

Vancouver Division of Family Practice Primary Care Network Steering Committee Terms of Reference (TOR)

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INTRODUCTION AND OVERVIEW

This document supports the Ministry of Health’s priority of implementing Primary Care Networks (PCN) across the province through a refreshed governance framework for PCN Steering Committees, as defined by the Family Practice Services Committee (FPSC) in [August 2023](#). Under the refreshed framework, PCN Steering Committees support a collaborative approach to patient care by building reciprocal accountability within a new membership structure, with representatives from across the community geography, including longitudinal and episodic clinics, the regional health authority, local Indigenous partners, and patients.

The Vancouver Collaborative Services Committee (“CSC”, comprised of the Executive leadership from the Vancouver Division of Family Practice and Vancouver Coastal Health Authority) has therefore established the Vancouver Primary Care Network Steering Committees (the “Steering Committees”). The Steering Committees are convened by Vancouver Division of Family Practice (VDOFP) Board members. VDOFP staff will provide backbone support to the PCNs and assume the secretariat role to the Steering Committees. Vancouver Coastal Health Authority (VCH) will support PCNs as the primary conduit for PCN service plan financial and human resources, and the associated reporting to the Ministry. Vancouver’s six PCNs received approval for their service plans in 2018 and 2019, which has allowed VDOFP and VCH to launch interprofessional teams (IPT), including nurses and pharmacists. The service plans also allowed the VDOFP to deploy “change management” initiatives to support PCN development, including new or expanded services to Patient Medical Homes and their physicians.

1. the Evolution of the service plan delivery strategy.
2. PCN-specific initiatives to address gaps brought forth through the VDOFP’s PCN community engagement.

This Terms of Reference (TOR) document defines the purpose, scope, accountability and foundational principles and processes of the Steering Committees as a framework for effective Steering Committee collaborative governance and transparency.

PCN STEERING COMMITTEE TERMS OF REFERENCE

1. Background

The Vancouver Division of Family Practice (VDOPF), Vancouver Coastal Health Authority (VCH), First Nations Health Authority, Doctors of BC, the Ministry of Health, and the Family Practice Services Committee (FPSC) recognize a shared responsibility for the health of the community. To support the Ministry’s priority of implementing Primary Care Networks across the province, the Vancouver Collaborative Services Committee (“CSC”) has established six Steering Committees, one for each of Vancouver’s PCNs.

The first iteration of the PCN Steering Committee began in 2020, and the lessons learned from the initial Steering Committee work and from the initial cycle for the 2024/25 refreshed Steering Committee are included in this revised TOR. One lesson learned is that the PCN Steering Committee must have a clear role and mandate. Another is that the Steering Committee must be physician-driven and focused on the needs of each PCN. The 2025/26 Steering Committee will therefore continue to be physician-led and include other practitioners, patient and partners to understand the PCN community and its needs, and to oversee targeted, time-bound initiatives that can positively impact a particular PCN and the evolution of the service plan.

2. Purpose

The Steering Committee enables the PCN to be responsive to the needs of patients, physicians and other professionals providing care, through advancing development of the PCN in a way that addresses the Quadruple Aim (improved health outcomes, effectively managed costs, and increased patient and provider satisfaction).

The *aspirational*, longer-term purpose of the PCN Steering Committee is to provide strategic guidance for the development and implementation of a local, coordinated, and comprehensive primary care delivery system that promotes and advances accessibility, attachment, affordability, and high-quality care for all members of the community as described in the PCN Core Attributes (see also Appendix A):

- Longitudinal Care
- Coordinated Care
- Timely Access
- Extended Hours
- Comprehensive Care
- Team-Based Care
- Population Health Promotion
- Digital Enablement
- Culturally Safe Care
- Equitable Access

In addition to the PCN Core Attributes, the Ministry of Health has issued recent guidance for PCNs to prioritize five patient populations:

- Patients seeking maternity care;
- Patients seeking care for mental health;
- Frail seniors;
- Patients seeking care for cancer diagnosis and treatment;
- Indigenous, First Nations and Inuit patients.

3. Steering Committee Responsibilities

To achieve its aspirational purpose in the *short-term*, each of Vancouver's six Steering Committees has the responsibility to:

- 1) Understand and approve the ongoing evolution of the PCN's service plan delivery strategy.
 - a. Strategy changes for the interprofessional teams (IPT), new-to-practice (NTP) physician contracts and Nurse Practitioner (NP) contracts.
- 2) Oversee PCN-specific initiatives to address gaps brought forth through community engagement.
 - a. Understand the PCN's needs acquired through various forms of community engagement;
 - b. Oversee time-bound initiatives (led by VDOFP's backbone support) that incrementally improve primary care for one or more of the Core Attributes and Priority Patient Populations above, and for the broader physicians, nurse practitioners and other caregivers providing primary care in that geography.

VDOFP Backbone Staff will lead the Steering Committee through a five-step lifecycle (see also Appendix B) to the time-bound initiatives it oversees by:

1. Assessing Needs – Engage with key community members to uncover PCN strengths, needs, gaps and barriers to success and underlying challenges.
2. Brainstorming – Conceptualize ideas to address identified needs and gaps, define a feasible initiative idea to define and pursue.
3. Planning – Review an actionable plan with a clear roadmap for the initiative.
4. Acting and Monitoring – Action and monitor the initiative timeline.
5. Closing and Sharing – Close out and evaluate the initiative, and share outcomes.

4. Accountability, Governance & Decision-Making

The PCN Steering Committee includes multiple interest holders and, as local decision makers, collaborators and initiative governance, must work collaboratively to deliver its responsibilities. The Steering Committee and its individual members operate in an environment of multiple individual and reciprocal accountabilities (see Appendix B), meaning that members have social, contractual, and fiduciary accountability to the Steering Committee itself, and to other interested parties such as those they represent at the Steering Committee, their funders, government, and especially the individual patients, families and communities inside their PCN.

All Steering Committee members must acknowledge and adhere to the [Code of Conduct for Steering Committee Members](#).

For decision making, the Steering Committee strives for inclusion through the presence of all member groups at all meetings and for consensus (everyone says “yes”) on items requiring a decision during the meeting. Members are expected to attend all Steering Committee meetings, and to familiarize themselves with the meeting materials in advance to participate in collaborative and effective discussions.

When not all members are present, quorum for decision making is achieved when fifty percent plus 1 (50% + 1) of the family physician members (including the Convenor) are present for a meeting.

Where quorum is achieved and consensus is not possible, the following will apply to Steering Committee decision-making:

- Decisions will be considered final when the attending members reach consent (no one says “no”).
- In the rare cases where neither consensus nor consent can be reached, decisions will be considered final when a simple majority (50% +1) approves the decision.

Steering Committee members must identify to the Convenor any conflict of interest, including discussions and decisions that may materially impact a specific Steering Committee, clinic, partner program, etc., and abstain from decision making.

5. Confidentiality

Confidential information is information that, if disclosed, might prejudice the interests of the organization or the privacy rights of its members or partners. This includes any information that is written or unwritten, or stored electronically.

Steering Committee members may not disclose such information unless such disclosure is required within the course of their participation. Any person who knowingly, recklessly or negligently releases personal or confidential information without appropriate authority may be removed from the Steering Committee.

PCN Steering Committee members are subject to VDOFP’s [Confidentiality and Privacy Policy](#) and will review and acknowledge by signing the Policy upon joining the Steering Committee and annually thereafter.

6. Membership

Steering Committee membership may differ by PCN, depending on factors like the number and type of clinics, and the patient population.

For Vancouver's PCN Steering Committees, membership will include the following:

a) Steering Committee Convenor

The Steering Committee Convenor is a member of, and appointed by, the VDOFP's Board of Directors, and ideally practices in that PCN. The Convenor is the primary liaison between the Steering Committee members and the VDOFP's backbone support staff, and ensures that their Steering Committee can carry out its responsibilities.

b) Steering Committee Members

The Steering Committee will have up to 12 members, including the Convenor, representing the groups providing or receiving primary care in the PCN.

Clinical representatives in longitudinal and episodic clinics in a community will comprise the majority of members, in approximate proportion to where patients receive care in the PCN, and may include the following:

- Family Practice clinics (Family Physicians and Nurse Practitioners);
- Indigenous primary care clinics;
- Health Authority primary care clinics, and Urgent and Primary Care Centres (UPCCs);
- Community Health Centres;
- Walk-in clinics;
- Foundry centres;
- Maternity clinics;
- Other longitudinal and episodic clinic types that emerge from time to time.

Steering Committee conversations and decisions are enriched when the following partners are part of the membership:

- Indigenous community representatives, based on their desire for involvement and representation, and local capacity for participation;
- Non-clinical local community and patient/family caregiver representatives.

Note that it may not be feasible to include all desired parties in a Steering Committee in a given year, and membership mix may change in future years to reflect evolving needs of the PCN.

To the degree possible, the Steering Committee will encourage equity, diversity and inclusion (EDI) and seek members from traditionally underrepresented voices.

Target member representation of Vancouver’s PCN Steering Committees:

Role and Representation	Number of Seats and Position	Selecting Organization
Convenor – Division of Family Practice Board Member	1 seat: <i>Family Physician (FP) Board Member</i>	<i>Appointed and supported by the Division of Family Practice Board of Directors</i>
Family Practice Clinics FP and NP Patient Medical Homes, Walk-in/Medical Clinics, Health Authority primary care clinics	3-4 seats: 2-3 FPs 1 Nurse Practitioner (in PCNs with NPs)	<i>FP representatives will be selected by the VDOFP based on a formal application process, proportional to clinics providing care in the PCN geography</i> <i>NP representatives will be selected by the local practicing NP community in collaboration with the <u>Regional NP Leads</u></i>
Health Authority Operational Leadership (e.g., UPCC, Allied Health resources)	1 seat: <i>One senior level leader</i>	<i>Health Authority determined</i>
Community Indigenous Representatives	Up to 2 seats	<i>Locally determined</i>
Patient Representative	1 seat	<i>Appointed by VDOFP through formal application process</i>
Others (ex-Officio members, non-members, advisors and guests)	Depending on the needs, ex-officio (non-voting) members, non-members, advisors and guests may participate in the Steering Committee for differing lengths of time, and may include the following: <ul style="list-style-type: none"> • VDOFP PCN Directors and other VDOFP staff • Health Authority PCN Leaders, Managers and Clinical Leads • VDOFP Executive Director or delegate • Ministry of Health and FPSC staff 	

c) Term of Membership

Initial term length is one (1) year, from 01 April 2025 to 31 March 2026. Upon mutual agreement between VDOFP and the Steering Committee member or the Selecting Organization, a term may be extended in 1-year increments. There is currently no maximum service length. As the refreshed PCN Steering Committees move forward, term length will be reassessed, including maximum length of service, and terms start/end dates will be staggered to ensure continuity and knowledge retention among the Steering Committee members.

d) Onboarding and Orientation

VDOFP will ensure orientation of Steering Committee members. The FPSC may also provide additional orientation to new PCN Steering Committee members.

e) Removal of a Steering Committee Member

VDOFP reserves the right to remove any PCN Steering Committee member who is deemed to be disruptive, problematic, or not actively participating in committee activities. Removal of a Steering Committee member is governed by the VDOFP's [Policy for Removal of a PCN Steering Committee Member](#).

7. Advisory Groups and Subcommittees

It is critical to ensure that community perspectives - including those of local leaders, patients and caregivers, and local non-profits contributing to the health of the community – are integrated within decision-making for the PCNs. As noted in the membership table above, each of the refreshed PCN Steering Committees will include a patient representative.

Vancouver already has a sizeable existing community services network, including groups that are city-wide in scope, focused on specific populations within the city, and have inter-agency tables that meet regularly to discuss common issues. VDOFP staff will, as needed to support the Steering Committees, connect with and attend meetings of these community groups and inter-agency tables, and invite representatives from exiting community groups to work directly with the Steering Committee on specific initiatives.

8. Meetings

a) Meeting Agendas and Minutes

PCN Steering Committee meeting agendas will be created by the VDOFP's backbone support staff, approved by the Convenor, and circulated at least 48 hours in advance of the meeting, including any supporting material.

The VDOFP's backbone support staff will take minutes, which will be reviewed by the Convenor, and circulated to the Steering Committee members for approval.

b) Meeting Location & Frequency

Meetings will primarily be held virtually. The Convenor and Steering Committee members may elect to hold some in-person meetings.

To deliver its responsibilities Steering Committees will meet monthly, including three joint city-wide (i.e., members from all six committees) PCN Steering Committee meetings per year. Members are expected to contribute 3-6 hours of time per month.

9. VDOFP Backbone (Operational) Support

VDOFP's backbone support to the Steering Committees has the following responsibilities:

- Ownership for PCN Steering Committee design, management and execution;
- Legal entity for all contracts executed on behalf of the PCN Steering Committees;
- Maintain the overall strategic coherence of the vision and strategy of the six PCN Steering Committees;
- Lead the work with partners to establish the membership of the PCN Steering Committee, including identifying the Convenor, physician, nurse practitioners and patient partner members;
- Update the Steering Committee about community and partner engagement to build Steering Committee member knowledge of their PCN and its particular needs;
- Seek Steering Committee input on recommended initiatives and move the initiatives from idea through implementation.
- Provide secretariat support to the Convenor and entire Steering Committee, including required materials to make timely and informed decisions;
- Manage the PCN Service Plan and support clinics and/or VCH to hire and manage PCN Service Plan funded staff (e.g., nursing and allied health).

10. Dispute Resolution

Tension and conflict are natural in working relationships. In PCNs, where value-based conflicts about goals of care, limited resources, and differing organizational priorities are involved, “creative conflict” is to be expected. In the event of a disagreement or divergence of views, members should always conduct themselves in a respectful manner, recognizing that the foundation of the PCN Steering Committee’s efficacy is the strength of relationships and depth of trust at the table.

If the PCN Steering Committee members cannot resolve a dispute internally, the following process will be engaged:

The PCN Steering Committee Convenor will make best efforts to work with members to resolve the dispute. If resolution cannot be reached locally, the Convenor will contact the VDOFP Backbone Support for assistance to resolve the disagreement, including informing VDOFP Executives.

Should the conflict remain unresolved, or if at any time the Member(s) does not respect the Code of Conduct for Steering Committee Members, the VDOFP may invoke at its sole discretion the [Policy for Removal of PCN Steering Committee Member](#).

11. Measurement and Reporting of PCN Steering Committee Work

Steering Committee members share reciprocal accountability for measuring their work, and the credible reporting, reasonable review, and adjustment based on the measurement (see Section 5 on Accountability). VDOFP Backbone Support will therefore create regular reporting of Steering Committee work to communicate progress, and any implemented continuous improvements. Once approved by the Steering Committee, these reports will be shared with interested parties including the Collaborative Services Committee (the entity that establishes the Steering Committees), the Ministry of Health and the groups represented on the Steering Committee.

12. Amendments

These Terms of Reference will be reviewed annually, and changes will be approved by the VDOFP Board of Directors.

Appendix A: PCN Core Attributes

The following core attributes of primary care have been adapted from the Government of British Columbia's official [description of its primary care system](#). These principles guide the planning and delivery of care to ensure services are person-centred, effective, and sustainable across the province.

1. *Longitudinal Care: Ongoing, consistent care from the same primary care provider over time.*
 - Delivery of longitudinal primary care to everyone within a PCN via attachment to a primary care provider or enrollment to a clinic (where applicable).
2. *Coordinated Care: Care providers across the healthcare system work in tandem to treat patients.*
 - Coordination of primary care across all parts of the health system, including, community service programs, specialist care, diagnostic services, emergency services, hospital care, facility-based care.
3. *Timely Access: Patients can get the care they need quickly, without long waits.*
 - Access to episodic or longitudinal primary care within 24 hours for urgent, non-life-threatening conditions, and within 7 days for non-urgent appointments.
4. *Extended Hours: Care is available outside of regular business hours, like evenings or weekends.*
 - Availability of extended clinic service hours for in-person primary care services during weekdays (5 pm to 8 pm), weekends (9 am to 5 pm) and statutory holidays (9 am to 5 pm); and access to virtual services after-hours.
5. *Comprehensive Care: A wide range of health needs are addressed, from prevention to treatment to follow-up.*
 - Access to a full-range of [comprehensive primary care services](#) including clinical screening, diagnostic testing and treatment provided through different clinical settings (e.g., community-based clinics, virtual care services, mobile outreach, long-term care facilities, in-patient care facilities).
6. *Team-Based Care: Health professionals (doctors, nurses, etc.) work as a team to support the patient.*
 - Intentional commitment to health care practitioners from different professional backgrounds (e.g., physicians, nurse practitioners, nurses, allied health providers, traditional wellness providers and administrative staff) working together as integrated primary care teams within clinics and across the network.
7. *Population Health Promotion: Supports healthy living for everyone in the community, beyond treating illness.*
 - Commitment to improving population health outcomes at a community level through collaboration in primary care and with other sectors.

8. *Digital Enablement: Leverage technology like electronic medical records or virtual appointments to improve care.*

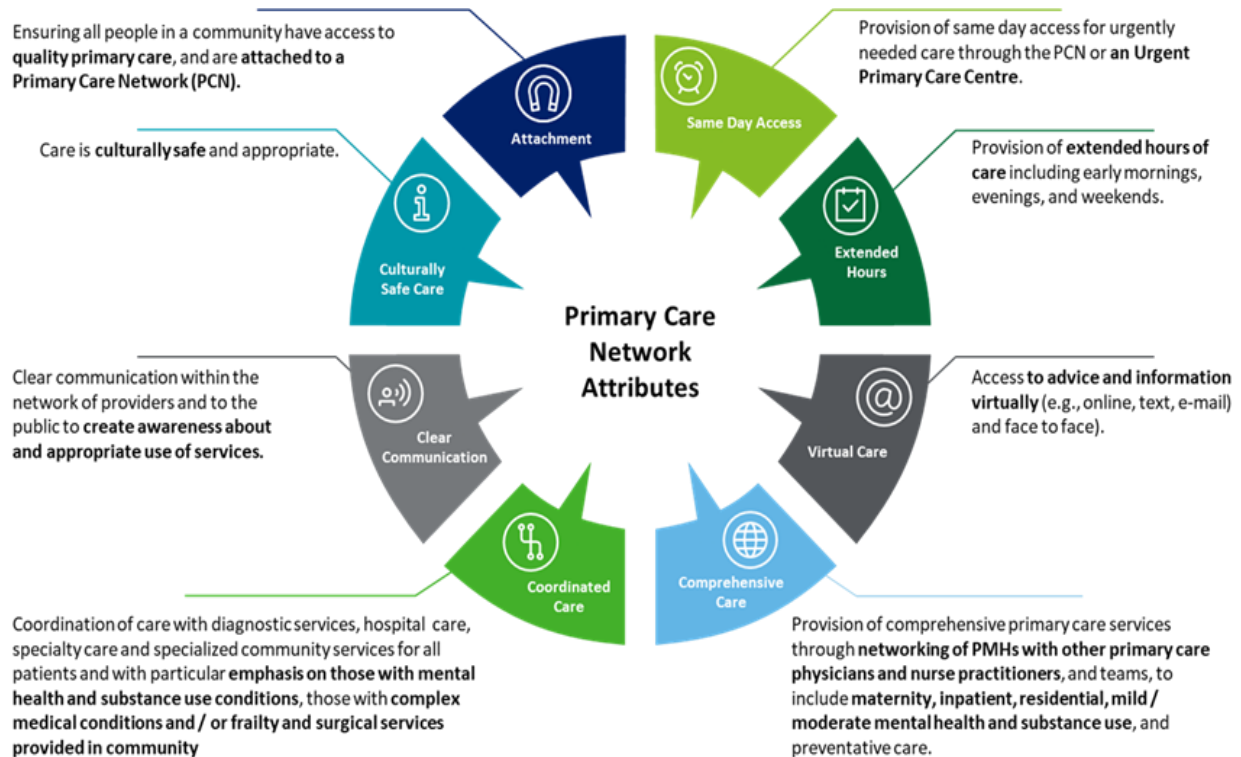
- Support innovation and improvements in care, and in particular, information continuity across care settings and team members, through the adoption of provincially/regionally endorsed digital technology solutions.

9. *Culturally Safe Care: Care is respectful of each patient’s cultural identity and free from racism or judgment.*

- Commitment to truth, reconciliation, and humility, ensuring provision of care that is culturally safe, addresses and eliminates racism and discrimination, and respects the dignity, well-being, and unique health care needs of Indigenous Peoples.

10. *Equitable Access: Everyone can get care, no matter their background, location, or income.*

- Removal of systemic barriers to ensure everyone is supported in achieving good health and wellbeing, regardless of age, ability, socio-economic status, ethnicity, gender, sexuality, or geographic location.



Note: This graphic represents a previous version and includes only 8 of the 10 current core attributes. An updated graphic from Divisions BC is under development.

Appendix B: Steering Committee Resources

1. [Establishing Values and Principles for Working Together.](#)

- Understand the importance of values and principles for collaborative efforts.
- Build an approach to considering values and principles.
- Access resources to help this conversation.

2. Tamarack Institute’s [Spectrum of Collaboration:](#)

- Defines a range of collaborative efforts, which span from “compete” to “integrate,” moving groups from “turf” to “trust.” It is important for a Steering Committee to be clear about where the work of their PCN is positioned within the spectrum.

3. [PCN Steering Committee Workbook.](#)

- This workbook is intended to support the PCN Steering Committees to:
 - a. Bring small scale PCN initiatives (projects) to life that target the area of focus.
 - b. Apply a consistent approach to project success – ensuring key steps are undertaken for each initiative.
 - c. Allow the PCN Steering Committees to complete the key steps in tandem – supporting timely execution.
 - d. Facilitate progress reporting to key interest holders.
 - e. Facilitate knowledge sharing between PCN Steering Committees.

4. Reciprocal Accountability

Reciprocal accountability means shared responsibility to achieve common goals. The principles that guide reciprocal accountability are:¹

- **Clear roles and responsibilities for the partners** that are well understood and agreed on.
- **Balanced expectations based on delivery capacity of the Steering Committee and its partners, and Clear performance expectations** including objectives, expected accomplishments and resource constraints that are understood and agreed on by all partners.
- **Reasonable review and feedback** on performance is undertaken, achievements and difficulties are highlighted, and **adjustments** made where needed.
- **Credible reporting** on the work of the Steering Committee.
- **Ethics** based on cultural teachings and best practices.

5. Consensus-Based Decision Making

- James Madden’s [Practical Guide for Consensus-Based Decision Making](#) provides helpful definitions, approaches, and roles when using the consensus model. Any local decision-making guidelines in this Terms of Reference will be evolving, stewarded by the convenor of the PCN Steering Committee, and reflective of the learning of the Committee regarding effective decision-making in its local context.

¹ Adapted from the *British Columbia First Nations Perspectives on a New Health Governance Agreement: Consensus Paper*