



**PRACTICING FULL SERVICE FAMILY PHYSICIANS
PRIMARY CARE SERVICES**

CLINIC NAME

BETWEEN:

**THOSE PHYSICIANS AND PROFESSIONAL MEDICAL CORPORATIONS LISTED ON THE
SIGNATURE PAGE OF THIS CONTRACT**

(each is individually a “Physician” and collectively all
are referred to as the “Physicians”)

AND:

VANCOUVER ISLAND HEALTH AUTHORITY

(the “Agency”)

WHEREAS the Ministry of Health is committed to increasing patient access to primary care and expanding primary care capacity across British Columbia via the implementation of Primary Care Networks and Patient Medical Homes and supporting comprehensive, high-quality, person-centred, culturally safe, interdisciplinary and team based primary care services;

AND WHEREAS the Agency has committed to participating in the development and implementation of Primary Care Networks;

AND WHEREAS the Physicians have an established primary care practice and are committed to transitioning their practice into a Patient Medical Home, and integrating their practice with the Primary Care Network in their community once established;

AND WHEREAS the Ministry of Health and the Doctors of BC have consulted on this form of provincial contract to enable Physicians with an established primary care practice to transition from fee-for-service to a contract;

AND WHEREAS the Physicians wish to contract with the Agency and the Agency wishes to contract with the Physicians to provide funding to allow the Physicians to receive compensation for providing comprehensive, accessible, patient-focused primary health care to their Practice’s patients on the terms, conditions and understandings set out in this Contract;

AND WHEREAS the Ministry of Health, the Agency and the Physicians confirm that the Physicians’ provision of the Services to the Practice’s patients does not make the Physicians employees of or independent contractors to, the Agency;

THEREFORE in consideration of the mutual promises contained in this Contract, the Physicians 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 2019 Physician Master Agreement or Physician Master Subsidiary Agreements have the same meaning as in the 2019 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:
- 1.1.1 **“2019 Physician Master Agreement”** means the agreement titled “2019 Physician Master Agreement” and entered into as of April 1, 2019 among the Government, the Medical Services Commission and the British Columbia Medical Association (the **“Doctors of BC”**), as subsequently amended from time to time.
 - 1.1.2 **“Access Services”** means those steps taken by Physicians to track access in accordance with sections 9 a. and b. of Appendix 2.
 - 1.1.3 **“Adequate Medical Record”** has the same meaning as that set out at Section C. 10 “Adequate Medical Records of a Benefit under MSP” of the General Preamble to the Medical Services Commission (MSC) Payment Schedule.
 - 1.1.4 **“Adjusted Clinical Groups (ACG)”** means a series of mutually exclusive health status categories that are defined by morbidity, age and gender as defined by the Johns Hopkins University ACG classification system in place as of the date of signing of this Contract.
 - 1.1.5 **“ACG Category”** or **“ACG Categories”** refers to the (morbidity-based) groups defined by the Johns Hopkins ACG software in place as of the date of signing of this Contract. Each patient is placed into one ACG category. ACG categories are assigned using a rolling 12-month diagnosis history.
 - 1.1.6 **“ACG Category Cost”** means the average in-community GP service FFS cost in each ACG Category.
 - 1.1.7 **“ACG Cost”** means the average ACG Category Cost for a specific cohort of patients.
 - 1.1.8 **“Attachment Code”** means the record of patient attachment provided to the Medical Services Plan (MSP)/Health Insurance BC by a Physician via a \$0 Teleplan attachment code and the Clinic’s Payee Number in accordance with Appendix 5.
 - 1.1.9 **“Attachment Services”** means those steps taken by the Physicians to confirm attachment of patients in accordance with sections 9 f. – h. of Appendix 2.
 - 1.1.10 **“Attached Patients”** means those patients who are attached to a Physician and identified through an Attachment Code.
 - 1.1.11 **“BC Attached Patients”** means those patients who are determined to be attached in accordance with the Ministry’s attachment algorithm, which identifies a patient’s attachment status by identifying the group practice or practitioner who provided the majority of a patient’s recent care.
 - 1.1.12 **“Clinic”** means **Clinic Name Inc.**, located at <address>.
 - 1.1.13 **“Clinic’s Payee Number”** means Medical Services Plan (MSP) Payee No. **XXXXX**.

- 1.1.14 “**Clinical Administrative Services**” means non-patient care activities that may not be patient-specific but require the professional expertise of a physician, including Attachment Services, Access Services and QI Services.
- 1.1.15 “**Clinically-related teaching**” means teaching provided concurrent with patient care.
- 1.1.16 “**Clinically-related research**” means research directly related to the needs of a particular patient (for example, investigating the appropriateness of particular diagnostic and therapeutic interventions).
- 1.1.17 “**College**” means the applicable professional college under the *Health Professions Act* for the Physicians and Practice Personnel providing Services under this Agreement.
- 1.1.18 “**Complexity Weight**” means the ACG Cost of the Practice Panel divided by the ACG Cost of BC Attached Patients.
- 1.1.19 “**Contract**” means this document including the Appendices, as amended from time to time in accordance with Article 24.
- 1.1.20 “**Contract Value**” is the specific value associated with each FTE as described at Appendix 3.
- 1.1.21 “**Direct Patient Care**” means clinical intervention with a specific patient present, including the concurrent provision of clinically-related teaching and clinically-related research.
- 1.1.22 “**Encounter Record**” means the record of the primary care services provided to a patient by the Physicians, including simplified encounter codes (which capture the Physicians’ practice activities) provided by the Medical Services Plan/Health Insurance BC, as amended from time to time, and diagnostic codes (ICD9).
- 1.1.23 “**Encounter Reporting**” means the transmission of Encounter Records to the Medical Services Plan (MSP)/Health Insurance BC.
- 1.1.24 “**Fee-for-service (FFS)**” means the right to bill the Medical Services Plan for benefits under the *Medicare Protection Act* according to the Medical Services Commission (MSC) Payment Schedule, as amended from time to time.
- 1.1.25 “**Fiscal Year**” means a period of twelve consecutive months beginning April 1 and ending March 31 inclusive.
- 1.1.26 “**FTE**” or “full time equivalent” means 1680 – 2100 hours of Services per year.
- 1.1.27 “**Indirect Patient Care**” means patient-specific service provided when the patient is not present, including the concurrent provision of clinically-related teaching and clinically-related research. Examples of indirect patient care include, but are not limited to patient-specific conferences, team meetings, telephone consultations and chart/report writing.
- 1.1.28 “**Ministry**” means the Ministry of Health.
- 1.1.29 “**Patient Medical Home (PMH)**” means primary care practices and clinics that are defined by the key attributes and core characteristics described in Appendix 1.
- 1.1.30 “**Personal Information**” means personal information (as defined in the *Freedom of Information and Protection of Privacy Act (FIPPA)* and the *Personal Information Protection Act (PIPA)*) which is collected, acquired, or obtained by or on behalf of the Agency or the Physicians, in relation to the Services.

- 1.1.31 **“Physician Panel”** means the Attached Patients of an individual Physician.
- 1.1.32 **“Practice”** means the combined primary care practices of the Physicians located at **<address>**.
- 1.1.33 **“Practice EMR”** means the electronic medical record software used by the Practice which contains personal information under the legal custody and control of the Physicians.
- 1.1.34 **“Practice Panel”** means the Attached Patients of all Physicians.
- 1.1.35 **“Practice Information System”** means any Practice or Clinic system (including electronic, paper based or other medium) that collects, stores, provides access to or otherwise handles confidential information.
- 1.1.36 **“Practice Personnel”** means any persons employed or engaged by of any of the Physicians or the Clinic, including any servants, employees, officers, independent contractors, subcontractors, volunteers, agents and representatives.
- 1.1.37 **“Primary Care Network (PCN)”** means a network of Patient Medical Homes linked with primary care services delivered or contracted by a health authority and community-based social and other health service organizations in a specific geographic region. PCNs are the foundation of an integrated system of team-based primary and community care. PCNs provide comprehensive, person-centered, culturally safe, quality primary care services to the population of a Community Health Service Area (CHSA) and, as required, coordinate patients’ access to specialized community services programs (SCSPs), the Surgical Services Program (SSP) and the broader health system. PCNs are expected to achieve meaningful health outcomes (effectiveness) and a quality service experience, based on the domains of quality (accessibility, appropriateness, acceptability, safety and efficiency).
- 1.1.38 **“Primary Care Services”** has the meaning given in section 9 j. of Appendix 2
- 1.1.39 **“Professional Medical Corporation”** has the same meaning as set out in Part 6 of the Bylaws of the College of Physicians and Surgeons of British Columbia and Part 4 of the *Health Professions Act*.
- 1.1.40 **“QI Services”** means participation in quality initiatives as described in section 9 c. of Appendix 2.
- 1.1.41 **“Services”** means Primary Care Services including but not limited to Direct Patient Care and Indirect Patient Care to the Practice’s Patients, clinically-related teaching and clinically-related research and Clinical Administrative Services. Those Services provided under this Contract are specifically described in Appendix 2, as amended from time to time by written agreement between the Agency and the Physicians. For clarity, the Services are not provided to or on behalf of the Agency.
- 1.1.42 **“Total Contract Value”** is the total of the various Contract Values associated with each FTE in the Contract, calculated as set out in Appendix 3.
- 1.1.43 **“Unattached Patient”** means a member of the patient population serviced by the Practice that are not members of the Practice Panel including transient patients.

Article 2 Term & Renewal

- 2.1 This Contract will be in effect from **<date>** to **<date>** 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:
- 2.2.1 If the Physicians wish to renew this Contract, the Physicians must provide written notice to the Agency no later than ninety (90) days prior to the end of the Term.
- 2.2.2 If the Agency wishes to renew this Contract, it must provide written notice to the Physicians no later than ninety (90) days prior to the end of the Term.
- As soon as practical after either the Physicians or the Agency has provided notice in accordance with this clause 2.2, 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 the Physicians and the Agency 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 the Physicians or the Agency 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.
- 2.5 The Agency will notify the Ministry of any renewals of this Contract within 30 days of the renewal coming into effect.

Article 3 Termination

- 3.1 The Physicians (collectively) or the Agency may terminate the Contract without cause upon six (6) months' written notice to the other, or immediately upon written notice if the other breaches a fundamental term of this Contract.
- 3.2 Subject to clause 3.3 and without affecting the rights and obligations of the remaining Physicians each Physician has the separate and distinct right to terminate the Contract as between that Physician and the Agency without cause upon six (6) months' written notice to the Agency, with an information copy of such notice to the remaining Physicians.
- 3.3 Each Physician or the Agency may terminate the Contract as between that Physician and the Agency immediately upon written notice if the other breaches a fundamental term of this Contract. For clarity, any license withdrawal or restriction in licensing that affects a Physician's ability to provide the Services, and is not a temporary suspension related to illness or parental leave, is a breach of a fundamental term of this Contract.
- 3.4 The Agency will notify the Ministry of any terminations of this Contract with any Physician or Physicians within 30 days of the termination coming into effect.

Article 4 General Principles Regarding Personnel

- 4.1 At times during the Term, the Physicians may employ or contract with Practice Personnel to perform the Services in accordance with the terms and conditions of this Contract. The following provisions will apply with respect to the Practice Personnel:
- 4.1.1 Unless specifically provided otherwise in this Contract, the Physicians will be responsible for the management and supervision of, and for the acts, omissions, performance of, and damage caused by the Practice Personnel in the performance of the Services.

- 4.1.2 The Physicians will ensure that the Practice Personnel performing the Services:
- a) possess a degree of skill and experience appropriate to providing the Services and will perform the Services to the standards set out in this Contract and which meet all standards of care as determined by the Practice Personnel's respective Colleges and that the Practice Personnel are in good standing with their respective Colleges;
 - b) comply with all applicable requirements of this Contract and in particular those provisions that are required for the Physicians to perform their obligations under this Contract including, without limitation: the Services, reporting, and audit and access rights and requirements; and
 - c) take all necessary steps to ensure that all records and medical records (including Electronic Medical Records) related to the provision of the Services are in the custody and control of the Physicians at all times.
- 4.1.3 Unless specifically provided otherwise in this Contract, any Physician that employs or contracts with any Practice Personnel to provide Services under this Agreement will be solely liable and responsible for all costs, expenses, liabilities or claims, whenever incurred, relating to:
- a) salaries and other compensation payable to the Practice Personnel, including any distribution among the Practice Personnel of those payments set out in Appendix 3 of this Contract, and
 - b) complaints, claims, decisions, applications, orders or prosecutions under any employment or labour standards, occupational health and safety, workers' compensation, pay equity, employment equity, privacy and human rights legislation relating to the Practice Personnel,
- regardless of the time that the matter or event given rise to any such costs, expenses, liability or claims arises or occurs, and for greater clarification, none of such costs, expenses, liabilities or claims referred to in this section 4.1.3 above will be subject to reimbursement by the Agency to any Physician.
- 4.1.4 The Physicians will comply at all times with all applicable employment standards, occupational health and safety, workers' compensation, privacy, human rights legislation and any other applicable laws or agreements relating to the Practice Personnel. The Physicians will, at their expense carry throughout the Term, workers compensation insurance for Practice Personnel, as required by the *Workers Compensation Act* (British Columbia).
- 4.1.5 Except as expressly provided otherwise in this Contract, any Physician that employs or contracts any Practice Personnel will be solely liable and responsible for all costs arising from or otherwise relating to the termination by the Physician of any Practice Personnel, and the Physician will not be reimbursed by the Agency for any such costs, expenses, claims or liabilities.
- 4.2 If any Physicians or Practice Personnel are employed or engaged to perform services for the Agency outside of this Contract, the parties agree that:

- 4.2.1 any such person is not an employee of or in an employment relationship with the Agency, with respect to the work carried out by that person under this Contract;
 - 4.2.2 any services provided to the Agency outside of this Contract must not overlap in time or payment with this Contract;
 - 4.2.3 any such person will not hold themselves out as being an employee of or in an employment relationship with the Agency, with respect to the work carried out by that person under this Contract; and
 - 4.2.4 any such person will not be entitled to any terms or conditions of employment or any employment benefits from the Agency, with respect to the work carried out by that person under this Contract.
- 4.3 In circumstances where the Agency provides Agency-employed healthcare professionals in order to support the Practice's patients ("**HA Personnel**"), the terms of such arrangements will be subject to a separate agreement between the Agency and the Physicians.
- 4.4 For clarity, any time spent by Practice Personnel or HA Personnel performing the Services is not to be included in calculating the hours of Services compensated under this Contract. Only those hours of Services provided by Physicians are to be included in the hours compensated under this Contract.

Article 5 Relationship of the Parties

- 5.1 Each Physician, as well as any Practice Personnel engaged by the Physicians to work at the Practice, are independent contractors and not the servants, employees, legal representatives or agents of the Agency. No employment relationship is created by the Contract or by the provision of the Services to the Practice's patients by the Physicians. No partnership relationship between the Physicians is created by this Contract or by the provision of the Services to the Practice's patients by the Physicians.
- 5.2 None of the Physicians 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.
- 5.3 If a Physician employs other persons or is a professional medical corporation, the Physician will apply to register with WorkSafeBC and:
- 5.3.1 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, or
 - 5.3.2 if advised by WorkSafeBC that the Physician or any Practice Personnel is a "worker", for the purposes of the *Workers Compensation Act*, advise the Agency and provide the Agency with any related documentation from WorkSafeBC. The parties acknowledge and agree that such determination by WorkSafeBC is not relevant to any Physician or Practice Personnel's status for any purpose except for the purposes of the *Workers Compensation Act* (British Columbia), that they

remain independent contractors, and that neither the Physician nor any of the Practice Personnel is an employee of the Agency.

- 5.4 If a Physician purchases Personal Optional Protection coverage with WorkSafeBC as an independent operator (at the Physician's option), the Physician will 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, a clearance letter with a clearance date as far into the future as possible.
- 5.5 Each Physician must pay any and all payments and/or deductions required to be paid by the Physician, including those required for income tax, Employment Insurance premiums, workers' compensations premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that the Physician 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.
- 5.6 The liability of the Physicians for payments referred to in clause 5.5 is several and not joint.
- 5.7 Each 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 any payments referred to in clause 5.5.
- 5.8 The indemnity in clause 5.7 survives the expiry or earlier termination of this Contract.

Article 6 Unincorporated Groups

- 6.1 As the Services are provided under this Contract by multiple Physicians, each Physician will be party to, and bound by, this Contract.
- 6.2 The Physicians must have an intra-physician group governance agreement. Each of the Physicians will be a party to the intra-physician group governance agreement, and the Physicians will ensure that any physician who becomes a Physician during the Term also becomes party to the intra-physician group governance agreement. The Physicians will provide the Agency and the MSC with a copy of the intra-physician group governance agreement if required in connection with any audit conducted under Article 22 and the Agency and the MSC will review the intra-physician group governance agreement only in relation to such audits.
- 6.3 Subject to sub-clause 3.2(b), the Physicians may designate a representative from among the Physicians to represent the Physicians with respect to notices, the proposed addition of new physicians to the Contract and all invoicing and payment matters under this Contract (the "**Representative**") and will notify the Agency of the identity of the Representative. If the Representative changes during the Term, the Physicians will notify the Agency of the new Representative.
- 6.4 Where a notice under any term of this Contract is to be given to all of the Physicians, the Physicians agree that a single notice to the Representative sent to the address provided in Article 23 will constitute notice to all of the Physicians. Where notice is to be given to less than all of the Physicians, it must be given to those individual Physicians at the address(es) provided at Appendix 6.

- 6.5 In the event of the departure of a Physician pursuant to clauses 3.2 or 3.3, the parties will meet to discuss whether amendments to any Appendices are required and to make agreed changes.
- 6.6 The Physicians must use reasonable efforts to replace departing Physicians.
- 6.7 Any replacement or new physicians that the Physicians propose to add are subject to approval by the Agency. Such approval will not be unreasonably withheld.
- 6.8 Subject to clause 6.7, for any new physician added to this Contract who is not an initial signatory to this Contract, the Physicians (collectively) or their Representative, the Agency and the new physician will sign and deliver to the others an acknowledgement and agreement in the form set out in Appendix 7 ("**New Physician – Agreement to Join**"), agreeing that the new physician will become party to and bound by the terms of this Contract.
- 6.9 The Agency will notify the Ministry of any new physicians that are added to this Contract and will provide a copy of the "New Physician – Agreement to Join" to the Ministry within 30 days of its execution.

Article 7 Waiver

- 7.1 Each Physician must not retain FFS billings, including any GPSC incentive fees (and in particular those GPSC fees related to the QI Services set out in Appendix 2), for the Services provided under the terms of this Contract. The Physician may bill FFS or directly for any and all services delivered outside the scope of this Contract, but must not bill any additional GPSC items other than those specific exceptions set out in Appendix 4.
- 7.2 Each Physician will sign a waiver in the form attached hereto as Appendix 4 and such other documentation in connection with such waiver as may be reasonably required.
- 7.3 Physicians may retain third party billings for the Services covered by this Contract ("**Third Party Services**"), provided that any time spent providing such Services to third parties is not included in the hours reported under this Contract. For the purposes of this Article, third party billings include but are not limited to:
- 7.3.1 services rendered by a health care practitioner that a person is eligible for and entitled to under:
- a) the *Aeronautics Act* (Canada),
 - b) the *Civilian War-related Benefits Act*,
 - c) the *Government Employees Compensation Act* (Canada),
 - d) the *Merchant Seaman Compensation Act* (Canada),
 - e) the *National Defence Act* (Canada),
 - f) the *Pension Act* (Canada),
 - g) the *Royal Canadian Mounted Police Pension Continuation Act* (Canada),
 - h) the *Royal Canadian Mounted Police Superannuation Act* (Canada),
 - i) the *Canadian Forces Members and Veterans Re-establishment and Compensation Act*,
 - j) the *Department of Veterans Affairs Act*,
 - k) the *Corrections and Conditional Release Act* (Canada),
 - l) the *Workers Compensation Act*,
 - m) the *Hospital Insurance Act*, or
 - n) the *Insurance (Vehicle) Act*.

- 7.3.2 billings for non-insured Services, and
 - 7.3.3 billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act*, including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.
- 7.4 The Physicians may retain FFS billings for Services provided to patients referred to a Physician by a physician or allied care provider from outside the Clinic for specialized services (such as obstetrics) where those patients are not and will not be attached to the Practice Panel, provided that any time spent providing such Services to these patients is not included in the hours reported under this Contract (**“Referred Services”**).
- 7.5 Physicians are permitted to bill third parties for medical/legal services that are provided outside of the hours reported under this Contract.

Article 8 Autonomy

- 8.1 Each Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice.
- 8.2 Subject to clause 8.1, each Physician is entitled to professional autonomy in the provision of the Services.

Article 9 Doctors of BC

- 9.1 Each Physician is entitled, at the Physician’s option, to representation by 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 10 Dispute Resolution

- 10.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.
- 10.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that any Physician(s) and the Agency (the Physician(s) or the Agency, each a **“Party to the Dispute”** or collectively **“Parties to the Dispute”**) are unable to resolve informally at the local level, may be referred to mediation on notice by either Party to the Dispute to the other, with the assistance of a neutral mediator jointly selected by the Parties to the Dispute. 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 to the Dispute in writing, the dispute will be referred to arbitration administered pursuant to the *Arbitration Act*.
- 10.3 For greater certainty, FFS claims, including in relation to GPSC incentive fees that are excluded from the Contract, remain within the sole jurisdiction of the Medical Services Commission.
- 10.4 Should the Parties to the Dispute 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.
- 10.5 Upon agreement of the Parties to the Dispute, the dispute may bypass the mediation step and be referred directly to arbitration.

- 10.6 The Parties to the Dispute 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 will 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.
- 10.7 Any dispute settlement achieved by the Parties to the Dispute, 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 11 Service Requirements

- 11.1 The Physicians will provide the Services as described in Appendix 2 and will schedule their availability, as set out in Appendix 2, to reasonably ensure the provision of the Services.
- 11.2 Hours are as agreed upon by the parties at Appendix 2. It is understood that many circumstances require flexibility of hours and the Physicians will respond to these needs.
- 11.3 If the Physicians are 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 party may request, through the Doctors of BC or the Government, the use of a Trouble Shooter who will conduct a fact finding review and issue recommendations. If they are unable to reach agreement following the use of a Trouble Shooter, either the Doctors of BC or the Government may refer the matter to the Physician Services Committee as a Local Interest Issue.

Article 12 Licenses & Qualifications

- 12.1 During the Term, each Physician, and each locum physician or subcontracted physician providing Services under this Contract for a Physician, will maintain:
- 12.1.1 registered membership in good standing with the College of Physicians and Surgeons of British Columbia and will conduct the practice of medicine consistent with the conditions of such registration;
 - 12.1.2 all licenses, qualifications, privileges and credentials required to deliver the Services.
- 12.2 During the term, it is a fundamental term of the Contract that each Physician, and each locum physician or subcontracted physician providing Services under this Contract for a Physician, maintains enrolment in the Medical Services Plan.
- 12.2.1 For clarity, an order of the Medical Services Commission under section 15(2)(a) of the *Medicare Protection Act* for the duration of that order, is a breach of a fundamental term of this Contract.
 - 12.2.2 Any Physician who is no longer enrolled in MSP or who is de-enrolled from MSP is to, within 15 days of such lack of enrollment, notify the Agency of the period of the lack of enrollment or de-enrollment. Such Physicians are not to provide Services during any period where they are not enrolled in MSP, regardless of the reason for the lack of enrollment.

- 12.3 All medical services under this Contract will be provided either directly by a Physician, by a resident under the supervision and responsibility of a Physician, by a clinical fellow under the supervision and responsibility of a Physician or by appropriate Practice Personnel, as delegated by the Physician, where the Services are generally and traditionally accepted as being those that may be carried out by such a delegate.
- 12.4 Where Services are being provided by a resident or clinical fellow under the supervision and responsibility of a Physician:
- 12.4.1 the Physician shall be identified to the patient at the earliest opportunity;
 - 12.4.2 the Physician must be available in person, by telephone or videoconferencing in a timely manner appropriate to the acuity of the patient's condition and the disposition of the patient;
 - 12.4.3 the payment by the Agency for Services under the Contract must not exceed the amount that the Physician could claim in the same time period in the absence of the resident or clinical fellow; and
 - 12.4.4 the Physician must review in person, by telephone or videoconference the Services provided by the resident or clinical fellow and sign off the Clinical Record relating to the Services within the next weekday workday.
- 12.5 For clarity, any time spent by residents or clinical fellows performing the Services is not to be included in calculating the hours compensated under this Contract. Only those hours of Services provided by Physicians are to be included in calculating the hours compensated under this Contract.

Article 13 Locum Physicians

- 13.1 The Physicians will work to recruit and retain qualified locum physicians when necessary and will notify the Agency of the name and MSP practitioner number of any locum physicians prior to such locum physician providing Services under this Contract.
- 13.2 In circumstances where a locum physician is providing Services and will report their hours as hours under the Contract, the Physicians will be responsible to pay such locum physicians from the amounts paid to the Physicians under this Contract and the Physicians will ensure that locum physicians:
- 13.2.1 do not bill FFS for the Services;
 - 13.2.2 sign a FFS waiver in the form set out at Appendix 4, and the Physicians will provide the FFS waiver to the Agency prior to the locum physician providing Services under the Contract;
 - 13.2.3 provide Encounter Reporting and hours reporting as required by the Contract; and
 - 13.2.4 assign any third-party billings to the Clinic's Payee Number.
- 13.3 In circumstances where a locum physician is providing Services and will not report their hours as hours under the Contract, that locum physician may bill FFS for the Services. If a short term locum is secured through the Rural GP Locum Program (RGPLP) or equivalent provincial locum program, that locum will be paid in accordance with the policies of the RGPLP or equivalent provincial locum program and their hours will not count towards the minimum Contract hours set out in Appendix 2.

Article 14 Subcontracting

- 14.1 Each 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.
- 14.2 Each 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, including signing a FFS waiver in the form set out at Appendix 4, and the Physician will provide a copy of that FFS waiver to the Agency prior to the subcontractor providing any Services under this Contract.
- 14.3 Prior to subcontracting any of their obligations, the Physicians will review the capabilities, knowledge, experience, competence of, and the standards employed by, the potential subcontractor in a manner sufficient to establish that the potential subcontractor is able to meet the requirements of this Contract.
- 14.4 The Physicians are responsible for any subcontractor and no subcontract relieves the Physicians from their obligations or liabilities under this Contract.

Article 15 Compensation

- 15.1 The Agency will pay to the Physicians, in full payment and reimbursement for providing the Services, the funding in the amounts and in the manner described in Appendix 3, and the Physicians will accept such funding as full payment and reimbursement for providing the Services.
- 15.2 The Physicians are responsible for disbursing the funding among the Physicians. Records showing the details of disbursement of the funding amongst Physicians are to be created and retained in accordance with the Contract.
- 15.3 The Physicians are to claim only for Services provided in accordance with the Contract.
- 15.4 Each Physician is entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician Master Agreement).
- 15.5 The Agency must forward the necessary information with respect to each Physician to the Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which this Contract is in effect. The Physicians will provide the Agency with any information necessary for the Physicians to access the Benefit Plans not in the possession of the Agency.

Benefits Manager
Doctors of BC
#115 – 1665 West Broadway
Vancouver, BC V6J 5A4

- 15.6 No Physician or Practice Personnel is entitled under this Contract to any benefit from the Agency including Canada Pension Plan contributions, Employment Insurance premiums, supplemental health coverage for the Physicians or Practice Personnel or their families, health benefits for travel outside Canada, dental insurance for preventative dental care and dental procedures, supplemental group life insurance, accidental death and dismemberment insurance death benefits, overtime or statutory holidays.

Article 16 Reporting and Information Sharing

- 16.1 The Physicians will:
- 16.1.1 comply with the reporting obligations set out at Appendix 5 of this Contract; and

- 16.1.2 complete and submit to the Agency all reports reasonably required by the Agency within 30 days (subject to the specific requirements in Appendix 5) of the Agency's written request.
- 16.2 The Physicians are responsible for the accuracy of all information and reports submitted by the Physicians to the Agency, including the information and reports submitted in regards to the Services provided by locum physicians and subcontractors providing Services on behalf of the Physicians.
- 16.3 Details of disbursement of the funding amongst the Physicians on the Contract are to be reported to the Agency on a quarterly basis.
- 16.4 The Physicians agree to enter into, comply with and ensure that any Practice Personnel comply with the terms of any Information Sharing Agreement between the Physicians, the Ministry of Health and the Agency, included for reference at Appendix 8.

Article 17 Records

- 17.1 For the purposes of this Contract, "**Clinical Record**" means a medical record maintained in accordance with the rules concerning practitioners' records under the *Health Professions Act* and an Adequate Medical Record. The Clinical Records (including those which are created by any Practice Personnel in the delivery of services to the Practice) are under the control of Physicians when the Clinical Record is created in a Practice Information System.
- 17.2 The Physicians will and will cause the Practice Personnel to make and maintain Clinical Records of all encounters that appropriately supports the Services and appropriate diagnosis.
- 17.3 The Physicians must retain records, including Clinical Records, for a period specified by the appropriate licensing body or as required by law including as stated in the MSC Payment Schedule.
- 17.4 The Physicians are responsible under PIPA to ensure that the Practice's patients understand and have provided any necessary consent for access, use or disclosure of their Personal Information.
- 17.5 All requests for records, including Clinical Records under the control of the Physicians will be processed by the Physicians in accordance with the requirements under PIPA.
- 17.6 Financial records, including the details of disbursement of the payments under this Contract among the Physicians and any intra-physician group governance agreement are to be retained by the Physicians for a minimum of 7 years from the date of the termination of the Contract.

Article 18 Third Party Claims

- 18.1 The Physicians and the Agency will provide the other with prompt notice of any action against either or any of them arising out of this Contract.

Article 19 Liability Protection

19.1 Commercial General Liability Insurance

- 19.1.1 The Physicians will, without limiting their obligations or liabilities herein, ensure that the Clinic maintains, or if the Clinic fails to maintain, the Physicians will jointly purchase and maintain throughout the Term, comprehensive or commercial general liability insurance with a limit of not less than \$2,000,000 inclusive per occurrence against bodily injury, personal injury and property

damage and including liability assumed under this Contract and this insurance must:

- a) include the Agency as an additional insured,
- b) be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change,
- c) include a cross liability clause, and
- d) be primary and not require the sharing of any loss by any insurer of the Agency.

19.2 Negligence/Malpractice Coverage

19.2.1 All Physicians must be members of the Canadian Medical Protective Association or have an alternative professional/malpractice protection plan. The Physicians will also take all reasonable steps to ensure that only Practice Personnel who can provide evidence they are adequately insured against acts of negligence and malpractice will provide the Services.

19.3 Additional Insurance

19.3.1 The Physicians will obtain, maintain and pay for any additional insurance which the Physicians are required by law to carry, or which the Physicians consider necessary to cover any risks they may assume as a result of entering into this Agreement.

19.4 The Physicians agree to provide the Agency with evidence of the membership/protection plan or insurance coverage required under this Article 19 at the time of execution of this Contract and otherwise from time to time as requested by the Agency.

Article 20 Confidentiality

20.1 Each Physician and the Agency will maintain as confidential and not disclose any patient information, except as required or permitted by law or by this Contract.

20.2 Each 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 required or permitted by law or by this Contract and is:

20.2.1 necessary for the Physician to fulfill the Physician's obligations under this Contract; or

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

20.2.3 in reference to this Contract.

20.3 For the purposes of this Article 20, information will be deemed to be confidential where all of the following criteria are met:

20.3.1 the information is not found in the public domain;

20.3.2 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

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

Article 21 Conflict of Interest

- 21.1 During the term of this Contract, absent the written consent of the Agency, each 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 under this Contract.
- 21.2 The Physicians and the Agency will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 21.1. Should they not be able to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 10 of this Contract.

Article 22 Audit, Evaluation and Assessment

- 22.1 Each Physician acknowledges and agrees that the auditing authority of the Medical Services Commission under section 36 the *Medicare Protection Act*, as amended from time to time, applies to this Contract.
- 22.2 Each Physician acknowledges and agrees that: (i) knowingly submitting reporting under this Contract for Services or hours that were not rendered, or that misrepresents the nature or extent of the Services or hours rendered, including but not limited to diagnostic coding; or (ii) double billing, including FFS claims contrary to this Contract, is a fundamental breach of this Contract and “cause” within the meaning of section 15 of the *Medicare Protection Act*.
- 22.3 Without limiting section 22.1 or 22.2 above, each Physician acknowledges and agrees that the terms in sections 36(3) to 36(12) of the *Medicare Protection Act* are hereby incorporated into this Contract for the purposes of audits in relation to this Contract, and that: (i) each Physician and any other person (as defined in the *Interpretation Act*) who owns, manages, controls or carries on business in relation to the Clinic is a “person described in section (2)(b) or (c)” within the incorporated meaning of s. 36(5)(a) from the *Medicare Protection Act*; and (ii) auditors of the Agency and Medical Services Commission (the “**Auditors**”) are “inspectors” within the incorporated meaning of sections 36(3) to 36(12) of the *Medicare Protection Act*.
- 22.4 Notwithstanding section 22.3 above, an Agency Auditor may not directly access the Practice EMR, unless the Physician permits access by the Agency Auditor.
- 22.5 Prior to attending the Clinic for audit under section 22.3 above, a notice of inspection of an audit must be provided to the Physicians. Unless determined otherwise by the Medical Services Commission, which in no case would include a random audit, notice of inspection must be provided at least 14 days prior to the inspection.
- 22.6 Each Physician must reasonably cooperate with Auditors for an audit in relation to this Contract, including by allowing Medical Services Commission Auditors to access the Practice EMR. A Physician’s failure to reasonably cooperate is a fundamental breach of this Contract for which the Agency may immediately terminate the Contract with one or more Physician(s) – up to and including all Physicians – upon written notice to Physician(s).

- 22.7 The Physicians agree that any monies received from sources in relation to Services that are not permitted by this Contract will reduce the amount owing by the Agency under this Contract, which the Agency may set-off immediately upon discovery of the additional payment.

Article 23 Notices

- 23.1 Any notice, report, or any or all of the documents that either the Physicians or the Agency 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 sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 23 or in Appendix 6 (as applicable); or
- 23.1.2 If mailed by prepaid registered mail to the addressee's address listed below or in Appendix 6 (as applicable), on date of confirmation of delivery; or
- 23.1.3 If delivered by hand to the addressee's address listed below or in Appendix 6 (as applicable), on the date of such personal delivery.

- 23.2 Each Physician and the Agency must give notice to the other of a change of address.

23.3

- 23.4 Address of Agency:

Medical Staff Contract Management
Medical and Academic Affairs, Island Health
1837 Fort Street
Victoria, BC V8R 1J6
physiciancontracts@islandhealth.ca

Address and e-mail address of the individual Physicians – see Appendix 6:

Address and e-mail address of the Representative:

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 2019 Physician Master Agreement and the Physician Master Subsidiary Agreements embody the entire understanding and agreement between the parties relating to the Agency's funding of 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 2019 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 a Physician or the Agency 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 Physician or the Agency 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 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 Headings

- 28.1 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 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 will be construed together and will 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 will be the equivalent of an original written paper agreement between the parties.

Article 30 Physicians as Professional Medical Corporations

- 30.1 Where a Physician in this Contract is a Professional Medical Corporation:
- 30.1.1 the Physician will ensure that its physician owner, being the individual signing this Contract on the Physician's behalf (the "**Physician's Owner**"), performs and fulfills, in accordance with the terms of this Contract, all obligations of the Physician under this Contract that cannot be performed or fulfilled by a Professional Medical Corporation;
 - 30.1.2 the Agency agrees to confer on the Physician's Owner, for the Physician's benefit, all rights of the Physician under this Contract that cannot be held by a Professional Medical Corporation; and
 - 30.1.3 for clarity, all remuneration for the Services will be paid to the Professional Medical Corporation.

Article 31 Representations and Warranties

31.1 As at the date this Contract is executed and delivered by, or on behalf of, the parties, the Physicians represent and warrant to the Agency as follows:

- 31.1.1 Except to the extent the Physicians have previously disclosed otherwise in writing to the Agency,
- a) all information, statements documents and reports furnished or submitted by the Physicians to the Agency and the Ministry in connection with this Contract are in all material respects true and correct,
 - b) the Physicians have sufficient Practice Personnel, facilities, materials, appropriate equipment and approved agreements in place to enable the Physicians to fully perform the Services, and
 - c) the Physicians hold all permits, licenses, approvals and statutory authorities issued by any government or government agency that are necessary for the performance of the Physicians' obligations under this Contract.

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

Signed and Delivered by the Physicians:

Unincorporated Physicians

Date

Incorporated Physicians

[] Inc.

Authorized Signatory

Date

Signed and Delivered on behalf of the Agency:

Authorized Signatory

Date

Authorized Signatory

Date

APPENDIX 1

TEAM BASED CARE, PATIENT MEDICAL HOME AND PRIMARY CARE NETWORKS

A. Policy Background

The Province of British Columbia is committed to an integrated system of person centred primary and community care that works for people and primary care providers across BC's geographical CHSAs and that provides value for money for BC citizens.

Primary care is built around team based care at the community health service area level provided through a mix of patient medical homes, urgent primary care centres, community health centres and health authority primary care services, through PCNs. These primary care services will be supported by local health service area specialized service programs for more medically complex patient populations focused on complex medical and/or frailty; mental health and substance use; cancer care linked with hospital and diagnostic and provincial specialized services.

B. Patient Medical Home (PMH)

1. Core Characteristics

The PMH is the foundation and corner stone of the integrated system of person centered primary and community care as the practice model for delivering key services associated with a full-service primary care practice. PMHs are premised on five core characteristics:

- Accessible to the patient as therapeutic partner.
- Engaged and motivated to achieve health service goals.
- Possess the knowledge, skills and competencies to deliver the services.
- Work in a safe and healthy environment.
- Receive support and leadership.

2. Key Attributes

A PMH has a number of key attributes that define how a practice can support patients, including through team-based care. Those key attributes are the following:

- i. Person centred, whole-person care
 - Care is easily navigated and centred on the needs of the individual, family and community.
 - Individuals are empowered in optimal self-management and contribute to the development and assessment of the practice/clinic and community care models.
 - Care will be delivered in a culturally appropriate manner with recognition of social determinants of health and attention to marginalized populations.
- ii. Commitment
 - A PMH will ensure that individuals have access to a regular primary care provider (a personal family physician or nurse practitioner) who is most responsible for their primary care.
 - Physicians and nurse practitioners have a defined patient panel and patients and providers have a shared understanding of their mutual therapeutic relationship.
- iii. Contact (Timely access)

- Individuals are able to access their own family physician or nurse practitioner, or their PMH team, on the same day if needed.
 - Individuals know how to appropriately access advice and care on a 24/7 basis.
- iv. Comprehensive
- The PMH delivers the majority of the comprehensive primary care services that patients need.
 - The specific comprehensive services provided through the PMH and network of PMHs are determined by context, considering both community need and available resources.
- v. Continuity
- Longitudinal relationships support care across the continuum and spanning all settings.
 - The enduring relationship between the individual, family physician or nurse practitioner and PMH team is key and needs to be supported by informational continuity (two-way communication that informs appropriate and timely care).
- vi. Coordination
- The PMH serves as the hub for the coordination of care through informational continuity, personal relationships and networks with other PMHs, interdisciplinary team members within and linked to the practice and linkages to speciality and specialized services across care domains.
 - Individuals are empowered to participate in the coordination of their care through access to their own medical information and shared decision making with their physician or nurse practitioner and team.
- vii. Team-based care
- The PMH generally includes more than one family physician and/or nurse practitioner working within an expanded interdisciplinary team within the practice, and/or linked to the practice, with a focus on person-centred, relationship-based care.
 - All providers within the practice are working to optimized scope.
- viii. Provider network teams supporting practice
- Family physicians and nurse practitioners are part of one or more clinical network teams working together to meet the comprehensive care needs of their patients and the patients of other PMHs in the community including extended hours of service, cross coverage and/or on-call.
- ix. PMH networks supporting communities
- PMHs are networked through the Divisions of Family Practice (or other similar community care service organization where divisions may not exist) to enable better coordination, partnership and integration with health authority and non-governmental community services, and the broader system of health care.
- x. Information-technology enabled
- Providers and staff in the practice are IT enabled, including optimized EMR use and data collection methods to inform quality improvements in patient care and practice workflow.
 - The Practice EMR is able to link appropriately with other providers and parts of the system, including other community providers, pharmacies and acute care facilities.
 - Virtual care options, including access to appropriate email, telephone and video conferencing advice/consults, are used and optimized.

- xi. Education, training and research
 - The PMH promotes mentoring and peer coaching for continuing professional development, training and research.
 - This will include providing support to new medical graduates and recruits coming to the community, providing training to medical students, residents, nurse practitioner students and allied health providers within the practice, participating in peer-led small group learning sessions and research within the PMH or as part of a network.
- xii. Evaluation and quality improvement
 - Providers and patients are involved in clinical quality improvement activities at a professional, practice, community and system level.
- xiii. Internal and external supports
 - The PMH has a business model which supports longitudinal, comprehensive, coordinated, team-based care and linkages with the SCSPs and SSP.
 - Practices/clinics are supported to enable this model of primary care and integrated care through provincial and regional policies and systems.

3. Physician Commitments

a. PMH

The Physicians agree and commit to work towards the following to transition the Practice to a PMH and to achieve high quality (effective, accessible, acceptable, appropriate, and safe) primary care service delivery:

- *PMH Attributes*: the key attributes of the BC PMH model as detailed above
- Based on achieving the triple aim of improved patient and provider experience, population health, and cost effectiveness.
- Enhancing the quality and value of care experienced by individual patients and specific populations.

b. PCN

The Physicians agree and commit to become part of, and contribute to the success of, a PCN in the community, including the planning and development of the PCN if it has not yet been developed at the beginning of the Term, working towards the following core PCN attributes:

- Process for ensuring all people in a community have access to quality primary care, and are attached within a PCN.
- Provision of extended hours of care including early mornings, evenings and weekends.
- Provision of same day access for urgently needed care through the PCN or an Urgent Primary Care Centre.
- Access to advice and information virtually (e.g. online, text, e-mail) and face-to-face.
- Provision of comprehensive primary care services through networking of PMHs with other primary care providers and teams, to include maternity, inpatient, residential, mild/moderate mental health and substance use, and preventative care.
- Coordination of care with diagnostic services, hospital care, specialty care and specialized community services for all patients and with particular emphasis on those with mental health and substance use conditions, those with complex medical conditions and/or frailty and surgical services provided in community.

- Clear communication within the network of providers and to the public to create awareness about and appropriate use of services.
- Care is culturally safe and appropriate.

c. Family Practice Readiness

The Physicians have met or commit to meet the following criteria:

- Participating in the development and implementation of the PCN within their community.
- Collaborating with the Agency, Ministry and other health system partners on the development and implementation of the PMH, including using the *PMH Readiness Assessment Tool* to develop a baseline understanding of and to support meeting the attributes of the PMH.
- Applying the principles of collaborative care and receiving practice support or participating in team building and training to support the integration of interdisciplinary members into the team.
- Improving patient access to primary care services.
- Employing practice and panel assessments, office efficiency practices, and other methods to support enhanced access.
- Engaging in continuous quality improvement.

d. Quality Improvement and Evaluation

- The Physicians commit to working towards improving performance in the provision of clinical services and improving efficiency and productivity within the PMH and PCN.
- The Physicians agree to participate in program evaluation through patient and provider surveys.

APPENDIX 2

SERVICES

Patient Medical Home and Primary Care Network

1. The Physicians agree to work collaboratively with the Agency, the Ministry, the PCN and other health system partners including Divisions of Family Practice as required towards implementing the attributes of the BC Patient Medical Home and the Primary Care Network as described in Appendix 1.

Hours, Appointments and Scheduling

2. The Physicians will provide ____ FTE of Services per year, a minimum of _____ hours of Services per year (____ FTE x 1680 hours), with each Physician providing a minimum of 840 hours and a maximum of 2100 hours of Services per year (inclusive of hours of Services provided by subcontractors or by locums that are compensated under the Contract in accordance with Article 13).
3. To ensure continuity of care for patients, each Physician agrees to distribute their hours of Services equitably over the course of each year of the Term and no Physician will provide more than 90 hours of Services (prorated for any partial FTE) on a bi-weekly basis during the Term.
4. Where reasonably possible, the Services will be provided by the Physicians (utilizing cross-coverage where required), rather than by locums or subcontractors.
5. The Physicians commit to using best practices in scheduling in order to provide timely access to appointments, including the ability for patients to access their own Physician or another Physician in the Practice or other Practice team members on the same day.
6. Each Physician will coordinate with the other Physicians in the Practice as required to ensure that non-emergency primary care services will be accessible during reasonable, regular hours each week of the year to provide adequate services and meet the health needs of the patient population served by the Practice. In particular, the Physicians and the Agency agree that the Practice's operating hours and minimum staffing levels will be as follows:

[Insert here locally negotiated schedule that includes operating hours for each day of the week and the minimum level of staffing by Physicians each day]
7. The Physicians also agree to coordinate with the Agency and other practitioners in the PCN in order to provide flexible scheduling as required for extended hours of service within the PCN, when and if the Physicians agree to provide such extended hours of service. Extended hours of service are subject to the ability of such hours to be accommodated given the nature of each Physician's practice and professionally recognized reasonable limits.
8. The Physicians will also make themselves available after hours for their patients and other patients of the Practice within professionally recognized reasonable limits and in accordance with the After Hours Coverage Standard of the College of Physicians and

Surgeons of BC. Any Services provided after-hours by the Physicians fall within the scope of this Contract and must be included in the hours of Services under this Contract.

9. The Physicians will provide the following Services during the Term:

Measuring Access and Quality Improvement

- a. The Physicians will track access against specific access measures, namely:
 - i. Typical time frame for 3rd available appointment.
- b. The Physicians will provide the Agency with a quarterly report each year during the Term regarding the access measures described in section 9 a, in accordance with Appendix 5.
- c. The Physicians will participate in the implementation of Quality Initiatives (QI) for the Practice during the Term, beginning in the first year of the Term including:
 - i. the participation of all Physicians in implementing and using the GPSC patient experience tool during the first year of the Term and then on an ongoing basis during the remainder of the Term, which can be accessed via the Practice Support Program (PSP), which surveys patients about their experiences and interactions with the Practice, including topics such as wait times, office hours, and coordination of care;
 - ii. all Physicians will also engage in the three phases of panel management to be initially completed during the first year of the Term and then on an ongoing basis during the remainder of the Term through annual completion of the Panel Maintenance review program. The three phases of panel management are:
 1. Empanelment – develop an accurate list of active patients.
 2. Panel clean-up – improve data entry procedures and develop accurate and up to day clinical registries.
 3. Panel Optimization – use the Practice EMR to proactively manage clinical registries.
 - iii. each Physician providing more than 0.75 FTE under the Contract will also engage in a minimum of two (2) of any of the following additional QI activities in each year of the Term (certain QI activities may carry forward year over year, while some may be one-time activities that take place in one year only). Physicians providing 0.75 FTE or less may choose one (1) additional QI activity:
 1. On a yearly basis, completing the PMH assessment tool – electronic self-assessment designed to identify practice strengths and opportunities in relation to the 12 attributes of the PMH in BC.
 2. Participating in practice facilitation cycles – includes in-practice visits, learning sessions, completion of assessments and other practice improvement tools, time spent developing and implementing the action plan.
 3. Optimizing the Practice EMR – electronic assessment, tailored group learning opportunities and EMR-enabled clinical and practice management tools.

4. Participating in team-based care small group learning sessions through the Practice Support Program.
 5. Participating in other small group learning sessions and learning opportunities – facilitated sessions to help physicians and their practice team stay up-to-date on the most current information and best practices in key areas of clinical and practice management.
 6. Participating in San'yas Indigenous Cultural Safety Training.
- d. The Physicians will provide the Agency with an annual report each year during the Term outlining the QI Services engaged in by the Physicians during that year, in accordance with Appendix 5.
 - e. Each Physician will report those hours of QI Services set out in 9 c. above that are provided as part of the hours of Services under this Contract. Physicians may claim for up to a maximum of one (1) hour per week each year of the Term per FTE for QI Services performed. The Physicians may not claim GPSC incentive fees for any of the activities provided and reported as QI Services under this Contract.

Measuring Attached Patients

- f. During each year of the Term, the Physicians will confirm the attachment of both their current patients and any new patients they have attached during that year by submitting an Attachment Code for each patient by year-end in accordance with Appendix 5.
- g. The Physicians will provide their patients with information on how patients may verify their attachment with the Ministry.
- h. For new patients and for the first visit during the Term of any existing patients, each Physician will conduct explicit attachment conversations with patients including a review of the following items:

As your primary care provider I, along with my practice team, agree to:

- Provide you with safe and appropriate care
- Coordinate any specialty care you may need
- Offer you timely access to care, to the best of my ability and as reasonably possible in the circumstances
- Maintain an ongoing record of your health
- Keep you updated on any changes to services offered at my clinic
- Communicate with you honestly and openly so we can best address your health care needs

As my patient I ask that you:

- Seek your health care from me and my team whenever possible and, in my absence, through my colleague(s)
 - Name me as your primary care provider if you have to visit an emergency facility or another provider
 - Communicate with me honestly and openly so we can best address your health care needs
- i. In the event this Contract is terminated and a Physician does not intend to maintain an ongoing attachment relationship with his/her patients, each Physician agrees to work with the other Physicians, the Agency and the Division of Family Practice in an effort to collaboratively maintain primary care access for the patients by maintaining their attachment to the remaining Physicians or by re-attaching them to another family practice where possible. Each Physician must abide by the College of Physicians and Surgeons of BC's guideline on severing the Patient-Physician Relationship.

Primary Care Services

- j. Each Physician will provide comprehensive, accessible, interdisciplinary, patient focused primary health care and will work towards aligning the Practice with the attributes of the PMH. The Physicians will utilize the principles of population health for prevention, identification and management of chronic illness including addictions and mental health, and will provide the following full scope of primary health care Services (including but not limited to Direct and Indirect Patient Care, clinically-related teaching and clinically-related research) during the Term:
- (i) Health promotion and illness prevention services;
 - Screening for early detection, intervention and counseling to reduce risk
 - Health assessments
 - Immunizations
 - Links with community-based services providing social supports for individuals and families
 - Patient advocacy
 - (ii) Primary care for minor or episodic illnesses;
 - Assessment and treatment services for minor illnesses
 - Referral to diagnostic services
 - Referral to specialized services, including medical and surgical specialties
 - (iii) Chronic disease management;
 - Early detection and primary treatment
 - Guideline informed chronic disease management and service coordination
 - Referral to specialized services programs for patients with complex conditions/frailty
 - (iv) Management and co-ordination of patient care across the spectrum of primary, secondary and tertiary care (i.e. referral to specialists and other providers, case management, case conferences and acting upon consultative advice);
 - (v) Primary reproductive care;
 - Sexual health, including prevention and management of sexually transmitted

- infections
 - Organization of appropriate screening
 - Provision of or arrangement with another provider for prenatal, obstetrical, postnatal and newborn care
- (vi) Primary mental health and substance use (MHSU) services;
 - Assessment and diagnosis and early support for emerging or unidentified MHSU problems
 - Development of individualized care plans that can include:
 - Information and tools to enhance resilience, including health literacy and self-management of MHSU conditions
 - Access to harm reduction resources
 - Time-limited, solution focused consultations
 - Shared care with community-based services, including social services for mild to moderate MHSU health needs
 - Treatment and medication monitoring
 - Shared care and/or referral to specialized service programs for patients with complex conditions/frailty
 - Step down care for those with more severe problems who have completed more intensive treatment
- (vii) Support for the terminally ill in the community (excluding patients in facilities);
- (viii) Coordination and access to rehabilitation;
- (ix) Provide medical coordination and participate in multidisciplinary team planning for the ongoing health needs of patients.
- (x) Provide health prevention and promotion activities including organizing and/or participating in health promotion forums focused on the health care needs of the Health Service Delivery Area.
- (xi) Clinically-related research, concurrent with Direct and Indirect Patient Care.
- (xii) Clinically-related teaching of medical students and Residents, concurrent with Direct and Indirect Patient Care.**

The Services will be provided at the Clinic, **the patient's home, or** other appropriate locations. The Physicians will provide the Services via face-to-face appointments, telephone consultations and virtual care options where available and as appropriate based on the clinical circumstances.

- k. Clinical Administrative Services, including but not limited to:
 - (i) 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 and chart reviews; and,
 - (ii) Those activities necessary to satisfy each Physician's obligations under Article 16 and Appendix 4 of this Contract.

Rural Locum Program

10. ***The parties agree that the Physicians if eligible, may request locum coverage through the Rural General Practitioners Locum Program (RGPLP), or any other locum program which may be established, and the Agency will make reasonable efforts to assist the Physicians in arranging for locum coverage through the RGPLP.***

Equipment/Facilities

11. The Physicians are solely responsible for procuring and providing all labour, support, technology, material, supplies, equipment, approvals, facilities and services required by the Physicians to perform the Services in accordance with this Contract.

APPENDIX 3

PAYMENT

Year One Income Guarantee

1. The Physicians will provide the Ministry with the names of each Physician, information regarding their relevant billing arrangements for work done at the Practice, and the number of FTEs that each Physician will commit to provide under the Contract.
2. The Ministry will determine the Physicians' FFS billings (excluding third party billings) for the most recently completed calendar year prior to the start of the Term ("**Physician FFS Billings**") and will provide this information to the Agency and the Physicians for use in administering the Contract.
3. The Ministry will then determine the amount of funding to be provided to the Physicians for the first year of the Term for the number of FTE under the Contract and will provide this information to the Agency and the Physicians for use in administering the Contract. Funding provided to the Physicians will be determined by the total of the greater of \$295,457 per FTE or the Physicians FFS Billings up to a maximum of \$336,257 per FTE (the "**Practice Income Guarantee**"). To receive the full amount of the Practice Income Guarantee, the Physicians must be engaging in QI Services as set out a 9 c. of Appendix 2 and provide the minimum number of hours required under the Contract.
4. The Practice Income Guarantee for this Contract is _____ for the first year of the Term.

Example (for illustrative purposes only)

Six physicians request a four FTE contract, FFS earnings are as follows:

- Physician A Historical FFS - \$170,000
- Physician B Historical FFS - \$155,000
- Physician C Historical FFS - \$185,000
- Physician D Historical FFS - \$205,000
- Physician E Historical FFS - \$145,000
- Physician F Historical FFS - \$280,000

Total earnings = \$1,140,000

4 FTE Band 1 Contracts = \$1,181,828

Year one Guarantee = \$1,181,828

Panel and Complexity Premium and Calculation of Total Contract Value

5. In each subsequent year of the Term, the Ministry, on behalf of the Agency and in order to allow the Agency to administer the Contract will determine the Practice Panel based on the Attachment Codes submitted by the Physicians (verified by the Ministry) in the previous year of the Term and calculate the complexity portion of the premium using a relative complexity measure, or "**Complexity Weight**", determined by the following formula:

- Complexity Weight equals the ACG Cost of the Practice Panel divided by the ACG Cost of BC attached patients
6. The Complexity Weight will then be used to adjust the panel size expectation per FTE (“PSE”) for the Practice Panel as compared to a panel size of 1,250 of average complexity. For example, a Complexity Weight of 1.25 results in a PSE of 1,000 (1,250/1.25). The PSE is multiplied by the number of FTE to arrive at the Practice PSE
 7. The Practice PSE is then compared to the actual Practice Panel to determine the overall weight, calculated as follows:
 - Overall Weight = Practice Panel divided by Practice PSE multiplied by 100.
 8. Contract Bands pay one of five amounts based on the Overall Weight as follows:

Contract Band	Overall Weight	Initial Contract Value for 1.0 FTE	QI Component for 1.0 FTE	Contract Value for 1.0 FTE
Band 1	100.1% - 103.4%	\$275,057	\$20,400	\$295,457
Band 2	103.5% - 106.8%	\$285,257	\$20,400	\$305,657
Band 3	106.9% - 110.3%	\$295,457	\$20,400	\$315,857
Band 4	110.4% - 113.8%	\$305,657	\$20,400	\$326,057
Band 5	113.9% +	\$315,857	\$20,400	\$336,257

9. The total of the Contract Bands for each FTE in the Contract results in a Total Contract Value.

Example (for illustrative purposes only)

Clinic A has four Physicians working a total of 4 FTE under the Contract. The Practice Panel is 3,750 and Complexity Weight is 1.40. Therefore, the PSE is 1,250/1.4 or 893 and the Practice PSE is 3,572. The Overall Weight is 3,750/3,572 x 100 or 105%. This qualifies Clinic A for Contract Band 2 for each FTE in the Contract and a Total Contract Value of **\$1,222,628**. This will be the Total Contract Value for year 2 of the Contract.

In reconciling year 1, the Physicians provided 6,384 hours of Services (95%), so the adjusted Total Contract Value for year 1 is \$1,222,628 * 95% = **\$1,161,497**. This will be compared to the Practice Income Guarantee amount for the purposes of determining any reconciliation payments.

10. The Ministry will provide information regarding the Panel and Complexity Premium and Calculation of Total Contract Value, including data submitted to the Physicians, to the Agency for the Agency’s use in administering the Contract.
11. Upon request, the Ministry will also provide to the Physicians data regarding each Physician’s contribution to Clinic payments, Panel, ACG Cost, Complexity Weight, PSE and Overall Weight. The Ministry will also commit to a regular process for continuing to develop reporting mechanisms to support the disbursement of payments among Physicians.

12. The Contract Band rates above are for the 2021-22 Fiscal Year. From April 1, 2023, Contract Band rates will increase based on agreement between the Ministry and the Doctors of BC as part of future Physician Master Agreement negotiations.

Reconciliation

13. At the end of the first year of the Term, the Ministry will determine:
- a. immediately, the Total Contract Value in accordance with sections 4 to 8 of this Appendix 3. This Total Contract Value will apply to the second year of the Term.
 - b. 120 days after the end of the first year of the Term, the Year 1 Total Contract Value as compared to the Practice Income Guarantee paid at the start of the Term. The differences will be reconciled on the following basis:
 - i. The Physicians will be required to make a reconciliation payment to the Agency if any of the Physicians do not provide (i) any QI Services as required by 9 c. of Appendix 2 or (ii) the minimum hours for the required number of FTE's under the contract. The reconciliation payment will be determined by first subtracting \$20,400 per FTE for each Physician that did not provide any QI Services and then multiplying the remainder by the % of hours provided.
 - ii. Where the Total Contract Value is greater than the Practice Income Guarantee, the Agency will provide the Physicians with the difference.
14. At the end of each subsequent year of the Term, the Ministry will immediately retroactively reassess the Practice's Total Contract Value for the year to determine the next year's advanced Total Contract Value and then will perform a final reconciliation 120 days after the end of the year to determine the final Total Contract Value for the previous year and undertake any required reconciliation with respect to both hours and QI Services.

Example (for illustrative purposes only)

The Total Contract Value for year 2 for Clinic A as established above is **\$1,222,628**. In year 2 of the Contract, the Practice Panel of Clinic A increases to 3900 and Complexity Weight to 1.45. Therefore, the PSE is $1,250/1.45$ or 862 and the Practice PSE is 3,448. The Overall Weight is $3900/3,448 \times 100$ or 113.1%. This qualifies Clinic A for Contract Band 4 for each FTE in the Contract and a Total Contract Value in Year 3 of **\$1,304,228**. Assuming no change in the next 120 days, no reduction based on QI Services and no prorating based on hours, the reconciliation payment for Year 2 due to the Physicians will be \$81,600.

Unattached Patients and Clinical Learners

15. ***Before the start of the Term, the Ministry will work collaboratively with the Physicians to adjust the PSE due to the Unattached Patient population and for the impact of clinical teaching in the Practice. PSE will be calculated based on an alternative number to the 1,250 patients of average complexity usually divided by the Complexity Weight to calculate PSE. Adjustments to PSE will be evidence and data informed, and Unattached Patients are assumed to have average complexity***

Addition of Physicians During a Contract Year

16. If the Physicians wish to adjust the FTE they will provide under the Contract due to the addition of new Physicians to the Contract, the Physicians and the Agency must agree on an appropriate amendment to the Contract.

Payment

17. The Agency will pay the Physicians the Practice Income Guarantee and subsequent annual Total Contract Values as determined in accordance with this Appendix 3 <**biweekly/monthly/other**> in ____ equal installments during the Term. Payment will be made to the Representative. It is the responsibility of the Physicians and the Representative to allocate payments among the Physicians providing the Services in accordance with this Contract and their intra-physician group governance agreement. Each Physician acknowledges that the Agency is not and will not be responsible for such allocation and for any disagreements between the Physicians over such allocation of payments from the Agency. In circumstances where the Physicians have not complied with the hours reporting requirements set out at section 7 of Appendix 5, the Agency may withhold the next installment payment until such time as those requirements are met.
18. ***The Agency agrees that the rates described in Section 7 above will be increased by the applicable Rural Retention Percentage Fee Premium for the community. In addition, the Agency will pay the Physicians the applicable Rural Retention Flat premium for the community.***

Reporting of Disbursement of Funds

19. The Physicians will report the details of the disbursement of the funding among the Physicians to the Agency on a quarterly basis during the Term.

APPENDIX 4 FEE FOR SERVICE WAIVER

Physician Name:

MSP Practitioner Number:

All capitalized terms herein have the meaning given to them in the Contract between the undersigned Physician and Agency dated <date>.

The Physician acknowledges that the payments by the Agency for the Services provided under the terms of the Contract are payments in full for those Services and the Physician will make no other claim for those Services.

The Physician will not retain and hereby waives any and all rights the Physician may have to receive any fee for service payments from the Medical Services Plan with respect any of the Services, including any GPSC incentive fees other than those specifically excluded herein.

The Physician may retain any payments for any such Services from any third party including but not limited to:

- (a) services rendered that a person is eligible for and entitled to under
 - i. *the Aeronautics Act (Canada),*
 - ii. *the Civilian War-related Benefits Act,*
 - iii. *the Government Employees Compensation Act (Canada),*
 - iv. *the Merchant Seaman Compensation Act (Canada),*
 - v. *the National Defence Act (Canada),*
 - vi. *the Pension Act (Canada),*
 - vii. *the Royal Canadian Mounted Police Pension Continuation Act (Canada),*
 - viii. *the Royal Canadian Mounted Police Superannuation Act (Canada),*
 - ix. *the Canadian Forces Members and Veterans Re-establishment and Compensation Act,*
 - x. *the Department of Veterans Affairs Act,*
 - xi. *the Corrections and Conditional Release Act (Canada),*
 - xii. *the Workers Compensation Act,*
 - xiii. *the Hospital Insurance Act, or*
 - xiv. *the Insurance (Vehicle) Act.*
- (b) billings for all non-insured Services, and
- (c) billings for Services provided to persons who are not beneficiaries under the *Medicare Protection Act* including but not limited to billings for persons in respect of whom MSP may seek payment from another Canadian province under a reciprocal payment arrangement.

The Physician may also retain any payments from third-parties for medical/legal services that are provided outside of any hours claimed in relation to the Services provided under this Contract.

Specific FFS and other exclusions, subject to Physician eligibility:

- Payment for any Services provided to third parties where those services are to be billed and retained by the Physician. For clarity, time spent providing such Services to third parties is not to be counted as part of the hours of Services provided under this Contract.
- Payment for any Services provided to patients referred to a Physician by a physician or allied care provider from outside the Clinic for specialized services (such as obstetrics) and who are not and will not be attached to the Practice panel, provided that any time spent providing such Services to these patients is not included in the hours reported under this Contract

- The following GPSC Fees and payments may be billed and retained by the Physician:
 - H14086 FP Assigned In-Patient Care Network Initiative
 - FP Unassigned In-Patient Care Network Incentive (adjustment code 'GU')
 - H14088 FP Unassigned In-patient Care Fee
 - H14010 Maternity Care Network Initiative Payment
 - Any payments under the GPSC's Long Term Care Initiative.

Date

APPENDIX 5 REPORTING

Encounter Reporting

1. Each Physician (and any Resident under the supervision of a Physician, using the supervising Physician's Practitioner Number) will submit Encounter Records to the Medical Services Plan/Health Insurance BC via Teleplan in accordance with the requirements, rules and procedures of the Medical Services Plan (MSP)/Health Insurance BC for the Services provided under this Contract and the Encounter Records will include the following information:
 - a. MSP Payee Number (Clinic's Payee Number XXXX),
 - b. Practitioner Number,
 - c. Patient's/Client's personal health number (PHN),
 - d. Patient/Client Name,
 - e. Date of services,
 - f. Encounter code(s),
 - g. ICD-9 diagnostic codes (1 code mandatory, 3 maximum),
 - h. Location Code,
 - i. Facility Number,
 - j. Note, and
 - k. Referring/Referred practitioner # (if the Physician is referring patient to or receiving a referral from another practitioner).

With respect to f. above, each Physician will use those simplified encounter codes for GPs provided by the Medical Services Plan/Health Insurance BC, as amended from time to time.

2. Each Physician will also submit a shift code fee item 97570 – Contracted Clinical Shift via Teleplan and in accordance with the requirements, rules and procedures of the Medical Services Plan (MSP)/Health Insurance BC for each period of time under which Contract Services are provided. The shift code record will include the following:
 - a. MSP Payee Number (Clinic's Payee Number XXXX),
 - b. Practitioner Number,
 - c. Patient's personal health number (PHN) (a patient seen during the day)
 - d. Patient Name (a patient seen during the day)
 - e. Date of services
 - f. Start time (for that day),
 - g. End time (for that day),
 - h. Time units (an estimate of the number of 15 minute time units spent providing Services under the contract – captured under the Billed Services field in Teleplan),
 - i. ICD-9 diagnostic codes (1 code mandatory, 3 maximum) (general symptoms ICD-9 code).
 - j. Location Code, and
 - k. Facility Number.
3. During the Term of this Contract, the Physicians may provide services outside the scope of this Contract on a fee-for-service basis. The Physicians, whether or not required by MSP or other paying agency, will enter start and stop times of the patient encounter for any services provided outside the scope of this Contract on a fee-for-service basis when those services are provided on the same day that the Physician provides Services under this Contract.

- a. For clarity, in circumstances where the Physician addresses multiple conditions during a visit, the Physician will report time providing Services under this Contract and bill fee for service to WorkSafeBC or Insurance Corporation of British Columbia or other third parties as appropriate.
4. Each Physician will also submit an Attachment Code each year during the Term for each patient where attachment is confirmed/agreed to by the Physician and the patient in accordance with sections 9 f. to h. of Appendix 2. An Attachment Code should not be submitted where attachment is not established (e.g. the Physician is seeing a patient attached to another Physician) or for any Services provided outside this Contract. As the Attachment Code is administrative, the Physician must also submit a separate Encounter Record as set out in 1 above for visit. The Attachment Code will include the following information:
 - a. MSP Payee Number (Clinic's Payee Number **XXXX**),
 - b. Practitioner Number,
 - c. Patient's/Client's personal health number (PHN),
 - d. Patient/Client Name,
 - e. Date,
 - f. Attachment code for PCN,
 - g. ICD-9 diagnostic codes (1 code mandatory, 3 maximum),
 - h. Location Code, and
 - i. Facility Number.
 5. The Physicians will also ensure that all appropriate Practice Personnel (non-physician health care practitioners) register with Teleplan and submit Encounter Records to the Medical Services Plan/Health Insurance BC via Teleplan in accordance with the requirements, rules and procedures of the Medical Services Plan (MSP)/Health Insurance BC for the Services provided under this Contract and the Encounter Records will include the following information:
 - a. MSP Payee Number (Clinic's Payee Number **XXXX**),
 - b. Practitioner Number,
 - c. Patient's/Client's personal health number (PHN),
 - d. Patient/Client Name,
 - e. Date of services,
 - f. Encounter code(s),
 - g. Start Time (for that day),
 - h. End Time (for that day),
 - i. ICD-9 diagnostic codes (1 code mandatory, 3 maximum),
 - j. Location Code,
 - k. Facility Number,
 - l. Note, and
 - m. Referring/Referred practitioner # (if the practitioner is referring patient to or receiving a referral from another practitioner).
 6. Each Physician acknowledges that information collected by the Medical Services Commission under the authority of the *Medical Protection Act*, including details of physician Encounter Reporting or fee-for-service billings, may be disclosed to the Agency, the Ministry and to the Auditors for any purposes authorized by law, including the purposes of administering, evaluating and monitoring this Contract. Personal information in the custody or under the control of the Agency is protected from unauthorized use and disclosure in accordance with

the *Freedom of Information and Protection Act* and may be disclosed only as provided by that Act.

Hours Reporting

7. Within 30 days after the end of each quarter during the Term, the Physicians will provide to the Agency an hours report with respect to the Services provided under the Contract which identifies the days Services were provided, the number of hours of Services provided each day by each Physician, including start and stop times and the total number of hours provided by the Physicians, in the form set out in Appendix 5A.

Access Reporting

8. Within 30 days after the end of each quarter during the Term, the Physicians will provide to the Agency a report on the access measures outlined in section 9 a. of Appendix 2, by providing an estimate of time to 3rd appointment for each month during the quarter.

QI Reporting

9. Within 30 days after the end of each year of the Term, the Physicians will provide to the Agency a report on the QI Services outlined in section 9. c. of Appendix 2.

**APPENDIX 5A
HOURS REPORTING FORM**

Payee	Practitioner. Number	Physician Name (Last Name, First Name)	Service Date	Start Time	End Time	Duration	Service Type
The following represents an example of how to complete the Hours Reporting Form							
XXXXX	YYYYY	Smith, Jane	July 17, 2020	08:00	12:30	4.5	Direct, Indirect or Clinical Administrative
XXXXX	YYYYY	Smith, Jane	July 17, 2020	13:00	17:00	2	Direct, Indirect or Clinical Administrative
XXXXX	YYYYY	Smith, Jane	July 17, 2020	13:00		1	QI
XXXXX	YYYYY	Smith, Jane	July 17, 2020	14:00		1	Third Party or Referred Services

1. Required information for Services provided under the Contract includes the date of recorded hours, shift start time and end time (the “Contract Shift”), and total shift hours (the difference between shift start and end time). Practitioner and Payee information is also required.
2. With the exception of QI Services, all hours claimed under the Contract should be recorded with Service Type ‘Direct, Indirect or ‘Clinical Administrative’.
3. For all excluded services (services compensated outside the contract) and QI Services undertaken during the Contract Shift, a separate entry is required in the reporting template.
 - a. The excluded service or QI entry must include the same provider and date information as the Contract hours entry, in addition to the estimated start time and duration of the excluded activity or QI. The Service Type for excluded service entries are:
 - i. QI Services
 - ii. Third Party Services or Referred Services.
 - iii. Non-contract Fee for Service
 - iv. Break (equal to or greater than 30 Minutes).

APPENDIX 6

PHYSICIAN NAMES AND CONTACT INFORMATION

APPENDIX 7

NEW PHYSICIAN - AGREEMENT TO JOIN

("New Physician-Agreement to Join")

Re: **Contract effective _____ (the "Contract") between the Agency and those physicians named on the signature page of the Contract, or who subsequently became a party to the Contract by entering into this New Physician - Agreement to Join.**

[Note: if a Representative has not been designated, replace all references to the "Representative" below with "Physicians" and make other consequential amendments]

For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by the undersigned:

1. The Representative, on behalf of and with the authority of all of the Physicians, confirms that the Physicians wish to add Dr. _____ (the "New Physician") as a "Physician" under the Contract to provide Services under the terms of the Contract.
2. The New Physician acknowledges having received a copy of the Contract and hereby agrees with the Agency and the other Physicians that the New Physician will be bound by, and will comply with, all of the terms and conditions of the Contract as a "Physician". The New Physician acknowledges that all payments for Services under the Contract will be made by the Agency to the Physicians as provided in the Contract and that the Representative, currently Dr. _____, has been granted certain authority to act as the representative of the Physicians, including the New Physician, under the Contract. [The New Physician confirms that Dr. _____ is the "Physician Owner" for the New Physician]
3. The New Physician will become party to any intra-group governance agreement between the Physicians.
4. The New Physician confirms that notices to the Physicians will be delivered as set out in clause 23.3 of the Contract. Where a notice is to be given to less than all of the Physicians, the address for notice for the New Physician is:

▼▼

▼▼

5. The Agency's agreement to the New Physician joining is subject to the New Physician meeting all credentialing, licensing and other qualifications set out in the Contract (if not already met).
6. All capitalized terms used in this New Physician – Agreement to Join and not otherwise defined will have the meaning given to them in the Contract. This New Physician – Agreement to Join may be executed in multiple counterparts and all such counterparts will constitute one and the same agreement.

IN WITNESS WHEREOF THE PARTIES to this New Physician – Agreement to Join have duly executed this New Physician – Agreement to Join as of the date written on the signature lines.

Dr. _____ as the Representative

Signed and Delivered On behalf of the Agency:

Date

Signed and Delivered by the New Physician:

New Physician's Signature (unincorporated)

Date

or

[] Inc.

Authorized Signatory

Date

APPENDIX 8

**INFORMATION-SHARING AGREEMENT
(the “Agreement”)****TO SUPPORT THE GROUP CONTRACT FOR PRACTICING FULL SERVICE FAMILY
PHYSICIANS****BETWEEN:****THOSE PHYSICIANS AND PROFESSIONAL MEDICAL CORPORATIONS LISTED ON THE
SIGNATURE PAGE OF THIS CONTRACT**

(each is individually a “Physician” and collectively all
are referred to as the “Physicians”)

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

(the “Ministry”)

AND:**HEALTH AUTHORITY**

(the “Agency”)

1. Background

The Group Contract for Practicing Full Service Family Physicians (the “Contract”) is a Service Contract option for GPs who have an existing patient panel and provide full scope primary care, and are willing to transition their practice to a Patient Medical Home (PMH).

The Contract is available to physicians working collaboratively with other physicians in a clinic setting as well as for physicians in independent practices. Payments are made by the health authority on an agreed upon schedule (bi-weekly/monthly/other). For agreements where there are multiple physician signatories, of physician group, the payment is made to the group representative and the representative is responsible for appropriate distribution.

The Contract has three components which determine the overall payment amount. The first payment component is hours based and uses a standardized FTE definition (1680 - 2100 hours per 1.0 FTE) where physicians are required to report their hours worked under the contract. The second payment component involves a variable payment which is intended to reflect both the size and the complexity of the patient panel. The methodology used to calculate the variable payment amount relies solely on Encounter Reporting and Attachment Reporting submitted through Teleplan. The Encounter Reporting data contains the diagnostic information required to assess patient panel complexity, while Attachment Reporting data is used to determine the size of the panel.

The third payment component is a payment for meeting a predetermined set of QI activities.

In addition to the reporting of information required to calculate regular payments under the Contract, three additional elements may also require information sharing:

1. Year One Practice Income Guarantee: The Physicians will provide the Ministry with the Physician names and relevant billing arrangements for the work done at the practice as well as the number of FTEs the Physicians will commit to under the Contract. The Ministry will then determine the amount of funding to be provided to the physicians for the first 12 months of the Contract term using 2019 calendar year data, or the most recent 12 months of FFS billings for each physician.
2. Reconciliation and Advance: At the end of each 12 months of the Term, the Ministry will use the Attachment Records and Encounter Reporting Records by the Physicians in the recently completed year to determine the complexity and panel size based variable payment for the completed year, which when combined with other calculations will generate the reconciled contract amount. The Ministry will also use this information to calculate the following year's contract amount.
3. Unattached Patients: Before the start of the Term and only if required, the Ministry will work collaboratively with the Physicians to adjust the payment calculations to accommodate any unattached patient population serviced by the physicians under the contract. These patients are not represented in the panel.

The indirect collection of patients' personal information for the Contract and for FFS under the MSP is similar in content, mechanics, and purpose:

- Under the Contract, essentially the same personal information elements as FFS are submitted under Teleplan, relating only to BC MSP beneficiaries;
- The information is directly collected by physicians (or nursing and allied health providers in physician-led practices), and is submitted through Teleplan to the Ministry;
- The Ministry uses MSP information (Encounter Reporting and Attachment Reporting) to facilitate the administration of payments and conduct monitoring and evaluation. For the Contract, this information must be shared, in aggregate form with the contract administrator, the regional Health Authority.

2. Interpretation

2.1 Capitalized terms used in this Agreement that are defined in the Contract have the same meaning as in the Contract, unless otherwise defined in this Agreement.

2.2 Where used in this Agreement:

a) **"Authorized Users"** means the individuals authorized to access, retain, use or disclose Personal Information, as listed in Section 6 (as such list may be amended from time with the approval of the Province);

(b) **"Party"** or **"Parties"** means the Ministry and the Physicians and the Agency;

(c) **"Personal Information"** means personal information as defined in the *Freedom of Information and Protection of Privacy Act (FIPPA)* and includes patient's personal health numbers (PHNs);

2.3 In this Agreement, all references to **"Sections"**, **"Paragraphs"** and **"Schedules"** refer to Sections, Paragraphs and Schedules of this Agreement unless the context requires otherwise.

3. Purpose of the Agreement

The purpose of this Agreement is to document the terms and conditions of the exchange of certain Personal Information by the Parties for the purpose of implementing the Contract with the Physicians at the Clinic, in compliance with the *Freedom of Information and Protection of Privacy Act* (“FIPPA”), *Personal Information Protection Act* (“PIPA”), *Medicare Protection Act* (“MPA”) and (“E-HEALTH”) *Personal Health Information Access and Protection of Privacy Act*.

This Agreement is a related agreement to the Group Contract for Practicing Full Service Family Physicians (“the Contract”), as described in Appendix 1 of the Contract and Section 16.4 of Article 16 of the Contract.

4. Collection, Use, and Disclosure of Personal Information

The flow of information between the Parties serves several distinct purposes and the legal authorities for the collection, use, and disclosure of personal information are described below. This section identifies the FOIPPA, PIPA and MPA legal authorities that allow for the collection, use, and disclosure of personal information. If you have any questions about the collection and use of your information, please contact the Director, Compensation Initiatives at PCN.Compensation@gov.bc.ca.

Mailing address: PO Box 9649 Stn Prov Govt, Victoria BC V8W 9P4.

#1. Calculation of Variable Payment for the Contract: This process involves the analysis of the Patient Panel for the purposes of calculating the variable contract payment.

Personal Information Flow Table				
	Description/Purpose	Type	FOIPPA Authority (s)	Other Act(s)
Prior to Contract Start				
1.	The Physician or Physician group provides practitioner and payee information to the Ministry	Collection	26(c) & (e) 27(1)(a)(i)	
2.	The Ministry uses the FFS billing information for 2019 or the most recently completed calendar year to determine the first year Income Guarantee amount	Use	32(a)	
3.	If required, the Ministry will collaborate with physicians to determine the patient population that will receive services under the contract but remain unattached to the contracted physicians. The Ministry reviews aggregated FFS data for those unattached patients and the panel Practice Panel Size Expectation (PSE) is adjusted accordingly	Non-PI		
During the Contract Term				
4.	Clinic Physicians submit Attachment codes via Teleplan for every patient for which a longitudinal attachment relationship has been established. Attachment codes are submitted within an Encounter Record and contain basic patient information, such as Personal Health Number (PHN).	Collection	26(c) & (e) 27(1)(a)(i)	

Personal Information Flow Table				
	Description/Purpose	Type	FOIPPA Authority (s)	Other Act(s)
5.	Complexity Weight is calculated based on the ACG Category Cost of BC Attached Patients.	Use	32(a)	
6.	Practice Panel Size Expectation (PSE) and Overall Weight are calculated based on the patients for which Attachment codes were submitted	Use	32(a)	
7.	Overall Weight is translated to a Contract Value amount and shared with the Agency to enable contract payment disbursements to the clinic.	Non-PI	N/A	
8.	Physician-level reports are created quarterly, or upon Physician request, by the Ministry and shared with the Agency to facilitate the disbursement of clinic-level payments. Reports will include physician panel: Size, ACG Cost, Complexity Weight, PSE and Overall Weight.	Disclosure	33.2(a)	MPA S.49.2(d) subject to E-Health Act S.4(e)(i)(ii)(g)
9.	At the end of the first year of the term, the Ministry will reconcile any differences between the Income Guarantee amount provided for Year One and the assessed Contract Value for Year One and provide a clinic-level report to the Agency and to the Physicians upon request.	Use/Disclosure	32(a) 33.2(a)	MPA S.49.2(d) subject to E-Health Act S.4(e)(i)(ii)(g)
10.	At the end of Year One and each subsequent contract year, the Ministry will use three quarters of the prior year information to calculate the advance for the following year. The clinic-level advance amount will be communicated to the Agency and to the Physicians upon request.	Use	32(a)	
11.	Within 120 days of the end of each subsequent contract year, the Ministry will perform a final reconciliation to determine the final Total Contract Value for the recently completed year and provide a clinic-level report to the Agency and to the Physicians upon request.	Use/Disclosure	32(a) 33.2(a)	MPA S.49.2(d) subject to E-Health Act S.4(e)(i)(ii)(g)

#2. Encounter Reporting

Personal Information Flow Table			
	Description/Purpose	Type	FOIPPA Authority
1.	Physicians Encounter report clinical services delivered for panel patients through Teleplan. Patient information includes PHN and diagnostic code(s). Encounter reporting provides the patient-level diagnostic information required to calculate the panel PSE, Complexity Weight, and Overall Weight	Collection	26(c) & (e) 27(1)(a)(i) 27(e)
2	The Ministry analyzes the quarterly encounter reporting for monitoring purposes and to support contract auditability.	Use	32(a)

#3. Hours Reporting

Personal Information Flow Table			
	Description/Purpose	Type	FOIPPA Authority
1.	Physician clinical service hours are used in the calculation of contract payments. Hours reporting is submitted to the Agency by the Physicians and includes information such as physician name, practitioner number, clinic payee and summary level hours worked.	Collection	26(c), (e)
2.	The Agency compiles the hours reports in aggregate form and submits to the Ministry on a quarterly basis via the reporting tool S.C.R.U.B.S.. The Ministry uses the Physician hours reporting to determine if contractual agreements are met. Hours below the agreed number of FTE will require a proration of the contract payment.	Use	32(a)

#4. Quality Improvement Measures

Personal Information Flow Table			
	Description/Purpose	Type	FOIPPA Authority
1.	The Physicians will track patient access against a specific set of access measures and report this information to the Agency on a quarterly basis.	Non-PI	N/A
2.	The Physicians will undertake all required Quality Improvement (QI) activities during the contract term and will be obligated to collect confirmation of QI activity completion from the General Practice Services Committee (GPSC) Practice Support Program.	Non-PI	N/A
3.	The Physicians will confirm, using an annual QI activity form, the completion of all required contract Quality Improvement (QI) to the Agency, within 30 days of the end of the contract year. Written confirmation will be co-signed by the clinic Physicians and a member of the General Practice Services Committee (GPSC) Practice Support Program (PSP).	Non-PI	N/A
4.	The Agency confirms the completion of required quality improvement activities with the Ministry for the purposes of payment reconciliation.	Non-PI	N/A

#5. Monitoring

Personal Information Flow Table			
	Description/Purpose	Type	FOIPPA Authority
1.	Detailed Physician clinical service hours are also submitted to the Ministry. This information is sent directly through Teleplan using a fee code created for this purpose (shift record). Physicians will report items such as personal identifiers, including the PHN of a patient seen during the clinical shift, date, start and end time, number of worked contract hours.	Collection	26(c) and (e)
2.	The Ministry will review the detailed hours Teleplan submissions and compare them to the quarterly hours reporting submitted through S.C.R.U.B.S. for monitoring and audit purposes.	Use	32(a)
3.	A Patient Attachment Verification form is completed by the patient annually and retained by the Clinic. At the request of the Ministry the Clinic will send the forms to the Ministry to support auditability.	Collection	26(c) and (e)

Other legal authorities for collection, use, and disclosure of personal information:Ministry collection, use, and disclosure:

- Ministry can also collect personal information from the contracted physicians based on FOIPPA 26(a) [MPA s.5(1)(e), s.27(1), s.27(6)].
- Ministry can also disclose personal information to the contracted physicians based on FOIPPA 33.1(1)(c)[MPA s.49(2)(a) and (d)].

The contracted physicians' collection, use, and disclosure:

- The contracted physicians can also collect personal information from Ministry based on PIPA s. 8(1) and/or s.12(1)(h)[MPA s.5(1)(e)] and PIPA s.12(2)(a) and (b).
- The contracted physicians can also use personal information collected from Ministry based on PIPA s. 8(1) and/or s.15(1)(h) [MPA s.5(1)(e)].
- The contracted physicians can also disclose personal information to Ministry based on PIPA s.17(a) and s. 8 (1) and/or s.18(1)(o) [MPA s.5(1)(e)].

Categories of information being collected, used and shared

The following data elements are used for the purposes of the following information flows (all info flows are described in detail in *Section 4* above):

#1 Calculation of Payments for the Contract**#2 Encounter Reporting**

Encounter Records are similar to FFS claims, and contain many of the same data elements, including:

- practitioner number (i.e. the physician delivering the service)
- payee number (i.e. the clinic's shared payee number)
- patient's personal health number (PHN);
- patient's name;
- date of service(s)
- date of birth;
- sex
- encounter code (which describes the service provided);
- diagnostic code(s)
- location code
- facility number
- note record if required, and
- referring/referred practitioner number (if the physician is referring patient to or receiving a referral from another practitioner)

Attachment Records

The following data elements are used for the purposes of the following information flows (all info flows are described in detail in *Section 4* above):

#1 Calculation of Payments for the Contract

The Attachment code is a \$0 administrative fee code submitted through Teleplan on an annual basis for patients when attachment is agreed to by the physician and the patient upon completion

of an attachment conversation. An attachment code should not be submitted when attachment is not established.

Attachment codes are submitted with an Encounter claim and contain the following data elements:

- practitioner number (i.e. the physician delivering the service)
- payee number (i.e. the clinic's shared payee number)
- patient's personal health number (PHN);
- patient's name;
- date
- attachment code
- diagnostic code (1 code mandatory – can use most recent code or “general symptoms”)
- location
- facility number

Monitoring

The following data elements are used for the purposes of the following information flows (all information flows are described in detail in Section 4 above)

#5 Monitoring

The shift code is a \$0 administrative fee code submitted through Teleplan to itemize the contract hours the physicians work in any given day. The purpose of the shift code is to differentiate contract hours worked and FFS billings for work done not under the contract.

- practitioner number (i.e. the Physician claiming hours under the contract)
- payee number (i.e. the clinic's shared payee number)
- PHN (first patient seen during the contract shift)
- Diagnostic code
- Date
- Shift code
- Start time
- End time
- Number of services (i.e. in 15-minute increments)
- Location code
- Facility number

The Patient Attachment Verification Form is a form filled in by the patient on an annual basis to confirm his or her attachment to the primary care provider. The form is kept on file at the Clinic.

- Patient name
- PHN
- Practitioner name

5. Categories of individuals who are authorized to access the information and the reasons for their access (“Authorized Users”):

Position	Role	Data Elements Containing Personal Information that will/may be Accessed by Users	Reason for Data Access
Ministry Of Health			
Executive Director, Compensation Policy and Programs Branch	Program management	All elements/variables described in previous section.	Program management, analysis and reporting.
Director, Compensation Policy and Programs Branch	Program management	All elements/variables described in previous section.	Program management, analysis and reporting.
Senior Programmer Analyst (Contractor), Compensation Policy and Programs Branch	Program administration	All elements/variables described in previous section.	Development of reports to facilitate calculation of PSE and overall weight. Program management, analysis and reporting.
Senior Policy Analysts, Compensation Policy and Programs Branch	Program administration	All elements/variables described in previous section.	Development of reports to facilitate calculation of PSE and overall weight. Program management, analysis and reporting.
Policy Analysts, Compensation Policy and Programs Branch	Program administration	All elements/variables described in previous section.	Development of reports to facilitate calculation of PSE and overall weight. Program management, analysis and reporting.
Economists, Health Sector Information, Analysis and Research	Program administration	All elements/variables described in previous section.	Development of reports to facilitate calculation of PSE and overall weight. Program management, analysis and reporting.
Manager, Health Sector Information, Analysis and Research	Program administration	All elements/variables described in previous section.	Development of reports to facilitate calculation of PSE and overall weight. Program management, analysis and reporting.
Executive Director, Audit and Investigations Branch	Audit and Accountability	All elements/variables described in previous section.	Audit
Director, Billing Integrity Program	Audit and Accountability	All elements/variables described in previous section.	Audit
Medical Consultant, Billing Integrity Program	Audit and Accountability	All elements/variables described in previous section.	Audit
Audit Manager, BIP	Audit and Accountability	All elements/variables described in previous section.	Audit
All Senior Auditors, BIP	Audit and Accountability	All elements/variables described in previous section.	Audit

Position	Role	Data Elements Containing Personal Information that will/may be Accessed by Users	Reason for Data Access
All Medical Inspectors appointed under section 36 of the MPA	Audit and Accountability	All elements/variables described in previous section.	Audit
Audit Data Analyst, Billing Integrity Program	Audit and Accountability	All elements/variables described in previous section.	Audit
Clinic			
Lead Physician	Clinic Operations	All elements/variables described in previous section.	Administration of provider-level payments; reconcile/review payments; hours reporting; QI reporting.
Physician/Other Provider (e.g. Nurse)	Clinic Operations	All elements/variables described in previous section.	Administration of provider-level payments; reconcile/review payments; hours reporting; QI reporting.
Office Manager / MOA	Clinic Operations	All elements/variables described in previous section.	Administration of provider-level payments; reconcile/review payments; hours reporting; QI reporting.
Health Authority			
Authorised HA Representative	Program Administration	All elements/variables described in Section 4 #1 (2)-(11) only, #3 and #4	Administration of clinic level payments, collection of physician hours and submission to Ministry.

The contracted Physicians agree to provide the Ministry with a regularly (at any change in Physicians or Personnel) updated list of Physicians and Personnel who have been authorized access to the information described in Section 5, as well as Physicians and Personnel who have been de-authorized from accessing the information. At minimum, the updated information must include the Physician or Personnel's full name, position title, and where possible, the Physician or Personnel's institution. The updates can be provided to the Ministry via the following form sent via email to HealthDataCentral@gov.bc.ca with a cc to the Director, Compensation Initiatives. <http://www2.gov.bc.ca/assets/gov/health/forms/5510fil.pdf>

6. Data Transmission

Any data transmitted between the Agency and the Ministry will use the Province's Secure File Transfer Protocol or other secure methods provided by the Province (e.g., secure encrypted media including password protection).

The information received by the Ministry will be hosted on Ministry's program area (HSIAR) secure schema and will be accessed only by the authorized personnel described in section 5.

The information received by the contracted Physicians will be maintained and stored in a secure manner.

7. Timeline(s) for the retention of the information and plans for its disposal once such information is no longer required for purposes of the Agreement

Upon termination of this Agreement and consistent with FIPPA and Government Core policy, all records disclosed and exchanged between the contracted Physicians, the Ministry and the regional Health Authority for the purposes of administering the Contract will be retained for a period of time consistent with Government Core Policy and then destroyed in a method appropriate for the recording media and that maintains the security of the information and the privacy of individuals. The confirmation of data destruction can be sent to the Province via the following form: <http://www2.gov.bc.ca/assets/gov/health/forms/5506fil.pdf>

8. Accuracy

Each Party will make every reasonable effort to ensure the Personal Information in its custody is accurate, complete and up to date.

9. Security

Each Party will make reasonable arrangements to maintain the security of the Personal Information in its custody, by protecting it against such risks as unauthorized access, collection, use, disclosure or disposal.

Each Party will implement this Agreement in conformity with the government's Information Security Policy: <http://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/services-policies-for-government/policies-procedures/information-security-policy/isp.pdf>.

Each Party will advise the other Parties immediately of any circumstances, incidents or events which to its knowledge have jeopardized or may in future jeopardize:

- the privacy of individuals;
- the security of any computer system in its custody that is used to access the Personal Information.

10. Compliance Monitoring and Investigations

Each Party will record and monitor access to the Personal Information in its custody, in order to establish a chain of responsibility:

Each Party will investigate all reported cases of:

- (i) unauthorized access to or modification of the Personal Information in its custody;
- (ii) unauthorized use of the Personal Information in its custody;
- (iii) unauthorized disclosure of the Personal Information in its custody;

- (iv) breaches of privacy or security with respect to the Personal Information in its custody or with respect to any computer system in its custody that is used to access the Personal Information.

Each Party will report to the other the results of any such investigation and the steps taken to address any remaining issues or concerns about the security of the Personal Information or computer systems, or the privacy of individuals to whom the Personal Information relates.

11. Modification or Termination of Agreement - General

This Agreement may be renewed or amended upon a written agreement between the Parties.

12. Termination for Non-Compliance with Agreement

This Agreement may be terminated at any time by a Party if one of the other Parties fails to meet its obligations under this Agreement.

13. Term of Agreement

Notwithstanding the date of execution and delivery of the Contract, this Agreement will be effective for the duration of the term of the Contract and will continue unless the Contract is earlier terminated in accordance with Article 3 or this Agreement is terminated in accordance with section 12.

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

Signed and Delivered by the Physicians:

Unincorporated Physicians

_____ Date

Incorporated Physicians

[] Inc.

Authorized Signatory

_____ Date

Signed and Delivered on behalf of the Ministry:

Authorized Signatory

_____ Date

Signed and Delivered on behalf of the Agency:

Authorized Signatory

_____ Date

Authorized Signatory

_____ Date