Issue
06
May 2019

Sunset Country Family Health Team

Quarterly Newsletter

Inspiring a healthier Kenora

Q4 Highlights

SCFHT HIGHLIGHT

Occupational Therapy

We are accepting referrals for our Occupational Therapy program! Brittan will see patients for:

- → **Home Environment Safety Assessments**
- → **Daily living skills assessments & recommendations**
- → **Fall prevention and Management**
- → **Mobility aids/adaptive equipment assessments & support**
- → **Chronic disease & pain management**
- → **Sensory processing**
- → **Cognitive assessments & interventions**
- → **Coping Skills**
- → **Return to work programming**
- → **Ergonomic Assessments**
- → **Stroke Rehabilitation**
- → **Fine and gross motor skills assessment and intervention**

And more! Any questions? Call us at (807) 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 Q4, 44.71% of NP patients received a same or next day appointment.

Stats: In Q4, there were 5,195 patient services administered under acute & episodic care.

Highlight: We are still 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 patients 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 the following events:

2 Craving Change workshop sessions

3 Bariatric Group sessions

5 Chronic Pain Management Group sessions

We screened 131 patients for Pap-A-Palooza in 2018. **Pap-A-palooza 2019, we screened 157 patients! *Great job everyone!***

Highlight: The Bariatric Support Group meets 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.

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: 62.7% of our patients are up to date for cervical screening.

Colorectal Cancer Screening: 67.2% of our patients are up to date for colorectal screening.

Breast Cancer Screening: 63.17% of our patients are up to date for breast screening.

Physicians and Nurse Practitioners: *please remember to update your patient's cancer screening HMP when you receive 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.

Access: In Q4 there were 337 patients seen and 655 patient contacts.

Stats: 82.75% 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%.

45.69% of patients with Type 1 or Type 2 diabetes most recent HbA1c (within the last 12 months) was within their individualized range.

69.65% of patients with Type 1 or Type 2 diabetes most recent blood pressure was less than 150/90.

53.35% of patients with Type 1 or Type 2 diabetes have had a foot screening completed within the last 12 months.

95.77% of patients with chronic foot issues seen by the foot care nurse had their problem under control at their most recent visit.

Highlight: We would like to take this time to thank you for the referrals and sending patients back to see us.

There will be a new 60 Second Foot Screen form that will be going into the EMR – the doctors will also receive a laminated copy of same.

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: 177 patients were seen by the program in Q4, resulting in 319 patient visits.

Stats: 57.85% of patients in the program have improved their blood pressure readings to target after 3 visits.

85.2% 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: We will be getting more home blood pressure monitors to aide our patients in recording their 24 ABPM's. *Please keep the referrals coming!*

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: 153 patients were seen by the SCFHT in Q4 resulting in 644 visits.

Stats: 69.81% of tests given were within INR target range. This is very close to our goal of 70%.

0.6% INR patients experienced a stroke in Q4 (1 event) 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: 74 of the 644 patient visits also had other care provided by our IHPs during their INR visit.

*Please continue to identify any patients who may be a candidate for a **DOAC**.* We currently have 150 INR patients and approximately 20% have already been switched to a DOAC.

Social Work

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

Access: 113 patient visits occurred in Q4.

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 92.0%.

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: 19 patients were seen in Q4 resulting in 24 patient visits.

Stats: 49.7% of babies seen for lactation in Kenora are still exclusively breastfed at 6 months.

Highlight: We are still 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 Q4 there were 123 patient visits.

Stats: 71.43% of patients with confirmed Asthma/COPD have an action plan.

80.00% of current smokers seen in the Asthma/COPD program have smoking cessation intervention. 70.59% of the patients offered the STOP Smoking Cessation program have joined.

85.0% of COPD patients received a yearly flu shot and 70.0% of COPD patients received a one-time pneumococcal vaccine. ***Please remember to update your patients flu shot documentation.***

Highlight: 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 Q4 there was 250 patient visits to the SCFHT program.

Stats: 45.2% of patient referrals received in Q4 were for high risk patients. This has gone up since Q3 where only 36.7% were for high risk. ***Thank you for the referrals!***

96.67% of patients in the program with wounds have controlled or improved their results.

We currently have a wait time of approximately 6-8 weeks to get an appointment scheduled with Andrea. We have Sue working part-time doing diabetic foot care, so that has freed up Andrea's time for the more high-risk patients.

Please keep sending us referrals!

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 99 patients, resulting in 180 patient contacts.

Stats: 8.3% of patients in the program have quit smoking at 12 months.

85.86% of patients in the program have smoking status documented in Risk Factors.

Highlight: The Nicotine Spray will eventually be eliminated from the program in the near future. We will use up existing stock and keep ordering until we can't get them anymore.

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 86 patients seen in Q4.

Stats: Our Pharmacist suggested 34 medication changes, and 11 of these suggestions were implemented by the primary care provider. 12 patients in the program had a medication reconciliation process completed.

Highlight: 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: 108 patient visits occurred in Q4.

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

80.0% of dyslipidemia patients who completed a repeat lipid assessment showed improved results 1 year after appointment.

Highlight: Therese Niznowski will be taking over for Kate, on a part-time basis, while she is off on maternity leave. Therese will be seeing acute cases or any other case that requires the immediate support of a dietician. Therese will be working on Monday's and Thursday's.

Our wait list for non-acute Nutritional Counselling is quite long and now with Kate's absence, will be that much longer. 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.***

Patients can speak with a Dietician in Ontario by calling Telehealth at 1-866-797-0000. Patients can also visit www.ontario.ca/page/get-medical-advice-telehealth-ontario for more information.

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: 21 patients were seen in Q4 resulting in 62 provider contacts.

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

100% of patients reported an increased understanding about their condition!

Highlights: 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

There is currently a 4-6 week waiting time to get into the Memory Clinic. The next scheduled one is on May 22, 2019.

OCCUPATIONAL THERAPRY

Program Goal: Occupational Therapy (OT) focuses on promoting and maintaining individual's function and independence. OT's collaborate with the patient to develop goals and problem solve barriers that may be preventing them from participating in chosen and meaningful self-care, productivity, and leisure activities. OT's use a variety of compensatory and remediation strategies to care, by modifying the task, altering the environment, provision of equipment, and function-based rehabilitation.

Access: 40 patients were seen in Q4 resulting in 110 patient visits.

Home Visits: 15 home patients resulting in 19 home visits.

Average Age of patients: 63

Highlight: Reminder to please keep sending referrals!

Congratulations

Congratulations to our Executive Director, Colleen Neil, who has been acclaimed as our regional representative on AFHTOs new Leadership Council. Colleen will be an advisor and conduit of information to and from the Association of Family Health Teams of Ontario.

Colleen will serve the next two-year term as the North West Regional Representative on the council.

COOP STUDENT PAP-A-PALOOZA DISPLAY

Our Coop Student, Paige Stevenson, created this informative Pap-A-Palooza display which we proudly showcased in our reception area waiting room. We received a number of comments from patients saying how surprized they were at how little they knew about the pap test. Thank you, Paige, for your hard work and creativity!

Upcoming Events

BARIATRIC SUPPORT GROUP
Hosted by
Kate Ronnebeck, Cindy Van Belleghem & Kati Heinrich
First Wednesday of Each Month

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.

This group will not be running over the summer months.

CHRONIC PAIN GROUP
Will resume in the Fall of 2019.

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

This group was successful and very well attended!

Please keep sending us your referrals for this upcoming Fall!

“Your opinion matters”

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

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

The Team

Executive Director – Colleen Neil
Finance/HR – Stephanie Evenden
QIDSS – Melonie Young
Administrative Assistant – Sandi Crandall
Reception – Tannis Romaniuk
RN, Health Links & Clinical Coordinator– 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/Therese Niznowski
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 – Vanessa Trent
Registered Practical Nurse – Whitney King
Registered Practical Nurse – Diane Morley
Social Worker – Kati Heinrich

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

Welcome to our new staff members

Sandi Crandall, Administrative Assistant

Therese Nizkowski, Dietician

Diane Morley, Registered Practical Nurse

And Welcome Back!

Vanessa Trent, Registered Practical Nurse