Primary Care Network

Central Okanagan

Nurse Coordinator Handbook

Date Created: May 2021
Last Edited: April 2022

Table of Contents

Acknowledgements

We want to acknowledge our place of work is within

the ancestral, traditional, and unceded territory

of the Syilx (Okanagan) Nation.

We also acknowledge the Métis Nation and

their contribution to the Aboriginal Way of

being and knowing in Canada.

In addition, a special thanks goes to all teams that dedicated their time to this program.

Family Practice Clinics and Staff

Nurse Practitioners (NP)

Patient Partners

Central Okanagan Division of Family Practice (CODFP)

Interior Health (IH)

Westbank First Nation (WFN) / stqaʔtxwɬn'íwt sqilxw

Ministry of Health – Primary Care Division (MoH)

General Practice Services Committee (GPSC)

Program Introduction

This handbook has been created to aid in the standardization of the Onboarding Process of the Nurse Coordinator.

The Central Okanagan Division of Family Practice will be working with the Interior Health Authority, and Family Practice Clinics to introduce the following resources to create Primary Care Networks (PCN) by the fall of 2024:

- 37 Nurse Coordinators
- 4 Family Practitioners
- 7.8 Nurse Practitioners
- 19 Allied Health Clinicians
- 3 Clinical Pharmacists
- 3 Indigenous Health Coordinators

Central Okanagan has been divided into three PCNs and each network also operates with a 'Hub".

- PCN-1: Kelowna Central
- PCN-2: Rutland/Lake Country
- PCN-3: West Kelowna/Peachland

Allied Health (AH) staff will support Team-Based Care (TBC) from the HUBs in PCN 1, 2, and 3. Team-Based Care HUBs will provide access to an expanded multi-disciplinary team to build capacity within the Patient Medial Home (PMH).

Patients attached to participating Family Practice PCN clinics in the Central Okanagan will have access to a wide network of primary care support through TBC HUBs.

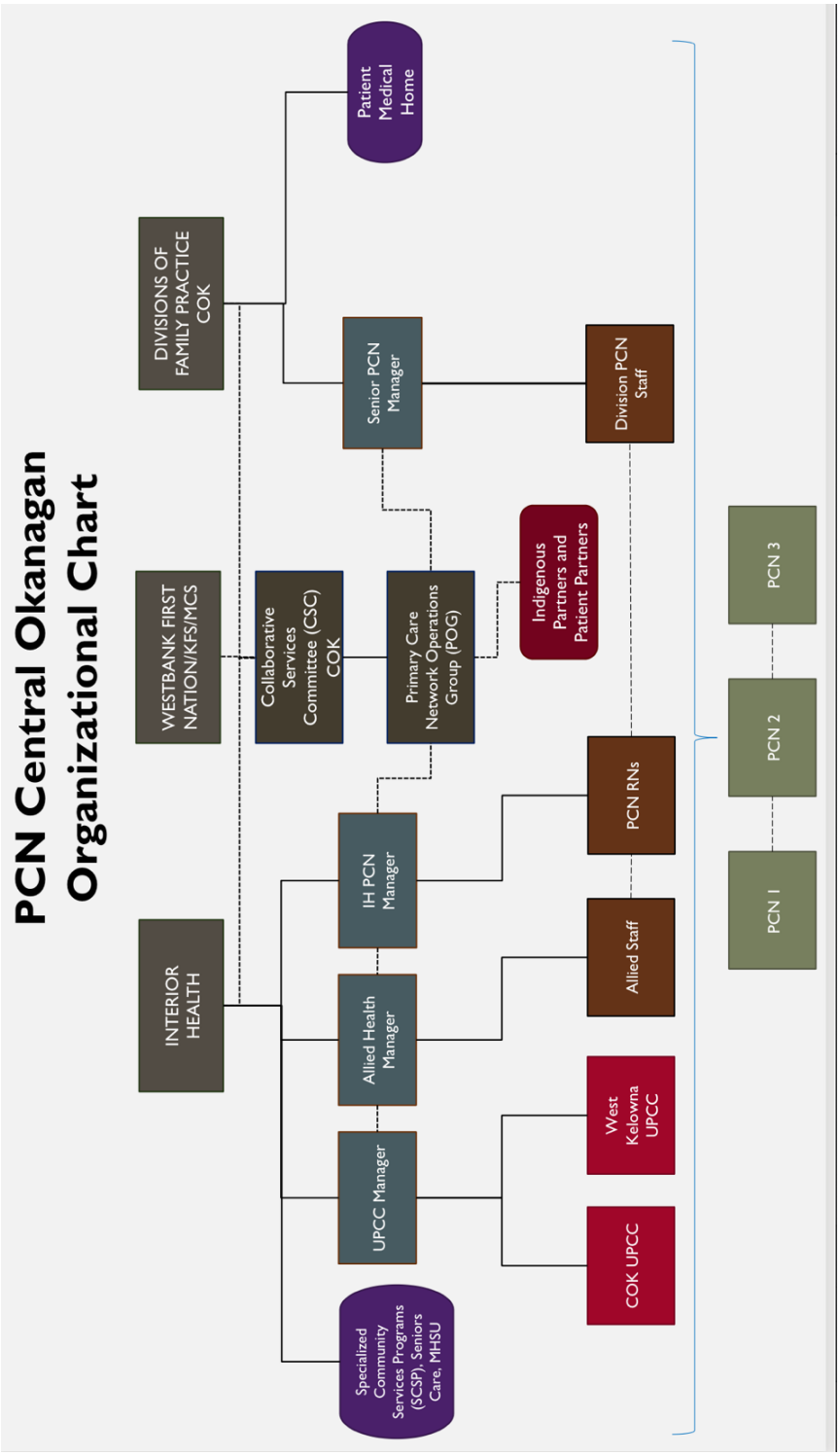
Central Okanagan Division of Family Practice (CODFP)

- Incorporated on July 23, 2010
- The Division of Family Practice membership consists of 295 physicians working in approximately 60 clinics
- Includes family physicians from Kelowna, West Kelowna, Lake Country, and Peachland
- Governed by a board of directors, consisting of nine family physicians.
- Day to day operations are led by the Board Physician Lead and the Executive Director, supported by CODFP staff

8 Core Attributes of the PCN

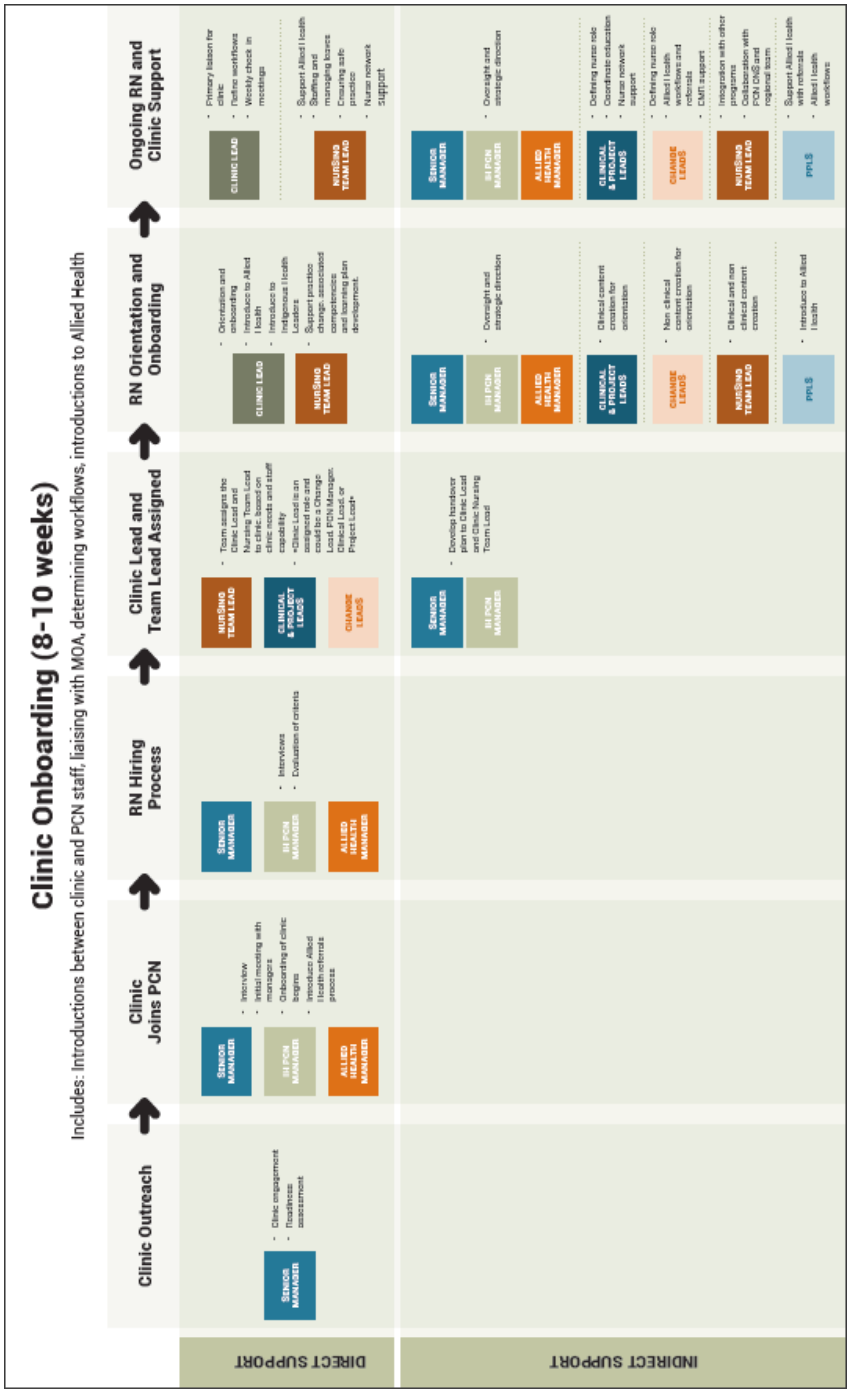
- Access and attachment to quality primary care
- Extended hours
- Same day access to urgent care
- Advice & information
- Comprehensive primary care
- Culturally safe care
- Coordinated care
- Clear communication

COK PCN Organizational Chart



Nurse Coordinator Onboarding Overview

This is a high-level overview of what the process is when a clinic joins the PCN.



Nurse Coordinator Clinic Skills Checklist

Nurse Coordinator Skills Checklist

To be completed by all Clinic providers prior to RN recruitment

Nurse Coordinator Role
Overview
Supports the patient with a team-based approach in the family practice setting. Supports the patient along the continuum of maintaining health, improving health, and living with illness to the end of life. This involves ○ health promotion and disease prevention ○ self-management of chronic disease ○ care planning ○ assessing patient knowledge and providing education ○ direct care skills and procedures ○ collaboration with primary care providers, MOAs, and the full PCN clinical support team (social worker, dietitian, occupational therapist, pharmacist, physiotherapist, psychologist, Indigenous health coordinators, off site hub nurse) ○ navigation of community resources and specialized community programs The Nurse Coordinator works as a team member within the clinic and strives to embed themselves into the clinic culture to support the patient and care team. The NC will start with a skillset that will build over time in response to the clinic, program, and professional development goals with the support of PCN leadership, the knowledge coordinator and peers.

Note: Items with checkmarks are an expectation of every NC in clinics	
Nurse Coordinator Skills *(For the full scope of practice of a Registered Nurse, please review the MoH RN Scope of Practice Document)* *https://www.bccnm.ca/Documents/standards_practice/rn/RN_ScopeofPractice.pdf*	Check which skills you would like the Nurse Coordinator to perform And put a *next any top priorities
Intake and Assessments	
Panel review and follow up	
New patient intake / health history/ chart review and prep	
Physical assessment/biometrics pre/post physician visit	
Specimen collection	
Point of care testing (glucose, pregnancy, urinalysis)	
Medication review, reconciliation, education	
Screening assessments: mental health, pain, cognitive (ie., MMSE, MoCA, PHQ-9)	
Lower limb/ foot assessment / education	
Assistance with driver's medical exam report	
Health promotion / prevention/disease management / follow up	
Screening with Lifetime Prevention Schedule Guide	
Immunization education / Vaccine administration	
Flu Clinic*	
Assist with complex care visit (pre or post / documentation)	

PCN Leadership/Orientation/Nurse Coordinator Orientation

Created Date: February 2022
Last Edited Date: 12-Dec-22

Nurse Coordinator Skills Checklist

Chronic disease care planning and follow up using clinical practice guidelines (i.e., COPD, diabetes, CKD, cardiac, frailty, obesity, mental health and substance use, high risk)	√
Coaching /education/ goal setting for health maintenance, risk factors, symptom management, lifestyle changes	√
Complete consults, laboratory requisitions, diagnostic imaging requisitions with patient specific order.	
Mental health adult and youth support and care coordination	
Coordination and referrals to PCN allied health clinicians	√
Coordination and referrals to specialized community programs (ie., MHSU, H&CC, SH&W)	√
Assistance with forms: Special authority, Disability Tax Credit, Long Term Disability forms (in collaboration with other professions)	
Pelvic Exam/STI assessment and testing *	
Contraceptive management *	
Medication adjustment with patient specific orders (i.e., INR, insulin)	
Post-hospital discharge/ED visit follow-up	√
Support transitions in care (ie., movement into AL or LTC)	
Advanced Care Planning/MOST/DNR	
Serious illness conversation and support *	
Palliative care support and coordination	
MAID education and support *	
Direct care treatment / interventions	
Ear irrigation*	
Simple skin and wound care / wound care referrals	
Complex skin and wound care (i.e., debridement)*	
Cryotherapy*	
Suture and staple removal	
ABPI (ankle brachial pressure index)*	
Medication administration / injections (ie., B12, birth control, hormone replacement)	
Obstetric Care	
New mom and well-baby assessment*	
Obstetric and maternity care*	
Other	
Long Term Care visits*	
Home visits*	
Other	

*Denote skills that require extra training or special consideration.

PCN Leadership/Orientation/Nurse Coordinator Orientation

Created Date: February 2022
Last Edited Date: 12-Dec-22

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Primary Health Care Nurse Duties and Responsibilities

Interior Health
PRIMARY CARE

Registered Nurse (RN)

Role of the Registered Nurse

Registered Nurses (RN) provide holistic, person centered, and culturally appropriate care along a continuum. They work within a team based environment, to help patients navigate through the health care system and access resources. Registered Nurses provide education and support directed at health promotion, disease prevention and management of chronic conditions.

Education and Registration

- Graduation from an approved School of Nursing with current practicing registration with the British Columbia College of Nurses and Midwives (BCCNM)
- Advance clinical skills training in the assigned practice area.

What can RNs do in Primary Care?

Within a Primary Care Network, Registered Nurses initiate, implement, and monitor health care plans in collaboration with the patient, physician and other members of the interdisciplinary team throughout the lifespan to optimize wellness. Through the Registered Nurses knowledge of community based resources, some functions may be better delivered with referrals to existing IH Specialized Community Service Programs. The list is meant to be illustrative and should not be considered exhaustive.

- Completes documentation, accurate statistical data and reports in a timely manner
- Participates in relevant meetings, committees, and network groups
- Seeks professional development opportunities consistent with current primary care practice, new and emerging issues, changing needs of patient population, and research
- Maintains and applies evidence-based knowledge to the nursing process
- Uses research findings and evidence to guide the delivery of services
- Recognizes personal attitudes, beliefs, feelings and values about health in their interactions with patients and their families
- Establishes and maintains effective professional relationships and partnerships with other organizations to benefit system integration, efficient service utilization, effective collaboration and optimal patient care.
- Follows the four levels of control on practice.
    - Regulation and legislation
    - BCCNM standards, limits & conditions
    - Organizational policies
    - Individual nurse competence

Resources

- Pathways (Includes BC Guidelines and BC Lifetime Prevention Schedule)
- Clinical Care Resources - Primary Care
- Elsevier
- Learning Plan – IH Professional Development (Learning) Plan
- Up to Date

Staying Healthy	**Indirect Care** • Health promotion and disease prevention strategies in collaboration with communities and interdisciplinary team members • Education and communication strategies to address health topics (e.g. Individual and group education, written, verbal, visual)

Created August 17, 2022 | Tannis Andersen; Tasha Kanigan; Natasha Goldsbury

Interior Health
PRIMARY CARE

	Direct Care • Health care planning in collaboration with patient and interdisciplinary team • Assess immunization status and provide or refer for immunization *(additional education)* • Care coordination and health care navigation support (community resources/referrals, PCN resources (regional resources) • Plan and participate in strategy to recall patients across the lifespan for monitoring and screening, using the British Columbia Governments Lifetime Prevention Schedule, British Columbia Governments Clinical Practice Guidelineselines, and best evidence based practice guidelines for chronic disease management • Reproductive and sexual health promotion through assessment, education and/or counselling (*additional education*) • Assess patients current knowledge, education, literacy levels, social supports, learning preferences and other factors that may affect the educational approach and plan • Provide patient-centered education related but not limited to healthy living, medications, chronic disease management, care and treatment • Document completion (eg: life insurance, workplace accommodation, extended health benefits, driver's medical fitness)
Getting Better	**Indirect Care** • Collaborate with primary care provider or most appropriate member of the health care team (eg: discharge follow up, community care) • Match community resources with patient needs and facilitates access to services in a timely and supportive manner • Gather appropriate information and prep charts for appointments – consults, labs, imaging and flag abnormal results • Complete consults and referrals (eg: laboratory requisitions, diagnostic imaging requisitions, and completed as per guideline care with patient specific order) • Provide additional supports, education, appointments for higher risk patients • Complete necessary documentation to access medications or treatments that are exception to BC Pharmacare formulary **Direct Care** • Bladder scans (post residual void/assess urine retention) • Simple/superficial skin and wound care (eg: skin tears, suture or staple removal, drain removal, peripheral line removal • Ear syringing • Adult immunizations (*additional education*) • Injections (e.g. B12, birth control) • Cryotherapy (*additional education*) • Pelvic exams, annual exams, cervical cancer screening (*additional education*) • Sexually transmitted infections (*certified practice*) community needs • Contraceptive management (*certified practice*) community needs • Epistaxis treatment • Point of care testing (glucose, pregnancy, urinalysis screening) • Insulin dose adjustments (*advanced education*) community needs • Assessment for pain, cognition, drug toxicity, chronic diseases, mental health etc.
Living with Illness and Disability	**Indirect Care** Collaborate and liaise with: • Specialized Community Service Programs (SCSPs) like MSHU, Complex Medical with/without Frailty (CMF) and Acute Care • Primary Care Provider and Home and Community Care (CMF SCSPs) for home bound patients to coordinate services. • Providers to support patients in long-term care or assisted living

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Interior Health
PRIMARY CARE

	Direct Care
	• Identify and support patients with complex health conditions
	  ○ Chronic diseases
	  ○ Frailty
	  ○ Obesity
	  ○ Mental health and substance use
	  ○ High risk
	• Support illness management following clinical practice guidelines and evidence based practices
	• Complete regular medication reconciliation
	• Counsel patients on drug therapies, side-effects, and interactions
	• Counsel and guide patients on symptom management, health maintenance and rehabilitation strategies, as well as risk factors and lifestyle changes
	• Document completion support
	• Information gathering, symptom review, treatment review, chart review
	• Disability Tax Credit, Long Term Disability forms (in collaboration with other professions)
	• Teach and coach patients to participate and manage their own care (eg: education strategies and Motivational Interviewing skills to support behavioral change)

Optimizing End of Life	**Direct Care**
	• Support advanced care planning conversations for patient and family/caregivers through assessment and support in completion of:
	  ○ MOST
	  ○ DNR
	• Support patients through life transitions including palliation and death (eg: referrals to palliative care supports, navigation through palliative care benefits
	• Assist with pain and symptom management
	• Assist primary care providers as appropriate with Medical Assistance in Dying support for patient and supports

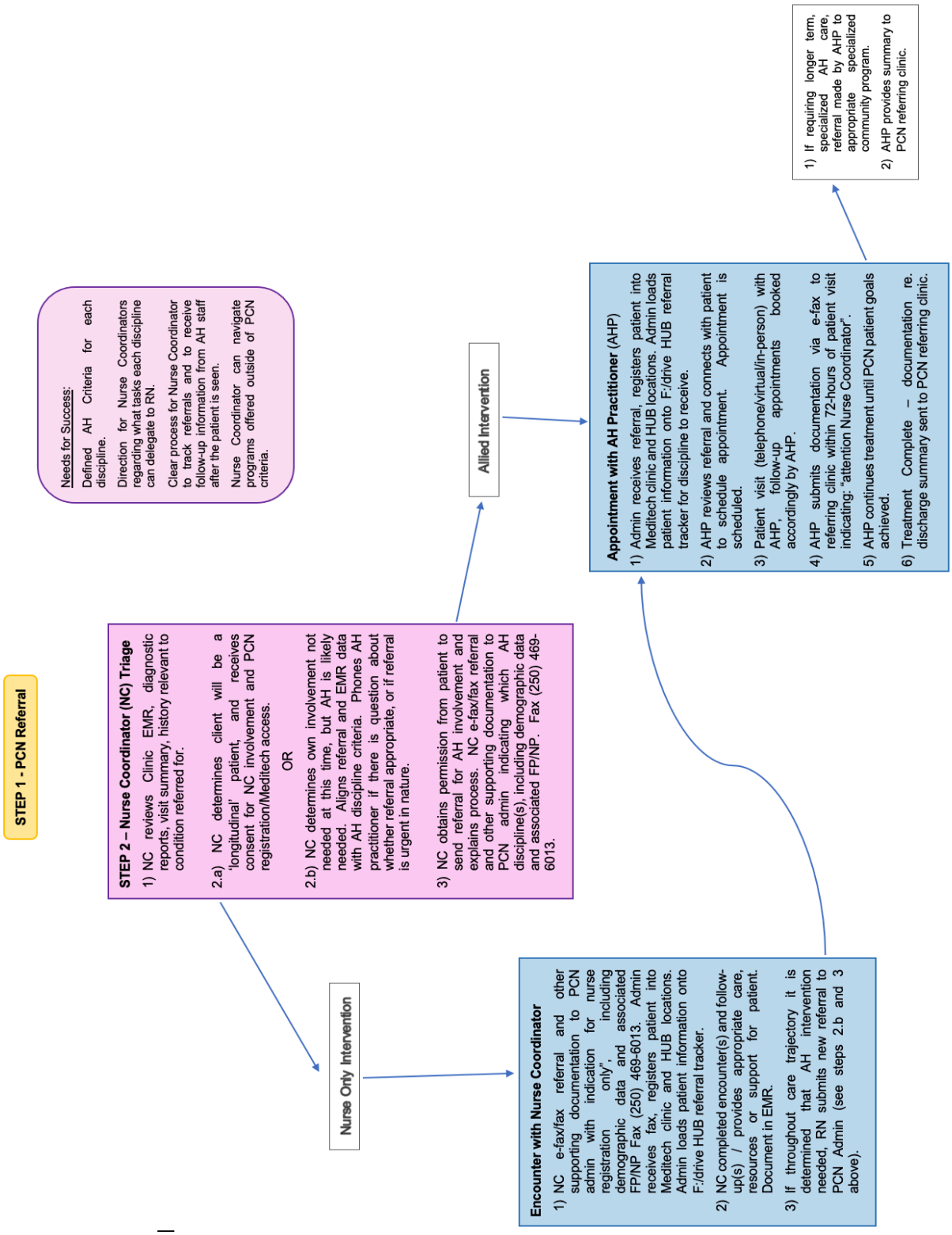
References

Canadian Family Practice Nurses Association. *Sample Role Description for Registered Nurse in Family Practice For Adaptation to your Primary Care Practice.* https://cna-aiic.ca/-/media/nurseone/files/en/sample_role_description_e.pdf?la=en&hash=07386589D135746C0C31D120BD893D998B84D8C9 . August 14, 2019

BCCNP (2019). *Scope of Practice for Registered Nurses.* https://www.bccnp.ca/Standards/RN_NP/StandardResources/RN_ScopeofPractice.pdf

Created August 17, 2022 | Tannis Andersen; Tasha Kanigan; Natasha Goldsbury

Allied Health Referral Workflow Diagram



Central Okanagan PCN
Primary Care Clinical Pharmacists

Primary Care Clinical Pharmacists (PCCPs) provide comprehensive medication management services focused on the on-going care of adult patients with complex conditions to prevent and resolve medication-related problems. PCCPs also provide education to patients about their medications and address barriers to adherence. PCCPs collaborate with the patient and healthcare team to implement treatment plans.

Refer complex patients:

- **Multiple** drug therapies or health conditions
- Optimize drug therapy for **chronic diseases**
- **Polypharmacy** concerns
- Medication **allergies or adverse reactions**
- **Sub-optimal** drug therapy outcomes
- Complexities from **self-treatment** including **supplements**
- Any medical **complexity, issues or concerns**

Refer patients experiencing change:

- **Starting** or **stopping** medications
- Recent **discharge** from hospital
- Recent **attachment** to a new provider
- Complex or **costly** drug therapies

Patients benefit from:

- Extra 1:1 time with a clinician (Initial appointments are 60 minutes)
- Support identifying and prioritizing drug therapy problems
- Addressing learning goals and obstacles to optimal medication use

Providers benefit from:

- Information about best and alternative treatment options
- Increased capacity to care for their patient panel with this added support for patients who need extra time

MSP Billing Notes:

An appointment with the PCCP fulfills the obligation for an Annual Medication Review for the Complex Care Fee, **PG14033**.

The PCCP can complete 1 of 2 mandatory in-person visits for Chronic Disease Management fees: **PG14050 , PG14051, PG14052, PG14053.**

Time spent case conferencing with the PCCP can be billed under **PG14067 or PG14077.**

For more information, please review the GPSC Billing Guides:
https://gpscbc.ca/what-we-do/incentives/fees

How Do I Submit A PCCP Referral?

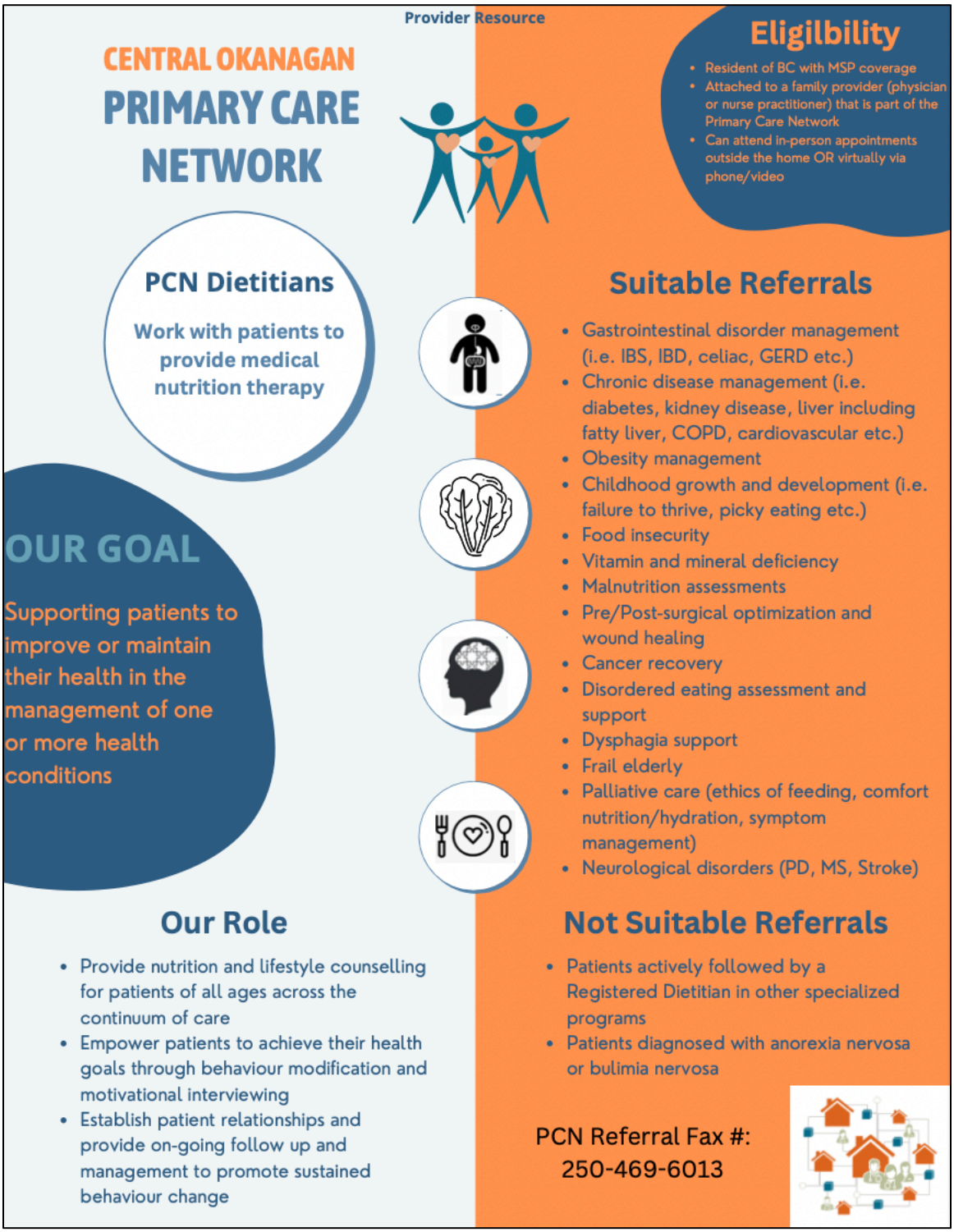
Please submit a referral for PCCP consultation services through the
Central Okanagan PCN Referral Intake Fax: 250-469-6013

The following patient information is required to process the referral:

- Patient's first and last name
- PHN
- Sex
- Date of birth
- Phone number
- Address
- Reason for referral and referral source
- Medical clinic summary, if available
- Any special requirements for patient consultation (translation services, accessibility considerations, etc.)

THE UNIVERSITY OF BRITISH COLUMBIA
Pharmacists in PCN Program
Faculty of Pharmaceutical Sciences

Registered Dietitian Provider Resource



Occupational Therapist Provider Resource

Physiotherapist Provider Resource

Social Worker Provider Resource

Perinatal Social Worker Provider Resource


CENTRAL OKANAGAN
PRIMARY CARE NETWORK
Clinic Nurse Coordinators
Work alongside family physicians and nurse practitioners to support patient care.
Our Goal
To offer patient-centred, culturally sensitive health care that complements your family practice.
Our Role
To provide ongoing, individualized care planning and coordination to support patients in their health journey across the life-span.
We provide
Connections and referrals to other members of the PCN team as well as services and programs in the community
System and resource navigation
Health promotion and preventative screening
Chronic disease and self-management support
Individual and group education
Screening assessments (eg. MMSE, MoCA, PHQ-9, GAD-7, etc)
Therapeutic interventions (eg. ear irrigations, basic wound care, routine immunizations, etc)
Care coordination for patients living with complex conditions (eg. frailty, chronic pain, mental health, addiction, etc)
Limitations
Must practice within the BCCNM standards, Interior Health safety policies and individual nurse competency.

Indigenous Health Coordinator Provider Resource

Indigenous Health Coordinator Referral Guidelines

Information to include in a referral to the Primary Care Network

Indigenous Health and Wellness Coordinators

CLIENT INFORMATION

- Use patient demographics on clinics own consult form in the EMR
- Status, Non-status, Metis

PROVIDER INFORMATION

- Date of referral
- Referring care provider
- Contact recommendations (client or alternate)
- Relationship to client

REFERRAL INFORMATION & ORDERS

- Primary Reason for Referral (client's needs/goals):
- Secondary Reason for Referral
- Services Requested (i.e., diabetes services, support with an appointment, etc.) & comments:

Please submit your request via the Indigenous Health Coordinator's fax number listed in the **PCN Contact List**

- Ki-Low-Na Friendship Society (Fax): **(250) 861-5514**
- Métis Community Services Society of BC (Fax): **(250) 765-0447**
- Westbank First Nation (Fax): **(236)582-2000**

Last edited December 21, 2022

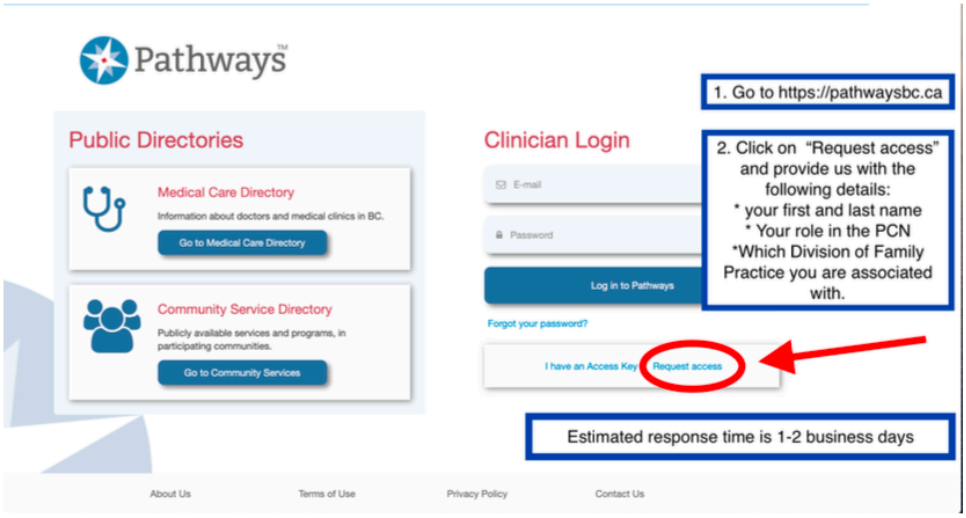
Introduction to Pathways for PCN Users

PATHWAYS ACCESS

Who is authorized to use Pathways?
Authorized users are limited to:

- Members of a Division of Family Practice. Typically, Division members include Family Practitioners, Hospitalists, and ER physicians. In addition, locums and medical students working in a Division member's office, as well as medical residents, are also authorized to use Pathways during their period of employment.
- Office staff (e.g. medical office assistant) working in the offices of Division members who use Pathways.
- Nurse practitioners and midwives are also eligible to use Pathways, though will be charged an annual fee if they require full access to specialist profiles.
- Specialists, specialty clinics (that have a physician attached), and their staff who are located within the geographic boundaries of Divisions that have launched Pathways.
- Pathways Administrators and other Division or Provincial Pathways staff who support or have a need to access Pathways, either on a permanent or temporary basis.
- PCN team members approved by the Divisions of Family Practice

How to request PCN access key
If you are a Primary Care Network Allied Care Provider and you would like access to Pathways follow the steps outlined below.



Pathways
www.pathwaysbc.ca

Community Service Partner Organizations
If you are a community service partner organization and would like access to Pathways please contact Erin Obi at eobi@pathwaysbc.ca. Please provide your first and last name along with your role and the organization you work for.

Creating PCN Listings

The local Division Pathways Administrator can work with their Division to create a listing for the local PCN in Pathways under the "PCN Allied Supports" specialty. This specialty will remain hidden to Pathways users until the Division has added content for their users.

If your Division is interested in adding local PCN information to Pathways and would like some assistance in navigating this, contact the Provincial Administrative Coordinator, Melissa Faraguna, at mfaraguna@pathwaysbc.ca.

Pathways Training

PCN Pathways Training Recording
CLICK HERE to watch a previously recorded PCN Pathways demo. Running time for this video is 51 minutes.

Index
0:01 – Introduction and history of Pathways
8:00 – Review the Pathways homepage and news banners
9:30 – Flu shot clinics/Immunize BC
10:07 – how to email content to patients
13:30 – describing PCN user access
16:50 – selecting favourite resources
21:25 – finding clinical tools (physician resources)
24:25 – using the search bar
28:05 – review Community and Health Authority Services
29:10 – how to provide feedback
32:55 – finding PCN services
34:55 – Q&A

Other Video Resources
Once logged into Pathways, you can also access a suite of training videos, including those that further explain how to search through resources and how to navigate community services.

Pathways Webinars
Pathways webinar for physicians and their teams on March 4th from 6:30 PM - 8:00 PM. We will review Pathways tools to help streamline workflow, including the topic areas of gastroenterology and mental health.

Feedback from our last webinar: *"The Pathways presentation was amazing! I never realized how powerful the platform is, with a huge collection of patient resources and community resources. The email to patients function is so helpful! This changed my practice.*

Pathways
www.pathwaysbc.ca

BENEFITS OF PATHWAYS FOR PRIMARY CARE NETWORKS

1. **Communication to physicians about PCN resources available**.
    a. Pathways is a highly used, highly visible resource.
        - Pathways has over 3 million page views per year.
        - Physicians are already using Pathways every day, opening it each morning along with their EMR.
        - Divisions can list their PCN services in a newly created specialty area in Pathways called PCN Allied Supports.

    b. Pathways makes PCN information usable to clinicians at point of care.
        - While Division newsletters, websites, emails, etc. are important communication vehicles, emails are quickly forgotten.
        - Posting information in a location where it persists allows it to then be quickly and easily searchable by physicians when they need it.

2. **Clinical tools**
    a. Physician resources
        - Scale and scoring tools, shared decision tools, and guidelines.

    b. Patient information
        - Includes handouts, websites, and videos.
        - These resources are emailable to patients from a 'no reply' address, and multiple resources can be bundled.
        - Useful for patient navigators and clinicians.

    c. Care pathways
        - Care pathways include embedded links to increase efficiency of clinical work for physicians and their teams.
        - The collaborative nature of PCNs are ideal for creating and documenting care pathways. These documents can then live inside Pathways so they can be easily found and used in future.
        - Accountable owners can be assigned for each care pathway so the information always stays up to date.

Pathways
www.pathwaysbc.ca

3. **Community service and health authority programs**
    a. For PCN clinicians
        - Pathways offers a highly structured and easily searchable database of services and programs. Results can be filtered by the modality of accessing services, language, topic, and others.
        - Helps PCN patient navigators and educators to find services.
        - Helps clinicians quickly search for programs and services to meet specific patient needs.
        - Clinicians can create, in seconds, a customized compilation of services and/or resources tailor made for their patient (i.e. low-cost counselling, after-hours care).

4. **Public Pathways Medical Care Directory**

    This new one-stop online directory (www.pathwaysmedicalcaare.ca) has been created for British Columbians to easily find up-to-date information on how their doctor is providing virtual and in-person care, how to book an appointment, and view other services their doctor may offer.

    The directory also provides information for patients who do not have a doctor, indicating how to access care in any area of the province. It describes how local clinics may be providing services in-person, by video, or by telephone, and includes links to local attachment registries where they exist.

Pathways
www.pathwaysbc.ca

Reference Documents

Patient Card Guidelines

Patient Card Sample

Health goals:

Primary Care Network

Patient Card

"For non-emergency health situations, always call your family practitioner or PCN team member first."

Patient name:

Patient medical home (clinic) & contact #:

Family provider:

Family/support person:

Nurse coordinator Name:

Nurse coordinator contact #:

Other PCN Team Members:

Other medical and community supports:

Next appointment time:

PURPOSE OF THE PCN PATIENT CARDS:

- This card is a physical reminder for the patient to present to their health care team and support system within the Primary Care Network and use for their own reference. It is designed to highlight healthcare team members involved in their care, in addition to their current healthcare goals. It is intended to keep things as simple and as clear as possible.

INSTRUCTIONS FOR NURSE COORDINATORS:

- **Script to Patients**
- "Hi my name is _____ and I am an RN that works with your family physician/NP. We are part of a Primary Care Network that gives patients access to a team of health professionals as needed. This card can help you keep track of your team (with me as your coordinator), and it helps us know who the members of your team are. This includes family or other supports that are important to you."

INSTRUCTIONS FOR ALLIED HEALTH CLINICIANS:

*Allied Health Team members may include: Social worker, Physiotherapist, Pharmacist, Dietitian, Occupational Therapist, Psychologist, or Indigenous Health and Wellness Coordinators

- **Script to patients** "I am part of the Primary Care Network and work with your clinic and RN coordinator _____."
- When completing their involvement, the AH clinician would encourage the patient to reach out to the clinic and/or RN coordinator if they need AH referral again.

Allied Health Phone Numbers May be added if clinician/ Health Coordinator or AH clinician deems it is appropriate for the patient to have their direct number.

OTHER INFORMATION:

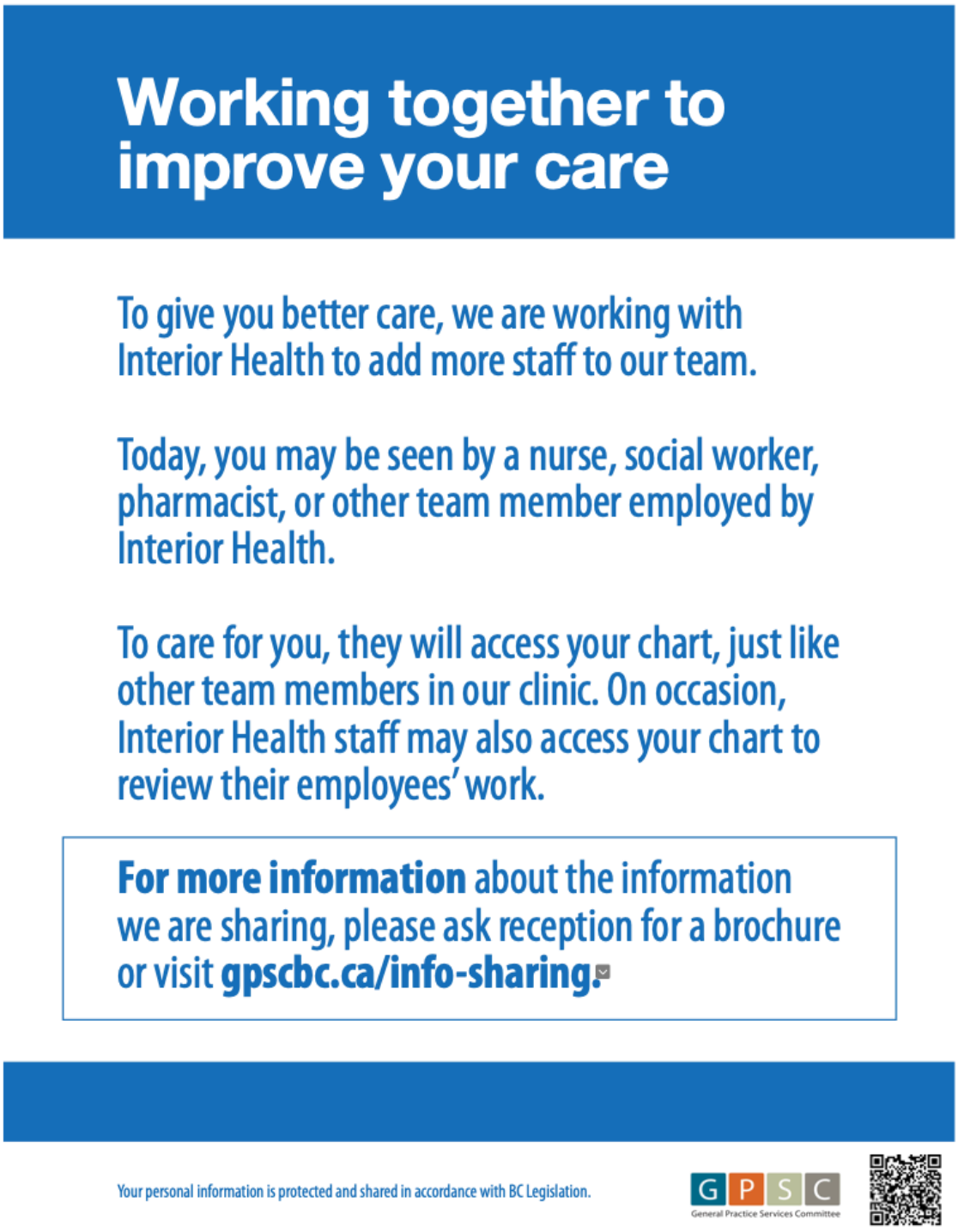
- **Who is considered 'Other IH or Community Supports'?**
    - Case manager, community support worker, life skills worker, family, close friend involved in care.
- **How to communicate access and communication around this card**
    - The card is to give you the names of your care team and keep things simple. Not everyone has the same schedules and availability.
- **What if the card is outdated?**
    - The team can change but typically the Patient Medical Home will not change. The nurse coordinator can make a new card at any time

NOTE: If the patient card is too small there is an online version available to print

January 5, 2022

Sample Poster for the Clinic

Clinics will be provided two copies of this poster to display in their clinic to inform patients that their care team has expanded to include Interior Health clinicians.



Most Common ICD-9 Codes

Chronic Condition	Codes
Hypertension	401
Heart Failure	428
Diabetes	250
COPD	491, 492, 494, 496
Chronic Non-Cancer Pain	338.4
Ischemic Heart Disease	410-414
Osteoarthritis	715
Dementia-Cognitive Impairment	290, 331.0
Ischemic Cerebrovascular Disease	433-436
Anxiety	300.0
Depression	296, 311
Alcohol Use Disorder	303
Drug Use Disorder	304
Chronic Kidney Disease	582, 585
Frailty	V15
Palliative/End of Life	V66

Most Common Encounter Codes used in 2021

- provided by Reichert and Associates

	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021
38130-38135 NIPCP CASE CONFERENCE/CASE MANAGEMENT/FAMILY CONFERENCE	505	545	646
38185-38186 NIPCP TELEPHONE CONSULTATION/FOLLOW UP	316	567	554
38160-38162 NIPCP INJECTIONS	43	94	404
38195 NIPCP VISIT - CHRONIC DISEASE MANAGEMENT	261	372	354
38010-38045 IMMUNIZATIONS	27	84	305
39080-38085 NIPCP VISIT - IN OFFICE VISIT	120	160	292
38184 NIPCP TELEPHONE CONTACT WITH PATIENT FAMILY/FRIEND	53	104	148
38117-38119 NIPCP PATIENT AND/OR BODY COMPOSITION ASSESSMENT	60	97	121
38071-39072 NIPCP REFERRAL TO IN-CLINIC TEAM MEMBER OR NON-HEALTH SERVICE PROVIDER	53	69	94
38180 NIPCP PHONE CONTACT WITH PROFESSIONAL CARE PROVIDER	57	52	90
38191-38192 NIPCP COUNSELING	30	82	79
38141-38155 NIPCP EDUCATION	66	56	61
38169-39170 NIPCP SUTURE/STAPLE REMOVAL/DRESSING CHANGE	77	77	56
38125 NIPCP COMPLETION OF FORMS, NO REIMBURSEMENT	42	78	43
38171 NIPCP ELECTROSURGERY/CRYOTHERAPY FOR REMOVAL/WARTS	</=5	9	42
38116 NIPCP ROUTINE HEALTH HISTORY - NEW PATIENT	</=5	9	36
38168 NIPCP SYRINGING - EAR	23	32	32
38175 NIPCP WOUND CARE	27	53	17
38073 NIPCP GP REFERRAL TO NURSE	24	17	15
38060-38062 AND 38064-38065 MEDICATION INTERVENTIONS, MONITORING AND INFORMATION*	25	12	12
38188 NIPCP TELEPHONE CALL (PHARMACY)*	</=5	9	9
38063 MEDICATION THERAPY COORDINATION*	</=5	6	</=5
38070 NIPCP REQUESTING ADVICE FROM AN NP/GP*	</=5	</=5	</=5
38174 NIPCP ASSISTING WITH PRODECURES*	9	</=5	</=5
38176 NIPCP INR MANAGEMENT*	6	0	</=5
38177 NIPCP ULTRASOUND - HANDHELD DEVICE*	0	</=5	</=5
38005 NIPCP LIFETIME PREVENTION SCREENING*	6	9	0
38123 NIPCP COMMUNICABLE DISEASE FOLLOW UP*	</=5	0	0
38165-38167 NIPCP GLUCOSE, PREGNANCY, URINE SCREENING*	</=5	</=5	0
38172 NIPCP FOOT CARE*	12	</=5	0

**In the data provided, categories that had 5 or fewer services billed/month were supressed. To enable data analysis, those values were replaced with the average between 1-5 services (i.e., 3 services) Therefore, any services denoted with a (*) include estimates of actual services provided.*

MSP Encounter Codes

RN/ LPN ENCOUNTER CODES	
FEE CODE	**TITLE**
IMMUNIZATIONS	
38010	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV
38011	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-IPV-HIB
38012	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD
38013	NIPCP IMMUNIZATION-PATIENT <19 YRS-TD/IPV
38014	NIPCP IMMUNIZATION-PATIENT <19 YRS-TDAP
38015	NIPCP IMMUNIZATION-PATIENT <19 YRS-INFLUENZA (FLU)
38016	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS A
38017	NIPCP IMMUNIZATION-PATIENT <19 YRS-HEPATITIS B
38018	NIPCP IMMUNIZATION-PATIENT <19 YRS-HIB
38019	NIPCP IMMUNIZATION-PATIENT <19 YRS-IPV
38020	NIPCP IMMUNIZATION-PATIENT <19 YRS-MEN-C
38021	NIPCP IMMUNIZATION-PATIENT <19 YRS-ACYW135
38022	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR
38023	NIPCP IMMUNIZATION-PATIENT <19 YRS-PCV13
38024	NIPCP IMMUNIZATION-PATIENT <19 YRS-PPV23
38025	NIPCP IMMUNIZATION-PATIENT <19 YRS-RABIES
38026	NIPCP IMMUNIZATION-PATIENT <19 YRS-VARICELLA
38027	NIPCP IMMUNIZATION-PATIENT <19 YRS-DTAP-HB-IPV-HIB
38028	NIPCP IMMUNIZATION-PATIENT <19 YRS-HPV
38029	NIPCP IMMUNIZATION-PATIENT <19 YRS-ROTAVIRUS
38030	NIPCP IMMUNIZATION-PATIENT <19 YRS-MMR/V
38035	NIPCP IMMUNIZATION-MMR -PATIENT >18 YEARS OF AGE
38038	NIPCP IMMUNIZATION-INFLUENZA- ADULTS WHO QUALIFY FOR FREE VACCINE
38041	NIPCP IMMUNIZATION-PNEUMOCOCCAL POLYSACCHARIDE (PPV23) For pts > 64 yrs of age or pts > 18 years of age whose health conditions qualify them for free vaccine or who reside in residential care or assisted living facilities. (pts < 19 yrs -bill 38024)
38042	NIPCP IMMUNIZATION HEPATITIS A - ADULTS AT RISK
38043	NIPCP IMMUNIZATION HEPATITIS B - ADULTS AT RISK
38044	NIPCP IMMUNIZATION-NOS (NOT OTHERWISE SPECIFIED) (includes oral polio vaccine, etc.)
38045	NIPCP CLIENT CONTACT FOR ADVERSE EVENT FOLLOWING IMMUNIZATION

FEE CODE	TITLE
MEDICATION	
38060	NIPCP MEDICATION USAGE INTERVENTIONS- The identification of a patient's drug related problems and recommendations for their resolution (ie. inappropriate dosing, drug level monitoring, drug interactions, treatment of adverse drug reactions)
38061	NIPCP MEDICATION WORK-UP - The completion of a patient's drug history during a structured interview and through chart and Pharmanet searches (upon obtaining patient consent)
38062	NIPCP MEDICATION THERAPY MONITORING-The regular monitoring of a patient's medication adherence and drug toxicity through structured interviews, especially for patients with complex medication regimens or patients that are confused, forgetful or less compliant about medications.
38063	NIPCP MEDICATION THERAPY COORDINATION - Liaising with community and hospital pharmacies in an effort to provide seamless care for a patient (i.e., coordinating refills, obtaining prescriptions, providing up to date information on the patient's current drug therapy, dispensing medication, obtaining approval for medications)
38064	NIPCP MEDICATION INFORMATION- Answering patient-specific medication information questions from health care professionals and patients (i.e., dosing, adverse effects, drug interactions, suggestions for therapy)
38065	NIPCP MEDICATION THERAPY COUNSELING-Counseling a patient on the appropriate use of the patient's medication(s), adverse effects, and monitoring via a structured interview (i.e., provision of drug information sheets, setting up weekly dosettes, setting up medication timers). **Claim must state start and end times**

FEE CODE	TITLE
VISIT	
38070	NIPCP REQUESTING ADVICE FROM AN NP/GP - Collaborate with team members to support nurses' assessment of patient care
38071	NIPCP REFERRAL TO IN-CLINIC TEAM MEMBER - Reviews assessment with GP/NP and queries action that is outside of scope of practice
38072	NIPCP REFERRAL TO NON-HEALTH SERVICE PROVIDER - Referral to community resources (e.g., any service provider that does not require an MSP referral)
38073	NIPCP - GP REFERRAL TO NURSE
38080	NIPCP VISIT - IN OFFICE (AGE 0-1) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38081	NIPCP VISIT - IN OFFICE (AGE 2-49) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38082	NIPCP VISIT - IN OFFICE (AGE 50-59) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38083	NIPCP VISIT - IN OFFICE (AGE 60-69) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT

38084	NIPCP VISIT - IN OFFICE (AGE 70-79) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38085	NIPCP VISIT - IN OFFICE (AGE 80+) Bill for routine visit unless it's for chronic disease than bill 38195 - VISIT CHRONIC DISEASE MANAGEMENT
38195	NIPCP VISIT - CHRONIC DISEASE MANAGEMENT A visit to review ongoing management of a chronic disease. Visit activities include: reviewing patient's care plan; patient's health outcomes; monitoring condition subsequent to an intervention; discussing continuing care strategies; discussing various management options, such as life style/self-care, psychotherapy, pharmacological management; etc. Activities performed in visit are generally brief discussions; however, if more elaborate discussion occurs, bill separate encounter code in addition visit encounter (e.g., education nutrition, medication therapy monitoring, etc.) **Claim must state start and end times.**
38116	NIPCP ROUTINE HEALTH HISTORY - NEW PATIENT-Recording the medical/social history of a new patient
38117	NIPCP BODY COMPOSITION ASSESSMENT-BIOELECTRICAL IMPEDANCE ANALYSIS AND/OR ANTHROPOMETRIC ASSESSMENT (MULTIPLE SITE SKINFOLDS AND CIRCUMFERENCES).
38119	NIPCP PATIENT ASSESSMENT Evaluation of a client's condition, problem or functional status to establish a nursing diagnosis and/or identify information to support a clinical diagnosis and/or identify treatment or rehabilitation measures and/or monitor a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc. **Claim must state start and end times.**
38120	NIPCP ROUTINE PELVIC EXAM INCLUDING PAP Routine pelvic examination including Papanicolaou smear.
38123	NIPCP COMMUNICABLE DISEASE FOLLOW UP Evaluation of a client's condition, related to a previously diagnosed communicable disease, and/or monitoring of a client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, coordinating care with other providers or agencies, etc.
38125	NIPCP COMPLETION OF FORMS, NO REIMBURSEMENT Completion of all relevant documentation/forms, where there is no reimbursement from third party or direct billing, required as a result of a specific incident, or to obtain client consent.
38130	NIPCP CASE CONFERENCE Meeting with members of the health care team, representatives of other agencies involved in the management of the client, to plan and coordinate activities and services and to share information necessary to meet the client's needs/goals and expected outcomes. **Claim must state start and end times.**
38131	NIPCP CASE MANAGEMENT Multiple telephone calls to develop a comprehensive service plan, link the client to the required services, coordinate and maintain links with resources/services/supports in the client's environment, and evaluate services provided. May include activities such as searching for the appropriate resources and negotiating with potential providers (eg. probation officers, child and family services, social assistance, education, housing etc.) Claim must state start and end times.
38135	NIPCP FAMILY CONFERENCE - A conference with the patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. The intervention includes activities such as goal setting and designing resources that are required (patient may or may not be present). **Claim must state start and end times.**

FEE CODE	TITLE
EDUCATION	
38140	NIPCP EDUCATION - GROUP **-** Bill to the PHN for each patient attending the group meeting. Start and end times should be listed for each PHN **Claim must state start and end times.**
38141	NIPCP EDUCATION - CHOLESTEROL **Claim must state start and end times.**
38142	NIPCP EDUCATION - INSULIN STARTS **Claim must state start and end times.**
38143	NIPCP EDUCATION - INHALER USE **Claim must state start and end times.**
38144	NIPCP EDUCATION - RELATED TO SPECIFIC DIAGNOSIS Information provided in a structured format, to enhance knowledge and skill that directly or indirectly assists the client/family to understand, monitor and manage their condition/impairment. Includes, where applicable, provision of educational material such as pamphlets, tapes, books and videos. **Claim must state start and end times.**
38145	NIPCP EDUCATION - HEALTH PROMOTION/DISEASE PREVENT Information provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy lifestyles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos (eg. exercise, nutrition, hygiene, STD education). **Claim must state start and end times.**
38146	NIPCP EDUCATION - FAMILY PLANNING Information about contraception provided in a structured format, to enhance knowledge and skill that directly or indirectly promotes health or influences changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos. **Claim must state start and end times.**
38147	NIPCP EDUCATION - SMOKING Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to smoking/tobacco use and their potential effect on health status, which could alter attitudes and in turn change/modify behaviour. **Claim must state start and end times.**
38148	NIPCP EDUCATION - SUBSTANCE ABUSE Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks due to drug use/abuse or alcohol consumption and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**
38150	NIPCP EDUCATION - PARENTING Information to improve parenting skills provided in a structured format, to enhance knowledge and skill that directly or indirectly promote health or influence changes in unhealthy life styles. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books, and videos. **Claim must state start and end times.**
38153	NIPCP EDUCATION - ENVIRONMENTAL ISSUES Therapeutic communication, provided to or on behalf of a client, to identify and evaluate, introduce and/or eliminate, reinforce and/or reduce certain attitudes on the part of the client regarding health risks related to environmental risk/injury and their potential effect on health status, which could alter attitudes and in turn change/modify behavior. **Claim must state start and end times.**
38155	NIPCP EDUCATION - NUTRITION Therapeutic communication, provided to or on behalf of a patient, to enhance knowledge and skill that directly or indirectly promote nutritional health status or influence changes in unhealthy lifestyles that impact on nutritional status for the specific patient. Includes, where applicable, provision of educational materials such as pamphlets, tapes, books and videos that pertain specifically to nutrition. **Claim must state start and end times.**

FEE CODE	TITLE
INJECTIONS	
38160	NIPCP INJECTION, INTRAMUSCULAR - Intramuscular medications.
38161	NIPCP INJECTION, VENEPUNCTURE - Venepuncture and dispatch of specimen to laboratory, when no other blood work performed.
38162	NIPCP MEDICATION INJECTION, SUBCUTANEOUS - Subcutaneous medication, including desensitization treatments

FEE CODE	TITLE
MISCELLANEOUS PROCEDURES	
38163	NIPCP MINI TRAY FEE
38165	NIPCP GLUCOSE - SEMIQUANTITATIVE (dipstick analyzed visually or by reflectance meter)
38166	NIPCP PREGNANCY TEST, IMMUNOLOGIC, URINE
38167	NIPCP URINALYSIS - SCREENING Urinalysis - Chemical or any part of (screening)
38168	NIPCP SYRINGING – EAR Irrigation of the external auditory meatus.
38169	NIPCP SUTURE/STAPLE REMOVAL Removal of sutures, staples, clips, etc.
38170	NIPCP DRESSING CHANGE Replacement of bandage/dressing.
38171	NIPCP ELECTROSURGERY/CRYOTHERAPY FOR REMOVAL/WARTS Forms of treatment other than excision, x-ray, or grenz ray; such as removal of haemangiomas and warts with electrosurgery, cryotherapy, etc. - per visit
38172	NIPCP FOOT CARE
38173	NIPCP SUTURING MINOR LACERATIONS
38174	NIPCP ASSISTING WITH PRODECURES
38175	NIPCP WOUND CARE Includes cleansing, irrigating, probing, debriding, packing and dressing a wound. It also includes suturing a laceration and changing dressings.
38176	NIPCP INR MANAGEMENT
38177	NIPCP ULTRASOUND - Handheld device
38005	NIPCP LIFETIME PREVENTION SCREENING Lifetime Prevention Screening includes initiating any of the clinical prevention services for specific patient groups as outlined in the Lifetime Prevention Schedule. Encounter is used for one or more intervention provided based on patient's demographics (e.g., age, sex).
38006	NIPCP PALLIATIVE/EOL CARE PLANNING

FEE CODE	TITLE
TELEPHONE	
38180	NIPCP PHONE CONTACT WITH PROFESSIONAL CARE PROVIDER Telephone contact to exchange information about a client between service providers, includes a verbal or written follow up communication with the Referring service provider (ag social worker, home care etc.)
38184	NIPCP TELEPHONE CONTACT WITH PATIENT FAMILY/FRIEND A single telephone call to patient's family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. This intervention includes activities such as goal setting and designing resources and services that are required.
38185	NIPCP TELEPHONE CONSULTATION
38186	NIPCP TELEPHONE FOLLOW-UP Telephone contact with a patient to monitor client's response to an existing treatment/rehabilitation plan. Also includes, where applicable, ordering diagnostic investigations, reviewing results, prescribing medications, counseling patient, etc.
38188	NIPCP TELEPHONE CALL (PHARMACY) Telephone call to initiate prescription or renew the directions and/or instructions for the preparation, dispensing, fabrication, or implementation of the pharmacological agents.

FEE CODE	TITLE
COUNSELING	
38191	NIPCP CRISIS COUNSELING Issue-or incident-specific counseling session with a patient, resulting from self, physician, health or non-health professional referral. **Claim must state start and end times**.
38192	NIPCP SHORT-TERM COUNSELING A counseling session with a patient resulting from self, physician, health or non-health professional referral. **Claim must state start and end times.**

Scenarios for Practice

Case Example Questions

Encounter Codes

Example 1:
A 69-year-old female patient has a visit booked for 1 hour: needing insulin review/follow up with additional diet support, has a lower leg wound that needs to be assessed and treated which ends up being infected and needing antibiotics.

What encounter codes would you consider using?

Example 2:
A 73-year-old female has a visit booked for 30 minutes: needing a B12 injection, inquiring about vaccines to ensure up to date, and recently had surgery on her wrist; would benefit from a physio referral for range of motion exercises as she isn't able to afford private services.

What encounter codes would you consider using?

Example 3:
A 50-year-old male has a visit booked for 1 hour: needing ears syringed due to wax accumulation. This patient is due for a blood pressure check the RN takes his BP and learns he isn't taking his medications, very stressed at home and work due to lack of stable housing, eating poorly and lack of exercise, interested in learning positive coping skills after teaching provided by RN about risk factors of hypertension. The patient is also interested in being referred to social work for housing options.

What encounter codes would you consider using?

Resource Navigation

Example 1:
A patient is new to new the community, needs support with immigration services, has a language barrier, needs a disability assistance form complete, needs food and is very low income, and also needs mild to moderate counselling.

What resources do you have easily accessible for you to use as you start to support this patient's case?

Answer Key for Scenarios for Practice

Example 1:
69-year-old female has a visit booked for 1 hour: needing insulin review/follow up with additional diet support, has a lower leg wound that needs to be assessed and treated which ends up being infected and needing antibiotics.

Answer:
38142- if reinforced how to give insulin
38144,38145,38195 (can bill 14029 for doctors too), 38155- depending on what education provided
38131-if referred to dietician
38071-referred to GP for antibiotics
38163, 38170, 38175-wound care

Example 2:
73-year-old female has a visit booked for 30 minutes: needing a B12 injection, inquiring about vaccines to ensure up to date, and recently had surgery on her wrist; would benefit from a physio referral for range of motion exercises as she isn't able to afford private services.

Answer:
38084- visit in office
38163, 38160- B12 injection
38064- information re: medications
38131- physio referral

Example 3:
50-year-old male has a visit booked for 1 hour: needing ears syringed due to wax accumulation. This patient is due for a blood pressure check the RN takes his BP and learns he isn't taking his medications, very stressed at home and work due to lack of stable housing, eating poorly and lack of exercise, interested in learning positive coping skills after teaching provided by RN about risk factors of hypertension. The patient is also interested in being referred to social work for housing options.

Answer:
38163, 38168- ear syringing
38064, 38065, 38062, 38061- medication teaching
38195 (can bill 14029-allied health code for doctor)- CDM visit re: HTN
38145,38144,38153
38180, 38131- discussing with SW situation
38192- if any counselling was provided
38071- update sent to doctor, needing to refill medications
38119

Example 1: Resource Navigation
A patient is new to new the community, needs support with immigration services, a PWD application

Answer: Pathways, call PCN social work, nursing email chain, team lead

EMR Goal Checklist

Foundational

- Basic system navigation
  - Search for a patient
  - Navigate different aspects of their chart
- Working with appointments
  - Book an appointment
  - Modify an existing appointment
  - Block off unavailable time (e.g., education on site or off site, vacation, PCN meetings, etc.)
- Creating a visit encounter
  - Start a new visit
    - Blank (default)
    - Using a template (SOAP, CDM, Complex Care, etc.)
  - Add a visit diagnosis (ICD9 code)
  - View existing patient details (medical history, lab results, allergies etc.)
  - Sign off/completing patient visit
- Generating a Nurse Only Intervention referral
  - Complete and fax consent for PCN registration
  - Attach supporting documents
- Generating an AH referral
  - E-fax PCN allied health referral
  - Attach supporting documents
  - Fax /eFax from EMR
  - Track referral once sent
- Task management
  - View tasks in the EMR
  - Reply/task other team members in the EMR
- Creating and submitting encounter reporting
  - Adding specific time frames for required encounter codes

Patient Management and Administration

- Run/view basic reports
  - CDM
  - Fragility
  - Medications
- Template basics
  - Macros (Med Access)
- Document new patient intake
  - Populate the chart
    - Patient Hx, Current medications, allergies, etc.

Scenarios

The goal of these scenarios is to demonstrate foundational knowledge of the EMR, and to interpret what is required in a nursing role, while using an EMR

Scenario One: A doctor tasked you with calling a patient to chat about the PCN. In your EMR, book an appointment for a test patient. Prior to them arriving at the clinic, you decide to review the patient chart and familiarize yourself with recent lab results.

Scenario Two: The patient calls and asks to have their appointment moved to the following week. Move the patient appointment, and then block off 30 minutes on your schedule following the appointment to spend documenting and submitting encounter codes.

Scenario Three: Your patient has arrived for their diabetic screening appointment. Create a new visit encounter, select the appropriate template (if applicable) and complete your notes. Once the visit is complete, ensure that the correct diagnosis is added. Create an encounter code for the visit. Lastly, you decide to task the doctor with your findings.

Scenario Four: The doctor reviewed your last visit and asks that the patient is referred to the Dietitian. Create a new referral letter, adding your last visit notes along with the patient's current medications and medical history. Once the letter is complete, fax to the PCN admin team. As this patient requires follow up, keep track of the referral.

Further Information

- Central Okanagan Division of Family Practice - https://divisionsbc.ca/central-okanagan
- Doctors of BC - https://www.doctorsofbc.ca/
- FPSC General Practice Services Committee - https://fpscbc.ca/
- FPSC Practice Support Program - https://fpscbc.ca/what-we-do/practice-supports/psp
- JCC Resource Catalogue - https://www.jcc-resourcecatalogue.ca/
- Ministry of Health - https://www2.gov.bc.ca/gov/content/governments/organizational-structure/ministries-organizations/ministries/health
- Oscar EMR - https://oscarbc.ca/resource
- PCN Tool Kit - https://www.pcnbc.ca/pcn
- Pathways - https://pathwaysbc.ca/login
  Pathways is a great reference for all clinical information and BC Practice Guidelines.