>st</sup> day of April, 2014,

**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 “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

**WITNESSES THAT WHEREAS:**

- A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the 2012 PMA, the 2012 General Practitioners Subsidiary Agreement, the 2012 Specialists Subsidiary Agreement, the 2012 Rural Practice Subsidiary Agreement, the 2012 Alternative Payments Subsidiary Agreement and the 2012 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, 2014; 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 2014 PHYSICIAN MASTER AGREEMENT**

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2014 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 2014 Physician Master Agreement have the same meaning as in the 2014 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 “**CMPA Rebate Program**” means the Canadian Medical Protective Association Rebate Program defined in the 2014 Benefits Subsidiary Agreement.

2.4 “**2014 Physician Master Agreement**” means the agreement titled “Physician Master Agreement” among the Government, the Doctors of BC and the MSC, dated April 1, 2014.

2.5 “**2014 Regional and Local Engagement Memorandum of Agreement**” means the memorandum of agreement titled “2014 Regional and Local Engagement Memorandum of Agreement” between the Government and the Doctors of BC.

2.6 The provisions of sections 1.2 to 1.8 inclusive of the 2014 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, 2014.

3.2 This Agreement shall be for the same term as the 2014 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the 2014 Physician Master Agreement.

## **ARTICLE 4 - COLLABORATION WITH SPECIALIST PHYSICIANS**

4.1 The Government and the Doctors of BC 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 Doctors of BC 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 2014 Physician Master Agreement, the Specialist Services Committee will fulfill the specific mandate as set out in this Agreement.

5.2 The Government and the Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Adjudicator, 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 2014 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 will be paid from the funds referred to in Article 6 of this Agreement, including the cost of physician participation other than physicians who are employees of the Government, Doctors of BC and Health Authorities, unless such Health Authority employed physicians are participating on behalf of the Doctors of BC.

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

6.1 The Government will continue to provide \$54,840,628 in annual funding to the Specialist Services Committee, of which \$7.6 million in annual funding has been transferred to the Available Amount to fund changes to the billing rules for certain perioperative fees. The balance



of \$47,240,628 shall 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 \$1.6 million in annual funding to be made available effective April 1, 2017, with such funding to be allocated by the Specialist Services Committee to, amongst other things, fund new initiatives and offset utilization pressures on its programs.

6.3 The Government will provide an additional \$1.8 million in annual funding to be made available effective April 1, 2018, with such funding to be allocated by the Specialist Services Committee to, amongst other things, fund new initiatives and offset utilization pressures on its programs.

6.4 The following funding will be made available on a one time basis for the CMPA Rebate Program from existing unexpended Specialist Services Committee funds from the 2012 Specialists Subsidiary Agreement and from existing unexpended General Practice Services Committee funds from the 2012 General Practitioners Subsidiary Agreement, or if existing unexpended funds are not sufficient for this purpose, from Specialist Services Committee funding described in section 6.1 and from General Practice Service Committee funding as described in the 2014 General Practice Subsidiary Agreement:

- (a) up to \$7.3 million for Fiscal Year 2014/2015 as required to mitigate CMPA cost increases to physicians; and
- (b) up to \$24.3 million for Fiscal Year 2015/2016 as required to mitigate CMPA cost increases to physicians.

For each of Fiscal Years 2014/2015 and 2015/2016 the contribution of these funds shall be apportioned between the General Practice Services Committee funds and the Specialist Services Committee funds based on the increased CMPA costs distribution between General Practitioners and Specialists in accordance with the applicable CMPA Fee Schedule for those years.

6.5 Any funds described in sections 6.1, 6.2 and 6.3 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 Government shall provide the Doctors of BC with any information in its control that is required by Doctors of BC in order for Doctors of BC to meet its reporting requirements described in the Joint Clinical Committee Administration Agreement.

## **ARTICLE 8 - FACILITY-BASED PHYSICIAN ENGAGEMENT**

8.1 Commencing in Fiscal Year 2014/2015, the Specialist Services Committee will allocate the funds described in sections 8.2 and 8.3 of this Agreement and section 5.6 of the General Practice Services Agreement to support the engagement of facility-based physicians with Health Authorities in accordance with the objectives described in the 2014 Regional and Local Engagement Memorandum of Agreement. In particular, the funding is intended to be used for the following purposes:

- (a) to fund staff such as Physician Engagement Leads as per the terms of the Joint Clinical Committee Administration Agreement; and
- (b) to fund Medical Staff Associations, or new local structures where agreed by physicians and their respective Health Authority.

8.2 The Government will transfer on a one time basis to the Doctors of BC the following unexpended funds available to the Specialist Services Committee:

- (a) \$4 million in Fiscal Year 2014/2015;
- (b) \$8 million in Fiscal Year 2015/2016; and
- (c) \$15 million in Fiscal Year 2016/2017.

8.3 Effective April 1, 2017, the Government shall provide the following additional annual funding to the Specialist Services Committee:

- (a) \$3 million to support facility-based General Practitioners who are paid on a fee-for-service basis or under an Alternative Payment Arrangement; and
- (b) \$15 million to support all facility-based Specialist Physicians who are paid on a fee-for-service basis or under an Alternative Payment Arrangement.

8.4 Upon termination of the 2014 Regional and Local Engagement Memorandum of Agreement, the Specialist Services Committee will decide to either reallocate the funding described in section 8.3 or to continue to allocate this funding to support facility based physician engagement with Health Authorities, and in particular for the following purposes:

- (a) to fund staff such as Physician Engagement Leads as per the terms of the Joint Clinical Committee Administration Agreement; and
- (b) to fund Medical Staff Associations, or new local structures where agreed by physicians and their respective Health Authority.

8.5 Subject to the termination provision at section 8.4, any funds described in sections 8.2 and 8.3 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 facility based engagement.

## ARTICLE 9 - DISPUTE RESOLUTION

9.1 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 2014 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 1<sup>st</sup> day of April, 2014.

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:

\_\_\_\_\_  
Signature of Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

MEDICAL SERVICES COMMISSION

Per: \_\_\_\_\_

Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

C/S

**APPENDIX C**

**2014 RURAL PRACTICE SUBSIDIARY AGREEMENT**

**THIS AGREEMENT** made as of the 1st day of April, 2014,

**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 “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

**WITNESSES THAT WHEREAS:**

A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the 2012 PMA, the 2012 General Practitioners Subsidiary Agreement, the 2012 Specialists Subsidiary Agreement, the 2012 Rural Practice Subsidiary Agreement, the 2012 Alternative Payments Subsidiary Agreement and the 2012 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, 2014; 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 2014 PHYSICIAN MASTER AGREEMENT**

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2014 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 2014 Physician Master Agreement have the same meaning as in the 2014 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 “**2014 Physician Master Agreement**” means the agreement titled “2014 Physician Master Agreement” among the Government, the MSC and the Doctors of BC, dated April 1, 2014.

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 “**RGPALP**” means the Rural General Practitioner Anaesthesia Locum Program referred to in section 7.2.
- 2.16 “**RGPLP**” means the Rural General Practitioner Locum Program referred to in section 7.1.
- 2.17 “**RIF**” means the Recruitment Incentive Fund referred to in section 10.1.
- 2.18 “**RRP**” means the Rural Retention Program referred to in section 6.1.
- 2.19 “**Rural Community**” means a community listed on Appendix A.
- 2.20 “**RRP Community**” means a Rural Community which has at least 6 Isolation Points.
- 2.21 “**RSLP**” means the Rural Specialist Locum Program referred to in section 7.6.
- 2.22 “**Rural Programs**” means the RRP, the RGPLP, the RGPALP, the RSLP, the RCME, the REAP, the RIF, the RCF, the NITAOP, and the IAF.
- 2.23 Subject to section 2.24, 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.
- 2.24 Notwithstanding section 2.23, Appendix A, Appendix B and Appendix C of this Agreement may be amended by the JSC, by consensus decision, as provided herein.
- 2.25 The provisions of sections 1.2 to 1.6 and 1.8 of the 2014 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, 2014.
- 3.2 This Agreement shall be for the same term as the 2014 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the 2014 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 RSLP, the RGPALP, 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 Doctors of BC may refer the matter in dispute in accordance with section 21.2 of the 2014 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 2014 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 The Government will continue to 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 The Rural GP Anaesthesia Locum Program (the “**RGPALP**”) is a program that provides support to General Practitioners with enhanced anesthesia skills 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.

7.3 Responsibility for the governance and oversight of the RGPLP and the RGPALP resides with the JSC, with day to day administration of the RGPLP and the RGPALP provided by the Ministry, or as determined by the JSC.

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

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

7.6 The Rural Specialist Locum Program (the “**RSLP**”) is a program that provides support to enable eligible Specialist Physicians practising in certain designated specialties 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.

7.7 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, or as determined by the JSC.

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

7.9 Effective April 1, 2014, the JSC shall allocate up to a maximum of \$700,000 per year from its existing funding to improve the services offered by the RGPLP, RSLP, and RGPALP. This funding is to be allocated in accordance with the agreed recommendations provided in the Working Report of the Sub Committee on Rural Locum Programs dated March 10, 2014, or as determined by the JSC.

7.10 The funding described in section 7.9 is in addition to the current funding of approximately \$300,000 annually provided by the Government for four (4) full time equivalent personnel who provide the day to day administration of the RGPLP, RSLP and the RGPALP.

## 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:

### General Practitioners

	Up to 2 years	in the 3rd & 4th year	Over 4 yrs
“A” communities	\$1,320	\$3,520	\$5,720
“B” communities	\$440	\$2,640	\$4,840
“C” communities	\$0	\$2,200	\$4,400
“D” communities	\$0	\$1,100	\$2,200

### Specialists

	Up to 2 years	in the 3rd & 4th year	Over 4 yrs
“A” communities	\$1,800	\$4,800	\$7,800
“B” communities	\$600	\$3,600	\$6,600
“C” communities	\$0	\$3,000	\$6,000
“D” communities	\$0	\$1,500	\$3,000

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, to be used for that Rural Community RCME fund..

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, or as determined by the JSC.

9.3 The JSC may provide advice and recommendations to the Government and the Doctors of BC 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 in annual funding identified in the 2007 Rural Subsidiary Agreements 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 The Government will continue to provide \$10 million in annual funding identified in the 2012 Rural Subsidiary Agreement 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 The Government will provide the following additional funding to be allocated by the JSC to, amongst other things, offset utilization pressures impacting Rural Programs excluding the RIF, RCME and RRP, and to address issues impacting Rural Programs and physicians practicing in rural communities in a manner aligned with the Government’s rural strategy:

- (a) an additional \$3.0 million per year effective April 1, 2015;
- (b) an additional \$4.0 million per year effective April 1, 2016; and
- (c) an additional \$5.0 million per year effective April 1, 2017.

12.5 Any funds identified in sections 12.2, 12.3 and 12.4 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 2014 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, 2014.

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:

\_\_\_\_\_  
Signature of Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

C/S

MEDICAL SERVICES COMMISSION

Per: \_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position



## Appendix A

### COMMUNITIES WITH AT LEAST 0.5 ISOLATION POINTS (As of April 1, 2014)

Physicians in communities listed in this Appendix may be entitled to receive RRP, RCME, REAP, RGPLP, RGPALP, 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		Kyuquot
Agassiz/Harrison	Edgewood	Ladysmith
Ahousat	Elkford	Lake Cowichan
Alert Bay	Enderby	Lillooet
Alexis Creek	Fernie	Logan Lake
Anahim Lake		Lower Post
Armstrong/Spallumcheen	Fort Babine	Lumby
Ashcroft	Fort Nelson	Lytton
Atlin	Fort St. James	
	Fort St. John/Taylor	Mackenzie
Balfour	Fort Ware	Madeira Park
	Fraser Lake	
Bamfield		Mayne Island
Barriere	Gabriola Island	McBride
Bella Bella	Galiano Island	Merritt
Bella Coola	Gold Bridge/Bralorne	Mill Bay
Big White	Gold River	Miocene
Blind Bay	Golden	Moricetown
Blue River	Granisle	Mount Currie
Blueberry River	Greenwood/Midway/Rock Creek	
Bowen Island		Nakusp
Bridge Lake	Haida Gwaii	
Burns Lake		Nedlah
	Halfway River	
Campbell River	Hartley Bay	Nee Tahi Buhn
Canal Flats	Hazelton	Nelson
Canoe Creek	Holberg	Nemaiah Valley
Castlegar	Hope	New Aiyansh
Chase/Scotch Creek	Hornby Island	New Denver
Cheslatta	Hot Springs Cove	Nitinat
Chemainus	Houston	
Chetwynd	Hudson's Hope	Ocean Falls
Christina Lk/Grand Forks		Osoyoos/Oliver
Clearwater		
Clinton	Invermere	
Cobble Hill		Parksville/Qualicum
Cortes Island	Kaslo	Pemberton
Courtenay/Comox/Cumberland	Keremeos	Pender Island
Cranbrook	Kimberley	Port Alberni
Crescent Valley	Kincolith	Port Alice
Creston	Kingcome	Port Clements
	Kitimat	Port Hardy
Dawson Creek	Kitkatla	Port McNeill
Dease Lake	Kitsault	Port Renfrew
Denman Island	Kitwanga	Port Simpson
Doig River	Klemtu	Powell River
Duncan/N. Cowichan	Kootenay Bay/Riondel	Prince George

Prince Rupert  
Princeton

Quadra Island  
Quatsino

Quesnel

Revelstoke  
Rivers Inlet

Saik'uz

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

Seton Portage  
Shawnigan Lake  
Sirdar  
Skatin  
Skin Tyee  
Slocan Park  
Smithers  
Sointula  
Sooke  
Sorrento  
Sparwood  
Spences Bridge  
Squamish  
Stellat'en  
Stewart

Tachet

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

Tofino  
Trail/Rossland/Fruitvale  
Tsay Keh Dene  
Ts'il Kaz Koh  
Tumbler Ridge

Ucluelet

Valemount  
Vanderhoof  
Wardner  
Wet'suwet'en  
Whistler  
Williams Lake  
Winlaw  
Woss  
Woyenne

Yekooche

Zeballos

## Appendix B

### NITAOP COMMUNITIES (As of April 1, 2014)

*Subject to meeting eligibility criteria per specialty*

100 Mile House

Ahousat

Alert Bay

Alexis Creek

Anahim Lake

Atlin

Bamfield

Bella Bella

Bella Coola

Blueberry River

Burns Lake

Campbell River

Canoe Creek

Castlegar

Cheslatta

Chetwynd

Clearwater

Clinton

Cortes Island

Courtenay/Comox

Cranbrook

Crawford Bay

Creston

Dawson Creek

Dease Lake

Doig River

Duncan/N. Cowichan

Edgewood

Fernie

Fort Babine

Fort Nelson

Fort St. James

Fort St. John

Fraser Lake

Galiano Island

Gold Bridge/Bralorne

Gold River

Golden

Grand Forks/Midway/ Rock Creek

Granisle

Haida Gwaii

Halfway River

Hartley Bay

Hazelton

Holberg

Hot Springs Cove

Houston

Invermere

Kaslo

Keremeos

Kingcome

Kitimat

Kitkatla

Klemtu

Kwadacha

Kyuquot

Lillooet

Mackenzie

McBride

Merritt

Nadleh

Nakusp/New Denver

Nee Tahi Buhn

Nelson

Nemaiah Valley

New Aiyansh

Nitinat

Ocean Falls

Oliver/Osoyoos

Parksville/Qualicum

Pender Island

Port Alberni

Port Alice

Port Hardy

Port McNeill

Port Renfrew

Port Simpson

Powell River

Prince George

Prince Rupert

Princeton

Quatsino

Quesnel

Revelstoke

Riondel

Rivers Inlet

Saik'uz

Salmo

Salmon Arm

Saltspring Island

Samaqham

Saturna Island

Sechelt/Gibsons

Seton Portage

Skatin

Skin Tyee

Smithers

Sointula

Sparwood

Stellat'en

Stewart

Tachet

Takla Landing

Tatla LakeTepella

Terrace

Tofino

Trail

Tsay Keh Dene

Ts'il Kaz Koh

Tumbler Ridge

Ucluelet

Wet'suwet'en

Woyenne

Valemount  
Vanderhoof

Whistler  
Williams Lake  
Woss

Yekooche  
  
Zeballos

## Appendix C

## ISOLATION POINT CRITERIA

<b>Medical Isolation and Living Factors</b>	<b>Points</b>	<b>Max Points</b>
<b>Number of Designated Specialties within 70 km</b>		
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
<b>Number of General Practitioners within 35 km</b>		
over 20 Practitioners	0	
11-20 Practitioners	20	
4 to 10 Practitioners	40	
0 to 3 Practitioners	60	60
<b>Community Size (If larger community within 35 km then larger population is considered)</b>		
30,000+	0	
10,000 to 30,000	10	
Between 5,000 and 9,999	15	
Up to 5,000	25	25
<b>Distance from Major Medical Community (Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford, Prince George)</b>		
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		
<b>Degree of Latitude</b>		
Communities between 52 to 53 degrees latitude	20	
Communities above 53 degrees latitude	30	30
<b>Specialist Centre</b>		
- 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
<b>Location Arc</b>		
- 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:

- (a) The number of General Practitioners and Specialists required to provide the physician services identified in the Physician Supply Plan; and
- (b) 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:

- (a) The number of General Practitioners and Specialists in the community as of December 31, 2012, plus any vacancies identified by the Health Authority as of that date where active recruitment was underway; and
- (b) 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, 2012 are deemed to be included in the Physician Supply Plan for the term of this Agreement.

**APPENDIX D**

**ALTERNATIVE PAYMENTS SUBSIDIARY AGREEMENT**

**THIS AGREEMENT** made as of the 1st day of April, 2014

**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 “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

**WITNESSES THAT WHEREAS:**

A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the 2012 PMA, the 2012 General Practitioners Subsidiary Agreement, the 2012 Specialists Subsidiary Agreement, the 2012 Rural Practice Subsidiary Agreement, the 2012 Alternative Payments Subsidiary Agreement, and the 2012 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, 2014; 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 2014 PHYSICIAN MASTER AGREEMENT

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2014 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 2014 Physician Master Agreement have the same meaning as in the 2014 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 “**2014 Physician Master Agreement**” means the agreement titled “2014 Physician Master Agreement” among the Government, the Doctors of BC, and the MSC, dated April 1, 2014.

2.6 “**Physician Placement System**” has the meaning given in section 12.6.

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 2014 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, 2014.
- 3.2 This Agreement shall be for the same term as the 2014 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the 2014 Physician Master Agreement.

### ARTICLE 4 - ALTERNATIVE PAYMENTS COMMITTEE

- 4.1 The Alternative Payments Committee will continue under this Agreement until the date on which it completes the implementation of the adjustments to Service Contract Ranges and Salary Agreement Ranges contemplated by the Consensus Decisions of the Alternative Payments Committee dated December 9, 2010 and May 22, 2014.
- 4.2 The membership of the Alternative Payments Committee will be composed of three members appointed by the Doctors of BC and three members appointed by the Government.
- 4.3 The Alternative Payments Committee will be co-chaired by one member chosen by the Doctors of BC appointees to the Alternative Payments Committee and one member chosen by the Government appointees to the Alternative Payments Committee.

### ARTICLE 5 - ALLOCATION COMMITTEE

- 5.1 On each of June 1, 2015, June 1, 2016 and June 1, 2017 the Government and the Doctors of BC shall appoint a temporary committee ("**Allocation Committee**") in accordance with the provisions of this Article 5, whose role it will be to adjust the Salary Agreement Ranges and the Service Contract Ranges by allocating the funding identified in sections 1.3(b), 1.4(c) and 1.5(b) of Appendix F to the 2014 Physician Master Agreement respectively.
- 5.2 The Allocation Committees will be composed of an equal number of members appointed by each of the Government and the Doctors of BC, and will be co-chaired by one member chosen by the Doctors of BC appointees and one member chosen by the Government appointees.
- 5.3 Decisions of the Allocation Committee will be by consensus decision.
- 5.4 The Allocation Committee shall be limited in its deliberations as follows:
- (a) the Allocation Committee appointed on June 1, 2015 will consider only the funding identified in section 1.3(b) of Appendix F to the 2014 Physician Master Agreement;
  - (b) the Allocation Committee appointed on June 1, 2016 will consider only the funding identified in section 1.4(c) of Appendix F to the 2014 Physician Master Agreement; and
  - (c) the Allocation Committee appointed on June 1, 2017 will consider only the funding identified in Section 1.5(b) of Appendix F to the 2014 Physician Master Agreement.
- 5.5 All decisions of the Allocation Committee are subject to this Agreement.
- 5.6 Prior to the Allocation Committee finalizing adjustments to the Service Contract and Salary Agreement Ranges, the Government will work with the Health Authorities and the

Doctors of BC to prepare the prospective costing of the adjusted Ranges at the level of individual Salary Agreements and individual or group Service Contracts, as well as the associated incremental RRP cost increases and the associated incremental benefit cost increases for salaried physicians to ensure the available funding for the applicable Fiscal Year is not exceeded.

5.7 The changes to the Salary Agreement Ranges and Service Contract ranges will be implemented on a prospective basis at the beginning of the applicable Fiscal Year.

5.8 The Allocation Committee will initially allocate 90% of the funds identified at sections 1.3(b), 1.4(c) and 1.5(b) of Appendix F to the 2014 Physician Master Agreement to adjust the Salary Agreement and Service Contract Ranges. If the adjusted Salary Agreement Ranges and adjusted Service Contract Ranges, plus the associated incremental RRP cost and the associated incremental benefit cost increases for salaried physicians, exceed the available funding for the applicable Fiscal Year, the adjustments to the Salary Agreement Ranges and the Service Contract Ranges will be revised downward by the Allocation Committee in the manner it determines appropriate. Notwithstanding section 5.4, if the funding limit is not exceeded and there are excess funds available, the Allocation Committee will apply those funds to the adjusted Salary Agreement Ranges and adjusted Service Contract Ranges in the manner it deems appropriate.

5.9 Schedule A and Schedule B of this Agreement will be revised to reflect the adjusted Salary Agreement Ranges and the adjusted Service Contract Ranges for the applicable Fiscal Year upon being confirmed by the Allocation Committee as final.

5.10 If the Allocation Committee is unable to reach a decision on the distribution of the funding identified in sections 1.3(b), 1.4(c) and 1.5(b) of Appendix F to the 2014 Physician Master Agreement by March 31 of the Fiscal Year preceding the Fiscal Year for which the funding is allocated, the applicable funding will be allocated, subject to the eligibility provisions of this Agreement, on the basis of an equal annual dollar increase per FTE to all Service Contract and Salary Rates and Ranges effective April 1 of the Fiscal Year for which the funding is allocated.

## **ARTICLE 6 - COMPENSATION ENTITLEMENT**

6.1 Subject to sections 6.2 and 6.3 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.

6.2 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 2014 Physician Master Agreement, the General Practitioners Subsidiary Agreement or the Specialists Subsidiary Agreement;

where eligible under those agreements and all applicable eligibility criteria.

6.3 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 7 - COMPENSATION ADMINISTRATION**

7.1 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 7.1 will normally be placed at the minimum rate on the appropriate range unless the Physician Services Committee approves placement elsewhere on the range.

7.2 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.

7.3 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 receive the applicable compensation increases described at sections 1.1 (a)(iii), 1.2(a)(iii), 1.3(a)(iii), 1.4(a)(iii) and 1.5(a)(iii) of Appendix F to the 2014 Physician Master Agreement. 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, and will only receive compensation increases that are identified in Sections 1.3(b), 1.4(c) and 1.5(b) of Appendix F to the 2014 Physician Master Agreement to the extent that their resulting compensation is within the then current applicable Salary Agreement Range or Service Contract Range.

7.4 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 8 - RELATIONSHIP WITH CONTRACTING AGENCIES**

8.1 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.

8.2 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.

8.3 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.

8.4 Subject to sections 8.5 and 8.6, all Service Contracts and Sessional Contracts must be in the forms for each set out in Schedules E and F to this Agreement.

8.5 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.

8.6 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 9 - COMPENSATION AND HOURS OF WORK**

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

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

9.3 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.

9.4 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 10 - STANDARD TERMS AND CONDITIONS OF EMPLOYMENT UNDERSALARY AGREEMENTS**

10.1 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.

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

10.3 Notwithstanding section 10.1, 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.

10.4 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 11 - BENEFITS, VACATION AND EXPENSES**

11.1 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.

11.2 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.

11.3 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.

11.4 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 11.4(a) and, in part, to use them for vacation leave under section 11.4(b).

### PART 3 - PHYSICIAN SERVICES PROVIDED UNDER A SERVICE CONTRACT

#### ARTICLE 12 - COMPENSATION AND HOURS OF SERVICE

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

12.2 Subject to section 12.7, 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 12. 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.

12.3 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 Doctors of BC and the Government, the use of the Trouble Shooter;
- (b) where either the Doctors of BC 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 12.2, to the Joint Agreement Administration Group and the local parties, and such recommendations will be treated by the Doctors of BC, 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 2014 Physician Master Agreement.

12.4 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.

12.5 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.

12.6 The Doctors of BC 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.

12.7 Subject to section 12.9, 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.

12.8 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).

12.9 A Physician or Physician group providing Physician Services under a Service Contract in existence as at March 31, 2014 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 12.7, 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 of the expiry of the Service Contract; and

D = the maximum rate on the Service Contract Range for the applicable practice category at the time of renewal of the Service Contract.

12.10 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.

12.11 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.

12.12 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 13 - COMPENSATION**

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

13.2 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.

13.3 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.

13.4 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.

13.5 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.

13.6 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 14 - DISPUTE RESOLUTION

14.1 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 2014 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 1<sup>st</sup> day of April, 2014.

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:

\_\_\_\_\_  
Signature of Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

C/S

MEDICAL SERVICES COMMISSION

Per: \_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

### Schedule “A” to the Alternative Payments Subsidiary Agreement

2014/15 Salary Agreement Ranges as reflected in the May 22, 2014 Consensus Decision of the Alternative Payments Committee, subject to change as contemplated in that Consensus Decision and Appendix F to the 2014 Physician Master Agreement and subject to final confirmation by the Alternative Payments Committee. These rates are not approved for implementation as of the date of this Agreement. Approved rates will be communicated and published once finalized.

<b>Practice Category</b>	<b>Minimum</b>	<b>Maximum</b>
General Practice - Defined Scope B	\$151,999	\$189,999
General Practice - Defined Scope A	\$173,561	\$216,951
General Practice - Full Scope B	\$173,561	\$216,951
General Practice - Full Scope A – Area A	\$198,057	\$247,571
General Practice - Full Scope A – Area B	\$192,083	\$240,104
General Practice - Full Scope A – Area C	\$184,621	\$230,777
Hospitalists	\$173,561	\$216,951
MHO Area A	\$154,861	\$193,576
MHO Area B	\$168,711	\$210,888
MHO Area C	\$199,537	\$249,421
MHO Area D	\$211,967	\$264,959
General Paediatrics (Defined Scope)	\$186,071	\$232,588
General Paediatrics	\$211,967	\$264,959
Psychiatry	\$211,967	\$264,959
Forensic Psychiatry	\$227,506	\$284,383
Physical Medicine	\$211,967	\$264,959
Neurology	\$277,709	\$277,709
Dermatology	\$277,709	\$277,709
Internal Medicine	\$211,967	\$264,959
Medical Genetics	\$222,167	\$277,709
Sub-specialty Paediatrics	\$222,167	\$277,709
Sub-specialty Internal Medicine	\$222,167	\$277,709
Anaesthesia	\$251,245	\$314,056
Critical Care	\$244,019	\$305,024
Haematology/Oncology	\$268,033	\$335,041
Medical Oncology	\$268,033	\$335,041
Radiation Oncology	\$268,033	\$335,041
Laboratory Medicine	\$242,844	\$303,555
Radiology	\$265,156	\$331,445
Pediatric Radiology	TBD	TBD
Otolaryngology	\$254,531	\$318,164
Orthopaedic Surgery	\$254,531	\$318,164
Urology	\$254,531	\$318,164
Ophthalmology	\$254,531	\$318,164
Plastic Surgery	\$254,531	\$318,164

Plastic Surgery at VGH	TBD	TBD
Obstetrics/Gynecology	\$254,531	\$318,164
General Surgery	\$254,531	\$318,164
Gynecological Oncology	\$279,250	\$349,062
Maternal Fetal Medicine	\$279,249	\$349,062
General Surgical Oncology	\$279,250	\$349,062
Sub-specialty Orthopaedics	\$336,376	\$420,470
Neurosurgery	\$336,376	\$420,470
Vascular Surgery	\$336,376	\$420,470
Cardiac Surgery	\$336,376	\$420,470
Thoracic Surgery	\$447,215	\$559,019
Emergency Medicine (Non-Hospital Based)	\$171,794	\$214,743
Emergency Medicine Area A	\$187,644	\$234,555
Emergency Medicine Area B	\$210,907	\$263,633

For specific and representative assignment to Practice Categories, see the Consensus Decision of the Alternative Payments Committee dated May 22, 2014, and any subsequent Consensus Decision of the Alternative Payments Committee or the Allocation Committee related to the assignment to Practice Categories.

### Schedule “B” to the Alternative Payments Subsidiary Agreement

2014/15 Service Contract Ranges as Reflected in the May 22, 2014 Consensus Decision of the Alternative Payments Committee, subject to change as contemplated in that Consensus Decision and in Appendix F to the 2014 Physician Master Agreement and subject to final confirmation by the Alternative Payments Committee. These rates are not approved for implementation as of the date of this Agreement. Approved rates will be communicated and published once finalized.

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

<b>PRACTICE CATEGORY</b>	<b>Minimum</b>	<b>Maximum</b>
General Practice - Defined Scope B	\$170,239	\$212,799
General Practice - Defined Scope A	\$194,388	\$242,985
General Practice - Full Scope B	\$194,388	\$242,985
General Practice - Full Scope A – Area A	\$221,823	\$277,279
General Practice - Full Scope A – Area B	\$215,133	\$268,917
General Practice - Full Scope A – Area C	\$206,776	\$258,470
Hospitalists	\$194,388	\$242,985
MHO Area A	\$173,444	\$216,805
MHO Area B	\$188,956	\$236,195
MHO Area C	\$223,481	\$279,352
MHO Area D	\$237,403	\$296,754
General Paediatrics (Defined Scope)	\$208,399	\$260,499
General Paediatrics	\$237,404	\$296,754
Psychiatry	\$237,404	\$296,754
Forensic Psychiatry	\$254,807	\$318,509
Physical Medicine	\$237,404	\$296,754
Neurology	\$248,828	\$311,034
Dermatology	\$248,828	\$311,034
Internal Medicine	\$237,404	\$296,754
Medical Genetics	\$248,828	\$311,034
Sub-specialty Paediatrics	\$248,828	\$311,034
Sub-specialty Internal Medicine	\$248,828	\$311,034
Anaesthesia	\$281,394	\$351,743
Critical Care	\$273,301	\$341,627
Haematology/Oncology	\$300,196	\$375,246
Medical Oncology	\$300,196	\$375,246
Radiation Oncology	\$300,196	\$375,246
Laboratory Medicine	\$271,986	\$339,982
Radiology	\$296,974	\$371,218
Pediatric Radiology	TBD	TBD
Otolaryngology	\$285,075	\$356,343
Orthopaedic Surgery	\$285,075	\$356,343
Urology	\$285,075	\$356,343
Ophthalmology	\$285,075	\$356,343

Plastic Surgery	\$285,075	\$356,343
Plastic Surgery at VGH/SPH	TBD	TBD
Obstetrics/Gynecology	\$285,075	\$356,343
General Surgery	\$285,075	\$356,343
Gynecological Oncology	\$312,760	\$390,949
Maternal Fetal Medicine	\$312,759	\$390,949
General Surgical Oncology	\$312,760	\$390,949
Sub-specialty Orthopaedics	\$376,741	\$470,927
Neurosurgery	\$376,741	\$470,927
Vascular Surgery	\$376,741	\$470,927
Cardiac Surgery	\$376,741	\$470,927
Thoracic Surgery	\$500,881	\$626,101
Emergency Medicine (Non-Hospital Based)	\$193,371	\$241,714
Emergency Medicine Area A	\$214,996	\$268,745
Emergency Medicine Area B	\$241,181	\$301,476

For specific and representative assignment to Practice Categories, see the Consensus Decision of the Alternative Payments Committee dated May 22, 2014, and any subsequent Consensus Decision of the Alternative Payments Committee or the Allocation Committee related to the assignment to Practice Categories.

**Schedule “C” to the Alternative Payments Subsidiary Agreement**

**PROVINCIAL SESSIONAL RATES, EFFECTIVE APRIL 1, 2014**

The sessional rates effective April 1, 2014 are as follows:

<b>General Practitioners</b>	<b>Specialists</b>
\$411.90	\$485.88

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:

<b>General Practitioners</b>	<b>Specialists</b>
\$446.78	\$527.78

As of April 1, 2015, the Specialist Sessional Rate 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) will be \$729.17.

## **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 “Doctors of BC”) 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 Doctors of BC 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, 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 Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC 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 Specialists 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 a resident under the supervision and responsibility of the Physician, or by 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; or
  - if delivered by e-mail, on the next business day following confirmed e-mail transmissions to the e-mail address listed below.

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. 2014 Physician Master Agreement and Physician Master Subsidiary Agreements**

- (a) This Salary Agreement is subject to the 2014 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 on the terms, conditions and understandings set out in this Service Contract;

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

**ARTICLE 1 - DEFINITIONS**

1.1 Words used in this Contract, including in the recitals and the Appendices, that are defined in the 2014 Physician Master Agreement or Physician Master Subsidiary Agreements have the same meaning as in the 2014 Physician Master Agreement or the Physician Master Subsidiary Agreements, unless otherwise defined in this Contract. In addition, in this Contract, including the recitals and Appendices, the following definitions apply:

- (a) “Contract” or “Service Contract” means this document including the Appendices, as amended from time to time in accordance with Article 24.
- (b) “2014 Physician Master Agreement” means the agreement titled “2014 Physician Master Agreement” and entered into as of April 1, 2014 among the Government, the Medical Services Commission and the Doctors of BC, as subsequently amended from time to time.
- (c) “Services” means clinical and related teaching, research and clinical administrative services, and those Services provided under this Contract are specifically described in Appendix 1, as amended from time to time by written agreement between the Agency and the Physician.

## **ARTICLE 2 - TERM & RENEWAL**

2.1 This Contract will be in effect from \_\_\_\_\_ to \_\_\_\_\_ notwithstanding the date of its execution, unless terminated earlier as provided herein (the “Term”).

2.2 This Contract may be renewed for such period of time and on the 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.

2.3 Subject to clause 2.4, 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.

2.4 In the event that notice is given by either party in accordance with clause 2.2 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 3 - TERMINATION**

3.1 Subject to clause 3.2, either party may terminate the Contract without cause upon six (6) months’ written notice to the other party.

3.2 Either party may terminate this Contract without notice if the other party breaches a fundamental term of this Contract.

## **ARTICLE 4 - RELATIONSHIP OF PARTIES**

4.1 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.



4.2 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.

4.3 The Physician shall apply to be registered with WorkSafeBC and:

- (a) if registered as an employer maintain that registration during the Term and provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible,
- (b) if registered as an independent operator (at the Physician's option), provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible, or
- (c) if advised by WorkSafeBC that the Physician is a "worker", advise the Agency and provide the Agency with any related documentation from WorkSafeBC.

4.4 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' 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 Physician pursuant to this Contract.

4.5 The liability of Physician Association members for payments referred to in clause 4.4 is several and not joint.

4.6 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 4.4.

4.7 The indemnity in clause 4.6 survives the expiry or earlier termination of this Contract.

## **ARTICLE 5 - UNINCORPORATED ASSOCIATIONS**

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

5.1 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.

5.2 The Physician Association must develop a process to govern their intra-association relationship.

5.3 Subject to section 5.6, the Physician Association may designate a representative to represent the Physician Association with respect to all invoicing and payment matters under this Contract.

5.4 Where a notice is to be given to the Physician Association in accordance with Article 23, the Physicians agree that a single notice to a representative identified in Article 23 will constitute notice to all members of the Physician Association. Where notice is to be given to less than all of the members of the Physician Association, it must be given to those individual Physicians at the address(es) provided at Article 23.

5.5 Each member of the Physician Association has the separate and distinct right to terminate his/her relationship with the Agency without affecting the rights and obligations of the remaining members of the Physician Association and each Physician member must do so individually by providing the Agency with the notice required by Article 3 of this Contract, with an informational copy of such notice to the remaining Physicians.

5.6 The Agency may terminate this Contract with respect to individual members of the Physician Association without affecting the rights and obligations of the remaining Physicians by providing that Physician with the notice required by Article 3 of this Contract, with an informational copy of such notice to the remaining Physicians.

5.7 In the event of the departure of a member of the Physician Association pursuant to clauses 5.5 or 5.6, the parties will meet to discuss whether amendments to Appendices “1” or “2” are required and to make agreed changes.

5.8 The Physician Association must use reasonable efforts to replace departing members.

5.9 Any replacement or new physicians that the Physician Association members propose to add as a member are subject to approval by the Agency in accordance with its normal policies, by-laws and rules. Such approval will not be unreasonably withheld.

5.10 Subject to clause 5.9, a Physician 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 6 - ASSIGNMENT**

6.1 Unless specified otherwise, the Physician must not retain fee-for-service billings, including third party 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. For the purposes of this Article, third party billings include but are not limited to WorkSafeBC, ICBC, Armed Forces, disability insurers, non-insured services and services provided to non-beneficiaries.

6.2 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.

6.3 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 7 - AUTONOMY**

7.1 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, rules and regulations that are not inconsistent with or represent a material change to the terms of this Contract.

7.2 Subject to clause 7.1, the Physician is entitled to professional autonomy in the provision of the Services.

## **ARTICLE 8 - BRITISH COLUMBIA MEDICAL ASSOCIATION**

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

## **ARTICLE 9 - DISPUTE RESOLUTION**

9.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.

9.2 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*.

9.3 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.

9.4 Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration.

9.5 The Agency and the Physician must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC 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.

9.6 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 10 - SERVICE REQUIREMENTS**

10.1 The Physician will provide the Services as described in Appendix “1” and will schedule his/her availability to reasonably ensure the provision of the Services.

10.2 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.

10.3 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 Doctors of BC or the Government may refer the matter to the Physician Services Committee as a Local Interest Issue.

## **ARTICLE 11 - LICENSES & QUALIFICATIONS**

11.1 During the Term, the Physician will maintain:

- (a) registered membership in good standing with the College of Physicians and Surgeons of British Columbia and shall conduct his/her practice of medicine consistent with the conditions of such registration;
- (b) enrolment in the Medical Services Plan; and
- (c) all other licences, qualifications, privileges and credentials required to deliver the Services.

11.2 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.

11.3 All medical services under this Contract will be provided either directly by the Physician, or by a resident under the supervision and responsibility of the Physician, or by a clinical fellow under the supervision and responsibility of the Physician.

## **ARTICLE 12 - 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. The Physician will ensure that any contract between the Physician and a subcontractor will require that the subcontractor comply with all relevant terms of the Contract.

### **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 Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which the Contract is in effect. The Physician will provide the Agency with any information necessary for the Physician to access the Benefit Plans not in the possession of the Agency.

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;

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 that 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 If requested to do so by the Agency the Physician will promptly return to the Agency all materials, including all 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 in connection with the Services, that are in the Physician's possession or control.

## **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:

18.1.1 Where the Physician owns or rents the premises where the Services are provided, the Physician shall maintain comprehensive or commercial general liability insurance with a limit of not less than \$2,000,000. The Physician will add the Agency 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 Corporation or a comparable plan of insurance.

18.2 All of the insurance required under Article 18.1.1 will be primary and will 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 by the Agency.

## **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 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 this Article 19, 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 judgement to be confidential; and
- 19.3.3 the Agency has maintained adequate internal control to ensure the information remained confidential.

## **ARTICLE 20 - CONFLICT OF INTEREST**

20.1 During the Term, 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. If the parties are unable to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 9 of this Contract.

## **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 agrees to be bound by and observe the relevant patent and licensing policies of the Agency in effect from time to time. Where such policies require the assignment of intellectual property to the Agency, the Physician will execute and deliver all documents and do all such further things as are reasonably required to achieve the assignment.

## **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 e-mail, 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; or



23.1.3 If sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 23.

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

23.3 Address of Agency:

Address of Physician:

*If the Physician Association has selected a representative as per 5.4:*

Address and e-mail address of the Representative:

Address and e-mail address of the individual Physicians:

#### **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 2014 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 2014 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 - PHYSICIAN MASTER AGREEMENT AND PHYSICIAN MASTER SUBSIDIARY AGREEMENTS**

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

29.2 In the event that during Term, 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 Contract to ensure compliance with the new Physician Master Agreement and/or new Physician Master Subsidiary Agreement(s).

## **ARTICLE 30 - EXECUTION OF THE CONTRACT**

30.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document. All counterparts shall be construed together and shall constitute one in the same original agreement.

30.2 This Contract may be validly executed by transmission of a signed copy thereof by any electronic means of sending messages, including e-mail or facsimile transmissions, which provide a hard copy confirmation.

30.3 The parties to this Contract may execute the contract electronically via e-mail by typing their name above the appropriate signature line in the document attached to the e-mail, saving that document, and returning it by way of an e-mail address that can be verified as belonging to that party. The parties to this Contract agree that this Contract in electronic form shall be the equivalent of an original written paper agreement between the parties.

Dated at \_\_\_\_\_, British Columbia this \_\_\_\_ day of \_\_\_\_\_.

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

**Signed and Delivered On behalf of the Agency:**

\_\_\_\_\_  
Authorized Signatory

**Signed and Delivered on behalf of the Physician:**

\_\_\_\_\_

**APPENDIX 1****SERVICES/DELIVERABLES**

1. The Physician agrees to provide \_\_\_\_\_ hours of service per year.
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 shall pay the Physician bi-weekly/monthly at the rate of \$\_\_\_\_\_ per day/month/year that the Physician provides Services under the terms of this Contract, upon receipt of the 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 a monthly basis:



**Schedule “F” to the Alternative Payments Subsidiary Agreement**  
**TEMPLATE SESSIONAL CONTRACT FOR PHYSICIAN SERVICES**

**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 on the terms, conditions and understandings set out in this Sessional Contract;

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

**ARTICLE 1 - DEFINITIONS**

1.1 Words used in this Contract, including in the recitals and the Appendices, that are defined in the 2014 Physician Master Agreement or the Physician Master Subsidiary Agreements have the same meaning as in the 2014 Physician Master Agreement or the Physician Master

Subsidiary Agreements, unless otherwise defined in this Contract. In addition, in this Contract, including the recitals and Appendices, the following definitions apply:

- (a) “Contract” means this document including the Appendices, as amended from time to time in accordance with Article 23.
- (b) “Fiscal Quarter” means a three month period consisting of one of April 1 to June 30, July 1 to September 30, October 1 to December 31, or January 1 to March 31, in any given year.
- (c) “2014 Physician Master Agreement” means the agreement titled “2014 Physician Master Agreement” and entered into as of April 1, 2014 among the Government, the Medical Services Commission and the Doctors of BC, as subsequently amended from time to time.
- (d) “Services” means clinical and related teaching, research and clinical administrative services and those Services provided under this Contract are specifically described in Appendix 1, as amended from time to time by written agreement between the Agency and the Physician.
- (e) “Session” means 3.5 hours of Services and may be an accumulation of lesser time intervals adding up to 3.5 hours.

## **ARTICLE 2 - TERM & RENEWAL**

2.1 This Contract will be in effect from \_\_\_\_\_ to \_\_\_\_\_ notwithstanding the date of its execution, unless earlier terminated as provided herein (the “Term”).

2.2 This Contract may be renewed for such period of time and on the 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.

2.3 Subject to clause 2.4, 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.

2.4 In the event that notice is given by either party in accordance with clause 2.2 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 3 - TERMINATION**

3.1 Subject to clause 3.2, either party may terminate this Contract without cause upon six (6) months’ written notice to the other party.

3.2 Either party may terminate this Contract without notice if the other party breaches a fundamental term of this Contract.

#### **ARTICLE 4 - RELATIONSHIP OF PARTIES**

4.1 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.

4.2 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.

4.3 The Physician shall apply to be registered with WorkSafeBC and:

- (a) if registered as an employer maintain that registration during the Term and provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible,
- (b) if registered as an independent operator (at the Physician's option), provide the Agency with proof of that registration in the form of the registration number, copies of whatever documentation is issued by WorkSafeBC to confirm registration, and a clearance letter with a clearance date as far into the future as possible, or
- (c) if advised by WorkSafeBC that the Physician is a "worker", advise the Agency and provide the Agency with any related documentation from WorkSafeBC.

4.4 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' compensation 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 this Contract.

4.5 The liability of Physician Association members for payments referred to in clause 4.4 is several and not joint.

4.6 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 4.4.

4.7 The indemnity in clause 4.6 survives the expiry or earlier termination of this Contract.

## ARTICLE 5 - UNINCORPORATED ASSOCIATIONS

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

5.1 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.

5.2 The Physician Association must develop a process to govern their intra-association relationship.

5.3 Subject to section 5.6, the Physician Association may designate a representative to represent the Physician Association with respect to all invoicing and payment matters under this Contract.

5.4 Where a notice is to be given to the Physician Association in accordance with Article 22, the Physicians agree that a single notice to a representative identified in Article 22 will constitute notice to all members of the Physician Association. Where notice is to be given to less than all of the members of the Physician Association, it must be given to those individual Physicians at the address(es) provided at Article 22.

5.5 Each member of the Physician Association has the separate and distinct right to terminate his/her relationship with the Agency without affecting the rights and obligations of the remaining members of the Physician Association and each Physician member must do so individually by providing the Agency with the notice required by Article 3 of this Contract, with an informational copy of such notice to the remaining Physicians.

5.6 The Agency may terminate this Contract with respect to individual members of the Physician Association without affecting the rights and obligations of the remaining Physicians by providing that Physician with the notice required by Article 3 of this Contract, with an informational copy of such notice to the remaining Physicians.

5.7 In the event of the departure of a member of the Physician Association pursuant to clauses 5.5 or 5.6, the parties will meet to discuss whether amendments to Appendices "1" or "2" are required and to make agreed changes.

5.8 The Physician Association must use reasonable efforts to replace departing members.

5.9 Any replacement or new physicians that the Physician Association members propose to add as a member are subject to approval by the Agency in accordance with its normal policies, by-laws and rules. Such approval will not be unreasonably withheld.

5.10 Subject to clause 5.9, a Physician 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 6 - ASSIGNMENT**

6.1 Unless specified otherwise, the Physician must not retain fee-for-service billings, including third party 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. For the purposes of this Article, third party billings include but are not limited to WorkSafeBC, ICBC, Armed Forces, disability insurers, non-insured services and services provided to non-beneficiaries.

6.2 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.

6.3 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 7 - AUTONOMY**

7.1 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, rules and regulations that are not inconsistent with or represent a material change to the terms of this Contract.

7.2 to clause 7.1, the Physician is entitled to professional autonomy in the provision of the Services.

## **ARTICLE 8 - BRITISH COLUMBIA MEDICAL ASSOCIATION**

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

## **ARTICLE 9 - DISPUTE RESOLUTION**

9.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.

9.2 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*.

9.3 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.

9.4 Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration.

9.5 The Agency and the Physician must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC 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.

9.6 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 10 - SERVICE REQUIREMENTS**

10.1 The Physician will provide the Services and the number of Sessions as described at Appendix "1".

#### **ARTICLE 11 - LICENSES & QUALIFICATIONS**

11.1 During the Term, the Physician will maintain:

- (a) registered membership in good standing with the College of Physicians and Surgeons of British Columbia and shall conduct his/her practice of medicine consistent with the conditions of such registration;
- (b) enrolment in the Medical Services Plan; and
- (c) all other licences, qualifications, privileges and credentials required to deliver the Services.

11.2 All medical services under this Contract will be provided either directly by the Physician, or by a resident under the supervision and responsibility of the Physician, or by a clinical fellow under the supervision and responsibility of the Physician.

#### **ARTICLE 12 - THIRD PARTY CLAIMS**

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

#### **ARTICLE 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. The Physician will

ensure that any contract between the Physician and a subcontractor will require that the subcontractor comply with all relevant terms of the Contract.

#### **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 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).

14.4 The Agency must forward the necessary information to the Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which the Contract is in effect. The Physician will provide to the Agency with any information necessary for the Physician to access the Benefit Plans not in the possession of the Agency.

Benefits Manager

British Columbia Medical Association

115 – 1665 West Broadway

Vancouver, BC V6J 5A4

## **ARTICLE 15 - REPORTING**

15.1 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;

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 that 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 rules concerning practitioners' records under 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 requested to do so by the Agency, the Physician will promptly return to the Agency all materials, including all 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, in connection with the Services, that are in the Physician's possession or control.

## **ARTICLE 17 - LIABILITY PROTECTION**

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

17.1.1 Where the Physician owns or rents the premises where the Services are provided, the Physician shall maintain comprehensive or commercial general liability insurance with a limit of not less than \$2,000,000. The Physician will add the Agency 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.

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

17.2 All of the insurance required under Article 17.1.1 will be primary and will 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.

17.3 The Physician agrees to provide the Agency with evidence of the insurance/coverage required under this Article 17 at the time of execution of this Contract and otherwise from time to time as requested by the Agency.

## **ARTICLE 18 - CONFIDENTIALITY**

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

18.2 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:

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

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

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

18.2.4 required or expressly permitted by an enactment of British Columbia or of Canada;

18.2.5 made in accordance with any other applicable law or rule of law;

18.2.6 made in accordance with the Physician's professional obligations as identified by the College of Physicians and Surgeons of BC; or

18.2.7 in reference to this Contract.

18.3 For the purposes of this Article 18, information shall be deemed to be confidential where all of the following criteria are met:

18.3.1 the information is not found in the public domain;

18.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgement to be confidential; and

18.3.3 the Agency has maintained adequate internal control to ensure the information remained confidential.

## **ARTICLE 19 - CONFLICT OF INTEREST**

19.1 During the Term, 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.

19.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 19.1. If the parties are unable to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 9 of this Contract.

## **ARTICLE 20 - OWNERSHIP**

20.1 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. Where such policies require the assignment of intellectual property to the Agency, the Physician will execute and deliver all documents and do all such further things as are reasonably required to achieve the assignment.

## **ARTICLE 21 - AUDIT, EVALUATION AND ASSESSMENT**

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

## **ARTICLE 22 - NOTICES**

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

- 22.1.1 If mailed by prepaid double registered mail to the addressee's address listed below, on date of confirmation of delivery; or
- 22.1.2 If delivered by hand to the addressee's address listed below on the date of such personal delivery; or
- 22.1.3 If sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 22.

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

22.3 Address of the Agency:

Address of the Physician:

*If the Physician Association has selected a representative as per 5.4:*

Address and e-mail address of the Representative:

Address and e-mail address of the individual Physicians:

### **ARTICLE 23 - AMENDMENTS**

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

### **ARTICLE 24 - ENTIRE CONTRACT**

24.1 This Contract, the 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 Physician Master Agreement and the Physician Master Subsidiary Agreements.

### **ARTICLE 25 - NO WAIVER UNLESS IN WRITING**

25.1 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 26 - HEADINGS**

26.1 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 27 - ENFORCEABILITY AND SEVERABILITY**

27.1 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 28 - PHYSICIAN MASTER AGREEMENT AND PHYSICIAN MASTER SUBSIDIARY AGREEMENTS**

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

28.2 In the event that during the Term, a new Physician Master Agreement and/or new Physician Master Subsidiary Agreements 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 Contract to ensure it complies with the new Physician Master Agreement and/or new Physician Master Subsidiary Agreements.

## **ARTICLE 29 - EXECUTION OF THE CONTRACT**

29.1 This Contract and any amendments thereto may be executed in any number of counterparts with the same effect as if all parties hereto had signed the same document. All counterparts shall be construed together and shall constitute one in the same original agreement.

29.2 This Contract may be validly executed by transmission of a signed copy thereof by any electronic means of sending messages, including e-mail or facsimile transmissions, which provide a hard copy confirmation.

29.3 The parties to this Contract may execute the contract electronically via e-mail by typing their name above the appropriate signature line in the document attached to the e-mail, saving that document, and returning it by way of an e-mail address that can be verified as belonging to that party. The parties to this Contract agree that this Contract in electronic form shall be the equivalent of an original written paper agreement between the parties.

Dated for reference this \_\_\_\_ day of \_\_\_\_\_.

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

**Signed and Delivered On behalf of the Agency:**

\_\_\_\_\_  
Authorized Signatory

**Signed and Delivered on behalf of the Physician:**

\_\_\_\_\_

## APPENDIX 1

### SERVICES/DELIVERABLES

1. Subject to paragraph 2 of this Appendix 1, the Physician shall provide \_\_\_\_\_ Sessions per fiscal year during the Term in the \_\_\_\_\_ [*insert Program/Department*], at \_\_\_\_\_ [*insert site or sites*].
  
2. If during any Fiscal Quarter during the Term, the Physician provides fewer than \_\_\_\_\_ Sessions [*The number to be inserted here will be ¼ of the number noted in paragraph 1 above*] then the Agency may reallocate from this Contract a number of sessions up to the number that is equal to the difference between \_\_\_\_\_ [*The number to be inserted here will be ¼ of the number noted in paragraph 1 above*] and the number of Sessions provided by the Physician during the Fiscal Quarter in question, in which case the total number of Sessions to be provided by the Physician under this Contract will be automatically reduced by the number of Sessions reallocated.
  
3.
  - (a) Subject to paragraph 3 b) of this Appendix 1, the Physician will provide the Sessions in accordance with a schedule established by the Parties, in advance for each Fiscal Quarter.
  - (b) It is understood that the schedule established in accordance with paragraph 3 a) of this Appendix 1 will be the expected and typical schedule but that variations may occur to it from time to time due to planned time off for the Physician, and client needs and care commitments of greater urgency. Unless impracticable, such variations will be discussed between the Physician and the \_\_\_\_\_ in advance.
  
4. In the event that in order to meet operational requirements, the Agency and the Physician agree that the Physician will provide Services beyond the Sessions agreed to in paragraph 1 above, the Agency will ensure that the Physician receives payment for such Services at the appropriate sessional rate.
  
5. 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.
- 6. The Physician will supply the following support, technology, material and supplies:
- 7. The Agency will provide the following support, technology, material and supplies:



**APPENDIX 2****PAYMENT**

1. The Agency will pay the Physician at the rate of \$\_\_\_\_\_ per Session that the Physician provides under the terms of this Contract, upon receipt of an invoice, in a form acceptable to the Agency, for the Services provided.
2. Subject to section 4 of Appendix 1, the total amount paid by the Agency to the Physician under this Contract will not exceed \$\_\_\_\_\_.
3. All invoices for Services provided under this Contract must:
  - (a) identify by date and hours the Sessions or partial Sessions for which payment is claimed;
  - (b) be accompanied by an identification of the specific Service(s) provided during each such Session or partial Session using the Agency's sessional coding system; and
  - (c) be submitted to the Agency within 30 days following the end of the month during which the Services were 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.

\_\_\_\_\_  
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 covered by that Contract.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

**APPENDIX 5**  
**REPORTING**

The following information must be provided by the Physician to the Agency on a monthly basis:

**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 or the Allocation  
Committee under Sections 4 and 5**

**General Principles**

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.

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.

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**

**2014 BENEFITS SUBSIDIARY AGREEMENT**

THIS AGREEMENT made as of the 1st day of April, 2014

**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 “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

**WITNESSES THAT WHEREAS:**

- A. The Doctors of BC, the MSC and the Government have agreed to renew and replace the 2012 PMA, the 2012 General Practitioners Subsidiary Agreement, the 2012 Specialists Subsidiary Agreement, the 2012 Rural Practice Subsidiary Agreement, the 2012 Alternative Payments Subsidiary Agreement and the 2012 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, 2014; 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 2014 PHYSICIAN MASTER AGREEMENT**

1.1 This Agreement is one of the Physician Master Subsidiary Agreements under the 2014 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 2014 Physician Master Agreement have the same meaning as in the 2014 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 Doctors of BC 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 “**2014 Physician Master Agreement**” means the agreement titled “2014 Physician Master Agreement” among the Government, the Doctors of BC, and the MSC, dated April 1, 2014.

2.11 The provisions of sections 1.2 to 1.8 inclusive of the 2014 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, 2014.

3.2 This Agreement shall be for the same term as the 2014 Physician Master Agreement and will be subject to renegotiation and/or termination pursuant to Articles 27 and 28 of the 2014 Physician Master Agreement.

### ARTICLE 4 - PHYSICIAN BENEFITS COMMITTEE

4.1 The Government and the Doctors of BC 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 Doctors of BC and up to three members appointed by the Government, and will be co-chaired by one member chosen by the Doctors of BC 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 2014 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 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 Doctors of BC may make recommendations to the Adjudicator regarding such matter. If the Government or the Doctors of BC initially refers the matter to the Adjudicator, the opposing party may, at their election and within 10 days of the receipt of the notice advise that it wishes to have the matter referred to the Adjudication Committee instead of an Adjudicator, and in such case the matter will be dealt with by the Adjudication Committee. The Adjudicator or the Adjudication Committee, as the case may be, shall then 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 Doctors of BC 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 2014 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 2014 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 PDI, CME, CPRSP and Parental Leave Program is as follows:

- (a) \$11,700,000 for the PDI;
- (b) \$9,725,000 for the CME;
- (c) \$52,370,000 for the CPRSP;
- (d) \$4,300,000 for the Parental Leave Program; and
- (e) \$4,690,000 to be allocated on annual basis by the Benefits Committee among the PDI, CME, CPRSP, and Parental Leave Program.

6.2 The Government will provide the following funds on an annual basis to be allocated by the Benefits Committee to increase the base funding of the PDI, CME, CPRSP, and Parental Leave Program:

- (a) an additional \$10.6 million will be made available effective April 1, 2015;
- (b) an additional \$2.9 million will be made available effective April 1, 2016;
- (c) an additional \$1.9 million will be made available effective April 1, 2017;
- (d) an additional \$1.9 million will be made available effective April 1, 2018.

6.3 Effective April 1, 2014:

- (a) \$2.95 million from any existing unexpended General Practice Services Committee funds from the 2012 General Practice Subsidiary Agreement will be applied by the Benefits Committee on a one time basis among the PDI, CME, CPRSP, and Parental Leave Program; and
- (b) \$2.95 million from any existing unexpended Specialist Services Committees funds from the 2012 Specialist Subsidiary Agreement will be applied by the Benefits Committee on a one time basis among the PDI, CME, CPRSP, and Parental Leave Program.

6.4 The annual base funding of \$22,000,000 for the CMPA Rebate Program shall continue and will be increased on an annual basis as follows:

- (a) an additional \$1.9 million will be made available effective April 1, 2015;

- (b) an additional \$5.0 million will be made available effective April 1, 2016;
- (c) an additional \$5.2 million will be made available effective April 1, 2017; and
- (d) an additional \$6.6 million will be made available effective April 1, 2018.

6.5 The following funding will be made available on a one time basis for the CMPA Rebate Program from the unexpended General Practice Services Committee funds as described in section 5.5 of the 2014 General Practitioners Subsidiary Agreement and unexpended Specialist Services Committee funds as described in section 6.4 of the 2014 Specialist Subsidiary Agreement:

- (a) up to \$7.3 million for Fiscal Year 2014/2015 as required to mitigate CMPA cost increases to physicians; and
- (b) up to \$24.3 million for Fiscal Year 2015/2016 as required to mitigate CMPA cost increases to physicians.

For each of Fiscal Years 2014/2015 and 2015/2016 the contribution of these unexpended funds shall be apportioned between the General Practice Services Committee funds and the Specialist Services Committee funds based on the increased CMPA costs distribution between General Practitioners and Specialists in accordance with the applicable CMPA Fee Schedule for those years.

6.6 The Government and physicians will share ongoing cost increases to the CMPA Fee Schedule in Fiscal Year 2016/17 and for each Fiscal Year thereafter for the term of this Agreement. On the basis of CMPA costs data for the Fiscal Year 2016/17, the parties will determine the amount by which CMPA costs are expected to exceed the funding provided by Government pursuant to section 6.4 of this Agreement (“Extraordinary Amount”). The Government will contribute 70% of the Extraordinary Amount to the CMPA Rebate Program up to a maximum of \$17 million in each such Fiscal Year and physicians will absorb the balance of the cost increase.

6.7 For each of the Fiscal Years 2014/2015 through to 2018/2019 inclusive, the Benefit Committee will support the level of the Benefit Plans (excluding the CMPA Rebate Program) in existence as of March 31, 2014 by:

- (a) allocating the funding described in sections 6.2 and 6.3 of the Agreement;
- (b) use of surplus funds in any of the Benefit Plans, other than the CMPA Rebate Program; and
- (c) if the funds referred to in section 6.7(a) and (b) 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.

6.8 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 6.7, 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.

6.9 The Government will provide funding to the PHP in order to support the increasing demand for its services among physicians as follows:

- (a) \$600,000 will be made available for Fiscal Years 2014/15 through to 2015/16 provided that in each such Fiscal Year the Doctors of BC and the College of Physicians and Surgeons of British Columbia together contribute an additional \$600,000 so that a total of \$1.2 million is available to the PHP in each of Fiscal Years 2014/15 through to 2015/16.
- (b) \$750,000 will be made available for Fiscal Year 2016/2017 provided that the Doctors of BC and the College of Physicians and Surgeons of British Columbia together contribute an additional \$750,000 so that a total of \$1,5 million is available to the PHP in Fiscal Year 2016/2017.
- (c) \$850,000 will be made available for Fiscal Year 2017/2018 provided that the Doctors of BC and the College of Physicians and Surgeons of British Columbia together contribute an additional \$850,000 so that a total amount of \$1.7 million is available to the PHP in Fiscal Year 2017/18.
- (d) \$900,000 per year will be made available effective from Fiscal Year 2018/2019 provided that the Doctors of BC and the College of Physicians and Surgeons of British Columbia together contribute an equal amount so that a total amount of \$1.8 million per year is available to the PHP.

## **ARTICLE 7 - ADMINISTRATION OF THE BENEFITS PLANS**

7.1 Concurrently with the execution and delivery of this Agreement, the Government and the Doctors of BC will renew and amend the contract between them for administration of the Benefit Plans, except the PHP (the “**2014 Benefits Administration Agreement**”). The 2014 Benefits Administration Agreement shall include the following:

- (a) The responsibilities of the Doctors of BC 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 Doctors of BC 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 Doctors of BC.

- (c) It is understood and agreed that the Doctors of BC may charge physicians who are not members of the Doctors of BC 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 Doctors of BC 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 Doctors of BC 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, 2018.

7.2 The costs associated with administering the Benefit Plans that are the subject of the 2014 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC associated with collecting the information.

7.6 The Doctors of BC 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 Doctors of BC 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 2014 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 - CMPA COST CONTAINMENT COMMITTEE**

10.1 The parties agree to make efforts and to take steps as described in this Article 10 to address the issue of rising CMAA costs and to reduce the costs associated with the CMAA Fee Schedule in Fiscal Year 2016/2017 and each Fiscal year thereafter for the term of this Agreement.

10.2 The Government and the Doctors of BC shall create a committee ("CMAA Cost Containment Committee" or "CCCC") in accordance with the provisions of this Article 10, whose role it will be to explore, analyze, develop and recommend options that the parties may take in order to reduce the Extraordinary Amount.

10.3 The CCCC will be composed of an equal number of senior representatives appointed by each of the Government and the Doctors of BC such as an Assistant Deputy Minister of Health, a Doctors of BC Executive Director or a Physician representative, and will be co-chaired by one member chosen by the Doctors of BC appointees and one member chosen by the Government appointees.

10.4 The recommendations of the CCCC will be by consensus decision. Where no consensus decision is reached on the recommendations, the Government members and the Doctors of BC members may make separate recommendations.

10.5 The CCCC shall engage the services of an individual with actuarial expertise to prepare a report setting out the sources of the extraordinary increases in CMPA membership dues and options to reduce those increases.

10.6 The CCCC may engage other third parties for expert assistance and advice or to prepare additional reports as it deems necessary.

10.7 Fifty percent of the costs and expenses of the CCCC will be paid from the CMPA annual base funding described at section 6.4 and the remaining fifty percent of such costs and expenses will be paid by the Government.

10.8 The CCCC will complete its work and present a written report to the Government and Doctors of BC no later than July 1, 2015 (“**CMPA Cost Containment Report**”).

10.9 The CCCC will consider all relevant information in preparing the CMPA Cost Containment Report, including any actuarial and expert reports or advice provided by third parties.

10.10 The Cost Containment Report must, among other things:

- (a) identify any cost increases arising from malpractice litigation;
- (b) identify any cost increases arising from other CMPA services provided to its members; and
- (c) include short term and long term recommendations, as applicable, to reduce the CMPA costs generally and the Extraordinary Amount in particular, commencing in the 2016/2017 Fiscal Year, and continuing thereafter.

10.11 No later than October 31, 2015, the Benefits Committee will provide to the Government and the Doctors of BC an estimate of the additional funding required in order to maintain the existing benefit level of the CMPA Rebate Program for the 2016/17 Fiscal Year. The Benefits Committee will base this estimate on the 2016 CMPA Fee Schedule and the physician population receiving benefits under the CMPA Rebate Program.



10.12 Following receipt of the Cost Containment Report and the Benefits Committee estimate described in section 10.10 and 10.11, the Government and the Doctors of BC will meet to:

- (a) review the implications of the Cost Containment Report;
- (b) determine the Extraordinary Amount;
- (c) determine what steps, if any, the parties may take to reduce the Extraordinary Amount;

and following this discussion, the parties may, by agreement and subject to the appropriate ratification processes, incorporate changes to the PMA to address rising costs of the CMPA Rebate Program.

10.13 If by December 31, 2015 the Government and the Doctors of BC are unable to agree on the determinations described in sections 10.12 (b) and (c), these matters will be referred to Eric Harris who will consider the CMPA Cost Containment Report and the recommendations therein, determine his own process and, no later than March 1, 2016, make a final and binding decision regarding the determinations described in sections 10.12(b) and (c).

## ARTICLE 11 - DISPUTE RESOLUTION

11.1 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 2014 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, 2014.

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 Doctors of BC 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 funding for the CMPA Rebate Program as set out in Article 6 of the Benefits Subsidiary Agreement will be allocated among physician type of work categorizations so that the net proportional contribution to CMPA dues by physicians as set out in the 1985 CMPA fee structure is maintained unless otherwise determined by a consensus decision of the Benefits Committee.

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 One-Time Payment in 2014/15**

- (a) A one-time payment will be made to individual Physicians equivalent to 0.5% of the amount of their payments during Fiscal Year 2014/15 from the following sources:
  - (i) Fees;
  - (ii) Sessional Contracts;
  - (iii) Service Contracts and Salary Agreements;
  - (iv) reading fees for screening mammography;
  - (v) MRI fees; and
  - (vi) Rural Retention Percentage Premiums.

In no event shall the total cost to the Government under this section 1.1(a) exceed \$15.2 million.

#### **1.2 Compensation Changes in 2015/16**

- (a) Effective April 1, 2015,
  - (i) 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 2014 Physician Master Agreement.
  - (ii) Sessional Contract Rates will be increased by 0.5% over the Sessional Contract Rates in effect on March 31, 2015 (excluding the Specialist Sessional Forensic Psychiatric fee) 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, 2015 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, 2015 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, 2015 to fund the increases in the cost of providing services.
- (b) Effective April 1, 2015, an additional \$4.5 million will be made available annually to fund further increases to the Sessional Contract Rates as follows:
  - (i) first to increase the Sessional Contract Rate for Specialist Physicians providing services to the Maples Adolescent Treatment Centre and Youth Forensic Services to bring the rate to \$729.17 effective April 1, 2015 ; and
  - (ii) the remainder of the \$4.5 million to be allocated as an equal percentage increase to the remaining Sessional Contract Rates in effect as of March 31, 2015.

In no event shall the total cost to the Government under this section 1.2(b) exceed \$4.5M in 2015/16.

### 1.3 Compensation Changes in 2016/17

- (a) Effective April 1, 2016,
  - (i) 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 2014 Physician Master Agreement.
  - (ii) Sessional Contract Rates will be increased by 0.5% over the Sessional Contract Rates in effect on March 31, 2016 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, 2016 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, 2016 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, 2016 to fund the increases in the cost of providing services.
- (b) Effective April 1, 2016, \$9 million will be made available to fund adjustments to be made by the Allocation Committee to the Salary Agreement Ranges and the Service Contract Ranges in response to physician recruitment and retention challenges and to address issues of equity within the Salary Agreement Ranges and the Service Contract Ranges respectively. 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 1.3(b) exceed \$9 million in any one Fiscal Year.

#### 1.4 Compensation Changes in 2017/18

- (a) Effective April 1, 2017,
  - (i) 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 2014 Physician Master Agreement.
  - (ii) Sessional Contract Rates will be increased by 0.5% over the Sessional Contract Rates in effect on March 31, 2017 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, 2017 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, 2017 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, 2017 to fund the increases in the cost of providing services.
- (b) Effective April 1, 2017, an additional \$4.5 million will be made available annually to fund further increases to the Sessional Contract Rates to be allocated as an equal percentage increase to the Sessional Contract Rates in effect as of March 31, 2017. In no event shall the total cost to the Government under this section 1.4(b) exceed \$4.5M in 2017/18.
- (c) Effective April 1, 2017, \$8 million will be made available to fund adjustments to be made by the Allocation Committee to the Salary Agreement Ranges and the Service Contract Ranges in response to physician recruitment and retention challenges and to address issues of equity within the Salary Agreement Ranges and the Service Contract Ranges respectively. 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 1.4(c) exceed \$8 million in any one Fiscal Year.

## 1.5 Compensation Changes in 2018/19

- (a) Effective April 1, 2018,
  - (i) 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 2014 Physician Master Agreement.
  - (ii) Sessional Contract Rates will be increased by 0.5% over the Sessional Contract Rates in effect on March 31, 2018 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, 2018 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, 2018 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, 2018 to fund the increases in the cost of providing services.
- (b) Effective April 1, 2018, \$11 million will be made available to fund adjustments to be made by the Allocation Committee to the Salary Agreement Ranges and the Service Contract Ranges in response to physician recruitment and retention challenges and to address issues of equity within the Salary Agreement Ranges and the Service Contract Ranges respectively. 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 1.5(b) exceed \$11 million in any one Fiscal Year.

## 1.6 Specialist Disparity Funding

- (a) The Government will provide the following funding (“Specialist Disparity Fund”) to be allocated to Fees paid to Specialist Sections in order to address interprovincial and intersectional disparity among fee-for-service specialists:
  - (i) \$15 million per year made available effective April 1, 2016;
  - (ii) an additional \$16 million per year made available effective April 1, 2017; and
  - (iii) an additional \$24 million per year made available effective April 1, 2018.

- (b) The gross allocation of the funds described in this section 1.6 among Specialist Sections for Fiscal Years 2016/2017, 2017/2018 and 2018/2019 will be adjudicated by a third-party adjudicator who will consider the effect of both intersectional and interprovincial disparities in compensation and will allocate half the funds in each Fiscal Year toward addressing intersectional disparities in compensation and half the funds in each Fiscal Year toward addressing interprovincial disparities in compensation. Once the gross allocation of funds for all three Fiscal Years is determined by the adjudicator, the resulting changes to the Payment Schedule will be determined in accordance with Articles 12 and 13 of the 2014 Physician Master Agreement, and will be effective as of April 1<sup>st</sup> of the Fiscal Year for which the funding is allocated. 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) The adjudication described in this section 1.6 will be conducted in accordance with procedures as determined by the adjudicator and will include an opportunity for the Specialist Sections, the Government and the Doctors of BC to make submissions on the allocation of the funds over all three Fiscal Years. The adjudication process will commence no later than June 1, 2015 and will conclude by December 31, 2015.

## 1.7 General

- (a) Consistent with section 7.3 of the Alternative Payments Subsidiary Agreement, 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 be entitled to the applicable lump sum payment and compensation increases described in sections 1.1, 1.2(a) (iii), 1.3(a) (iii), 1.4(a) (iii) and 1.5(a) (iii) of this Appendix F only.
- (b) The increases identified in sections 1.2(a), 1.3(a), 1.4(a), and 1.5(a) do not apply to targeted funds including, but not limited to, new targeted funds which have been reflected in sections 1.2(b), 1.3(b), 1.4(b), 1.4(c), 1.5(b) and 1.6(a) 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 the year in which those targeted funds are introduced. 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, 2014 for any Targeted Increase made effective April 1, 2015, Fiscal Year commencing April 1, 2015 for any

Targeted Increase made effective April 1, 2016, Fiscal Year commencing April 1, 2016 for any Targeted Increase made effective April 1, 2017 and Fiscal Year commencing April 1, 2017 for any Targeted Increase made effective April 1, 2018; and

- (ii) the increases identified in sections 1.2,(a), 1.3(a), 1.4(a), and 1.5(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 1.2,(a), 1.3(a), 1.4(a), and 1.5(a) in the year in which such Targeted Increase is introduced.

- (c) The lump sum payment and increases to Fees set out in sections 1.1(a)(i), 1.2(a)(i), 1.3(a)(i), 1.4(a)(i) and 1.5(a)(i) of this Appendix F do not apply to Laboratory Fees, General Practice Services Committee Fees, Specialist Services Committee Fees and Shared Care Committee Fees.

#### 1.8 Economic Stability Dividend

- (a) The Government's 2014 Economic Stability Dividend applies to physicians where funding for their services is, in whole or part, provided by the Government either directly or through Agencies as described in Appendix I.
- (b) Any payments from the Economic Stability Dividend are to be allocated as an equal percentage increase to Fees, Sessional Rates, Service Contract Ranges and Service Contract Rates, and Salary Agreement Ranges and Salary Agreement Rates.

## **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 2014 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 “2014 Physician Master Agreement” and entered into as of April 1, 2014 among the Government of British Columbia, the Medical Services Commission (MSC) and the British Columbia Medical Association (Doctors of BC), 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.

## **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 delivered by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address listed below.

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 2014 Physician Master Agreement and the 2014 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

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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 Doctors of BC to initiate a Call Back Dispute on his/her behalf. If the Doctors of BC agrees to do so, the Doctors of BC 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 Doctors of BC 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 Doctors of BC 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 Doctors of BC will share the costs associated with the referral of Call Back Disputes to the Call Back Adjudicator.

-190-  
**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 ✓ 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:

1. I assessed the patient as requiring medical services on an emergency basis; and
2. 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 Doctors of BC to initiate a Call Back Dispute on my behalf. The Doctors of BC 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**

**MEMBERS OF THE ROSTER (AS OF April 1, 2014)**

Rod Germaine

Stan Lanyon

Robin McFee

## **APPENDIX I**

### **LETTER OF AGREEMENT – ECONOMIC STABILITY DIVIDEND BETWEEN:**

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

(the “**Government**”)

**AND:**

**BRITISH COLUMBIA MEDICAL ASSOCIATION**

(the “**Doctors of BC**”)

**AND:**

**MEDICAL SERVICES COMMISSION**

(the “**MSC**”)

### **Definitions**

1. In this Letter of Agreement:

“**Agreement year**” means each twelve (12) month period commencing on the first day of the 2014 Physician Master Agreement. Specifically, the agreement year that commences on April 1, 2014 is April 1, 2014 to March 31, 2015 and each period from April 1 to March 31 for the term of the 2014 Physician Master Agreement.

“**Economic Forecast Council**” means the Economic Forecast Council appointed under s. 4 of the *Budget Transparency and Accountability Act*, [S.B.C. 2000] c. 23;

“**Forecast GDP**” means the average forecast for British Columbia’s real GDP growth made by the Economic Forecast Council and as reported in the annual February budget of the government;

“**Fiscal year**” means the fiscal year of the Government as defined in the *Financial Administration Act* [1996 S.B.C.] c. 138 as ‘the period from April 1 in one year to March 31 in the next year’;

**“Calendar year”** Is a twelve (12) month period starting January 1<sup>st</sup> and ending December 31<sup>st</sup> of the same year based upon the Gregorian calendar;

**“GDP” or “Gross Domestic Product”** for the purposes of this LOA means the expenditure side value of all goods and services produced in British Columbia for a given year as stated in the BC Economic Accounts;

**“GI” or “General Increase”** means a general increase resulting from the formula set out in this LOA and applied as a percentage increase to all rates in the 2014 Physician Master Agreement referred to in paragraph 9 of this Letter of Agreement on the first pay day after the commencement of the eleventh (11<sup>th</sup>) month in an agreement year;

**“Real GDP”** means the GDP for the previous fiscal year expressed in constant dollars and adjusted for inflation produced by Statistics Canada’s Provincial and Territorial Gross Domestic Product by Income and by Expenditure Accounts (also known as the provincial and territorial economic accounts) and published as “Real Gross Domestic Product at Market Prices” currently in November of each year.

### **The Economic Stability Dividend**

2. The Economic Stability Dividend shares the benefits of economic growth between physicians and the Province contingent on growth in BC’s real GDP.
3. Physicians will receive a general increase (GI) equal to one-half (1/2) of any percentage gain in real GDP above the forecast of the Economic Forecast Council for the relevant calendar year.
4. For greater clarity and as an example only, if real GDP were one percent (1%) above forecast real GDP then physicians would be entitled to a general increase of one-half of one percent (0.5%).

### **Annual Calculation and publication of the Economic Stability Dividend**

5. The Economic Stability Dividend will be calculated on an annual basis by the Minister of Finance for each agreement year commencing in 2015/16 to 2018/2019 and published through the PSEC Secretariat.
6. The timing in each calendar year will be as follows:
  - (a) February Budget – Forecast GDP for the upcoming calendar year;
  - (b) November of the following calendar year – Real GDP published for the previous calendar year;
  - (c) November - Calculation by the Minister of Finance of fifty percent (50%) of the difference between the Forecast GDP and the Real GDP for the previous calendar year;



- (d) Advice from the PSEC Secretariat to employers' associations, funders, employers, agencies, professional associations, and unions of the percentage allowable General Increase, if any, for each bargaining unit or group with authorization to employers and agencies to implement the Economic Growth Dividend.

7. For greater clarity and as an example only:

For agreement year 3 (2016/17):

- (a) February 2015 – Forecast GDP for calendar 2015;
- (b) November 2016 – Real GDP published for calendar 2015;
- (c) November 2016 - Calculation of the fifty percent (50%) of the difference between the 2015 Forecast GDP and the 2015 Real GDP by the Minister of Finance through the PSEC Secretariat;
- (d) Direction from the PSEC Secretariat to employers' associations, agencies, employers, associations and unions of the percentage allowable General Increase, if any, for each group with authorization to employers and agencies to implement the Economic Growth Dividend;
- (e) Payment will be made concurrent with the Increases on the first pay period after respectively February, 1, 2016, February 1, 2017, February 1, 2018 and February 1, 2019.

#### **Availability of the Economic Stability Dividend**

8. The Economic Stability Dividend will be provided for each of the following agreement years: 2015/16 (based on 2014 GDP); 2016/17 (based on 2015 GDP); 2017/18 (based on 2016 GDP); and, 2018/19 (based on 2017 GDP).

#### **Allowable Method of Payment of the Economic Stability Dividend**

9. The Economic Stability Dividend must be applied as a percentage increase to Fees, Sessional Rates, Service Contract Ranges and Service Contract Rates, and Salary Agreement Ranges and Salary Agreement Rates, as defined in the 2014 Physician Master Agreement and for no other purpose or form.