Sunset Country Family Health Team
Quarterly Report
Inspiring a healthier Kenora

Issue 9
October 2020

Q2 Highlights - *July, August, September 2020*

SCFHT COVID-19 Update

SCFHT Programs are **open** and we are accepting new referrals to all programs.
We are adhering to the guidelines in place for physical distancing, patient and staff symptom screening, ensuring common areas are sanitized regularly and PPE/mask requirements.

As we continue to navigate the COVID-19 pandemic, thank you for your patience and for your hard work in ensuring that we are keeping our patients and staff safe!

Acute & Episodic Care Program

Program Goal: To provide high quality acute care to FHN patients.
Stats: In Q2, 2,548 patients were seen by the Sunset Country Family Health Team and 4,339 visits were provided by the team under acute and episodic care.

- 52% were in-office visits.
- 46% were phone visits.
- 2% other visits.
- 4 ER diversions from LWDH.

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: *All public group events are currently on hold due to the COVID-19 pandemic restrictions. We are moving events and support groups to a virtual platform where possible.*
Highlight: **NEW!** Janet and Kati are offering a new virtual program called Mindful Eating: weekly group sessions to help encourage patients foster a more positive relationship with food. New referrals are welcome, as we will be creating a wait list for future sessions.

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: 53% of our patients are up to date for cervical screening.
Breast Cancer Screening: 53% of our patients are up to date for breast screening.
Colorectal Cancer Screening: 65% of our patients are up to date for colorectal screening.
*Note: SAR values are different from our EMR values; we are working on reconciling the EMR.
Highlight: The COVID-19 pandemic situation has been challenging and our team would like to share that we are doing our best during these exceptional times due to the current restrictions.

- PAP tests have resumed at SCFHT and we are accepting referrals for appointments.

- As of October 20, 2020 LifeLabs announced they will be accepting FIT tests for *all* eligible patients, no longer being restricted to high-risk patients only.
- The Ontario Breast Screening Program has started sending reminders to patients in the Kenora area to book their screening mammograms.

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 Q2 there were 175 patients seen and 378 contacts by the Diabetes Management Program.

Stats:

- 89.31% of patients with Type 1 or Type 2 diabetes had an A1c in the last year.
- 80.57% of patients with Type 1 or Type 2 diabetes had their blood pressure measured in the last six months.
- 58.49% of patients had a validated foot screen in the last year.
- 53.14% of patients had a retinal exam within the last two years.
- 68% of patients set a SMART goal within the last six months.

Highlight: The Diabetes Management Program team continued to offer services throughout the COVID-19 pandemic by phone appointments as well as seeing new patients and urgent referrals in-office. The team hosted a drive-thru point of care testing day which was a success! They will consider scheduling another drive-thru day in the future.

Cindy is the primary lead for the DMP team right now as Carolyn is currently sharing her time between the COVID-19 Assessment Centre 2 days/week and 3 days/week at SCFHT.

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 Q2, resulting in 397 patient visits.

Stats:

- 80.77% of patients in the program have improved their blood pressure readings to target after 3 visits.
- 95% of patients have set a new lifestyle goal after 3 visits.

Highlight: Jill, Alanna and Janet are offering virtual group education sessions for patients in the Hypertension Management Program. The next session will be Thursday, November 26, 2020 at 2:00pm-3:00pm via Zoom. We are accepting new referrals for the virtual education session.

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 harm and/or hospitalization.

Access: 138 patients were seen by the SCFHT in Q2 resulting in 584 visits.

Stats:

- 77.52% of tests given were within INR target range.
- 0 INR patients experienced a stroke in Q2, keeping us below our 2% target.
- One INR patient experienced a major bleeding event; this keeps us below our 2% target.

Highlight: There has been a recent decrease in the number of patients in the INR program as some patients have transitioned to different medications.

The INR Program has continued providing services throughout the COVID-19 pandemic, ensuring proper physical restrictions were in place to protect high-risk groups. We are encouraging patients to attend their appointments regularly. We are also offering flu shots to all INR patients seen.

Social Work

Program Goal: To improve the overall wellbeing and mental health of patients served by the SCFHT.
Access: 70 patients were seen which resulted in 123 patient visits 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.
No SRS surveys were completed in Q2, as the majority of visits were completed virtually.
Highlight: The Social Work program was primarily done through Virtual Visits throughout the spring due to the COVID-19 pandemic. Kati is now available to see patients in-office for those who prefer to meet face-to-face. We are accepting new referrals for the social work program.

Lactation Consultation Program

Program Goals: Provide individual patient sessions with expectant parents and mother/baby dyads for support, education and strategies to establish, maintain or continue exclusive breastfeeding until 6 months.
Access: 19 patients were seen in Q2 resulting in 28 patient visits.
Highlight: In partnership with the Kenora Baby Friendly Coalition, we hosted a virtual event in celebration of National Breastfeeding Week (October 1-7, 2020). While we had hoped that more moms and babies were able to join us, the event was still successful.
New referrals for lactation consultations are always welcome and we will do our best to assist and schedule them in quickly!

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 55 patients and 73 patient visits.
Stats:

- 97.92% of Asthma and COPD patients have a spirometry confirmed diagnosis.
- 66.67% of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention.
    - 22.22% of the patients who smoke have joined the STOP program.
- 57.14% of COPD patients received a yearly flu shot and 78.57% of COPD patients received a one-time pneumococcal vaccine.

Highlight: **Spirometry tests will be resuming at SCFHT on October 23, 2020!**
Colleen Snyder will be doing spirometry appointments on Fridays only (maximum of 4 appts each Friday). We have a significant backlog of referrals to catch-up on that were cancelled or postponed due to the COVID-19 pandemic in the spring, but we are accepting new referrals. New referrals will be triaged for urgency and can be sent to be performed at LWDH as needed. (*LWDH will be doing 3 spirometry appts/day to a maximum of 15/week*).

Chiropody Program

Program Goals: 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 provide custom foot orthotics to patients who require offloading.

Access: In Q2 there were 123 patient visits and 195 office visits at the SCFHT program and 96 patients and 141 visits to the LWDH Wound Care program.

Stats:

- 0.81% of patients had a hospitalization due to an unstable wound since their last visit.
- 100% of patients in the program with wounds have controlled or improved their results.

Highlight: Eligible patients must be rostered to a FHN physician or a registered patient of the NP Clinic. Patients *must* be referred into the program – please send us referrals through the PS Suite EMR using the referral forms.

Foot Care Services

Program Goal: To screen for and treat diabetic foot conditions in order to prevent or delay complications.

Access: In Q2 there were 117 patients and 143 visits.

Stats:

- 88.17% of patients have had a 60 second foot screen within the last year.
- 70.94% of patients have an action plan who follow up with the foot care nurse on an annual basis.
- 96.40% of patients with chronic problems have their conditions now under control with regular clinic visits.

Highlight: The Foot Care team would like to thank everyone for their patience in the services that were delayed due to the COVID-19 pandemic and to everyone for being active and diligent in their role in keeping patients safe.

Chris Anderson has resigned from SCFHT but will be returning to Kenora periodically to offer foot care services for his patients until a new Foot Care RPN is able to fill the role.

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 61 patients, resulting in 108 patient visits.

Stats:

- 18.2% of patients in the program have quit smoking at 12 months.
- 100% of patients in the program have smoking status documented in Risk Factors.

Highlight: Please continue to document smoking status. In PS Suite, smoking status is found on the toolbar in the patient's chart.

The Smoking Cessation program is open; we are offering the program through phone, virtual or in-person appointments for interested patients. We are accepting patients requiring a spirometry test to be done; we will be working through our current backlog of postponed appointments, but will accept new referrals.

Pharmacist Services

Program Goals: Assess medications are working effectively and are not negatively impacting the patient's well-being; to identify and help solve possible medication related problems soon after discharge to help minimize risk of re-admittance to hospital; and to provide patient and provider education about medication therapies.

Access: There were 132 patients seen in Q2.

Stats:

- 18 patients had a medication review completed in Q2.
- 110 patients had their medications updated in the EMR.
- 26 patients had a medication reconciliation.
- 27 patients had drug information questions answered.
- 21 patients received assistance with drug navigation (forms, etc.)
- 73 patients had hospital discharge medication follow-up.

Highlight: New referrals for pharmacy services and medication reviews are welcome; please ensure that patients bring their medications or a medication list to all appointments (physical bottles or blister packs are ideal!).

Nutritional Counselling

Program Goals: Provide nutrition 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: In Q2 there were 74 patients and 137 contacts at the SCFHT program.

Stats:

- 97.73% of follow-up patients have achieved their most recent SMART goal.
- 60% of dyslipidemia patients had a documented Framingham risk assessment.

Highlight: Janet and Therese are the dietitians at the SCFHT Nutritional Counselling Program; Kate Ronnebeck has resigned from SCFHT and accepted an opportunity through WNHAC.

Janet and Therese have split their areas of focus for nutritional counselling:

- Janet offers nutrition counselling for hypertension, prediabetes and celiac disease;
- Therese will see patients for eating disorders and hyperlipidemia;
- *Both* dietitians will see patients for any concerns or needing assistance with weight loss, healthy eating, irritable bowel syndrome or any GI issues, kidney, liver disease, etc.

Memory Clinic

Program Goal: Optimize access, diagnosis, and care for 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: 10 patients were seen in Q2 resulting in 46 provider contacts.

Stats:

- 18 patients had a documented MOCA in Q2; 10 were performed by Memory Clinic.
- 100% of patients are satisfied with the service (4/4).
- 75% of patients reported an increased understanding about their condition (3/4).

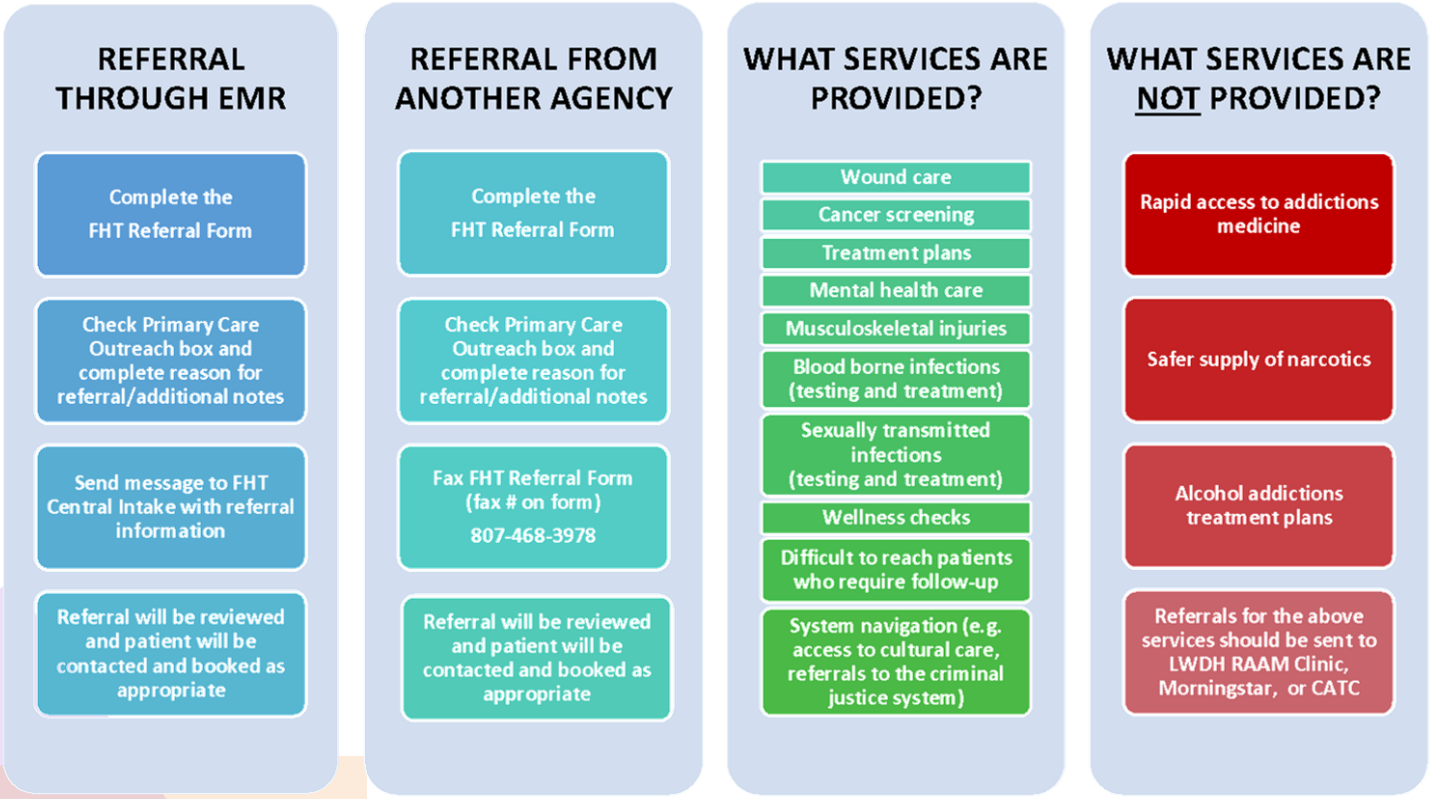
Highlights: Memory Clinic services have resumed with a slightly modified clinic and are accepting new referrals. Please reach out to us if it is an urgent referral.

Occupational Therapy

Program Goals: Provide support to improve and maintain daily functioning for patients. Decrease unnecessary visits to physicians and LWDH and decrease costs to health care system.
Access: 55 patients were seen in Q2 resulting in 111 patient visits.
Home Visits: 25 home assessments completed.
Falls Assessments: 72.41% of patients over 65 had falls assessments.
Highlight: October is Occupational Therapy Month! Brittan, our OT, works with our patients to help create goals and problem solve barriers that prevent them from participating in their self-care, productivity and leisure activities. The Occupational Therapy program is open to new referrals and is offering in-person visits, phone consultations and home visits. Brittan can also help patients with the Assisted Devices Program.

NEW Primary Care Outreach Program

Primary Care Outreach is an evidenced-based approach that is effective in expanding access to programs and services for those most adversely affected by the social determinants of health. The SCFHT Primary Care Outreach program will offer primary care services throughout outreach in various community settings for difficult to reach populations and those who have barriers in accessing these services through formal channels. Primary Care Outreach is a method to help ensure equitable access to those facing barriers in accessing primary care programs and services.



October 20, 2020

Upcoming Events

Mindful Eating: Virtual Group

A virtual weekly group session for 6 weeks to help encourage patients foster a more positive relationship with food.

First session begins **October 28, 2020** and runs until December 2, 2020. Contact Janet or Kati for more info – new referrals for a future session welcome!

Hepatitis C Screening Clinic: Thursday, November 5, 2020

A nurse from AbbVie will be on site for point of care testing, a technologist will provide a fibroscan, and a Nurse Practitioner will be available to provide results and counselling as needed. *By appointment only – no referral needed.* Contact Lindsay Whitaker through the PS Suite EMR or have interested patients call SCFHT directly.

Hypertension Education Group Session: Thursday, November 26, 2020

Jill, Alanna and Janet will be hosting another virtual education session for patients in the Hypertension Management Program. New referrals welcome!

Your opinion matters!

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

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

Sunset Country Family Health Team

Do you have something you'd like to submit for the Quarterly Newsletter?

Please reach out to Lindsay Whitaker, SCFHT Admin Assistant with your content or suggestions: info@scfht.ca

The Team

Executive Director – Colleen Neil
Finance – Stephanie Evenden
QIDSS – Melonie Young
NEW **Administrative Assistant** – Lindsay Whitaker
NEW **Reception** – Addyson Kasprick
Clinical Coordinator– Lindsay Kinger
Chiropodist – Andrea Clemmens
Diabetes Dietitian – Cindy Van Belleghem
Diabetes RN – Carolyn Hamlyn
Foot Care Nurse – Sue McLeod *(part time)*
Nurse Practitioner – Barb Pernsky
Nurse Practitioner – Carol Wilson
Nurse Practitioner – Holly Rose
Nurse Practitioner – Kate McEachern
Nurse Practitioner – Michael Reid
NEW **Nurse Practitioner** – Michèle Berthiaume *(Docside Clinic + Minaki Nursing Station)*
Occupational Therapist – Brittan Van Belleghem
Pharmacist – June Dearborn
Registered Dietitian – Therese Niznowski *(part time)*
Registered Dietitian – Janet Gilfix *(part time)*
Registered Nurse – Jillian Faulds
Registered Nurse – Colleen Snyder
Registered Nurse – Alanna Mutch *(part time)*
NEW **Registered Nurse** – Becky Shorrock (Outreach)
NEW **Registered Nurse** – Jen Carlson (Outreach)
Registered Practical Nurse – Breanne Becker *(casual)*
Registered Practical Nurse – Kendra Madussi *(maternity leave)*
Registered Practical Nurse – Vanessa Trent *(part time)*
Registered Practical Nurse – Kim Loranger
Registered Practical Nurse – Rika Schadek-Parson *(Keewatin Medical Centre)*
Social Worker – Kati Heinrich