

TEMPLATE: New-to-Practice Family Physicians Contract – For Private Clinics (December 2020)
Provisions in *bold italics* within this template contract are optional provisions.

BETWEEN:

PHYSICIAN/CORPORATION NAME

(the “**Physician**”)

AND:

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 Physician has committed to establishing their practice according to the attributes of a Patient Medical Home, attaching new patients, establishing and maintaining a minimum panel size, and integrating their practice with the Primary Care Network once it has been established;

AND WHEREAS the Physician has entered into a Practice Agreement, in the form set out in Schedule 1 to Appendix 2, to join an existing or new Practice with other primary care practitioners;

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

AND WHEREAS the Ministry of Health, the Agency and the Physician confirm that the Physician’s provision of the Services does not make the Physician an employee of, or independent contractor to, the Agency;

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

Article 1 Definitions

1.1 Words used in this Contract, including in the recitals and the Appendices, that are defined in the 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 “**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.

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- 1.1.3 “**Attachment Code**” means the record of patient attachment provided to the Medical Services Plan (MSP)/Health Insurance BC by the Physician via a \$0 Teleplan attachment code and the Physician’s Payee Number in accordance with Appendix 5.
- 1.1.4 “**Attachment Services**” means those steps taken by the Physician to confirm attachment of patients in accordance with sections 10 a.-c. of Appendix 2.
- 1.1.5 “**Attached Patients**” means those patients who are attached to the Physician and identified through an Attachment Code.
- 1.1.6 “**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 and QI Services.
- 1.1.7 “**Clinically-related teaching**” means teaching provided concurrent with patient care.
- 1.1.8 “**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).
- 1.1.9 “**Contract**” means this document including the Appendices, as amended from time to time in accordance with Article 23.
- 1.1.10 “**Direct Patient Care**” means clinical intervention with a specific patient present, including the concurrent provision of clinically-related teaching and clinically-related research.
- 1.1.11 “**Encounter Record**” means the record of the primary care services provided to a patient by the Physician, including simplified encounter codes (which capture the Physician’s practice activities) provided by the Medical Services Plan/Health Insurance BC, as amended from time to time, and diagnostic codes (ICD9).
- 1.1.12 “**Encounter Reporting**” means the transmission of Encounter Records to the Medical Services Plan (MSP)/Health Insurance BC.
- 1.1.13 “**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.
- 1.1.14 “**Fiscal Year**” means a period of twelve consecutive months beginning April 1 and ending March 31 inclusive.
- 1.1.15 “**FTE**” or “full time equivalent” means 1680 - 2100 hours of Services per year.
- 1.1.16 “**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.
- 1.1.17 “**Patient Medical Home (PMH)**” means primary care practices and clinics that are defined by the key attributes and core characteristics described in Appendix 1.
- 1.1.18 “**Practice**” means the primary care practice the Physician will be joining or establishing with a group of primary care practitioners, located at <address>.
- 1.1.19 “**Practice EMR**” means the electronic medical record software used by the Physician and the Practice which contains personal information under the legal custody and control of the Practice.

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- 1.1.20 “**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).
- 1.1.21 “**Primary Care Services**” has the meaning given in section 10 g. of Appendix 2.
- 1.1.22 “**QI Services**” means participation in the quality initiatives as described in sections 10 g. and h. of Appendix 2.
- 1.1.23 “**Services**” means Primary Care Services including but not limited to Direct Patient Care and Indirect Patient care provided 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 Physician. For certainty, the Physician is not providing the Services to or on behalf of the Agency.

Article 2 Term & Renewal

- 2.1 This Contract will be in effect from <insert date> to <insert 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. If either party wishes to renew this Contract, it must provide written notice to the other party no later than ninety (90) days prior to the end of the Term and, as soon as practical thereafter, the parties will meet to discuss and endeavour to settle in a timely manner the terms of such a renewal.
- 2.3 Subject to clause 2.4, if both parties agree to renew the Contract the terms and conditions of this Contract must remain in effect until the new contract is signed and any continuation past the Term is without prejudice to issues of retroactivity.
- 2.4 In the event that notice is given by either party in accordance with clause 2.2 above and if a new contract is not completed within six (6) months following the end of the Term, this Contract and any extensions will terminate without further obligation on either party.

Article 3 Termination

- 3.1 Subject to clause 3.2, either party may terminate this Contract without cause upon six (6) months written notice to the other party.
- 3.2 Either party may terminate this Contract immediately upon written notice if the other party breaches a fundamental term of this Contract. For clarity, any license withdrawal or restriction in licensing that affects the 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.
- 3.3 The Physician may terminate this Contract upon sixty (60) days’ written notice to the Agency in order for the Physician to transition to a group contract in place for other physicians in the Practice.

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- 3.4 The Physician may also terminate the Contract on sixty (60) days' written notice to the Agency and elect to be paid under FFS, on the condition that the Physician will continue for the balance time left on the Term as a member of the Practice, providing ongoing primary care to the Practice's patients.

Article 4 Relationship of Parties

- 4.1 The Physician and the Agency are independent contractors and the parties are not the servants, employees, agents or legal representatives of each other. No employment relationship is created by the Contract or by the provision of the Services to the Practice's patients by the Physician.
- 4.2 Neither the Physician nor the Agency will in any manner commit or purport to commit the other to the payment of any monies or to the performance of any other duties or responsibilities except as provided for in this Contract, or as otherwise agreed to in writing between the parties.
- 4.3 If the Physician employs other persons or is a professional medical corporation, the Physician will apply to register with WorkSafeBC and:
- 4.3.1 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,
- 4.3.2 if advised by WorkSafeBC that the Physician is a "worker", for the purposes of the *Workers Compensation Act*, advise the Agency and provide the Agency with any related documentation from WorkSafeBC.
- 4.4 If the 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.
- 4.5 The 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 it is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to this Contract.
- 4.6 The Physician agrees to indemnify the Agency from any and all losses, claims, damages, actions, causes of action, liabilities, charges, penalties, assessments, re-assessments, costs or expenses suffered by it arising from the Physician's failure to make any payments referred to in clause 4.5.
- 4.7 The indemnity in clause 4.6 survives the expiry or earlier termination of this Contract.

Article 5 FFS Waiver

- 5.1 Unless specified otherwise, the Physician must not retain FFS billings, including any GPSC incentive fees related to the Services provided under this Contract. The Physician may bill FFS or directly for any and all services delivered outside the scope of this Contract.
- 5.2 The 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.
- 5.3 The Physician may retain third party billings for the Services covered by this Contract, provided that any time spent providing such Services to third parties is not included in the hours reported

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under this Contract. For the purposes of this Article, third party billings include but are not limited to:

5.3.1 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*.

5.3.2 billings for non-insured Services, and

5.3.3 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.

5.4 The Physician may retain FFS billings for Services provided to patients referred to a Physician by a physician or allied care provider from outside the Practice for specialized services (such as obstetrics) and who are not and will not be attached to the Physician's panel, provided that any time spent providing such Services to these patients is not included in the hours reported under this Contract ("**Referred Services**").

5.5 The Physician is permitted to bill third parties for medical/legal services that are provided outside of the hours reported under this Contract.

Article 6 Autonomy

6.1 The Physician will provide the Services under this Contract in accordance with applicable standards of law, professional ethics and medical practice.

6.2 Subject to clause 6.1, the Physician is entitled to professional autonomy in the provision of the Services.

Article 7 Doctors of BC

7.1 The Physician is entitled, at his or her 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.

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Article 8 Dispute Resolution

- 8.1 This Contract is governed by and is to be construed in accordance with the laws of British Columbia.
- 8.2 All disputes with respect to the interpretation, application or alleged breach of this Contract that the parties are unable to resolve informally at the local level, may be referred to mediation on notice by either party to the others, with the assistance of a neutral mediator jointly selected by the parties. If the dispute cannot be settled within thirty (30) days after the mediator has been appointed, or within such other period as agreed to by the parties in writing, the dispute will be referred to arbitration administered pursuant to the *Arbitration Act*.
- 8.3 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.
- 8.4 Should the parties be unable to agree on the selection of the mediator or arbitrator within seven (7) days after notice is served by any party seeking the appointment of a mediator or arbitrator, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the mediator or arbitrator.
- 8.5 Upon agreement of both parties, the dispute may bypass the mediation step and be referred directly to arbitration.
- 8.6 The Agency and the Physician must advise the Ministry of Health and the Doctors of BC respectively prior to referring any dispute to arbitration. The Ministry of Health and the Doctors of BC 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.
- 8.7 Any dispute settlement achieved by the parties, up to the point of arbitration, will be deemed to have been concluded without prejudice to other disputes or proceedings involving other parties, and will not be referred to in any other dispute or proceeding.

Article 9 Service Requirements

- 9.1 The Physician will provide the Services as described in Appendix 2 and will schedule the Physician's availability, as set out in Appendix 2, to reasonably ensure the provision of the Services.
- 9.2 Hours are as agreed upon by the parties at Appendix 2. It is understood that many circumstances require flexibility of hours and the Physician will respond to these needs.
- 9.3 If the Physician is unable to provide the Services under the terms of this Contract on a persistent basis due to significant unanticipated increases in volume or the departure of one or more Physicians, then the parties will meet to discuss and develop an approach to attempt to resolve the concern. If they are unable to reach an agreement, either 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 10 Licenses & Qualifications

- 10.1 During the Term, the Physician and each locum physician and subcontracted physician providing Services under this Contract for a Physician will maintain:

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- 10.1.1 registered membership in good standing with the College of Physicians and Surgeons of British Columbia and the Physician will conduct his/her practice of medicine consistent with the conditions of such registration;
- 10.1.2 all other licences, qualifications, privileges and credentials required to deliver the Services.
- 10.2 During the term, it is a fundamental term of the Contract that the Physician, each locum physician and subcontracted physician providing Services under this Contract for the Physician maintains enrolment in the Medical Services Plan.
 - 10.2.1 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.
 - 10.2.2 If the Physician is no longer enrolled in MSP or is de-enrolled from MSP, the Physician must , within 15 days of such lack of enrollment, notify the Agency of the period of the lack of enrollment or de-enrollment. The Physician is not to provide Services during any period where they are not enrolled in MSP, regardless of the reason for the lack of enrollment.
- 10.3 All medical services under this Contract will be provided either directly by the Physician, by a resident under the supervision and responsibility of the Physician or by a clinical fellow under the supervision and responsibility of the Physician.
- 10.4 Where Services are being provided by a resident or clinical fellow under the supervision and responsibility of the Physician:
 - 10.4.1 the Physician shall be identified to the patient at the earliest opportunity;
 - 10.4.2 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;
 - 10.4.3 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
 - 10.4.4 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.
- 10.5 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 the Physician are to be included in calculating the hours compensated under this Contract.

Article 11 Locum Coverage

- 11.1 The Physician 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.
- 11.2 In circumstances where a locum physician is providing Services and will report their hours as hours under the Contract, the Physician will be responsible to pay such locum physicians from the

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amounts paid to the Physician under this Contract and the Physician will ensure that locum physicians:

- 11.2.1 do not bill FFS for the Services;
 - 11.2.2 sign a FFS waiver in the form set out at Appendix 4, and the Physician will provide the FFS waiver to the Agency prior to the locum physician providing Services under the Contract;
 - 11.2.3 provide Encounter Reporting and hours reporting as required by the Contract; and
 - 11.2.4 assign any third-party billings to the Physician's Payee Number.
- 11.3 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 12 Subcontracting

- 12.1 The Physician may, with the written consent of the Agency, subcontract or assign any of the Services. The consent of the Agency will not be unreasonably withheld.
- 12.2 The Physician will ensure that any contract between the Physician and a subcontractor will require that the subcontractor comply with all relevant terms of the Contract, 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.
- 12.3 Prior to subcontracting any of their obligations, the Physician 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.
- 12.4 The Physician is responsible for any subcontractor and no subcontract relieves the Physician from their obligations or liabilities under this Contract.

Article 13 Compensation

- 13.1 The Physician will invoice the Agency for all the Services provided in a form acceptable to the Agency, substantially in the form set out at Appendix 3A.
- 13.2 The Agency will pay the Physician pursuant to Appendix 3.
- 13.3 The Physician is to claim only for Services provided in accordance with the Contract.
- 13.4 The Physician is entitled to access the Benefit Plans as defined and described in the Benefits Subsidiary Agreement (as defined in the Physician Master Agreement).
- 13.5 The Agency must forward the necessary information to the Doctors of BC Benefits Department, at the address set out below, prior to March 31 of each year in which this Contract is in effect. The Physician will provide the Agency with any information necessary for the Physician to access the Benefit Plans not in the possession of the Agency.

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

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- 13.6 The Physician is not entitled under this Contract to any benefit from the Agency including Canada Pension Plan contributions, Employment Insurance premiums, supplemental health coverage for Physicians 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 14 Reporting

- 14.1 The Physician will:

- 14.1.1 comply with the reporting obligations set out at Appendix 5 of this Contract; and
14.1.2 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.

- 14.2 The Physician is responsible for the accuracy of all information and reports submitted by the Physician 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 Physician.

Article 15 Records

- 15.1 The Physician will create and maintain Clinical Records in the manner provided for in the Bylaws of the College of Physicians and Surgeons of British Columbia.
15.2 For the purposes of this Article 15, "**Clinical Record**" means a clinical record maintained in accordance with the Bylaws of the College of Physicians and Surgeons of British Columbia and an adequate medical record in accordance with the Medical Services Commission Payment Schedule.

Article 16 Third Party Claims

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

Article 17 Liability Protection

- 17.1 The Physician will without limiting the Physician's obligations or liabilities herein purchase and maintain, and cause any subcontractors to maintain throughout the Term:
17.1.1 Where the Physician owns or rents the premises where the Services are provided, the Physician will maintain comprehensive or commercial general liability insurance with a limit of not less than \$2,000,000. The Physician will add the Agency as an additional insured and the policy(s) will contain a cross liability clause. It is understood by the parties that this comprehensive or commercial general liability insurance is a reasonable overhead expense.
17.1.2 Membership with the Canadian Medical Protective Association or alternative professional/malpractice protection plan.
17.2 All of the insurance required under Article 17.1.1 will be primary and will not require the sharing of any loss by any insurer of the Agency and must be endorsed to provide the Agency with 30 days' advance written notice of cancellation or material change.
17.3 The Physician agrees to provide the Agency with evidence of the membership/protection plan or insurance coverage required under this Article 17 at the time of execution of this Contract and otherwise from time to time as requested by the Agency.

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Article 18 Confidentiality

- 18.1 The Physician and the Agency will maintain as confidential and not disclose any patient information, except as required or permitted by law.
- 18.2 The Physician must not, without the prior written consent of the Agency, publish, release or disclose or permit to be published, released, or disclosed before, during the Term 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 and is:
- 18.2.1 necessary for the Physician to fulfill the Physician’s obligations under this Contract; or
 - 18.2.2 made in accordance with the Physician’s professional obligations as identified by the College of Physicians and Surgeons of BC; or
 - 18.2.3 in reference to this Contract.
- 18.3 For the purposes of this Article 18, information will be deemed to be confidential where all of the following criteria are met:
- 18.3.1 the information is not found in the public domain;
 - 18.3.2 the information was imparted to the Physician and disclosed in circumstances of confidence, or would be understood by parties exercising reasonable business judgement to be confidential; and
 - 18.3.3 the Agency has maintained adequate internal control to ensure the information remained confidential.

Article 19 Conflict of Interest

- 19.1 During the term of this Contract, absent the written consent of the Agency, the Physician must not perform a service for or provide advice to any person, firm or corporation where the performance of the service or the provision of the advice may or does give rise to a conflict of interest.
- 19.2 The parties will attempt to resolve at the local level any question as to whether the Physician has breached or may breach clause 19.1. Should they not be able to resolve the issue, it will be referred to mediation and/or arbitration pursuant to Article 8 of this Contract.

Article 20 Audit, Evaluation and Assessment

- 20.1 The Physician acknowledges and agrees that the auditing authority of the Medical Services Commission under section 36 of the *Medicare Protection Act*, as amended from time to time, applies to this Contract.
- 20.2 The 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*.
- 20.3 Without limiting section 20.1 or 20.2 above, the 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) the Physician and any other person (as defined in the *Interpretation Act*) who owns, manages, controls or carries on business in relation to the Practice 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

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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*.

- 20.4 Notwithstanding section 20.3 above, an Agency Auditor may not directly access the Practice EMR unless the Physician permits access by the Agency Auditor.
- 20.5 Prior to attending for audit under section 20.3 above, a notice of inspection of an audit must be provided to the Physician. 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.
- 20.6 The 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. The Physician’s failure to reasonably cooperate is a fundamental breach of this Contract for which the Agency may immediately terminate the Contract with the Physician upon written notice.
- 20.7 The Physician agrees 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 21 Notices

- 21.1 Any notice, report, or any or all of the documents that either party may be required to give or deliver to the other in writing, unless impractical or impossible, must be delivered by e-mail, mail, or by hand. Delivery will be conclusively deemed to have been validly made and received by the addressee:
 - 21.1.1 If sent by e-mail, on the next business day following confirmed e-mail transmission to the e-mail address provided in this Article 21;
 - 21.1.2 If mailed by prepaid registered mail to the addressee’s address listed below, on date of confirmation of delivery; or
 - 21.1.3 If delivered by hand to the addressee’s address listed below on the date of such personal delivery.
- 21.2 Either party may give notice to the other of a change of address.
- 21.3 Address of Agency:

<insert address>

Address of Physician:

<insert address>

Article 22 Amendments

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

Article 23 Entire Contract

- 23.1 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

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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 24 No Waiver Unless in Writing

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

Article 25 Enforceability and Severability

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

Article 26 Headings

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

Article 27 Execution of the Contract

27.1 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.

27.2 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.

27.3 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 28 Physicians as Professional Medical Corporations

28.1 Where the Physician is a professional medical corporation:

- (a) 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;
- (b) 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
- (c) for clarity, all remuneration for the Services will be paid to the professional medical corporation.

TEMPLATE: New-to-Practice Family Physicians Contract – For Private Clinics (December 2020)

Provisions in *bold italics* within this template contract are optional provisions.

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

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

Signed and Delivered by the Physician:

[Sign here if you are a Physician who is not incorporated]

Dr.

[Sign here, on behalf of your professional medical corporation, if you are a Physician who is incorporated and do not sign your personal name above]

[] Inc.

Authorized Signatory

Signed and Delivered on behalf of the Agency:

Authorized Signatory

Authorized Signatory

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.

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- 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 EMR is able to link appropriately with other providers and parts of the system, including other community providers, pharmacies and acute care facilities.

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- 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 grads 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 Physician agrees and commits to work towards the following to transition his/her 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 Physician agrees and commits 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, with 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.

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- 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 Physician has met or commits to meet the following criteria:

- Participating in development and implementation of the PCN within their community.
- Collaborating with the Province, Agency 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, including meeting the target panel sizes set out in this Contract.
- 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 Physician commits to working towards improving performance in the provision of clinical services and improving efficiency and productivity within the PMH and PCN.
- The Physician agrees to participate in program evaluation through patient and provider surveys.

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APPENDIX 2

SERVICES

Practice Agreement, Patient Medical Home and Primary Care Network

1. This Contract is conditional upon the Physician entering into a Practice Agreement, in the form set out in Schedule 1 to Appendix 2 to join an existing group primary care practice or establishing a group primary care practice with other practitioners (the “**Practice**”). In the event of any conflict between the Practice Agreement and this Contract, this Contract will prevail.
 - a. Such group practice must utilize an EMR and must also have indicated its willingness to join the PCN once it is established.
 - b. The Physician will provide the Agency with a copy of the completed Practice Agreement in advance of the Agency executing this Contract. Any amendments to the Practice Agreement made during the Term will be promptly disclosed to the Agency.
2. The Physician agrees to work collaboratively with the Agency, the PCN and other health system partners including the Division 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

3. The Physician will provide 1680 – 2100 hours (1.0 FTE) of the Services per year (inclusive of hours of Services provided by subcontractors or by locums that are compensated under the Contract in accordance with Article 11). The Physician is not entitled to additional compensation for hours of service in excess of 2100 hours under this Contract unless such excess hours and compensation have been agreed to in writing by the Agency.
4. To ensure continuity of care for patients, the Physician agrees to distribute the hours of Services equitably over the course of each year of the Term and the Physician will not provide more than 90 hours of Services (prorated for any partial FTE) on a bi-weekly basis during the Term.
5. Where reasonably possible, the Services will be provided by the Physician rather than by locums or subcontractors.
6. It is understood that individual appointment times will be dictated by patient need and acuity and the structure of the Physician’s practice.
7. The Physician commits to use best practices in scheduling in order to provide timely access to appointments, including the ability for patients to access the Physician or another primary care practitioner within the Practice or other Practice team members on the same day.
8. The Physician will coordinate with the other practitioners 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. The Physician also agrees 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 Practice agrees to provide such extended hours of service, provided such hours can be accommodated given the nature of the Physician’s practice and professionally recognized reasonable limits.
 - a. For clarity, physicians in the Practice who are compensated through FFS are entitled to bill Fee for Service for Services delivered to patients on the Physician’s panel; and,
 - b. The Physician is not entitled to bill Fee for Service for Services delivered to patients of the other physicians in the Practice.

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9. The Physician will also make himself/herself available after hours for his/her patients and other patients of the Practice as agreed with 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. Services provided arising from being called in after-hours fall within the scope of this Contract.
10. The Physician will provide the following Services during the Term:

Patient Attachment and Panel Requirements

- a. Attach patients as appropriate based on the nature of the Physician's practice and the composition of the Physician's patient panel from any existing local primary care waitlist used by the Division of Family Practice or the Agency and from any future provincial primary care waitlist, using those patient attachment mechanisms available during the Term, including any designated by the PCN.
- b. Conduct explicit attachment conversations with patients including a review of the following items:
 - i. 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
 - ii. 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
- c. Submit an Attachment Code for each newly Attached Patient in accordance with Appendix 5.
- d. Patient attachment is permanent unless a patient dies, moves away, or changes to another primary care provider. Panel size refers to those patients attached to the Physician that have had an appointment during the two year Term of this Contract. The Physician agrees to act as the regular and most responsible primary care provider for a minimum patient panel that is broad with respect to factors such as age and complexity, unless a different panel composition is agreed to by the Physician, the Agency and the Practice to service a particular population need. If the panel size is below those minimums set out in this Contract, the Physician agrees to attach referred patients where such referrals can be reasonably accommodated based on the nature of the Physician's practice and the composition of the Physician's patient panel.
 - (i) Year 1 of the Term – panel size of a minimum of 800 patients per 1.0 FTE.

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- (ii) Year 2 of the Term – panel size of a minimum of 1250 patients per 1.0 FTE.
- e. The Physician agrees to engage in appropriate panel management, including accessing and utilizing the GPSC’s Practice Support Program (PSP) Understanding Your Patient Panel or any future applicable practice support programs as available and appropriate.
- f. In the event this Contract is terminated and the Physician does not intend to maintain an ongoing attachment relationship with their patients, the Physician agrees to work with the Practice, the Agency and the Division of Family Practice in an effort to collaboratively maintain primary care access for the patients and to re-attach them to another family practice where possible. The Physician must abide by the College of Physicians and Surgeons of BC’s guideline on severing the Patient-Physician Relationship.

Quality Improvement

- g. In the first year of the Term the Physician will participate in the following Quality Initiatives (QI):
 - (i) the three phases of panel management which are:
 1. Empanelment – develop an accurate list of active patients.
 2. Panel clean-up – improve data entry procedures and develop accurate and up to date clinical registries.
 3. Panel Optimization – use the Practice EMR to proactively manage clinical registries.
 - (ii) completion of the Making Practice Improvement Work for You learning opportunity in a Practice Facilitation Cycle offered by the Practice Support Program.
- h. In the second year of the Term, the Physician will participate in the following Quality Initiatives (QI):
 - (i) implementing and using the GPSC patient experience tool, 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) engaging 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.

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- (iii) if the Physician is providing more than 0.75 FTE under the Contract, the Physician will also engage in a minimum of two (2) of any of the following additional QI activities (certain QI activities may carry forward year over year, while some may be one-time activities that take place in one year only). If the Physician is providing less than 0.75 FTE, the Physician 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.
- i. The Physician will provide the Agency with an annual report for each year of the Term outlining the QI Services engaged in by the Physician during that year, in accordance with Appendix 5.
- j. The Physician will report those hours of QI Services set out in 10 g and h. above that are provided as part of the hours of Services under this Contract. The Physician 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 Physician may not claim GPSC incentive fees for any of the activities provided and reported as QI Services under this Contract.

Primary Care Services

- k. The Physician will provide comprehensive, accessible, interdisciplinary, patient focused primary health care and will work towards aligning their practice with the attributes of the PMH. The Physician 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) in accordance with the Practice Agreement during the Term:
 - (i) Health promotion and illness prevention services;
 - Screening for early detection, intervention and counseling to reduce risk

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- 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

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- (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.*
- l. The Services will be provided, in accordance with the Practice Agreement, at the location of the Physician's practice, *the patient's home*, or other appropriate location. The Physician 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 and in accordance with the Practice Agreement.
- m. Clinical administrative services, including but not limited to:
- (i) Participation in the evaluation of the efficiency, quality and delivery of the Service, including and without limiting the generality of the foregoing, participation in medical audits, peer and interdisciplinary reviews, chart reviews, and incident report reviews.
 - (ii) Those activities that are necessary to satisfy the Physician's obligations under Article 14 and Appendix 4 of this Contract.

Rural Locum Program

11. *The parties agree that the Physician, 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 Physician in arranging for locum coverage through the RGPLP.*

Equipment/Facilities

12. **By the Physician:** Except as expressly set forth in paragraph 13 below, the Physician is solely responsible for procuring and providing all labour, support, technology, material, supplies, equipment, approvals, facilities and services required by the Physician to perform the Services in accordance with this Contract.
13. **By the Agency:** The Agency will provide the following support, technology, material and supplies for use by the Physician for the sole purpose of performing and providing the Services for the Term: *<insert what will be supplied by Agency, if anything>*

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SCHEDULE 1 TO APPENDIX 2

[Note: This Agreement is a template only intended to assist practitioners when a Contracted Physician joins a practice. It is not intended to be a comprehensive association agreement among practice members and largely assumes that such an agreement already exists in an existing group practice. This Agreement does not and is not intended to deal with the various legal, professional and business issues relevant to a group practice and should not be taken as legal advice.]

PRACTICE AGREEMENT

THIS PRACTICE AGREEMENT (the “**Agreement**”) is made with effect from the ____ day of _____, 20__

AMONG:

_____, of _____, BC
AND:

_____, of _____, BC

(collectively, the “**Practice Practitioners**”)

_____, of _____, BC
AND:
(the “**Contracted Physician**”)

(each a “**Practitioner**” or a “**party**”, and together referred to as the “**Practitioners**” or the “**parties**”)

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WHEREAS:

- A. The Practice Practitioners operate a group primary care practice known as **<Insert Name of Practice>** (the “**Practice**”), providing Primary Care Services (defined below) to patients of the Practice.
- B. The Contracted Physician intends to enter into a service contract with the Health Authority (defined below) for the provision of Primary Care Services (the “**Service Contract**”) on the condition that the Contracted Physician join an existing group primary care practice, or establish a new group primary care practice with other practitioners and enter into a practice agreement with the other primary care providers in that practice.
- C. The parties wish to enter into this Agreement to have the Contracted Physician join the Practice in accordance with the Service Contract and to set out the parties’ respective rights and obligations toward each other as a result of the Contracted Physician’s addition to the Practice.

NOW THEREFORE, IN CONSIDERATION OF THE MUTUAL PREMISES AND COVENANTS CONTAINED IN THIS AGREEMENT, THE PARTIES AGREE AS FOLLOWS:

DEFINITIONS

- 1. In this Agreement, the following terms shall have the following meanings:
 - (a) “**Contracted Physician**” has the meaning set out in the introductory clause of this Agreement.
 - (b) “**Health Authority**” means **<Insert Name of Health Authority>**.
 - (c) “**Panel size**” means those patients attached to the Contracted Physician that have had an appointment during the three-year term of the Service Contract.
 - (d) “**Practitioner**” or “**Practitioners**” has the meaning set out in the introductory clause of this Agreement.
 - (e) “**Practice Practitioners**” has the meaning set out in the introductory clause of this Agreement.
 - (f) “**Practice**” has the meaning set out in Recital A.
 - (g) “**Primary Care Services**” means those services set out in Section 12 below and detailed in the Service Contract.
 - (h) “**Service Contract**” has the meaning set out in Recital B.
 - (i) “**Short Term Locum**” means a qualified practitioner who replaces a Physician to provide Primary Care Services at the Practice and who is not a member of the Practice.

ACCEPTANCE INTO PRACTICE

- 2. The Practitioners hereby agree and confirm that, effective as of the date of this Agreement, the Contracted Physician will join and become a member of the Practice along with the Practicing Practitioners.

RELATIONSHIP

- 3. The Practitioners hereby agree that they are independent contractors and are associated solely for the purpose of facilitating delivery of their respective Primary Care Services at the Practice. This Agreement does not constitute and shall not be construed as constituting a partnership, joint venture, or employment relationship among the parties, and, except as otherwise set out herein, no party shall have any right to obligate or bind any other party in any manner whatsoever. In no event shall the relationship between the Practitioners be construed as imposing any liability whatsoever on one Practitioner for the acts, omissions, or obligations of another in his or her professional capacity as a practitioner or otherwise.

ACKNOWLEDGEMENT OF SERVICE CONTRACT

- 4. The Practice Practitioners hereby acknowledge that the Contracted Physician will enter into the Service Contract for the provision of Primary Care Services. Each Practice Practitioner agrees to respect the

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Contracted Physician's rights, obligations, and limitations under the Service Contract, including with respect to hours, scheduling, patient attachment, panel size and audit requirements. No Practitioner will require the Contracted Physician to do any act or thing or impose on the Contracted Physician any limitation that is inconsistent with the terms of the Service Contract or that interferes with the Contracted Physician's ability to fulfill any of his/her/its obligations under the Service Contract. Each Practice Practitioner also agrees to reasonably support the Contracted Physician, as may be necessary, in fulfilling his/her/its obligations under the Service Contract, including with respect to coordinating with the Contracted Physician as required to ensure that non-emergency Primary Care Services will be accessible during reasonable, regular hours each week of the year to the patients served by the Contracted Physician and the Practice.

CONTRIBUTION

5. Subject to the Service Contract being in effect and the monies owed to the Contracted Physician under the Service Contract are duly paid and received by the Contracted Physician, the Contracted Physician agrees to remit to the Practice in a timely fashion \$_____ as contribution to the overhead costs of the Practice.

COVENANTS OF PRACTITIONERS

6. The Practitioners each covenant and agree as follows:
- (a) To maintain, and on request provide proof to the other Practitioners, that they or any practitioners sub-contracted or otherwise engaged by them holds a valid license to provide primary care in the Province of British Columbia and professional liability protection with the Canadian Medical Protective Association, Canadian Nurses Protective Society or other like association as applicable and commensurate with the nature of their practice;
 - (b) That, subject to any existing agreement of the Practice, each Practitioner is personally responsible for all professional and personal expenses including, but not limited to, Canadian Medical Protective Association or Canadian Nurses Protective Society membership, licensing fees and other society/association memberships;
 - (c) That, subject to any existing agreement of the Practice, each Practitioner is responsible for obtaining and maintaining adequate disability or medical insurance to deal with his/her financial needs in the event of disability due to illness, injury or otherwise. No party shall have responsibility to provide compensation to another party who is disabled;
 - (d) That the Contracted Physician's contribution under Section 5 of this Agreement constitutes the total required contribution of the Contracted Physician for Practice overhead;
 - (e) To execute, on an annual basis on the anniversary of the date of this Agreement, a renewal agreement or ratification agreement to confirm the validity and effectiveness of this Agreement for the following year (provided that failure to renew or ratify this Agreement will not invalidate this Agreement if the parties continue to operate pursuant to its terms);
 - (f) To provide detailed contact information, including, but not limited to, business and home addresses, electronic mail and other forms of electronic messaging addresses, and telephone numbers to the Practice and to each other for the purposes of communication and correspondence;
 - (g) To observe and perform their professional obligations in accordance with applicable standards of law, professional ethics and medical practice and in accordance with the terms of this Agreement;
 - (h) To maintain an Electronic Medical Record in accordance with the rules concerning health practitioner's records under all current and applicable legal and professional regulatory requirements and provide access to the EMR if required in accordance with the audit provisions of the Service Contract;

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- (i) To promptly upon execution of this Agreement, review, amend as necessary, and add the Contracted Physician to any existing policies or agreements of the Practice in order to give effect to, or ensure consistency with, the parties' agreements and obligations under this Agreement;
- (j) That any new practitioner joining the Practice must execute and become a party to this Agreement;
- (k) That the Contracted Physician has permission of the Practice Practitioners to provide a copy of this Agreement and disclose any amendments to this Agreement to the Health Authority pursuant to the Service Contract.

[consider any additional covenants, representations, or warranties that the parties may wish to include]

SCHEDULING

- 7. Subject to the terms and conditions of the Service Contract, the expected work arrangements for the Contracted Physician are:
 - (a) expected number of days of work a year is ____ to _____.
 - (b) expected number of days of work in a week is ____ to ____.
 - (c) expected number of hours of work in a day is ____ to ____.
- 8. Subject to the terms and conditions of the Service Contract and any other legal or professional obligations, the Contracted Physician will consult with the Practice Practitioners on the establishment of his/her schedule and expected appointment duration.
- 9. Subject to the terms and conditions of the Service Contract, the expected leave scheduling and coverage obligations of the Contracted Physician are:
 - (a) The Contracted Physician <is/is not> expected to work on Statutory Holidays.
 - (b) The Contracted Physician may take up to ____ weeks' vacation per calendar year and will either:
 - (i) attempt to secure a Short Term Locum or a subcontractor to cover such periods of vacation;
or
 - (ii) make specific arrangements for coverage with another physician in the Practice.

The Contracted Physician shall ensure that any Short Term Locum who is a physician remits __% of their billings to the Practice to cover overhead.

 - (c) The Contracted Physician will provide advance notice of at least __ months of absences due to vacations.

NATURE OF SERVICES

- 10. Subject to the Service Contract, the Contracted Physician will maintain a Panel Size consistent with the following:
 - (a) In the first year of the contract, a minimum of _____ patients
 - (b) In the second year of the contract, a minimum of _____ patients
- 11. The Contracted Physician will maintain a panel composition similar to that of other Practitioners who are physicians in the Practice with respect to factors such as age and complexity, unless otherwise agreed to by all Practitioners in order to meet a particular population need.
- 12. The Contracted Physician will provide a full scope of Primary Care Services consistent with the Service Contract and that provided by other Practitioners in the Practice, including, but not limited to the following:
 - (a) Health promotion and illness prevention services;
 - (b) Primary care for minor or episodic illnesses;

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- (c) Chronic Disease Management;
 - (d) Management and coordination of patient care across the spectrum of primary, secondary and tertiary care;
 - (e) Primary reproductive care;
 - (i) Sexual health, including prevention and management of sexually transmitted infections
 - (ii) Organization of appropriate screening
 - (iii) Provision of or arrangement with another provider for prenatal, obstetrical, postnatal and newborn care
 - (f) Primary mental health and substance abuse services;
 - (g) Support for the terminally ill (excluding patients in facilities);
 - (h) Coordination and access to rehabilitation;
 - (i) Provide medical coordination and participate in multidisciplinary team planning for the ongoing health needs of patients;
 - (j) Provide health prevention and promotion activities including organizing and/or participating in health prevention forums focused on the health care needs of the Health Service Delivery Area.
 - (k) ***Insert other services that all Practitioners who are physicians in the Practice Provide. Include if the Practice and the Contracted Physician agree that the Contracted Physician will provide services in addition to those set out above.***
13. The Contracted Physician will provide the Primary Care Services at locations and by means consistent with that provided by other Practitioners in the Practice, including:
- (a) at the location of the Practice,
 - (b) by telephone, where clinically appropriate,
 - (c) *insert other locations of practice such patient's home, where permitted and appropriate*
 - (d) *insert other means of providing the services such as digital/virtual care, where available and appropriate*

TERMINATION

14. This Agreement will be subject to any termination provisions in any existing agreement of the Practice to which the Contracted Physician will become a party in accordance with Section 6(i) of this Agreement, provided that the Contracted Physician may terminate this Agreement on six (6) months' written notice if the Health Authority exercises its termination rights to terminate the Contracted Physician on six (6) months' notice under the Service Contract. In the absence of any termination provisions or existing agreement of the Practice, the Practice Practitioners may terminate this Agreement with the Contracted Physician, and the Contracted Physician may terminate this Agreement with the Practice Practitioners, on _____ months' written notice to the other(s) or without notice if the Practice Practitioners or the Contracted Physician, as the case may be, breaches a fundamental term of this Agreement or any existing agreement of the Practice.

DISPUTES

15. The parties shall resolve any disputes under this Agreement in accordance with the dispute resolution provisions of any existing agreement of the Practice, if any.

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Provisions in *bold italics* within this template contract are optional provisions.

GENERAL PROVISIONS

16. This Agreement shall enure to the benefit of and be binding upon the parties and their respective heirs, executors, administrators and successors.
17. Any notice required or contemplated to be given by this Agreement shall be given in writing and may be delivered personally or sent by certified mail posted in British Columbia or by electronic mail, addressed to the parties hereto at the addresses provided to the Practice. The time of the giving of such notice shall be, if delivered, when delivered, if postal mail, then on the third (3rd) business day after the date of mailing and if electronic mail, the date the electronic mail is sent. In the event of a postal strike, notice shall be hand delivered to the home address of the parties.
18. Subject to this Section 18, the Contracted Physician may not assign this Agreement without the written consent of the Practice Practitioners, such consent not to be unreasonably withheld. If an individual, the Contracted Physician may assign this Agreement and his or her membership in the Practice without consent to a company holding a valid permit under the *Health Professions Act* to carry on his or her medical practice. Such an assignment shall not be effective unless notice is given to the Practice Practitioners, the company shall have agreed to observe and perform the obligations to be performed in this Agreement by the Contracted Physician, and the physician through which the company will carry on business (the “**Designated Physician**”) remains the Contracted Physician. The Designated Physician may not be changed without the approval of the Practice Practitioners.
19. This Agreement and any existing agreement of the Practice to which the Contracted Physician becomes a party constitute the entire agreement between the parties. This Agreement may be amended or modified by the written consent of all Practitioners, such consent not to be unreasonably withheld by any Practitioner.
20. This Agreement is governed by, and will be construed in accordance with, the laws of the Province of British Columbia.
21. No provision of this Agreement and no breach by any party of any such provision will be deemed to have been waived unless such waiver is in writing signed by the other parties. The written waiver of a party of any breach of any provision of this Agreement by the other parties must not be construed as a waiver of any subsequent breach of the same or of any other provision of this Agreement.
22. If any provision of this Agreement is determined to be invalid, void, illegal or unenforceable, in whole or in part, such invalidity, voidance, or unenforceability will attach only to such provision or part of such provision, and all other provisions or the remaining part of such provision, as the case may be, continue to have full force and effect.
23. The parties agree to execute all such further documents and take such further actions as necessary to carry out the intent of this Agreement.
24. This Agreement may be executed in any number of counterparts, each of which, when executed and delivered, will be deemed to be an original and all of which, together, shall constitute one and the same document.

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IN WITNESS WHEREOF the parties hereto have executed this Agreement as of the date written above.

(insert name)

APPENDIX 3

PAYMENT

1. The Agency will pay the Physician [*biweekly/monthly/other*] in [*26/12/other*] equal instalments as follows during the Term upon receipt of an invoice, in a form acceptable to the Agency, for the Services provided:
 - a. \$269,664 for 1.0 FTE of the Services (pro-rated for any partial FTE) per Fiscal Year or portion thereof during the Term.
 - b. at the end of Year 1 of the Term, the Agency will pay the Physician an additional \$10,000 for 1.0 FTE (prorated for any partial FTE) if the physician completed the QI Services described in Section 10, g) of Appendix 2 and has met the target for attachment described in Section 10, d, i) of Appendix 2.
 - c. beginning in Year 2 of the Term, the Agency will pay the Physician an additional \$20,000 for 1.0 FTE (prorated for any partial FTE) for completion of the QI Services described in section 10 h. of Appendix 2 per Fiscal Year or portion thereof during the Term.
2. At the end of each Fiscal Year in the Term, the Agency will reconcile the hours paid under the Contract against hours reported by the Physician to ensure the Physician has reached 1.0 FTE (1680 hours) and provided QI Services set out in Section 10 g) and h) of Appendix 2, pro-rated for any partial FTE. If the Physician has not reached 1.0 FTE or not provided the QI activities in accordance with Section 10 h) there will be an appropriate adjustment made to reflect the actual FTE and QI Services provided during that Fiscal Year, either by adjusting the next biweekly/monthly payment to the Physician to reflect any excess amount paid to the Physician in the previous fiscal year or, if the Term has expired, the Physician will be responsible to repay to the Agency any excess amounts that were paid to the Physician in the previous fiscal year.
3. The rates in 1 above are for the 2020-21 Fiscal Year. On April 1, 2021, the rates will be increased by 2%. From April 1, 2022, rates will increase based on agreement between the Ministry and Doctors of BC as part of future Physician Master Agreement negotiations.
4. ***The Agency agrees that the rates described in Section 1 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.***
5. The Physician will keep and maintain all business records, invoices and other documents relating to all payments from the Agency set out in this Appendix 3 and keep them available for review by the Agency.

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APPENDIX 3A
INVOICE

Insert form of invoice used by Agency

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.

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- 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.

Physician’s Signature

Date

APPENDIX 5
REPORTING

1. The Physician (and any Resident under the supervision of the Physician, using the 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,
 - 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, the 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 Physician may provide services outside the scope of this Contract on a fee-for-service basis. The Physician, 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.

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- 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. The Physician will also submit an Attachment Code to the Medical Services Plan/Health Insurance BC via Teleplan on a one-time basis for each patient where attachment is agreed to by the Physician and the patient upon completion of the attachment conversation set out in section 10 b. of Appendix 2. An Attachment Code should not be submitted when attachment is not established (e.g. the Physician is seeing a patient attached to another practitioner in the same clinic) 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 the visit. The Attachment Code will include the following information:
 - a. MSP Payee Number,
 - 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), and
 - h. Location Code.
5. On a monthly basis during the Term (within 30 days of the end of the previous month), the Physician will provide to the Agency an hours report with respect to the Services provided under the Contract which identifies the days of services provided, the number of hours of Services provided each day, including start and stop times and the total number of hours provided by the Physician and the total number of hours provided during the month in the form set out in Appendix 5A.
6. Within 30 days after the end of each year of the Term, the Physician will provide to the Agency a report on the QI Services outlined in sections 10 g. and h. of Appendix 2 as applicable.
7. The 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 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.

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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 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 and Referred Services
 - iii. Non-contract Fee for Service
 - iv. Break (equal to or greater than 30 Minutes).