Issue
05

November
2018

Sunset Country Family Health Team

Quarterly Newsletter

Inspiring a healthier Kenora

Q2 Highlights

SCFHT HIGHLIGHT
Social Work Program

We are always accepting referrals for our Social Work program! Kati will see patients for:

- → **System Navigation**
- → **Adaptation to Illness**
- → **Alcohol/Substance Abuse**
- → **Anxiety/Depression**
- → **Case Coordination**
- → **Children's Mental Health**
- → **Cognitive Screening**
- → **Diabetes Social Work**
- → **Grief/Loss**
- → **Parent/Caregiver Support**
- → **Relationship Issues**
- → **Stress**

And more! Any questions? Drop by Kati's office, or e-mail kheinrich@scfht.ca or call 468-6321

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, 39.25% of NP patients received a same or next day appointment.

Stats: In Q2, there were 6,294 patient services administered under acute & episodic care.

Highlight: We are working on a new medication reconciliation process. Please take the time with patients to check and make sure that what is on their chart matches what they're taking, and refer complex to June Dearborn, Pharmacist.

Health Promotion and Disease Prevention Program

Program Goal: To increase access to Health Promotion services within the community as part of a comprehensive Primary Care delivery model.

Stats: We hosted/attended the following events:

1 Craving Change workshop

4 Fitness for Breath sessions

8 Family Health Team Walking Groups

10 Breastfeeding Baby Stop Tents

1 Bariatric Group

1 Community Safety Night

Highlight: In Quarter 3, the Bariatric Support Group will begin to meet the first Wednesday of each month. If you have a patient who is asking about bariatric surgery or is already involved in the process, please encourage them to attend. More details on page 7.

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: 64.93% of patients are up to date for cervical screening. We also administered 83 paps to patients during our Paptastic Cervical Cancer Screening Week in October.

Colorectal Cancer Screening: 68.46% of patients are up to date for colorectal screening.

Breast Cancer Screening: 66.75% of patients are up to date for breast screening.

Physicians and Nurse Practitioners, please remember to update your patient's cancer screening HMP when you've received a result.

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.

Remember to refer patients to our Bariatric support group! Check out Lloyd Mack's personal experience with bariatric surgery on page 6!

Access: In Q2 there were 325 patients seen and 584 patient contacts.

Stats: 83.5% of patients with Type 1 or Type 2 diabetes have a documented personalized A1c on their chart – we're getting closer to our goal of 90%.

54.05% of patients with Type 1 or Type 2 diabetes most recent HbA1c (within the last 12 months) was within their individualized range. This exceeds our goal of 50%!

75.4% of patients with Type 1 or Type 2 diabetes most recent blood pressure was less than 150/90.

47.9% of patients with Type 1 or Type 2 diabetes have had a foot screening completed within the last 12 months.

95.38% of patients with chronic foot issues seen by the foot care nurse had their problem under control at their most recent visit.

Highlight: Tresiba now has coverage by both ODB and NIHB. Toujeo is now covered by ODB. There is also a new injection combination of insulin glargine (Lantus) and a GLP1 receptor antagonist lixisenatide (Adlyxin) called Soliqua. Soliqua is not covered as of yet.

Carolyn and Cindy have been very busy holding blood sugar and blood pressure clinics. Four clinics were held in Q2 screening 60 community members. At the CNIB Eye Van they saw 98 members! Dates for upcoming community clinics are found on page 7.

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: 153 patients were seen by the program in Q2, resulting in 233 patient visits.

Stats: 62.38% of patients in the program have improved their blood pressure readings to target after 3 visits.

82.58% of patients in this program have completed an HMP form and set a lifestyle goal after their first 3 visits. 80% was our target and we have exceeded this!

Highlight: Dr. Ross Feldman did a great presentation on the new 2018-2020 guidelines in October. Thank you to those whom attended!

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: 178 patients were seen by the SCFHT in Q2 resulting in 723 visits.

Stats: 69.47% of tests given were within INR target range. This is very close to our goal of 70%.

No INR patients experienced a stroke in Q2 keeping us below our 2% target.

One INR patient experienced a major bleed resulting in an ER visit or hospitalization keeping us below our 2% target.

Highlight: 50 of the 723 patient visits also had other care provided by our IHPs during their INR visit.

Social Work

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

Access: 119 patient visits occurred in Q2.

Stats: The Session Rating Scale is a four-item scale survey designed to assess the patient's relationship with their mental health program in terms of respect and understanding, relevancy, client-practitioner fit, and overall alliance. Our Social Work program scored 88.6%.

Highlight: We're always encouraging more referrals to this 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: 25 patients were seen in Q2 resulting in 43 patient visits.

Stats: 53.3% of babies seen for lactation in Kenora are still exclusively breastfed at 6 months.

The BABY STOP tent was set up for 10 events in Q2.

Highlight: We're above the national average for breastfeeding rates! We are doing very well for exclusive breastfeeding at 6 months. Thank you for the referrals and please continue to encourage prenatal and postnatal mothers to see Colleen for lactation.

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 Q2 there were 102 patient visits.

Stats: 76.09% of patients with confirmed Asthma/COPD have an action plan.

81.48% of current smokers seen in the Asthma/COPD program have smoking cessation intervention. 31% of the patients offered the STOP Smoking Cessation program have joined.

Highlight: We've had eight patients registered for Fitness for Breath and we are currently halfway through the fall program.

A reminder that Asthma or COPD diagnosis should be confirmed with a spirometry so please keep referring!

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 Q2 there was 162 patient visits to the SCFHT program.

Stats: 41.4% of patient referrals received in Q2 were for high risk patients. This has gone up since Q2 where only 26.4% were for high risk. Thank you for the referrals!

95.45% of patients in the program with wounds have controlled or improved their results.

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 89 patients, resulting in 192 patient contacts.

Stats: 26.3% of patients in the program have quit smoking at 12 months.

75.28% of patients in the program have smoking status documented in Risk Factors.

Highlight: Please remember to document smoking status in Risk Factors. Thank you for doing so! Our documentation accuracy is increasing.

Brandi Milko, RN, is now trained in STOP Smoking Cessation and is also seeing patients.

We are keeping very busy in this program! A big thanks to our staff who are able to support and promote this program amongst everything else they're doing!

Pharmacist Services

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 109 patients seen in Q2.

Stats: Our Pharmacist suggested 74 medication changes, and 47 of these suggestions were implemented by the primary care provider. 12 patients in the program had a medication reconciliation process completed with 9 patients having reconciliations as part of another program (i.e., Memory Clinic).

Highlight: Ideally, more time for June could be allotted to practice in pharmacist services. We are continuing to look at ways to accomplish this. In the meantime, please continue to send referrals!

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: 131 patient visits occurred in Q2.

Stats: 55.9% of follow-up patients have achieved their most recent SMART goal.

56.2% of dyslipidemia patients who completed a repeat lipid assessment showed improve results 1 year after appointment.

Highlight: Our wait list for Nutritional Counselling is quite long, ranging from a 4-6 week wait. Please let your patient know this when referring. If your patient needs to be seen urgently, please mark as such and we will do our best to accommodate them.

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: 11 patients were seen in Q2 resulting in 40 provider contacts.

Stats: 90% of patients are satisfied with the service!!

70% of patients reported an increased understanding about their condition.

Highlights: Staff attended a Memory Clinic Booster event and they will be presenting the information to the rest of the Memory Clinic group at a meeting.

Brittan Van Belleghem, our new Occupational Therapist, will be joining the Memory Clinic group and recently attended Memory Clinic training.

Please ensure that when referring to Memory Clinic, your referrals are complete. Use our FHT Program Referral Form found under Custom Forms, enter the reason for referral, and ensure the following is complete or attached:

- → Consult report/specialist report
- → EKG
- → CT Scan/MRI
- → Current medication list
- → Significant medical history
- → Bloodwork including a CBC, TSH, Creatinine, Electrolytes, Glucose, Vitamin B12, and Calcium
- → Name, phone number, and relationship to patient of the caregiver/family member who will be attending the appointment with the patient
- → And please inform the patient that driving concerns will be assessed at this assessment

Upcoming Events

Bariatric Support Group
Hosted by
Kate Ronnebeck, Cindy Van Belleghem & Kati Heinrich
First Wednesday of Each Month
at 5:00pm
Held in the Conference Room

For anyone who is interested in joining, whether wishing to hear others experiences and learn more about bariatric surgery, those who have had the surgery and wishing to share, and anyone in between

Diabetes Blood Pressure & Blood Sugar Readings
Hosted by
Cindy Van Belleghem and Carolyn Hamlyn
Benedickson Court – November 13th, 2018– 1:15pm
Gardner House – November 19th, 2018 – 1:00pm
Park Place – November 27th, 2018 – 1:15pm

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
Nurse Practitioner – Leanne Bratland
Nurse Practitioner – Michael Reid
Occupational Therapist – Brittan Van Belleghem
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

Welcome to our new staff

Brittan Van Belleghem, Occupational Therapist

Michael Reid, Nurse Practitioner

Leanne Bratland, Nurse Practitioner