Issue
03

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Sunset Country Family Health Team

Quarterly Newsletter

Inspiring a healthier community together

Q4 Highlights

PROGRAM HIGHLIGHT

Do you know about our Hospital Discharge Phone Follow-Up Program?

Run by our Pharmacist: June Dearborn

When the SCFHT is notified of a patient being discharged from the hospital, and they are >65 years old and on multiple medications, June will phone and follow up with them: this helps to reduce hospital readmissions.

Please refer your patients to us if they meet the criteria for this program

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 Q4 the SCFHT Nurse Practitioners had 1688 patient encounters.

Highlight: 45.5% of patients received 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 Q4 there were 947 patient visits (558 immunizations, 635 preventative care, and 9 physical assessments).

Highlight: 1514 patients had a flu-shot administered between Q1 & Q4 of 2017/18.

The Nutri Step program is up and running!

Welcome to our new staff member

Lisa Hatfield-Johnston, RN Clinical Coordinator

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: 134 paps were completed by IHPs, 49 patients received education by an RPN. Per SAR, 68.52% of patients are up to date in screening.

Colorectal Cancer Screening: 38 requisitions were ordered by IHPs, 127 patients received education by an RPN. Per SAR, 68.95% of patients are up to date in screening.

Breast Cancer Screening: 38 requisitions were ordered by IHPs, 42 patients received education by an RPN. Per SAR, 67.76% of patients are up to date in screening.

Diabetes Management Program

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

Access: In Q4 there were 364 appointments, 135 phone follow-up calls and e-mails, and 14 consults. The diabetes team accommodated 2 Bariatric groups in Q4 with 11 attendees.

Highlight: Diabetes Canada (formerly the Canadian Diabetes Association) has new guidelines for 2018: http://guidelines.diabetes.ca/cpg

Carolyn Hamlyn, RN & Diabetes Educator, will be making the rounds to physicians to chat with you.

The Team

Executive Director – Colleen Neil
Finance/HR – Stephanie Evenden
QIDSS – Melonie Young
Administrative Assistant – Chelsea Greig
Reception – Tannis Romaniuk
Clinical Coordinator – Lisa Hatfield-Johnston
Chiropodist – Andrea Clemmens
Diabetes Dietitian – Cindy Van Belleghem
Diabetes RN – Carolyn Hamlyn
Foot Care Nurse – Sue McLeod
Nurse Practitioner – Barb Pernsky
Nurse Practitioner – Carol Wilson
Nurse Practitioner – Kristen Patrick
Pharmacist – June Dearborn
Registered Dietitian – Kate Ronnebeck
Registered Nurse – Brandi Milko
Registered Nurse – Colleen Snyder
Registered Nurse – Stacey Greer
Registered Practical Nurse – Breanne Becker
Registered Practical Nurse – Kendra Madussi
Registered Practical Nurse – Megan Wesley
Registered Practical Nurse – Whitney King
Social Worker – Kati Heinrich

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 diabetic patient visits in Q4. 26 high-risk non-diabetic patients were also seen.

Highlight: 91.8% of patients with a chronic foot condition were controlled at last visit.

90% of DMP patients had a foot screen completed within the year.

Hospital Discharge Program

Program Goal: Provide phone follow-up to post-hospital discharge patients age 65 and over on more than 4 medications 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 readmittance to hospital.

Access: Total of 10 patient visits in Q4.

Highlight: Seniors with multiple medications are high risk and need medication reviews; we would like to see more referrals from doctors, NPs, and other healthcare providers.

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: 175 patients were seen by the program in Q4 resulting in 298 visits.

Highlight: 59.43% of patients seen are currently at target. 53.33% of patients were at target after three visits.

The Hypertension Management Program has started a walking group!

Every Tuesday and Thursday they meet at Husky the Muskie at noon and walk on their lunch breaks. Please encourage your patients to come. More details on page 6.

INR Program

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

Access: 190 patients were seen by the program in Q4 resulting in 763 visits.

Highlight: 69.15% of patients were in their target range of ideal INR.

0.53% of these patients had strokes.

2.12% of these patients had experienced major bleeds resulting in an ER visit or hospitalization.

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: 18 patients were seen by the program in Q4.

Highlight: 100% of patients who completed the satisfaction survey reported increased confidence in breastfeeding.

Asthma Program

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

Access: In Q4 there were 81 patient visits.

Highlight: In Q4 96 % of patients screened have had diagnosis confirmed with a Spirometry test. 75% have action plans.

COPD Program

Program Goal: To improve the overall health and wellbeing of individuals with moderate to severe COPD.

Access: In Q4 there were 32 patient visits.

Highlight: For the patients we follow in the COPD program, 96.5% have been confirmed with a Spirometry test.

All Fitness for Breath participants have been meeting or exceeding their targets.

Smoking Cessation

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

Access: In Q4 there were 150 patient contacts.

Highlight: In Q4, 45.5% of patients in the program have quit at 6 months. The program is seeing 80+ patients with 100+ follow-up calls per quarter.

Our quit rates are above provincial averages.

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 wellbeing.

Access: There were 39 patient visits in Q4.

Highlight: Pharmacist suggested medication changes for 15.8% patients. 97.4% of patients in the program had a medication reconciliation process completed and their EMR medication lists reviewed and updated.

RPNs should be given extra time when triaging patients to review their medications and stop any inactive drugs on the EMR.

All IHPs and physicians should make it practice that for every patient you see you ask "Have your medications been reviewed since your last appointment?".

Social Work

Program Goal: To improve the overall wellbeing and mental health of patients.

Access: 158 patient visits occurred in Q4.

Highlight: 10 external referrals were received in Q4.

A Chronic Pain Self-Management Program group was held for those dealing with chronic pain and their caregivers/family members. This was a six-week course starting Tuesday, January 9th, and we had a total of nine participants. It went very well and we hope to offer this group in the fall. If you have anyone you think would benefit from this program, please refer them to the Family Health Team.

"Your opinion matters"

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

Colleen Neil
Executive Director
cneil@scfht.ca
468-6321

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 Physician or Nurse Practitioner and increase access to care.

Access: 7 patient visits occurred in Q4.

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: 178 patient visits occurred in Q4.

Highlight: In Q4, 100% of patients found the appointments helpful and 91% 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 11 participants in total.

Memory Clinic

Program Goal: Optimize access, diagnosis and care to patients with memory difficulties. Early diagnoses and treatment of memory loss can help to maintain and support cognitive health and quality of life. This can decrease crises and avoidable ER visits and hospitalizations and delay institutionalization. It will also create capacity at the primary care level to free up specialist resources to focus on the most complex cases.

Access: 24 patients were seen in Q4.

Highlight: 40% of patients have deprescribing recommended.

100% of patients have had medications reviewed.

90% of patients have home care plans that should be reviewed.

Upcoming Events

Hypertension Walking Group
Hosted by
Sunset Country Family Health Team
Starting May 29th 2018, running every Tuesday and Thursday
from 12:00pm to 1:00pm
Meet at Husky the Muskie

Although we're a hypertension walking group, all are welcome to join, including yourselves. Please let your patients know about our group! And tell them to bring their walking shoes and a water bottle. Free pedometers will be given.

Great Cycle Challenge Canada
Our very own RPN Megan Wesley is raising money to fight kids' cancer and will be bicycling 200km in the month of June and is raising money for the cause; her goal being $500

We hope you'd consider donating to Megan or sign up for the Great Cycle Challenge yourself!
https://greatcyclechallenge.ca/Riders/MeganWesley