Sunset Country Family Health Team

Issue 01

September 2017

Sunset Country Family Health Team

Quarterly Newsletter

Inspiring a healthier community together

The purpose of this newsletter is to report on our programs, activities and events for each quarter so as to reflect on our achievements and progress as the year goes by. This newsletter is open to members of the board as well as our staff.

Q2 HIGHLIGHTS

Did You know?

SCFHT currently offers 17 programs

- Acute and Episodic Care
- Health Promotion and Disease Prevention
- Cancer Screening
- Diabetes Management Program
- Diabetes Foot Care Program
- Hospital Discharge
- Hypertension
- INR
- Lactation Consult
- Lung Health – Asthma
- Lung Health – COPD
- Smoking Cessation
- Medication Review
- Memory Clinic
- Nutritional Counselling
- Dyslipidemia
- Social Work

Acute & Episodic Care Program

Program Goal: To divert patients from the emergency department and increase access to a primary care provider for presenting complaints.

Access: In Q2 the SCFHT Nurse Practitioners had 6,652 Patient visits. Only 1.63% of NP same day/next day appointments in Q2 Failed to attend their appointment

Highlight: 51.65% of patients receive a same day or next day appointment with SCFHT Nurse Practitioners.

Health Promotion and Disease Prevention Program

Program Goal: To deliver Primary and Secondary prevention services aimed at avoiding the onset and/or early detection of disease as part of a comprehensive primary care delivery model.

Access: In Q2 there were 870 patient visits (474 immunizations, 621 preventative care and 21 physical assessments)

Highlight: 48.41% of patients seen by an NP had smoking status documented in risk factors. 20.62% of smokers seen were offered the smoking cessation program.

Cancer Screening Program

Program Goal: Maintain or improve rates of cancer screening of eligible FHN patients according to current evidence-based clinical practice guidelines.

Cervical Cancer Screening: 112 paps were completed by IHP's, 81 pts received education by RPN

Colorectal Cancer Screening: 26 requisitions ordered by IHP's, 119 pts received education by RPN

Breast Cancer screening: 20 requisitions ordered by IHP's, 47 pts received education by RPN

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The Team

Executive Director – Colleen Neil
Finance/HR – Stephanie Evenden
QIDDS – Melonie Young
Admin. Assistant – Esther Odeyale
Reception – Tannis Romaniuk
Nurse Practitioner – Carol Wilson
Nurse Practitioner – Barb Pernsky
Nurse Practitioner – Kristen Patrick
Registered Nurse – Collen Snyder
Registered Nurse – Brandi Milko
Registered Nurse – Stacey Greer
Registered Practical Nurse – Kendra Madussi
Registered Practical Nurse – Megan Wesley
Registered Practical Nurse – Breanne Becker
Registered Practical Nurse – Whitney King
Diabetes RN – Carolyn Hamlyn
Diabetes Dietitian – Cindy Van Belleghem
Chiropodist – Andrea Clemmens
Foot Care Nurse – Sue McLeod
Pharmacist – June Dearborn
Dietitian – Kate Ronnebeck

Diabetes Management Program

Program Goal: Provide patient centered, accessible, evidence based care with screening, early diagnosis and treatment of diabetes aimed preventing or delaying disease progression and complications, according to best practice as outlined by the Canadian Diabetes Association 2013 Clinical Best Practice Guidelines

Access: In Q2 there were 381 appointments, 123 phone follow up calls and 23 consults. The Diabetes team held 4 community sessions with a total of 143 attendees.

Highlight: 81.88% of patients seen by the DMP program in Q2 have a documented personalized A1c

42.03% of patients most recent HbA1c (within the last 12 months) was within their individualized range.

Diabetes Foot Care Program

Program Goal: To screen for and treat diabetic foot conditions in order to prevent or delay complications. Also to educate patients regarding the importance of and the need for preventative foot care. To establish contact with diabetic patients and to engage them in the importance of regular foot care

Access: 101 patient visits in Q2, 20 high risk non Diabetic patients were also seen.

Highlight: 90.48% of DM patients seen in the program have had a foot screen in the last year.

67 of 74 patient with chronic foot conditions were controlled at last visit. Of those 20 have improved or been resolved

Hospital Discharge Program

Program Goal: Provide phone follow up to post hospital discharge patients to identify and help to resolve medication problems that can occur in a patient's transition from hospital to home. To identify and solve possible medication related problems soon after discharge to help minimize the risk of re-admittance to hospital.

Access: In Q2 there were 21 patient visits

Highlight: Only 3 patients were readmitted to the hospital within 30 days.

90% of patients in the program had a MED REC done and an updated medication list in the EMR

11 medication related problems were identified and 9 resolved in Q2.

We have increased the number of patients by 950% from last year to current quarter.

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Did you Know?
Your patients have access to Evening Clinic on Wednesdays until 7pm.

Hypertension Management Program

Program Goal: Assess patients for hypertension and cardiovascular risk factors, provide education and tools to manage and improve lifestyle and blood pressure.

Access: 269 patient visits occurred in Q2

Highlight: 55.23% of patients seen are currently at target. 52.83% of patients were at target after three visits.

INR Program

Program Goal: To reduce the cost to the healthcare system by providing point of care INR testing and minimizing adverse events of warfarin therapy that cause hard and/or require hospitalization.

Access: 823 patient visits occurred in Q2

Highlight: 72.46% of patient's test results are in range.

No patients had a stroke or major bleed in this quarter.

Lactation Consultation Program

Program Goal: Provide new mothers with education and support to exclusively breastfeed to 6 month and beyond. To raise awareness in Kenora of the normalcy of breastfeeding in healthy infant nutrition. Increase the presence of Baby Friendly initiatives within the Kenora Area.

Access: 41 patient visits occurred in Q2

Highlight: 67% of patients who complete the satisfaction survey reported increased confidence in breastfeeding.

5 Health care professionals are registered in the fall 20 hours lactation course

Lung Health – Asthma Program

Program Goal: To improve the overall health and wellbeing of individuals with Asthma

Access: In Q2 there were 93 patient visits

Highlight: In Q2 99% of patients screened have had diagnosis confirmed with a spirometry. Of those patients diagnosed with Asthma, 79% have action plans. In Q2 91% of Smoking Asthma patients received smoking intervention, 3 joined the STOP study.

Lung Health – COPD Program

Program Goal: To improve the overall health and well-being of individual with moderate to severe COPD

Access: In Q2 there were 28 patient visits

Highlight: 90% of smoking COPD patients received smoking intervention, 3 joined the STOP study.

95% of COPD patients have their diagnosis confirmed with a spirometry

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Smoking Cessation

Program Goal: Provide education, ongoing support, and appropriate pharmacotherapy, if needed, to assist patients in becoming smoke-free.

Access: In Q2 there were 173 patient contacts

Highlight: In Q2, 36% of patients the program have quit at 6 months.

In Q2, 42.90% of patients in the program have quit at 12 months

Did you Know?

Physician roster numbers are part of the Ministry of Health calculation when determining and number of health care professionals SCFHT is funded for.

Choices and Changes: Motivating Healthy Behaviour Workshop

This interactive IHC workshop develops the capacity to influence patient health behavior from adherence with medication regimens to curbing risky behavior. A model is presented which enables clinicians to have an impact in a brief office visit.

Open to Health Care Professional. This workshop is accredited by the college of Family Physicians for 4 Mainpro M1 credits.

Venue: Sunset Country Family Health Team (Conference Room)

Medication Review

Program Goal: To improve patient and provider education about drug therapy and to ensure medications are working effectively and are not negatively impacting the patient's well-being.

Access: There were 63 patient visits in Q2

Highlight: Pharmacist suggested medication changes for 11 patients, 9 of which were implemented. 100% of patients in the program have MED REC process completed and EMR medication lists reviewed and updated.

18 drug information requests were completed

Social Work

Program Goal: To improve the overall well-being and mental health of patients

Access: 127 patient visits occurred in Q2

Highlight: SCFHT Social work program is hosting a student placement. Rochelle is completing her masters and will be at the clinic every Friday until April 2017.

Of the patients who completed the Session Rating Scale (SRS) Tool, the average rating was 92% overall.

Nutritional Counselling

Program Goal: Provide tools and education to help patients improve quality of life and decrease likelihood of developing a chronic disease or to help patients manage the nutritional component of dealing with a chronic disease to decrease possibility of adverse events.

Access: 188 patient visits occurred in Q2

Highlight: In Q2 our Registered Dietitian and Social Worker held a Craving Change session and 75% of patients rated the program a 5/5 for understandable and 50% rated 5/5 for helpfulness

Dyslipidemia

Program Goal: to improve lipid levels in patients with dyslipidemia to decrease risk of cardiovascular events. This program will decrease the number of appointments patients require with their physicians or Nurse Practitioner and increase access to care.

Access: 11 patient visits occurred in Q2

Highlight: 100% of patients have action plans and a documented Framingham Risk Assessment.

Of patients seen last year, 8/16 have not yet had a repeat assessment, 6/16 have improved levels, 2/16 have worsened

Memory Clinic

Watch for the Memory Clinic Newsletter
Coming Soon