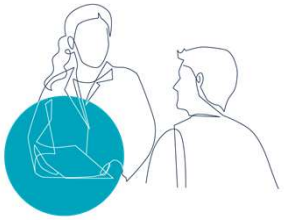
Improving Access to Maternity Care: Successful Approaches from Across BC

September 23, 2026 | 1830–2000 PT



Ask your questions: slido.com | #maternity

THE UNIVERSITY OF BRITISH COLUMBIA
Continuing Professional Development
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TERRITORIAL ACKNOWLEDGMENT

We acknowledge that UBC CPD is located on the traditional, ancestral and unceded territory of the Skwxwú7mesh (Squamish), xʷməθkwəy̓əm (Musqueam), and Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations.

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Medicine
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What is your relationship to the territory or the land that you're on?

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FUNDING ACKNOWLEDGEMENT

Funding for this webinar has been provided by the Perinatal Community of Practice, an initiative of the Shared Care Committee and Joint Collaborative Committees.

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SharedCare Partners for Patients

JCC Joint Collaborative Committees

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DR. HAYLEY BOS

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INTERESTED? STAY CONNECTED!

The Perinatal Community of Practice (CoP) works to equip perinatal care professionals with relationships, knowledge, skills and tools to advance perinatal care across BC.

Vision Statement: Families across BC receive timely, comprehensive and culturally safe access to care from preconception to two years postpartum.

Scan the QR code to stay informed about:

- Perinatal care forums and networking opportunities
- Educational webinars hosted with UBC CPD
- Project highlights

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LEARNING OBJECTIVES

1. Describe key barriers affecting access to maternity care in BC, including challenges in rural and remote communities.
2. Examine strategies to improve access to maternity services, including centralized referral systems and team-based care models.
3. Identify resources that can support patients and providers in accessing and navigating maternity care services.

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DISCLOSURES

Speakers

- **Dr. Hayley Bos:** Received payments from Pfizer for presentations for local community advisory board for RSV vaccination. There is **no potential conflict of interest** between this funding and this webinar.
- **Dr. Ana Boskovic:** Received payments from BC College of Family Physicians as a Board Member, and UBC's Department of Family Practice as a Clinical Instructor. There is **no potential conflict of interest** between this funding and this webinar.
- **Dr. Tracy Monk:** Received payments from PathwaysBC as Medical Director. There is **no potential conflict of interest** between this funding and this webinar.
- **Dr. Jane McGregor:** Received payments from the Physician Quality Improvement program to fund central referral program.
- **Alex Crandall, Mary Decker:** Nothing to disclose.

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DISCLOSURES

Planning Team

- **Dr. Bruce Hobson:** Has received funding from UBC CPD, Doctors of BC, PHSA, and several Divisions of Family Practice. There is **no potential conflict of interest** between this funding and this webinar.
- **Dr. Kathleen Ross:** Received payments from College of Family Physicians of Canada, Pathways Patient Referral Association, Health Data Coalition and FHA Physician Quality Improvement. There is **no potential conflict of interest** between this funding and this webinar.
- **Stephanie Din, Caldon Saunders** are employees of UBC CPD.

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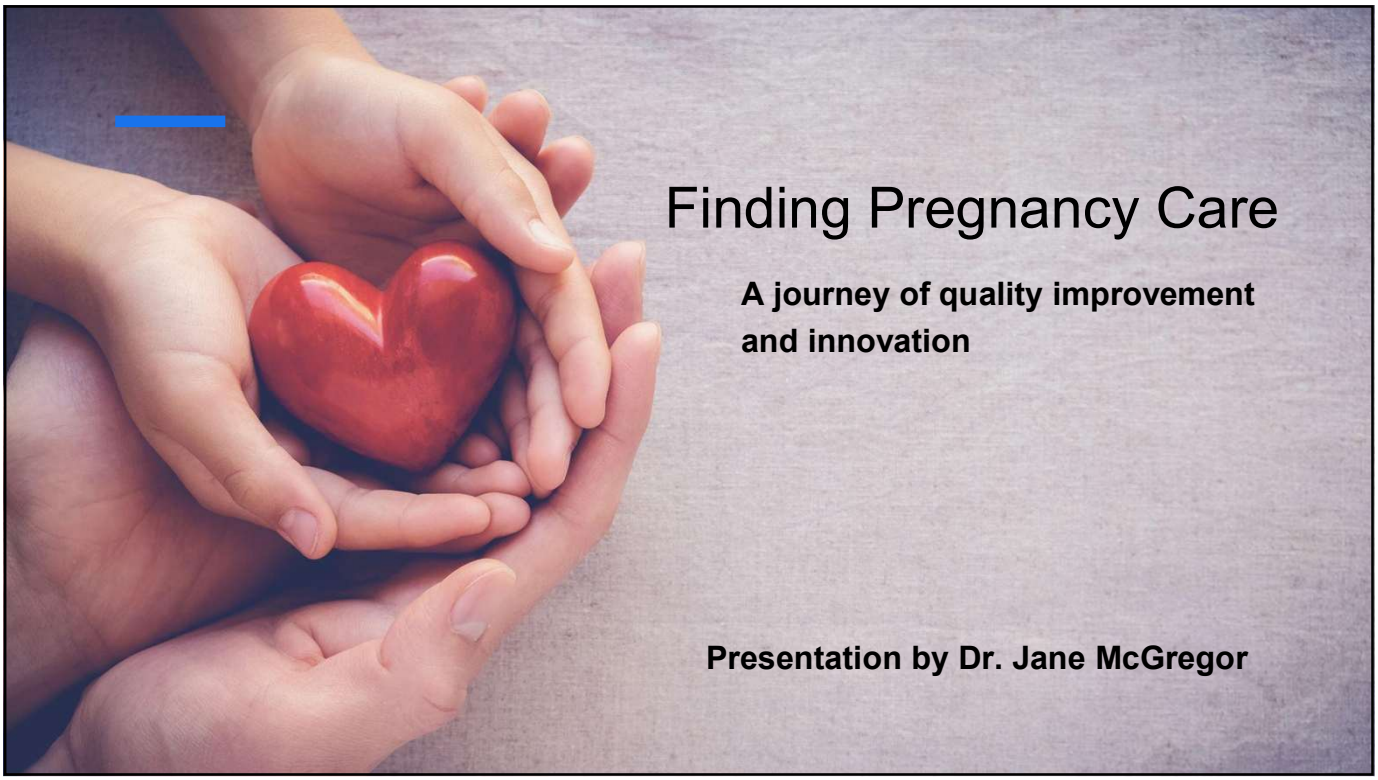


Finding Pregnancy Care

A journey of quality improvement and innovation

Presentation by Dr. Jane McGregor

Part 1: What was the Problem?

Part 2: What did we do about it?

Part 3: How is it going?

Part 1: What was the problem?

Patient and Provider Surveys (Fall 2023)

1. 56% of patients were not happy with the current process of finding pregnancy care in Victoria
2. 64.5% of Family Doctors and Midwives were not happy with the process of pregnant people finding care
   a. additional 17% thought it was “just ok”

Part 1: What are *Patients* saying?

Patient Voice – Anonymous Survey (2023)

"This was a very stressful process when I was supposed to be calm and happy. I felt no one cared that I was without any help and was alone."

Part 1: What did Patients and Providers want (Survey Data Fall 2023)

Centralized place to find all contact info for pregnancy providers

Centralized Self referral system for FP-OB and Midwifery

Continue to allow for patient autonomy in choice of provider and continuity for returning patients

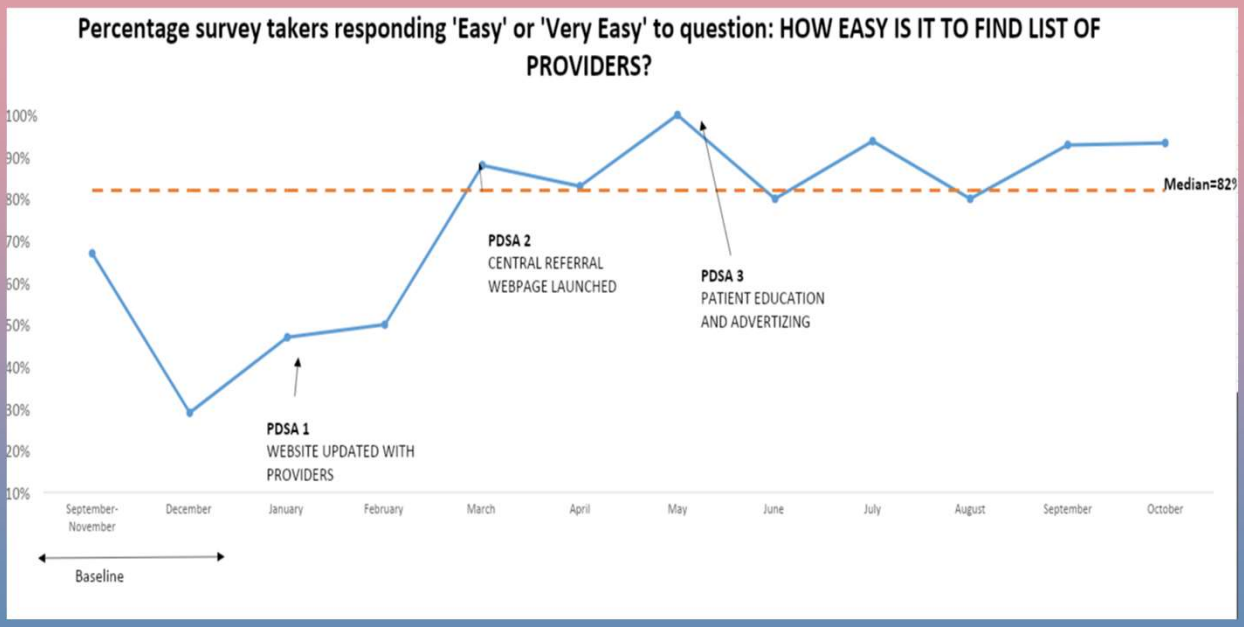
- **Barrier (But an important one)**
- **PIPA** (Personal information and protection act)

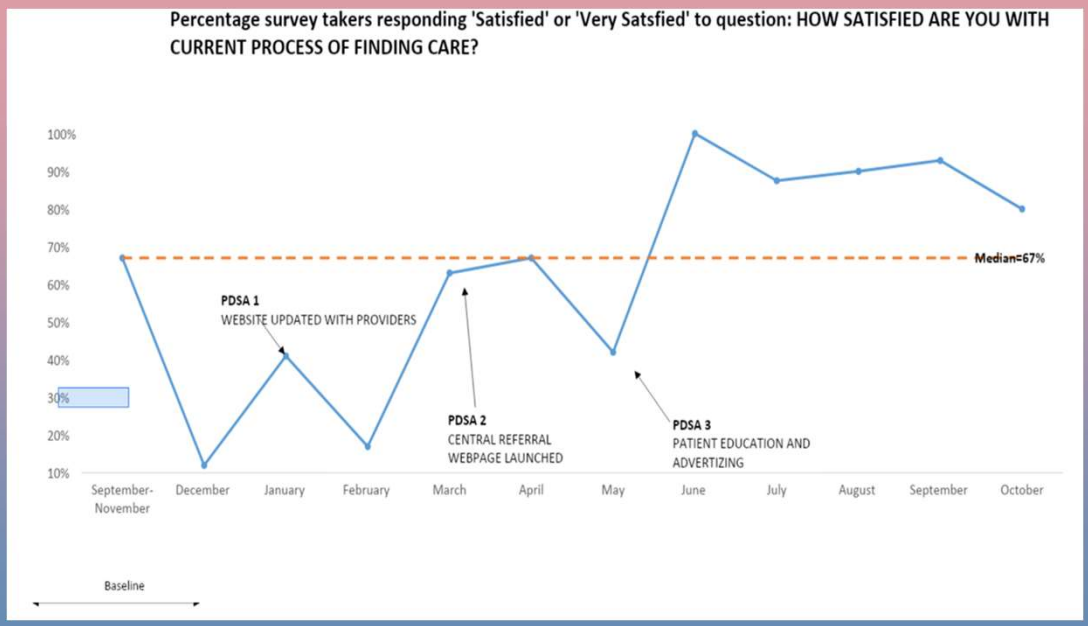
Lock screens/devices
Use strong authentication/multifactor authentication where available.
Never share passwords or accounts.
Access only records you need for your role/care.
Use approved/secure messaging and email, not personal accounts.
Verify the recipient before sending patient information.
Secure paper records and dispose of them appropriately.
Have a process for privacy incidents/breaches and have a named privacy officer for your clinic.
Ensure vendors/cloud services have appropriate privacy/security arrangements.
Follow your professional college's confidentiality, record-keeping and technology requirements in addition to legislation.

Central Self-Referral System

- Partnered with Veribook to create the software
- PIPA(Personal information protection act) compliant.
- Tries to connect patients with providers in their geographic location while still maintaining full patient autonomy to choose between providers that still have capacity for their estimated due date.
- Medical screening questionnaires to help direct patients to most appropriate care provider if they are out of midwifery scope.
- Fluid system that show's real time capacity, controlled by each individual office
- Does not inhibit offices from saving spots for returning patients, marginalized patients etc (Used as a hybrid system)

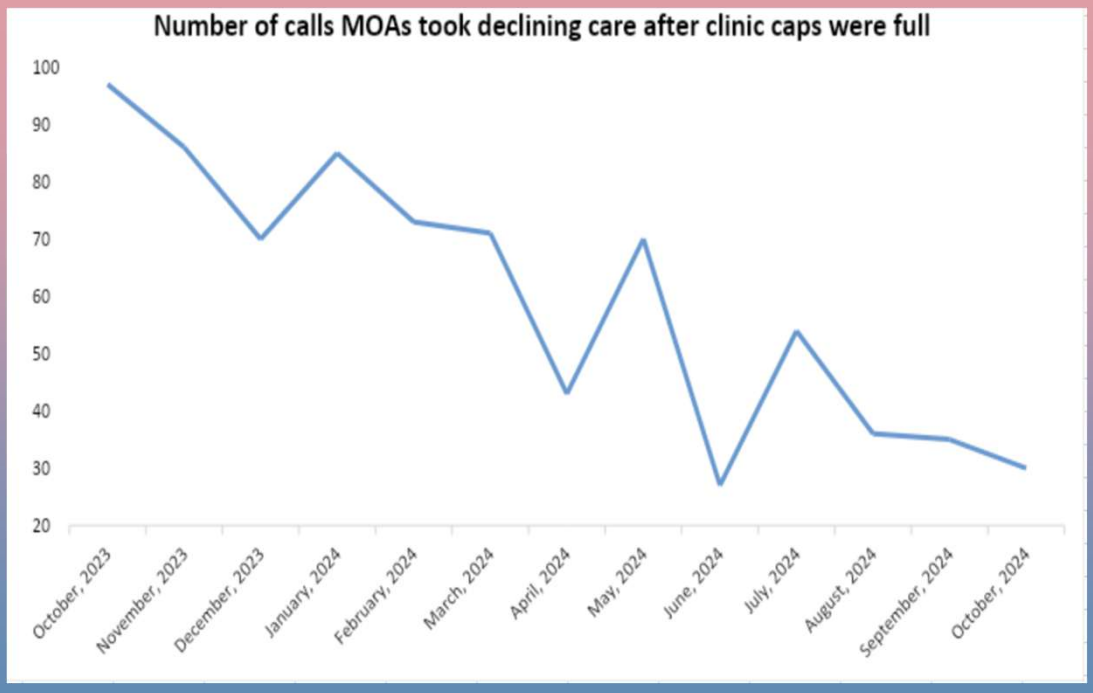
Part 3: How's it going - Phase 1 Data

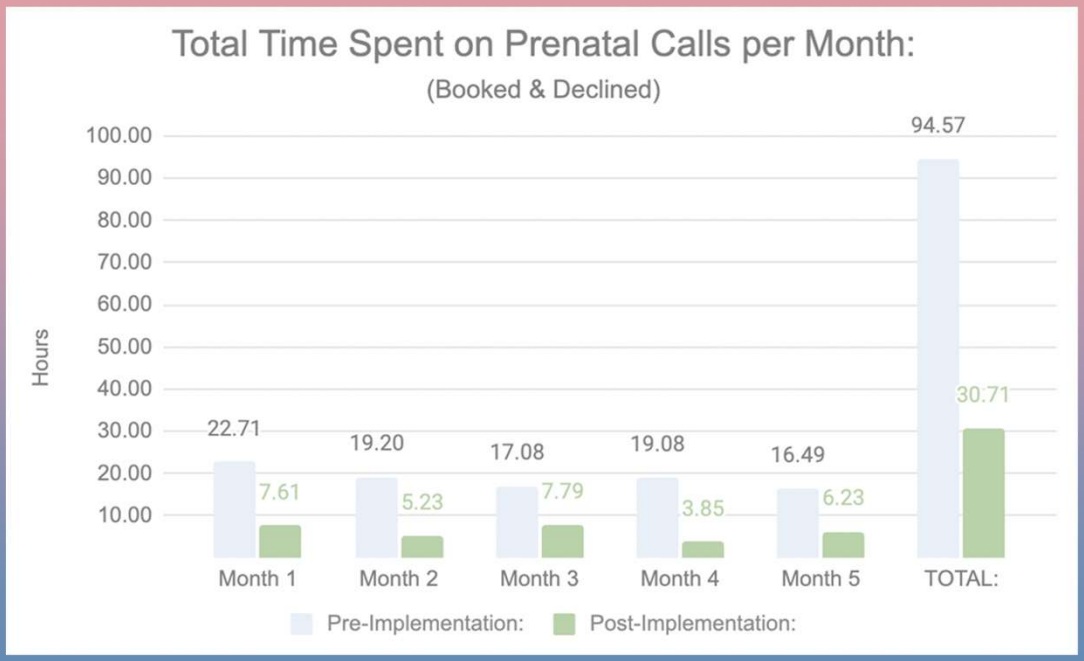

Percentage survey takers responding 'Easy' or 'Very Easy' to question: HOW EASY IS IT TO FIND LIST OF PROVIDERS?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
Median=82%
PDSA 1
WEBSITE UPDATED WITH PROVIDERS
PDSA 2
CENTRAL REFERRAL WEBPAGE LAUNCHED
PDSA 3
PATIENT EDUCATION AND ADVERTIZING
September-November
December
January
February
March
April
May
June
July
August
September
October
Baseline


Percentage survey takers responding 'Satisfied' or 'Very Satsfied' to question: HOW SATISFIED ARE YOU WITH CURRENT PROCESS OF FINDING CARE?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
Median=67%
PDSA 1
WEBSITE UPDATED WITH PROVIDERS
PDSA 2
CENTRAL REFERRAL WEBPAGE LAUNCHED
PDSA 3
PATIENT EDUCATION AND ADVERTIZING
September-November
December
January
February
March
April
May
June
July
August
September
October
Baseline

Ok…but do you have any qualitative data?

So, it's good for patients… what about me??


Number of calls MOAs took declining care after clinic caps were full
100
90
80
70
60
50
40
30
20
October, 2023
November, 2023
December, 2023
January, 2024
February, 2024
March, 2024
April, 2024
May, 2024
June, 2024
July, 2024
August, 2024
September, 2024
October, 2024


Total Time Spent on Prenatal Calls per Month:
(Booked & Declined)
Hours
100.00
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
22.71
7.61
19.20
5.23
17.08
7.79
19.08
3.85
16.49
6.23
94.57
30.71
Month 1
Month 2
Month 3
Month 4
Month 5
TOTAL:
Pre-Implementation:
Post-Implementation:

*Average Time per Booked Prenatal Call (as documented by MOAs):
Pre-Implementation: 10-15 mins; average of 12.5 mins
Post-Implementation: 4-7 mins; average of 5.5 mins

Post central referral survey of FP-OBs and MOAs (18 FP, 12 MOA, 2 Office Managers)

90% of respondents felt central referral was a positive change for **patients** (10% neutral, 0% disagree)

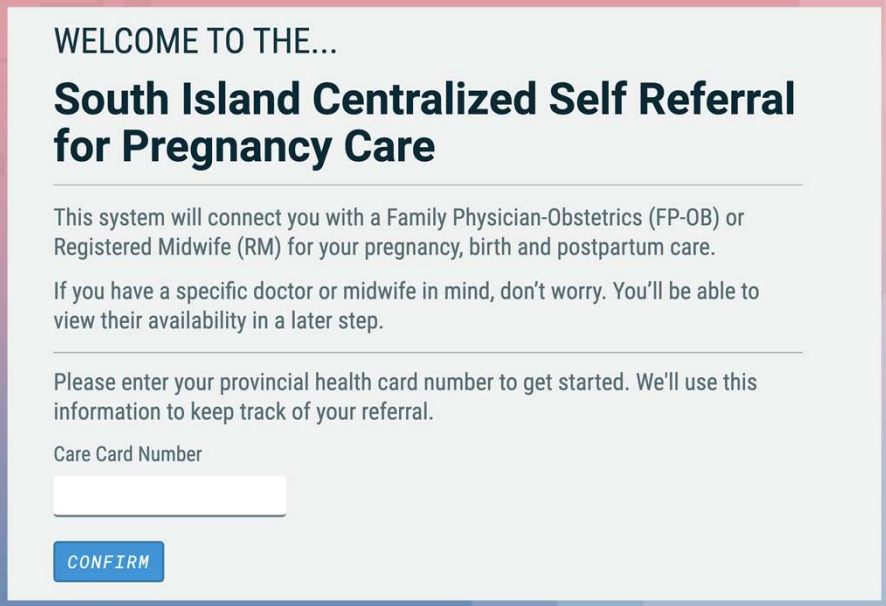
90% respondents felt central referral was a positive change for **MOAS** (9% neutral, 1% disagreed)

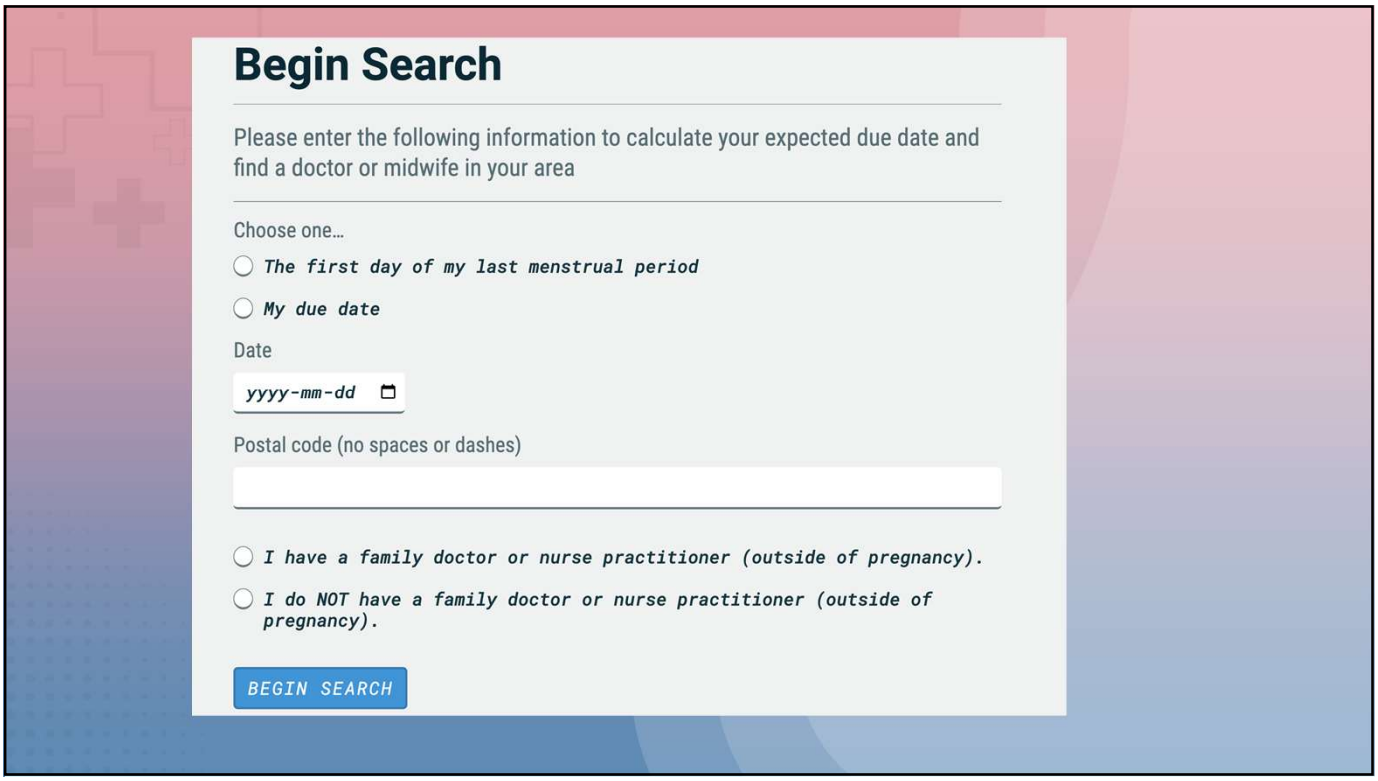
71% respondents felt central referral was a positive change for **Physicians** (29% neutral, 0% disagree)

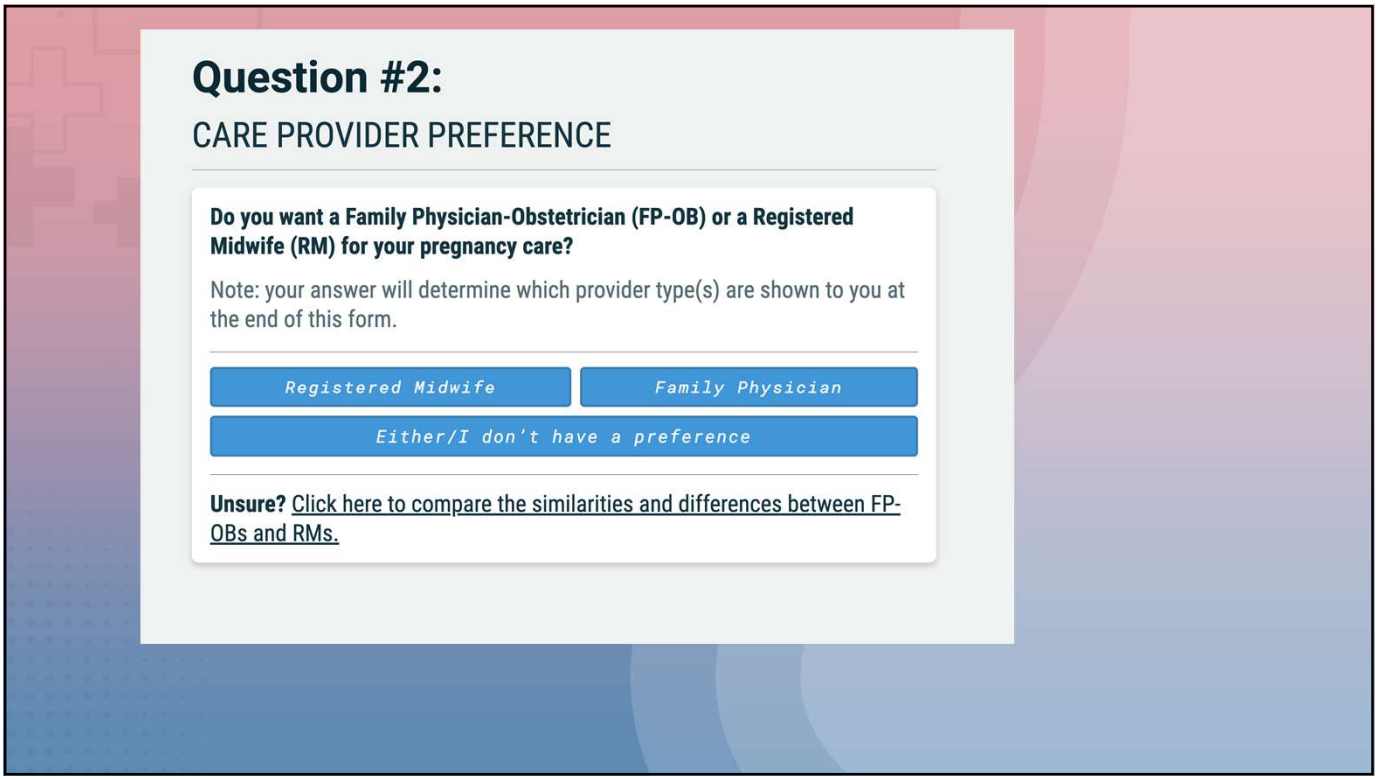
90% respondents felt we should continue using central referral (10% neutral)

What's was next?

-Over the last year we expanded to include all primary pregnancy care providers in Victoria (RM and MD)
-Working with other communities to build similar pathways depending on their needs
-Working to improve the system where possible, ensure no one is left without care etc.




Begin Search
Please enter the following information to calculate your expected due date and find a doctor or midwife in your area
Choose one…
The first day of my last menstrual period
My due date
Date
yyyy-mm-dd
Postal code (no spaces or dashes)
I have a family doctor or nurse practitioner (outside of pregnancy).
I do NOT have a family doctor or nurse practitioner (outside of pregnancy).
BEGIN SEARCH


Question #2:
CARE PROVIDER PREFERENCE
Do you want a Family Physician-Obstetrician (FP-OB) or a Registered Midwife (RM) for your pregnancy care?
Note: your answer will determine which provider type(s) are shown to you at the end of this form.
Registered Midwife
Family Physician
Either/I don't have a preference
Unsure? Click here to compare the similarities and differences between FP-OBs and RMs.

Question #3:

MEDICAL ELIGIBILITY SCREENING

Do you have any of the following pre-existing health conditions?

- Diabetes (type 1 or type 2) unrelated to pregnancy
- Chronic high blood pressure/hypertension unrelated to pregnancy
- A heart/cardiac condition
- A kidney/renal condition
- A rheumatologic condition (e.g., Lupus or Sjogren's syndrome)

Yes | No

Question 4:

OUT-OF-PROVINCE HEALTH INSURANCE

Do you have health coverage under the British Columbia Medical Services Plan (BC MSP)?

- ○ *Yes, I have valid BC MSP coverage*
- ○ *No, my health coverage is from a Canadian province/territory outside of BC*

Continue...

Available Physicians or Midwives within 10km

The following providers have space to accept patients with your estimated delivery date. Please register with your chosen clinic below.

Please do not continue to apply for/accept care at other clinics after registering through this website.

See FP-OBs' individual bios here. RMs' individual bios can be found on each clinic's website; click HERE for a complete list of midwifery clinics in Victoria.

FAMILY PHYSICIAN-OBSTETRICS

DR. LINDSAY TAYLOR REGISTER

FULL CIRCLE FAMILY PRACTICE 1964 Fort St #101, Victoria, BC V8R 6R3

DR. KARA WARDER REGISTER

3066 SHELBOURNE 3066 Shelbourne St, Victoria, BC V8R 6T9

DR. ALLISON FERG REGISTER

TUSCANY MEDICAL CLINIC 217-3561 Blanshard St, Victoria BC V8Z 0B9

COOK STREET MIDWIVES REGISTER

101-1005 Cook Street, Victoria, BC, Canada, V8V 3Z6

THE MIDWIVES COLLECTIVE REGISTER

107-1120 Yates Street, Victoria, BC V8V 3M9

EARTHSIDE BIRTH REGISTER

1-481 Head Street, Esquimalt, BC, V9A 5S1 | NOTE: This clinic primarily serves the communities of Esquimalt, View Royal, and Victoria West, with service extending to Langford, Colwood, Victoria, and Saanich. If you live outside of these areas, please do NOT register for this clinic. If you still wish to request care from these midwives, please contact the clinic directly to discuss your situation.

To see all physicians & midwives, including those who are at capacity, click the button below.

See ALL physicians & midwives in our network

THANK YOU

Primary Care OB Clinic

Access and Flow in Perinatal Care

ACCESSING AND INTEGRATING NURSES INTO PRACTICE

Dr. Ana Boskovic, MD CCFP
Primary Care Obstetrics Clinic
Royal Columbian Hospital

OUR TEAM & CLINIC

- 12 Family Physicians, 1 per clinic day
- 1 full-time Perinatal RN
- 1 float Perinatal RN
- 1 MOA
- Residents & Medical Students
- Oscar EMR
- 40 patients per day
- 2 exam rooms
- Blood pressure area
- RN office + Physician office

Primary Care OB Clinic

OUR NURSES

- Multiple perinatal contract nurses
  - All worked on L&D unit
  - Selected clinic days based on availability
  - Paid by clinic overhead
- RN in Practice (RNiP) Program through Division of Family Practice
  - Application and advocacy for perinatal RN

Primary Care OB Clinic

OUR NURSES

- RN in Practice (RNiP) Program through Division of Family Practice
  - Health Authority employee
    - Salary, benefits, vacation
- Perinatal RN specifically for this role
  - 3 RNs between two maternity clinics
- Clinical and administrative tasks

Primary Care OB Clinic

CLINICAL TASKS

PATIENT FLOW:

- **MOA:** checks patient in, takes weight (enters in ANR)
- Patient waits in waiting room
- **Nurse:** sees patient in blood pressure area
  - Takes BP (enters into ANR)
  - Reviews upcoming labs that are due, prepares requisition, provides teaching
    - GTT
    - GBS kit
    - IOL pamphlet
- **Physician:** sees patient in examination room
- **MOA:** books next appointment

Primary Care OB Clinic

ADMINISTRATIVE TASKS

NEW PATIENTS:

- MOA receives referral – confirms referral meets criteria
  - Compiles all documents received, makes patient chart in EMR, scans all files/results into EMR
  - Contacts patient to book initial visit
- Nurse preps ANR
  - Reviews all received labs and ultrasounds, inputs results into ANR
  - Makes list of missing initial investigations

Primary Care OB Clinic

ADMINISTRATIVE TASKS

NEW PATIENTS:

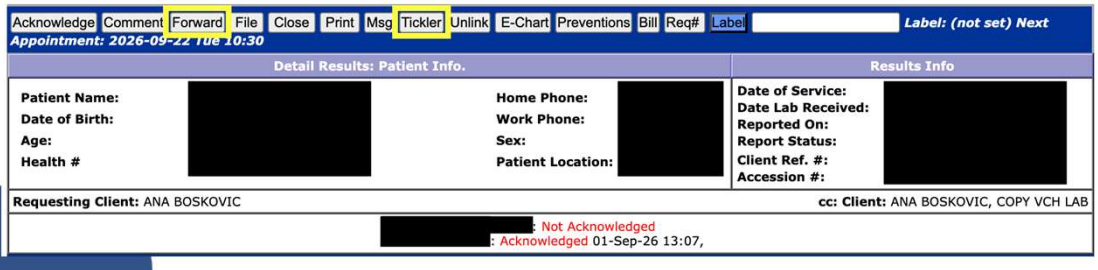
- Initial patient visit
  - Nurse completes intake history, filling out page 1 of ANR
  - Prepares lab/imaging requisitions for missing investigations
  - Review of clinic, assists newcomers with registering for family physician waitlist, provides educational materials

Primary Care OB Clinic

ADMINISTRATIVE TASKS

INBOX RESULTS:

- Physicians review all results coming into inbox
  - Results to be added into ANR are *forwarded* to Nurse for data entry
- Any positive results that require action, *Tickler* sent to Nurse with instructions for next steps



ADMINISTRATIVE TASKS

TASKS ASSIGNED TO NURSE:

- **Abnormal GTT:**
  - 1hr GTT: phones patient, prepares/emails requisition for 2hr GTT
  - 2hr GTT: phones patient, completes referral forms to Diabetes Clinic
- **Low Ferritin:**
  - PO iron: phones patient and provides instructions for starting PO iron
  - IV iron: phones patient and completes IV iron order sets
- **Swabs + yeast:** phones patient and provides instructions for OTC Canesten treatment
  - *Physicians call for + BV/C&G/UCx as requires Rx*

Primary Care OB Clinic

ADMINISTRATIVE TASKS

OTHER ASSIGNED TASKS:

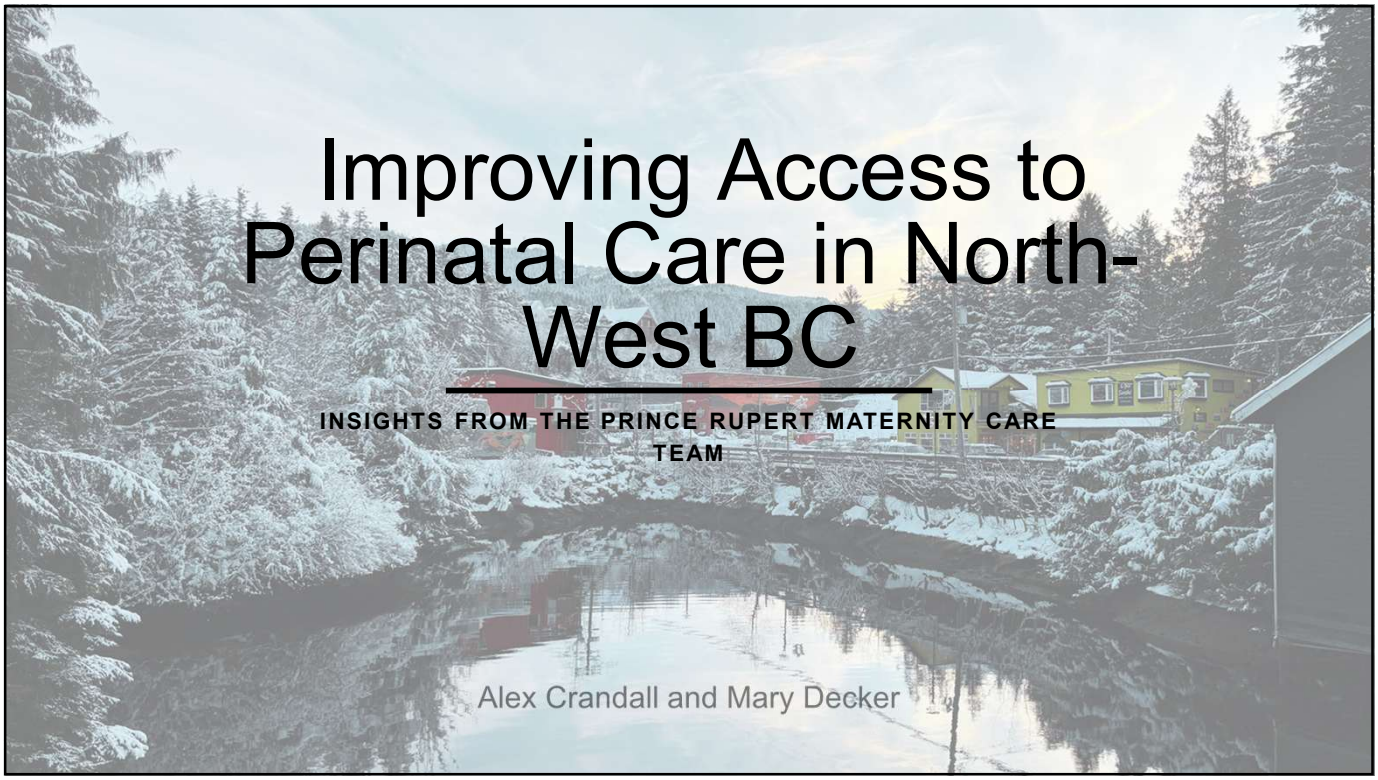
- **Seamless Referral:** if patients meet criteria at any visit

- **Antepartum Clinic:**
  - Complete referral forms for NST
  - Complete referral forms for IOL

Primary Care OB Clinic

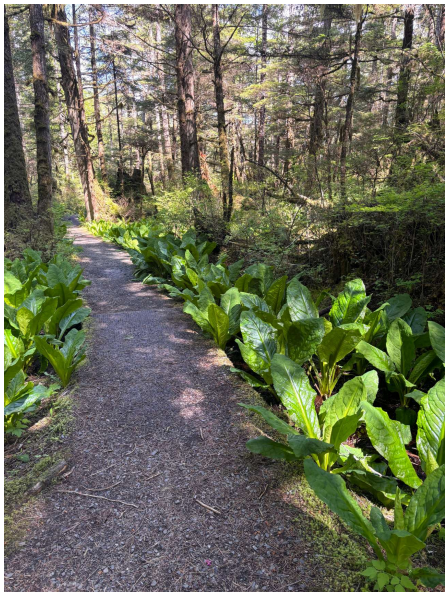
THANK YOU!

Primary Care OB Clinic



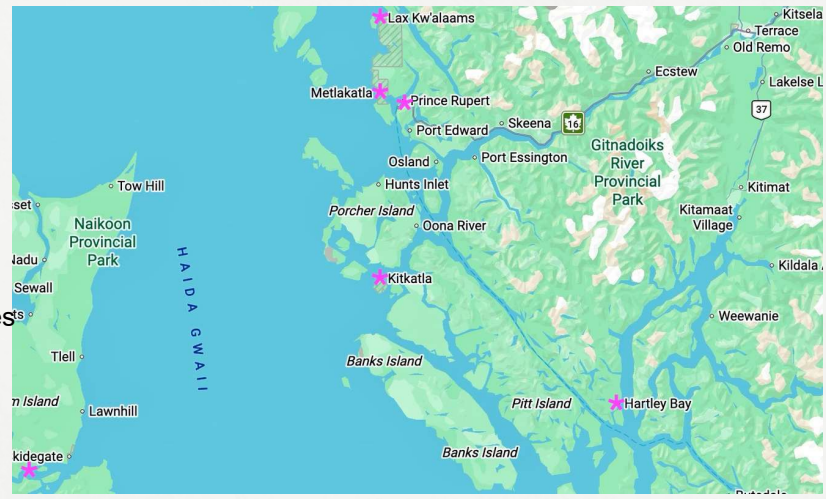
Overview

1. Community background
2. Strategies for improvement
3. Future dreams
4. Barriers



Community Background

- Prince Rupert/Kxeen
- Ts'ymsyen First Nations
- Population 12,300
- Referral site for remote communities
  - Haida Gwaii, Lax Kw'alaams, Metlakatla, Kitkatla, Gitga'at
- New comers to Canada



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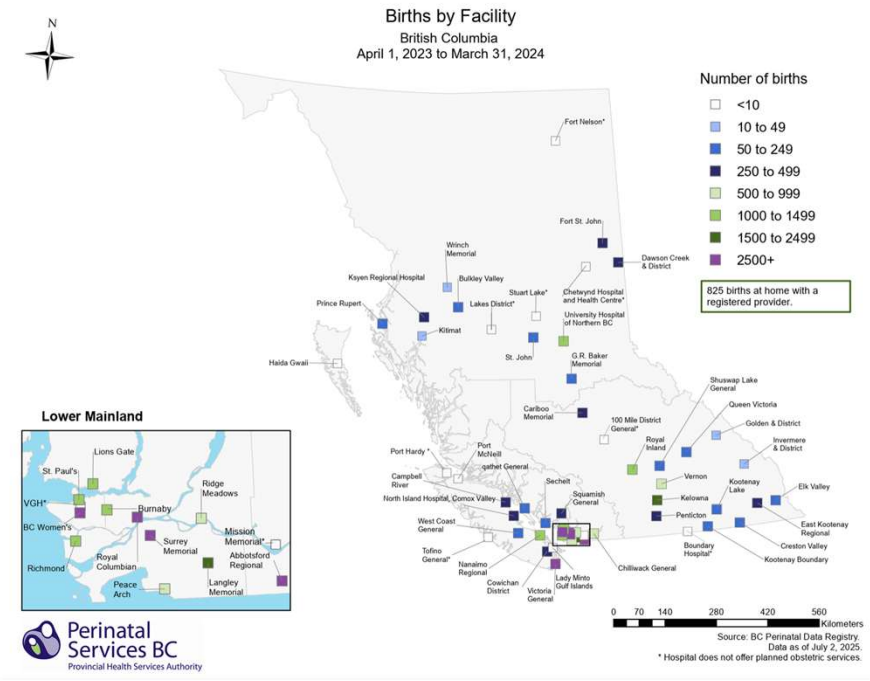

- Case load of 10-20 EDDs per month
- Tier 2 site with OB/Gyn and Anesthesia, but no Peds or NICU

Maternity Clinic Background

Historically

- Exclusively GP maternity clinic with multiple providers
- Referral required from GP to book initial
- Low risk call = GP; High risk call= OBGyn
- 1 day of clinic/wk, 10 min appts
- 1-2 hospital PP visits, ER for urgent concerns or family doctor for non urgent concerns

Current Model

- Primary Care Network, collaborative practice with 2 FT RMs, 1 PT RM, 1 PT GP
- Self referral process
- Low risk call = RM/GP; High risk call= OBGyn/GP-OSS
- 3 days of clinic/wk, 30 min appts
- 6w of home PP care with RMs and 24/7 access to phone line

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Strategies to Improve Access to Perinatal Care

Collaborative Care

- Continuity of care
- Midwifery model
- High risk clinic run by GP (IDGDM, GHTN, SSRIs etc)

Referral Process

- Self referral by calling health unit or maternity clinic to book in
- Continue to accept referrals from pts with family doctors

Patient communication

- Non-Urgent line- triaged by RMs
  - Prenatal pts can text/call between 0900-1700, 7 days/wk; PP pts can call/text 24/7
- Urgent line- triaged by L&D RNs.
  - 20w+ pts text or call any time

Strategies to Improve Access to Perinatal Care

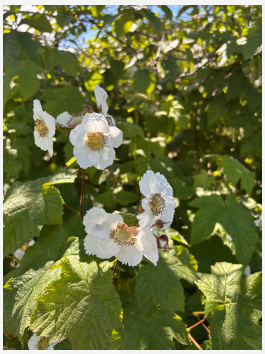
Longer appointments

- Relationship building
- More time for questions
- More time for complex clinical care

Home Postpartum Care

- Continuity of care
- Keeps patients out of ER
- Improved feeding support
- Closer follow up for clinical concerns
- Easier for patients to access care

Future Dreams



1. Remote Indigenous community care
   - Rotating clinic in remote communities
   - More collaboration with with remote RN stations
   - Better support for patients who relocate to Prince Rupert
2. Website for Maternity Clinic
   - Patient facing clinical information and resources
   - Online intake process
   - Bios of providers
3. Home birth
   - L&D RNs for 2nd attendant
   - Well selected low risk candidates
4. Group Postpartum Care
   - 2w and 4w postpartum visits done in group setting
   - New parents can share experiences and build community

Barriers

- Systemic racism and history of colonialism
- Inadequate staffing to meet the needs of community
- Complex beaurocratic systems that delay and prevent positive systems change and cultural safety

Pathways

Supports for Maternity Care

Pathways Support for Maternity Care

Pathways has an MOU with Perinatal Services BC to collaborate on:

- Maternity provider data collection working with Divisions, Midwifery Association, Individual Providers
- Perinatal mental health – directory of services
- Education and clinical tools (e.g. some care pathways in Pathways align with evidence and information in the Perinatal Hub, with links to relevant Hub content and the ability to email selected information directly to patients.)

Pathways has a public facing directory of maternity providers www.PathwaysMedicalCare.ca

Pathways
www.pathwaysbc.ca

Pathways to Optimize Maternity Care Access

Things Pathways can do to support optimizing access to maternity care:

1)Support Central intake by creating a pooled intake listing in Pathways. If a group of mat clinics want to work together and become a pooled intake, once they determine their process for allocating the inbound referrals, it is simple to create a central intake point in Pathway. If they have a single central fax number and a pooled intake listing can be created in Pathways and all the participating clinic's listings can point at that central intake point. (The challenge is determining how to work together and who will do the pooled intake triage and how cases will be allocated)

2) Create an updated primary care early pregnancy care pathway/physician tip sheet that covers the material that some divisions have been adding to referral forms. Easier to ensure the clinical evidence-based information is being kept up to date if it is not embedded inside a referral form and referrers are instead directed to a care pathway in Pathways

3) Create a new consolidated Maternity Care tab

4) Slot based availability Pathways will add the option for maternity providers to update their # of available slots per month in Pathways.

5) Pathways secure fillable webforms for intake (Optional) a standardized maternity patient intake form using Pathways free secure fillable webform (or other purchased option). It could include questions about preference for provider type and medical complexity

Other add-on software could Use AI to e-triage inbound referrals & send out patient questionnaires

Pathways
www.pathwaysbc.ca

Pathways to Optimize Maternity Care Access

Central intake by creating a "pooled intake" listing in Pathways. If a group of mat clinics want to work together to accept inbound referrals. (Fictional example below).

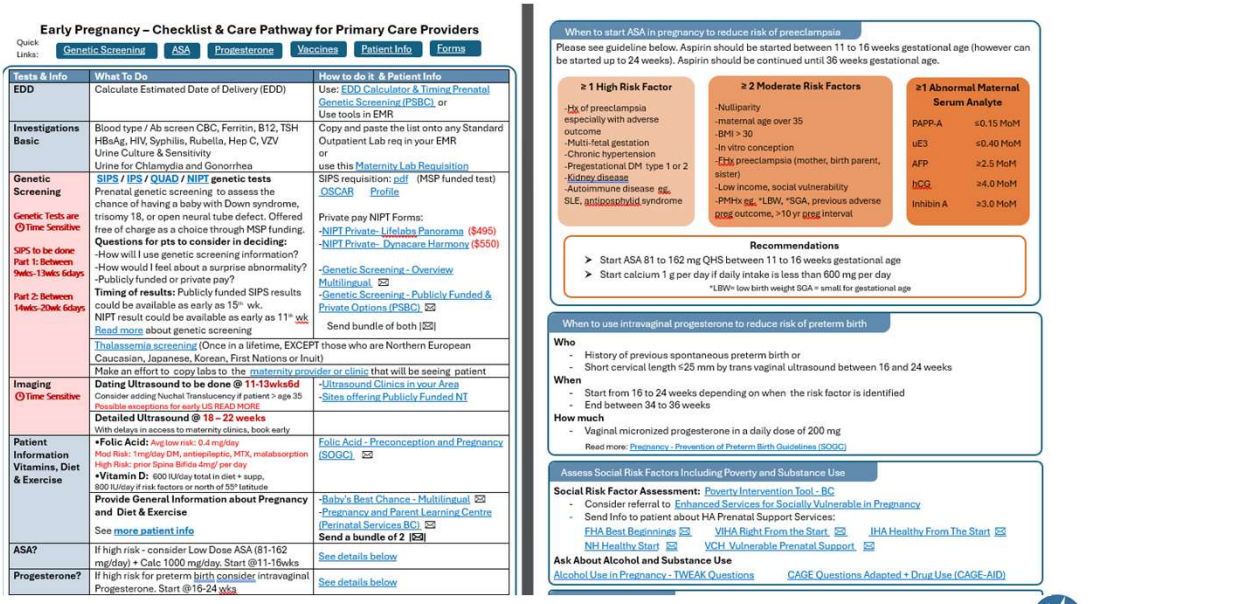
If a group of mat clinics want to work together and become a pooled intake, once they determine their process for allocating the inbound referrals, it is simple to create a central intake point in Pathway.

If they have a single central fax number and a pooled intake, a listing can be created in Pathways and all the participating clinic's listings can point at that central intake point.

The challenge is determining how to work together, who will do the pooled intake triage and how cases will be allocated.

Pathways
www.pathwaysbc.ca

Updated Early Pregnancy Care Pathway / Tips



Early Pregnancy – Checklist & Care Pathway for Primary Care Providers

Quick Links: Genetic Screening | ASA | Progesterone | Vaccines | Patient Info | Forms

Tests & Info	What To Do	How to do it & Patient Info
EDD	Calculate Estimated Date of Delivery (EDD)	Use: EDD Calculator & Timing Prenatal Genetic Screening (PSBC) or Use tools in EMR
Investigations Basic	Blood type / Ab screen CBC, Ferritin, B12, TSH HBsAg, HIV, Syphilis, Rubella, Hep C, VZV Urine Culture & Sensitivity Urine for Chlamydia and Gonorrhea	Copy and paste the list onto any Standard Outpatient Lab req in your EMR or use this Maternity Lab Requisition
Genetic Screening Genetic Tests are Time Sensitive SIPS to be done Part 1: Between 9wks-13wks 6days Part 2: Between 14wks-20wk 6days	SIPS / IPS / QUAD / NIPT genetic tests Prenatal genetic screening to assess the chance of having a baby with Down syndrome, trisomy 18, or open neural tube defect. Offered free of charge as a choice through MSP funding. **Questions for pts to consider in deciding:** -How will I use genetic screening information? -How would I feel about a surprise abnormality? -Publicly funded or private pay? **Timing of results:** Publicly funded SIPS results could be available as early as 15th wk. NIPT result could be available as early as 11th wk Read more about genetic screening	SIPS requisition: pdf (MSP funded test) OSCAR Profile Private pay NIPT Forms: -NIPT Private- Lifelabs Panorama ($495) -NIPT Private- Dynacare Harmony ($550) -Genetic Screening - Overview Multilingual -Genetic Screening - Publicly Funded & Private Options (PSBC) Send bundle of both
	Thalassemia screening (Once in a lifetime, EXCEPT those who are Northern European Caucasian, Japanese, Korean, First Nations or Inuit)	
	Make an effort to copy labs to the maternity provider or clinic that will be seeing patient	
Imaging Time Sensitive	**Dating Ultrasound to be done @ 11-13wks6d** Consider adding Nuchal Translucency if patient > age 35 Possible exceptions for early US READ MORE	-Ultrasound Clinics in your Area -Sites offering Publicly Funded NT
	Detailed Ultrasound @ 18 – 22 weeks With delays in access to maternity clinics, book early	
Patient Information Vitamins, Diet & Exercise	•**Folic Acid:** Avg low risk: 0.4 mg/day Mod Risk: 1mg/day DM, antiepileptic, MTX, malabsorption High Risk: prior Spina Bifida 4mg/ per day •**Vitamin D:** 600 IU/day total in diet + supp, 800 IU/day if risk factors or north of 55° latitude	Folic Acid - Preconception and Pregnancy (SOGC)
	Provide General Information about Pregnancy and Diet & Exercise See more patient info	-Baby's Best Chance - Multilingual -Pregnancy and Parent Learning Centre (Perinatal Services BC) **Send a bundle of 2**
ASA?	If high risk - consider Low Dose ASA (81-162 mg/day) + Calc 1000 mg/day. Start @11-16wks	See details below
Progesterone?	If high risk for preterm birth consider intravaginal Progesterone. Start @16-24 wks	See details below

When to start ASA in pregnancy to reduce risk of preeclampsia

Please see guideline below. Aspirin should be started between 11 to 16 weeks gestational age (however can be started up to 24 weeks). Aspirin should be continued until 36 weeks gestational age.

≥ 1 High Risk Factor	≥ 2 Moderate Risk Factors	≥1 Abnormal Maternal Serum Analyte	
-Hx of preeclampsia especially with adverse outcome -Multi-fetal gestation -Chronic hypertension -Pregestational DM type 1 or 2 -Kidney disease -Autoimmune disease eg. SLE, antiposphylid syndrome	-Nulliparity -maternal age over 35 -BMI > 30 -In vitro conception -FHx preeclampsia (mother, birth parent, sister) -Low income, social vulnerability -PMHx eg. *LBW, *SGA, previous adverse preg outcome, >10 yr preg interval	PAPP-A	≤0.15 MoM
		uE3	≤0.40 MoM
		AFP	≥2.5 MoM
		hCG	≥4.0 MoM
		Inhibin A	≥3.0 MoM

Recommendations

- Start ASA 81 to 162 mg QHS between 11 to 16 weeks gestational age
- Start calcium 1 g per day if daily intake is less than 600 mg per day

*LBW= low birth weight SGA = small for gestational age

When to use intravaginal progesterone to reduce risk of preterm birth

Who
- History of previous spontaneous preterm birth or
- Short cervical length ≤25 mm by trans vaginal ultrasound between 16 and 24 weeks

When
- Start from 16 to 24 weeks depending on when the risk factor is identified
- End between 34 to 36 weeks

How much
- Vaginal micronized progesterone in a daily dose of 200 mg

Read more: Pregnancy - Prevention of Preterm Birth Guidelines (SOGC)

Assess Social Risk Factors Including Poverty and Substance Use

Social Risk Factor Assessment: Poverty Intervention Tool - BC
- Consider referral to Enhanced Services for Socially Vulnerable in Pregnancy
- Send Info to patient about HA Prenatal Support Services:
  FHA Best Beginnings | VIHA Right From the Start | IHA Healthy From The Start | NH Healthy Start | VCH Vulnerable Prenatal Support

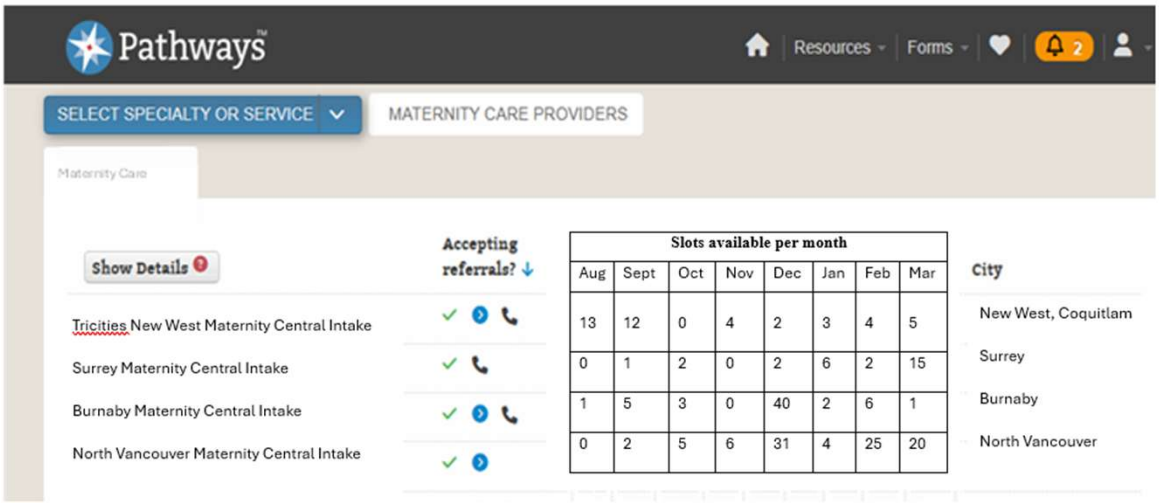
Ask About Alcohol and Substance Use

Alcohol Use in Pregnancy - TWEAK Questions | CAGE Questions Adapted + Drug Use (CAGE-AID)

Pathways
www.pathwaysbc.ca

Conceptual Unified Provider Experience

Supporting Slot Based Availability



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THANK YOU!

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