About Nanaimo's Primary Care Network

Vision

The Nanaimo PCN is a cohesive network of primary care services where all patients have a primary care provider and access to culturally safe, team-based primary care that meets the needs of both patients and providers.

In our PCN, patient-centred care is inspired by the "One Canoe Model of Care" of the Snuneymuxw Health Centre. In this model the patient is the skipper, guiding their care and inviting the care team into their canoe to pull together in their journey to wellness.

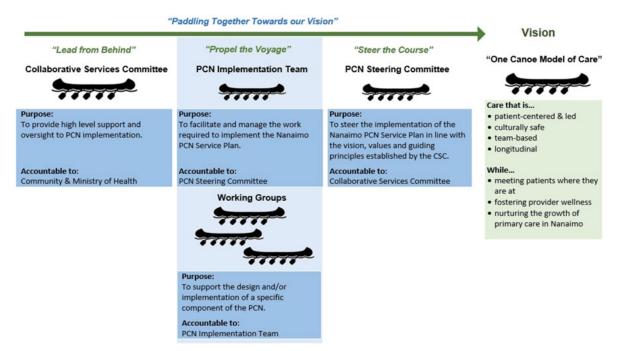
We will achieve our Vision by:

- Designing services that enhance team-based care within primary care practices to encourage a strong foundation of relational, longitudinal patient care in Nanaimo.
- Creating new opportunities to attract early career Physicians to provide longitudinal care.
- Providing access to relational, team-based primary care for patients who face significant health, social and system barriers to care.
- Designing services that value cultural sensitivity, wellness and equity for patients and providers.

Governance

Inspired by Indigenous ways of being, our PCN Governance model reflects a non-hierarchical and collaborative leadership structure. The PCN is a partnership between the Nanaimo Division of Family Practice, Island Health and Indigenous Community Partners. Family Physicians are present across all committees and working groups and have a strong voice in decision making. The PCN Administration Team includes a dyad management structure with PCN Managers from both the Division of Family Practice and Island Health. The PCN Managers work closely together towards the collective vision of the Primary Care Network and are directly accountable to the PCN Steering Committee.

Nanaimo's PCN Governance Model



Priority Populations

The PCN services are intended to address gaps in care that were identified through community and provider engagement, as well as, local data on health and social determinants of health. Through this work, several key populations where identified. These include community members who...

- experience significant social, cultural or system barriers to care,
- have moderate to high complex health needs and/or frailty,
- live with mental health and/or substance use concerns, and/or,
- do not have a Family Physician or Nurse Practitioner.

These populations span all ages and cultural backgrounds, recognizing that some community members are disproportionately represented due to significant inequities and barriers to care. In particular, the needs of Indigenous community members, vulnerable children and youth, seniors, and those who are unsheltered or hard to attach were considered in these PCN services.