Sunset Country Family Health Team

Issue 02

January 2018

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 to reflect on our achievements and progress as the year goes by. This newsletter is open to members of the FHN and the SCFH Team.

Q3 HIGHLIGHTS

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 Q3 the SCFHT Nurse Practitioners had 5,986 patient visits. Only 1.73% of NP same day/next day appointments in Q3 Failed to attend their appointment

Highlight: 48.70% 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 Q3 there was an increase of over 80% in patient visits from the last quarter (1,629 visits; 1240 immunizations, 676 preventative care and 9 physical assessments)

Highlight: 46.1% of children aged 24 months have completed all scheduled immunizations. Also, 53.82% of patients seen by NPs had their smoking status documented in their risk factors section of their EMR. 33.33% of patients who smoke, who were seen in the quarter were offered the smoking cessation program.

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
- Asthma Program
- COPD Program
- Smoking Cessation
- Medication Review
- Social Work
- Dyslipidemia
- Nutritional Counselling
- Memory Clinic

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: 168 paps were completed by IHP's, 57 pts received education by RPNs

Colorectal Cancer Screening: 28 requisitions ordered by IHP's, 83 pts received education by RPN

Breast Cancer screening: 21 requisitions ordered by IHP's, 18 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
Clinical Coordinator - TBA
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 – Vanessa Trent
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
Social Worker – Kati Heinrich

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 Clinical Best Practice Guidelines

Access: In Q3 there were 368 appointments, 110 phone follow up calls and 12 consults. The Diabetes team held 7 community sessions with a total of 184 attendees.

Highlight: 83.70% of patients seen by the DMP program in Q3 have a documented personalized A1c.

47.78% of patients most recent HbA1c (within the last 12 months) was within their individualized range.

74.81% of patients had a BP of less than 150/90.

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: 87 patient visits in Q3, 26 high risk non Diabetic patients were also seen.

Highlight: 56 of 61 patients with a chronic foot condition were controlled as at their last visit and 26 of those conditions have been improved or resolved.

90% of DMP patients had a foot screen completed in the last quarter.

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: Total of 4 patient visits in Q3.

Highlight: Only 1 patient was readmitted to the hospital within 30 days.

All patients in the program, this quarter, had a MED REC done and an updated medication list in the EMR.

1 medication related problem was identified and resolved in Q3.

"Your opinion matters"

Help us further develop our programs by sending comments or ideas to:

Colleen Neil
Executive Director
cneil@scfht.ca

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Did you Know?

Ontarians can now access emergency department and diagnostic imaging wait times on the Health Quality Ontario website.
www.hqontario.ca

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: 133 patients were seen by the program in Q3.

Highlight: 54.89% of patients seen are currently at target. 56.38% of patients were at target after three visits.

81 patients received ABPM. Of the patients who did not receive ambulatory monitoring, home readings or subsequent HTN visits were scheduled.

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: 814 patient visits occurred in Q3.

Highlight: 72.85% of patient's test results are in the therapeutic range (above 70%).

There were no known strokes reported this quarter for patients in the INR program.

Lactation Consultation Program

Program Goal: Provide new mothers with education and support breastfeeding to 6 months 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: 19 patients were seen by the program in Q3.

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

13 Health care professionals have completed the 20 hour Lactation course. Monthly baby friendly meetings are now being held and there is also a baby feeding clinic that holds at the Best Start Hub, Kenora Public Library from 9am – 11am every Friday.

Asthma Program

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

Access: In Q3 there were 102 patient visits.

Highlight: In Q3, 96.6% of patients screened have had diagnosis confirmed with a spirometry. Of those patients diagnosed with Asthma, 79% have action plans. Also, 74.1% of Smoking Asthma patients received smoking intervention, 2 joined the STOP study.

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COPD Program

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

Access: There were 46 patient visits in Q3.

Highlight: 78.9% of smoking COPD patients received smoking intervention. Also, 67.5% of COPD patients have had the flu shot this year.

For the patients we follow in the COPD program, 95% have been confirmed with a Spirometry test.

Smoking Cessation

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

Access: In Q3, there were 190 patient contacts.

Highlight: In Q3, 24.5% of patients the program have quit at 6 months. The program is seeing 90+ patients with 100+ follow up calls per quarter.

In Q3, 64.65% of patients in the program smoking status documented in their risk factors.

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 37 patient visits in Q3.

Highlight: Pharmacist suggested medication changes for 8 patients, all of which were implemented. 97.3% of patients in the program have MED REC process completed and EMR medication lists reviewed and updated.

14 drug information requests were completed.

Did you Know?
The SCFHT has active members in the Kenora Area Pregnancy & Infant Loss Coalition

Social Work

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

Access: 161 patient visits occurred in Q3.

Highlight: 1 internal referral and 11 external referrals were received in Q3. Four group sessions were held in Q3 and participants indicated 100% satisfaction and rated the group sessions as excellent.

The SCFHT Social work program is hosting a student placement. Rochelle Livingstone has been assisting the program and will be at the clinic every Friday until April, 2018.
Our social worker, Kati, is involved in the LEAP program and she co-chairs the Palliative Care Committee.

Of the patients who completed the Session Rating Scale (SRS) Tool, the average rating was 92.5% overall.

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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: 8 patient visits occurred in Q3.

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

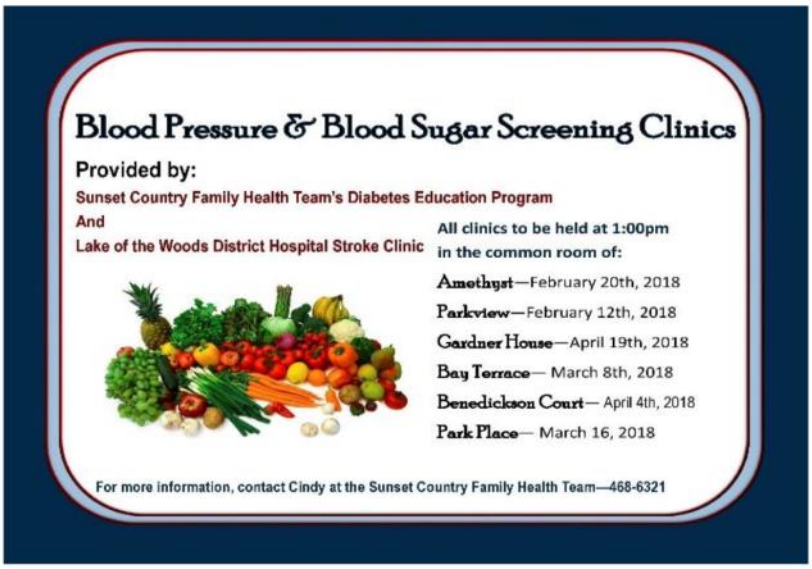
Nutritional Counselling

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: 191 patient visits occurred in Q3.

Highlight: In Q3, 96.4% of patients found the appointments helpful and 82.1% felt they would be able to change their eating habits.

This program has also supported patients before and after bariatric surgery by holding 2 bariatric group sessions with 9 participants in total.



Chronic Pain Workshop

The Sunset Country Family Health Team is currently hosting a Chronic Pain Workshop every Tuesday that started on the 9th of January and runs until the 13th of February, 2018 at 5:00pm

This workshop is helping participants to learn coping strategies that will improve quality of life while living with long – term chronic pain.