# 2012 RURAL PRACTICE SUBSIDIARY AGREEMENT

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

**BETWEEN:**

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

(the "**Government**")

**AND:**

**BRITISH COLUMBIA MEDICAL ASSOCIATION**

(the "**BCMA**")

**AND:**

**MEDICAL SERVICES COMMISSION**

(the "**MSC**")

**WITNESSES THAT WHEREAS:**

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

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

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

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

## ARTICLE 1 - RELATIONSHIP TO THE 2012 PHYSICIAN MASTER AGREEMENT

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

## ARTICLE 2 - DEFINITIONS AND INTERPRETATION

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

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

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

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

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

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

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

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

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

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

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

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

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

2.14 "**REAP**" means the Rural Education Action Plan referred to in section 9.1.

2.15 "**RGPLP**" means the Rural General Practitioner Locum Program referred to in section 7.1.

2.16 "**RIF**" means the Recruitment Incentive Fund referred to in section 10.1.

2.17 "**RRP**" means the Rural Retention Program referred to in section 6.1.

2.18 "**Rural Community**" means a community listed on Appendix A.

2.19 "**RRP Community**" means a Rural Community which has at least 6 Isolation Points.

2.20 "**RSLP**" means the Rural Specialist Locum Program referred to in section 7.5.

2.21 "**Rural Programs**" means the RRP, the RGPLP, the RSLP, the RCME, the REAP, the RIF, the RCF, the NITAOP, and the IAF.

2.22 Subject to section 2.23, this Agreement may be amended at any time but only by written agreement of the parties. Any waiver of any provision of this Agreement shall only be effective if in writing signed by the waiving party, and no waiver shall be implied by indulgence, delay or other act, failure to act, omission or conduct. Any waiver shall only apply to the specific matter waived and only in the specific instance and for the specific purpose for which it is given.

2.23 Notwithstanding section 2.22, Appendix A, Appendix B and Appendix C of this Agreement may be amended by the JSC, by consensus decision, as provided herein.

2.24 The provisions of sections 1.2 to 1.6 and 1.8 of the 2012 Physician Master Agreement are hereby incorporated into this Agreement and shall have effect as if expressly set out in this Agreement, except those references in such sections to "this Agreement" shall herein be construed to mean this Agreement.

## ARTICLE 3 - TERM

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

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

## ARTICLE 4 - SCOPE

4.1 Subject to section 4.2, this Agreement applies to physicians practising in British Columbia except those whose practice is in Greater Vancouver, greater Victoria, Nanaimo, Kelowna, Kamloops, Vernon, Penticton, and the Fraser Valley west of Agassiz/Harrison Lake.

4.2 This Agreement applies to all physicians who practice in Rural Communities and are required by a Physician Supply Plan, subject to the specific terms, conditions, rules and

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

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

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

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

## ARTICLE 5 - THE JOINT STANDING COMMITTEE ON RURAL ISSUES

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

(a) increasing relativities between Rural Communities;

(b) supporting hospital based core services;

(c) supporting new physicians moving into Rural Communities;

(d) enhancing support for rural emergency departments;

(e) developing a response to Rural Communities in crisis; and

(f) supporting the use of physician extenders in Rural Communities.

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

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

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

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

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

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

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

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

(a) less than 6 Isolation Points then, in the year to which that assignment applies,

(i) eligible physicians, who received a Flat Premium the immediately preceding year, will be entitled to receive a Flat Premium in the amount of 50% of their Flat Premium entitlement from the immediately preceding year.

(ii) eligible physicians who received a Percentage Fee Premium for medical services performed in such community in the immediately preceding year will be entitled to receive a Percentage Fee Premium on medical services performed in such community in the amount of 50% of their Percentage Fee Premium for such community from the immediately preceding year.

(b) between 0.5 and 5.99 Isolation Points, it will be deemed to be a “D” community and physicians residing and practising in such community will only be eligible for the RCME, the RGPLP, the RIF, the RCF and the REAP, all in accordance with the specific terms, conditions, rules and eligibility criteria applicable to each of those programs as established by the JSC from time to time; and

(c) less than 0.5 Isolation Points, it will be deleted from Appendix “A” and, if prior to such review it was listed in Appendix B, it will be deleted from Appendix B and

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

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

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

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

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

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

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

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

## ARTICLE 6 - RURAL RETENTION PROGRAM

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

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

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

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

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

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

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

(a) for RRP Communities without a resident physician and without a vacancy, a Percentage Fee Premium will be available in an amount equal to the total Isolation Points for the RRP Community in question but to a maximum Percentage Fee Premium of 30%;

(b) for RRP Communities with at least one resident physician or at least one vacancy, a Percentage Fee Premium will be available in an amount equal to 70% of the Isolation Points for the RRP Community in question but to a maximum Percentage Fee Premium of 30%;

(c) for RRP Communities with at least one resident physician, a Flat Premium will be available in an amount equal to 30% of the Isolation Points for the RRP Community in question multiplied by $2,040;

(d) if the JSC chooses not to implement reductions in Isolation Points for RRP Communities as a result of the application of Appendix C, the cost of maintaining the Percentage Fee Premium and Flat Premium values will be paid out of funds provided in Article 12; and

(e) if the JSC changes the application of the terms, conditions, rules and eligibility criteria for the RRP, any increased cost associated with such changes will be paid out of funds provided in Article 12.

## ARTICLE 7 - RURAL LOCUM PROGRAMS

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

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

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

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

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

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

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

## ARTICLE 8 - RURAL CONTINUING MEDICAL EDUCATION

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

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

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

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

where:

(a) an "A" community is a Rural Community that received 20 or more Isolation Points as a result of the most recent application by the JSC of Appendix C to that community;

(b) a "B" community is a Rural Community that received between 15 and 19.99 Isolation Points as a result of the most recent application by the JSC of Appendix C to that community;

(c) a "C" community is a Rural Community that received between 6 and 14.99 Isolation Points as a result of the most recent application by the JSC of Appendix C to that community; and

(d) a "D" community is a Rural Community that received between 0.5 and 5.99 Isolation Points as a result of the most recent application by the JSC of Appendix C to that community.

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

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

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

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

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

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

## ARTICLE 9 - RURAL EDUCATION ACTION PLAN

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

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

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

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

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

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

## ARTICLE 10 - RECRUITMENT INCENTIVES

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

(a) vacancies identified in a Physician Supply Plan; or

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

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

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

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

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

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

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

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

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

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

## ARTICLE 11 - NORTHERN AND ISOLATION TRAVEL ASSISTANCE OUTREACH PROGRAM

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

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

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

## ARTICLE 12 - ADDITIONAL FUNDING

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

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

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

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

## ARTICLE 13 - EXPENSES WHILE ACCOMPANYING A PATIENT

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

## ARTICLE 14 - ISOLATION ALLOWANCE FUND

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

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

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

## ARTICLE 15 - DISPUTE RESOLUTION

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

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

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

Signature of Witness

Name
ENA ACKERMAN

Address
200-1333 WEST BROADWAY

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

Signature of Authorized Signatory

SHELLEY ROSS
Name

PRESIDENT
Position

MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

SHEILA TAYLOR
Name

MSC DEPUTY CHAIR
Position

## Appendix A

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

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

100 Mile House

Agassiz/Harrison
Ahousat
Alert Bay
Alexis Creek
Anahim Lake
Armstrong/Spallumcheen
Ashcroft
Atlin

Bamfield
Barriere
Bella Bella
Bella Coola
Big White
Blind Bay
Blue River
Blueberry River
Bowen Island
Bridge Lake
Burns Lake

Campbell River
Canal Flats
Castlegar
Chase
Chemainus
Chetwynd
Christina Lk/Grand Forks
Clearwater
Clinton
Cobble Hill
Cortes Island
Courtenay/Comox/Cumberland
Cranbrook
Crescent Valley
Creston

Dawson Creek
Dease Lake
Denman Island
Doig River
Duncan/N. Cowichan

Edgewood
Elkford
Enderby

Fernie
Fort Nelson
Fort St. James
Fort St. John/Taylor
Fort Ware
Fraser Lake

Gabriola Island
Galiano Island
Gold Bridge/Bralorne
Gold River
Golden
Granisle
Greenwood/Midway/Rock Creek

Halfway River
Hartley Bay
Hazelton
Holberg
Hope
Hornby Island
Hot Springs Cove
Houston
Hudson's Hope

Invermere

Kaslo
Keremeos
Kimberley
Kincolith
Kingcome
Kitimat
Kitkatla
Kitsault
Kitwanga
Klemtu
Kootenay Bay/Riondel
Kyuquot

Ladysmith/Chemainus
Lake Cowichan
Lillooet
Logan Lake
Lower Post
Lumby
Lytton

Mackenzie
Madeira Park
Masset
Mayne Island
McBride
Merritt
Mill Bay
Miocene
Mount Currie

Nakusp
Nelson
New Aiyansh
New Denver
Nitinat

Ocean Falls
Osoyoos/Oliver

Parksville/Qualicum
Pemberton
Pender Island
Port Alberni
Port Alice
Port Clements
Port Hardy
Port McNeill
Port Renfrew
Port Simpson

Powell River
Prince George
Prince Rupert
Princeton

Quadra Island
Quatsino
Queen Charlotte
Quesnel

Revelstoke
Rivers Inlet

Salmo
Salmon Arm/Sicamous
Saltspring Island
Samahquam
Saturna Island
Savary Island
Sayward
Sechelt/Gibsons
Seton Portage
Shawnigan Lake
Sirdar
Skatin
Slocan Park
Smithers
Sointula
Sooke
Sorrento
Sparwood
Spences Bridge
Squamish
Stewart

Tahsis
Takla Landing
Tatla Lake
Tatlayoko Lake
Telegraph Creek
Tepella
Terrace
Texada Island
Tofino
Trail/Rossland/Fruitvale
Tsay Keh Dene
Tumbler Ridge

Ucluelet

Valemount
Vanderhoof
Wardner
Whistler
Williams Lake
Winlaw
Woss

Zeballos

## Appendix B

## NITAOP COMMUNITIES (As of April 1, 2012)

*Subject to meeting eligibility criteria per specialty*

100 Mile House

Ahousat
Alert Bay
Alexis Creek
Anahim Lake
Atlin

Bamfield

Bella Bella
Bella Coola
Blueberry River
Burns Lake

Campbell River

Castlegar
Chetwynd
Clearwater
Clinton
Cortes Island
Courtenay/Comox
Cranbrook
Crawford Bay
Creston

Dawson Creek
Dease Lake
Doig River

Edgewood

Fernie
Fort Nelson
Fort St. James
Fort St. John

Galiano Island
Gold Bridge/Bralorne
Gold River
Golden
Grand Forks/Midway/ Rock Creek

Halfway River

Hartley Bay
Hazelton
Holberg
Houston
Hudson's Hope

Invermere

Kingcome
Kitimat
Kitkatla
Klemtu
Kyuquot
Lillooet

Mackenzie
Masset
Mayne Island
McBride
Merritt

Nakusp
Nelson
New Aiyansh
New Denver
Nitinat

Ocean Falls

Pender Island
Port Alberni
Port Hardy
Port McNeill
Port Renfrew
Port Simpson
Powell River
Prince George
Prince Rupert
Princeton

Quatsino
Queen Charlotte
Quesnel

Revelstoke
Riondel
Rivers Inlet

Salmo
Salmon Arm
Saltspring Island
Samaqham
Saturna Island
Sechelt/Gibsons
Seton Portage
Skatin
Smithers
Sointula
Sparwood
Stewart

Tahsis
Tepella
Terrace
Tofino
Trail
Tsay Keh Dene
Tumbler Ridge

Ucluelet

Valemount
Vanderhoof

Whistler
Williams Lake
Woss

Zeballos

## Appendix C

## ISOLATION POINT CRITERIA

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

## Appendix D

## PHYSICIAN SUPPLY PLANS

1.1 A Physician Supply Plan is a plan created by a Health Authority further to the Ministry's Health Human Resource Strategy, in consultation with the Health Authority's medical advisory committee, and approved by the Ministry, which addresses issues related to access to physician services within the geographic jurisdiction of the Health Authority.

1.2 For purposes of this Agreement, the key elements of a Physician Supply Plan are:

- The number of General Practitioners and Specialists required to provide the physician services identified in the Physician Supply Plan; and
- The on-call requirements necessary to ensure coverage.

1.3 In some cases, Health Authorities do not yet have approved Physician Supply Plans. Pending development and approval of a Physician Supply Plan covering a community within the jurisdiction of a Health Authority without a Physician Supply Plan, a reference to "Physician Supply Plan" in this Agreement means, with respect to that community:

- The number of General Practitioners and Specialists in the community as of December 31, 2007, plus any vacancies identified by the Health Authority as of that date where active recruitment was underway; and
- On-call requirements as determined by the Health Authority.

1.4 Despite any provision to the contrary, all physicians working in any Rural Community as of December 31, 2007 are deemed to be included in the Physician Supply Plan for the term of this Agreement.