Issue

04

August

2018

Sunset Country Family Health Team

Quarterly Newsletter

Inspiring a healthier Kenora

Q1 Highlights

SCFHT HIGHLIGHT

Med Review HMP

The SCFHT has introduced a Med Review HMP. Any patient >65 on multiple medications should have an annual medication review. This can be done by the family physician or NP, or you can refer to June, or to the patient's pharmacy.

When a medication review has been done, please update the HMP date to one year.

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 Q1, 45.24% of NP patients received a same or next day appointment.

Highlight: In Q1, there were 6,681 patient visits in Acute & Episodic Care.

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.

Highlight: 14 events were held in Q1 with 162 participants

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: 67.91% of patients are up to date for cervical screening.

Colorectal Cancer Screening: 68.5% of patients are up to date for colorectal screening.

Breast Cancer Screening: 66.58% of patients are up to date for breast screening.

We are meeting our screening targets as well as exceeding our colorectal screening targets!

Welcome to our new staff members

Kendall Gray, Alanna Mutch, Robyn Hall, & Greg Kolisnyk

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 Diabetes Canada 2018 Clinical Practice Guidelines.

Access: In Q1 there were 337 patients seen and 622 patient contacts.

Stats: 82.28% of patients with Type 1 or Type 2 diabetes who have a documented personalized A1c on their chart.

41.46% of patients with Type 1 or Type 2 diabetes whose most recent HbA1c (within the last 12 months) was within their individualized range.

69.94% of patients with Type 1 or Type 2 diabetes who have had their most recent blood pressure be less than 150/90.

40.51% of patients with Type 1 or Type 2 diabetes who have had a foot screening completed within the last 12 months.

96.7% of patients with chronic foot issues seen by the foot care nurse have had their problem under control at their most recent visit.

Highlight: Community blood pressure & blood sugar screenings have been going great and are very well attended! More community screening will be held this fall.

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: 182 patients were seen by the program in Q1 resulting in 280 patient visits.

Stats: 55.86% of patients in the program who have improved blood pressure readings to target after 3 visits.

80% of patients in this program have completed an HMP form and set a lifestyle goal after their first 3 visits.

The Team

Executive Director – Colleen Neil
Finance/HR – Stephanie Evenden
QIDSS – Melonie Young
Administrative Assistant – Chelsea Greig
Reception – Tannis Romaniuk
Health Links & Clinical Coordinator, RN – Lisa Hatfield-Johnston
Chiropodist – Andrea Clemmens
Diabetes Dietitian – Cindy Van Belleghem
Diabetes RN – Carolyn Hamlyn
Foot Care Nurse – Sue McLeod
IT Specialist – Greg Kolisnyk
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 – Alanna Mutch
Registered Practical Nurse – Breanne Becker
Registered Practical Nurse – Kendall Gray
Registered Practical Nurse – Kendra Madussi
Registered Practical Nurse – Robyn Hall
Registered Practical Nurse – Whitney King
Social Worker – Kati Heinrich

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.

Highlight: You and your patients are invited to join us on our Family Health Team Walking Group, held Thursdays at 12:00pm at Husky the Muskie.

> “Your opinion matters”
>
> **Help us further develop our programs by sending comments or ideas to:**
>
> Colleen Neil
> Executive Director
> cneil@scfht.ca
> 468-6321

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: 181 patients were seen by the SCFHT in Q1 resulting in 702 visits.

Stats: 67.64% of patients were in their target range of ideal INR which is close to reaching our target of 70%.

1.66% of these patients had strokes and our target is <2%.

0.55% of these patients had experienced major bleeds resulting in an ER visit or hospitalization and our target is <2%.

Social Work

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

Access: 113 patient visits occurred in Q1.

Stats: The Session Rating Scale is a survey our patients use to report their satisfaction for our Social Work program. 91% of our patients have reported satisfaction and our goal is 90%.

Highlight: SCFHT Social Worker is assisting with creating a Mental Health Services Chart which shows all of the services in Kenora, and how to get inducted into the programs.

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: 30 patients were seen in Q1 resulting in 42 patient visits.

Stats: 48.8% of babies seen for lactation are still exclusively breastfed at 6 months.

The BABY STOP tent was set up for 7 events in Q1.

Highlight: We are still accepting referrals for prenatal moms, especially high-risk for pre-term, i.e., Diabetes, taking methadone, or who have had breast surgery.

Asthma & COPD Program

Program Goal: To improve the overall health and wellbeing of individuals with Asthma and moderate to severe COPD. To provide Spirometry screening to patients with breathing issues.

To provide assessment, education, and support to patients and their families with diagnosis of Asthma or COPD.

Access: In Q1 there were 154 patient visits.

Stats: 76.92% of Asthma/COPD diagnosed patients have an action plan.

89.36% of Asthma/COPD diagnosed patients have smoking cessation intervention.

Highlight: We are always taking referrals for this program. Anyone with recent exacerbations without an Asthma/COPD diagnosis should be sent for Spirometry.

Chiropody Program

Program Goal: To reduce amputations or adverse events related to foot care and manage those patients who already have a condition and prevent further problems and delay disease progression. To assess patient's feet, provide preventative foot care and education, and treat existing foot conditions.

Access: In Q1 there was 260 patient visits to the SCFHT site, and 123 patient visits to the LWDH Wound Care site.

Stats: 90.4% of patients who had success with the use of device due to requiring offloading for chronic conditions.

66.7% of patients in the program with wounds who have controlled or improved their results by their 3rd visit.

Highlight: SCFHT Chiropodist has a new schedule template that is well-liked by IHPs for consultations when required: "I love, love, love it!" one IHP stated, and the new template has also greatly improved access which has increased patient satisfaction.

Smoking Cessation

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

Access: In Q1 there were 106 patients resulting in 223 patient contacts.

Stats: 29.4% of patients in the program have quit smoking at 12 months.

75% of patients in the program have smoking status documented in Risk Factors.

Highlight: Please always remember to document smoking status in Risk Factors.

Our quit rates remain above the provincial average!!

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 91 patients seen in Q1.

Highlight: Pharmacist suggested medication changes for 36 patients, and 24 of these suggestions were implemented by the primary care provider. 18 patients in the program had a medication reconciliation process completed with 15 patients having reconciliations in other programs (i.e., Memory Clinic).

Our Pharmacist is continuing to set time aside on Thursdays for hospital discharges. She is focusing on those who are >65, on 5+ meds, and also prioritizing for those with chronic conditions (such as COPD, CHF).

August was our Medication Safety Month and we've implemented a Medication Safety Checklist as well as created an HMP you may come across called 'Med Review' which we are attaching to patients who are 80 and may need a medication review. When you see a patient with this alert, please ask "Have you had a medication review in the last year?". If so, please note it in the To Do and mark it as done. If not, please either review their medications yourself, refer them to June, or you can send a prescription to their pharmacy requesting a medication review.

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: 186 patient visits occurred in Q1.

Stats: 70.6% of follow-up patients have achieved their most recent SMART goal.

71% of dyslipidemia patients who completed a repeat lipid assessment showed improve results 1 year after appointment.

Highlight: When recommending the FODMAP diet to patients, please also recommend a referral to the SCFHT dietitian.

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: 27 patients were seen in Q1.

Stats: 100% of patients are satisfied with the service!!

94.7% of patients reported increased understanding about their condition.

Highlights: Keep your referrals coming! We're all caught up with patients.

Did you know?

We have created a Nurse Practitioner Clinic Advisory Committee which has members from multiple stakeholders and meets bi-weekly. The goal of the group is to decide how best to implement and roll out the future Sunset Country Family Health Team's Nurse Practitioner Clinic.

The priority patients will be those from the Health Care Connect list. If you meet with a patient who does not have a family primary care provider, please have them register with Health Care Connect.

Upcoming Events

Have you checked out our new website yet?

www.scfht.ca

And we are now on Facebook, Instagram, and Twitter!

Family Health Team Walking Group
Hosted by
Hypertension Management Program
Every Thursday
at 12:00pm
Meet at Husky the Muskie

All are welcome to join, including yourselves. Any age, walking ability, and we're pet-friendly. Please let your patients know about our group! And tell them to bring their walking shoes and a water bottle.

Chronic Pain Workshop
Hosted by
Kati Heinrich & Colleen Snyder
Tuesdays from October 23 to November 27
5:00pm – 7:30pm
At Sunset Country Family Health Team

For patients or family members living with long-term chronic pain to learn strategies to help improve your quality of life.

Paptastic
Hosted by Our Nurses
The week of October 15th to October 19th
8:00 - 4:30pm (some evening appointments available)
At Sunset Country Family Health Team

Please feel free to book paps with our participating nurses for this week or have them call 468-6321. They do not need to have a family physician/nurse practitioner to attend.