Sunset Country Family Health Team
Quarterly Report
Inspiring a healthier Kenora

Issue 11
April 2021

Q4 Highlights – *January, February, March 2021*

SCFHT COVID-19 Update

The Sunset Country Family Health Team will remain open during the provincial Stay at Home order issued in April 2021 and will continue to offer our programs and services. The majority of our appointments will be offered virtually during this time but will continue to see patients in-person for those who require an in-office appointment.

Thank you to all of our staff and partner clinics and agencies for their ongoing commitment and dedication to keeping our patients and community safe throughout these exceptional times.

Acute & Episodic Care Program

Program Goal: To provide high quality acute care to FHN patients.
Stats: In Q4, 2,485 patients were seen by the Sunset Country Family Health Team and 4,693 visits were provided by the team under acute and episodic care.

- 45% were in-office visits.
- 53% were phone visits.
- 2% other visits (home or virtual visits).
- 1 ER diversion 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. The SCFHT is transitioning events and support groups to a virtual platform where possible.*
Highlight: The SCFHT has wait lists for future group sessions (hypertension education sessions, dyslipidemia groups and Mindful Eating groups); please contact the SCFHT to add interested patients to a wait list for a future event date.

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: 52% of FHN patients are up to date for cervical screening.
Breast Cancer Screening: 53% of FHN patients are up to date for breast screening.
Colorectal Cancer Screening: 65% of FHN patients are up to date for colorectal screening.
Highlight: PAP tests, FIT tests, and mammograms are offered to all patients. Although the pandemic has affected regular screening, providers are working to ensure that cancer screening is completed for all patients.

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, 220 were patients seen resulting in 513 contacts.

Stats:

- 91.96% of patients with Type 1 or Type 2 diabetes had an A1C in the last year.
- 66.36% of all patients seen had their blood pressure measured in the last six months.
- 57.79% of patients with Type 1 or Type 2 diabetes had a validated foot screen in the last year.
- 46.36% of patients had a retinal exam within the last two years.
- 68.18% of patients set a SMART goal within the last six months.

Highlight: The Diabetes Management Program team is continuing to offer services throughout the provincial stay at home order by phone appointments or virtual visits, as well as seeing new patients and urgent referrals in-office.

- The DMP team will be offering **Parking Lot POCA1c days** at the SCFHT and Keewatin Medical Clinic later this spring. The Keewatin Clinic day will be May 28, 2021; the date at the SCFHT is to be determined.

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: In Q4, 210 patients were seen resulting in 427 visits.

Stats:

- 70.45% of patients in the program have improved their blood pressure readings to target after 3 visits.
- 75% of patients have set a new lifestyle goal after 3 visits.

Highlight: The Hypertension Team is accepting new referrals and are able to see patients in-person or by phone; and the team is able to set up patients with a home BP monitor (24hr or 7-Day) to determine their average BP reading.

- ***New*** The SCFHT Hypertension Education Video is now live and embedded on the SCFHT website as an educational resource for patients to watch as part of their referral to the hypertension program.

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: In Q4, 124 patients were seen resulting in 480 visits.

Stats:

- 72.71% of tests given were within INR target range.
- 0 INR patients experienced a stroke in Q4, keeping the SCFHT below their 2% target.
- 0 INR patients experienced a major bleeding event, which keeps the SCFHT below their 2% target.

Highlight: The INR Program continues to provide services throughout the Stay at Home Order. The INR team is able to offer home visits or 'car visits' in the parking lot depending on how comfortable the patient is with coming into the clinic.

Social Work

Program Goal: To improve the overall wellbeing and mental health of patients served by the SCFHT.
Access: In Q4, 74 patients were seen, resulting in 126 visits.
Highlight: The SCFHT Social Worker is available to see patients virtually which is a great alternative for patients to access services during the COVID-19 pandemic and Stay at Home order. The SCFHT is 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: In Q4, 17 patients were seen resulting in 36 visits.
Highlight: Our Lactation Consultant has provided a list of details for referral reasons:

Prenatal:

- For breastfeeding education especially if delivery is expected in Winnipeg or is high-risk;
- Has had previous breast surgeries (especially breast reduction);
- Has metabolic disorders (e.g., polycystic ovarian syndrome, diabetes, hypo- or hyperthyroidism)

Post-partum:

- Failure to latch/poor latching;
- Poor weight gain/low output;
- Nipple pain/cracked, sore nipples;
- Low or declining milk supplies;
- Blocked dusts or mastitis;
- Over active let down;
- Green mucus-y stooling or bloody stools;
- Reflux, gassiness, frequent regurgitations, choking or gagging;
- Metabolic disorders (e.g., diabetes, hypo- or hyperthyroidism);
- Long continuous feeds 24/7;
- Pulling on and off the breast;
- Favors only one side;
- Weaning/going back to work;
- Overwhelmed moms with non-content babies

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 111 patients seen, resulting in 130 visits.
Stats:

- 98.72% of Asthma and COPD patients have a spirometry confirmed diagnosis.
- 77.78% of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention.
    - 7% of the patients who smoke have joined the STOP program.
- 65.96% of COPD patients received a yearly flu shot and 74.47% of COPD patients received a one-time pneumococcal vaccine.

Highlight: ***Notice*** Please be advised that spirometry testing through the Primary Care Asthma Program at the Sunset Country Family Health Team is currently on hold until further notice.

As per the recommendation from the Canadian Thoracic Society and the Ontario Lung Health Foundation guidelines, due to the prevalence of COVID-19 in the NWHU area, the SCFHT has suspended spirometry testing until it can be safely resumed in a primary care setting.

There is currently at least a six month wait for a spirometry appointment. The SCFHT will continue to accept referrals for spirometry testing and they will be placed on a waiting list for future booking.

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 Q4, there were 153 patient visits and 225 office visits at the SCFHT program; and 90 patients and 125 visits to the LWDH Wound Care program.

Stats:

- 0% of patients had a hospitalization due to an unstable wound since their last visit.
- 91.67% of patients in the program with wounds have controlled or improved their results.

Highlight: The SCFHT Chiropodist is accepting new referrals. Please note that eligible patients must be rostered to a FHN physician. Patients must be referred into the program; please continue to send 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 Q4, there were 141 patients seen, resulting in 189 visits.

Stats:

- 95.73% of patients with diabetes have had a 60 second foot screen within the last year.
- 97.87% of patients have an action plan who follow-up with the foot care nurse on an annual basis.
- 92.55% of patients with chronic problems have their conditions now under control with regular clinic visits.

Highlight: The SCFHT has updated our Chiropody / Foot Care Program referral eligibility. When referring patients to the Chiropody or Foot Care program, please review to determine which of our providers is best suited to see your patient.

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 70 patients seen, resulting in 139 patient visits.

Stats:

- 26.3% of patients in the program have quit smoking at 12 months.
- 100% of patients in the program in Q4 have smoking status documented in Risk Factors.

Highlight: Smoking remains the single largest preventable cause of disease and premature death, and our team at the SCFHT is dedicated to helping patients with quitting smoking. Please remember to document patients' smoking status in the EMR.

Please note that the SCFHT has temporarily placed spirometry testing on hold. Patients who have been referred to the SCFHT Smoking Cessation program will have their spirometry referral sent, however they will be placed on a wait list to be scheduled at a later date. There will be a 6 month wait list for an appointment and we will work through our referral wait list as soon as we are able to resume the service.

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: In Q4, there were 108 patients seen, resulting in 126 visits.

Stats:

- 17 patients had a medication review completed in Q4.
- 83 patients had their medications updated in the EMR.
- 26 patients had a medication reconciliation.
- 30 patients had drug information questions answered.
- 24 patients received prescription samples.
- 8 patients received assistance with drug navigation (forms, etc.)
- 54 patients had hospital discharge medication follow-up.

Highlight: Please note there is a new template being used for medication reviews in PS Suite, named 'SCFHT Pharmacist Encounter'. This is a collapsible custom form and providers will need to open the form to review (see: 'Drug Therapy Problems' and 'Management and Recommendations for DTPs' in the form).
The SCFHT is continuing to accept referrals for patients to see the Pharmacist.

Nutritional Counselling

Program Goals: Provide nutrition tools and education to help patients improve their quality of life and decrease the likelihood of developing a chronic disease, or to help patients manage the nutritional component of dealing with a chronic disease to decrease the possibility of adverse events.
Access: In Q4, there were 121 patients seen, resulting in 210 visits.
Stats:

- 89.06% of follow-up patients have achieved their most recent SMART goal.
- 66.67% of dyslipidemia patients had a documented Framingham risk assessment.

Highlight: One of the dietitians at the SCFHT, Janet Gilfix, has chosen to further pursue her time and dedication in long-term care. Thank you, Janet for your dedication and care to your patients! The SCFHT is working on filling this position.
The SCFHT is continuing to accept new referrals for Nutritional Counselling and are able to provide services through phone or virtual appointments.

Memory Clinic

Program Goal: Optimize access, diagnosis, and care for patients with memory difficulties. Early diagnosis 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 also creates capacity at the primary care level to free up specialist resources to focus on the most complex cases.

Access: In Q4, 23 patients were seen. 19 Memory Clinic assessments and 15 post clinic follow-up contacts were completed.
Stats:

- 39 patients had a documented MoCA in Q4; 21 were performed by Memory Clinic.
- 100% of patients are satisfied with the service (8/8).
- 100% of patients reported an increased understanding about their condition (8/8).

Highlight: Memory Clinic is open and will continue to remain open during the Stay at Home order. Please contact the SCFHT with urgent referrals or with requests from family members for a follow-up appointment.

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 the health care system.
Access: 41 patients were seen in Q4 resulting in 96 patient visits.

- Home Visits: 11 home assessments completed.

- Falls Assessments: 56.52% of patients over 65 had falls assessments.

Highlight: Occupational Therapy services are available throughout the Stay at Home order and the SCFHT is accepting new referrals. The Occupational Therapist is offering visits through virtual video and phone appointments, and home visits for urgent needs.

Primary Care Outreach Program

Program Goals: To provide primary care outreach to the vulnerable sector and to increase access to primary care and mental health services for underserviced populations in Kenora, leading to improved outcomes and quality of life, and reduced emergency room visits and hospitalizations.

Access: In Q4, 172 patients were seen, resulting in 417 visits.

Stats:

- 5 patients were seen for trauma/injury.
- 287 patients were seen for acute illness.
- 1 patient was seen for chronic illness.
- 2 patients seen for prebooked appointments.
- 9 patients were seen for mental health.
- Patients seen for substances: 1 – alcohol, 31 drugs
- Other: 81
- 162 connections and referrals to All Nations Health Partners programs and services were made.
- 7 patients self-reported they would have sought care from the LWDH Emergency Department.
- 6 referrals to the LWDH Emergency Department were made.

Highlight: In Q4 the program played a large role in the Kenora incident management for vulnerable and high-risk patients. The program provided medical support and patient navigation at the Kenora isolation centre and vaccine administration for vulnerable populations and those unable to isolate in communities in partnership with WNHAC and NWHU.

The program will be starting a nurse led Hepatitis C micro elimination project in May 2021.

Upcoming Events

Hypertension Education Group – Video is now available!

The Hypertension Team will be hosting a virtual education session for patients in the Hypertension Management Program – there is currently a wait list for future sessions and they are accepting new referrals for interested patients.

A pre-recorded video of the education session is now available for patients on the SCFHT website to review for their initial appointment.

Mindful Eating: Emotional Eating and Food Craving Management Group

This virtual group session, offered by the SCFHT Social Worker and Dietitian, is accepting new referrals for patients who may be interested in attending this group. By attending this group, patients will learn:

- about the benefits of mindfulness and how to practice mindful eating
- how to become more in tune with their body and learn to respond to natural cues
- powerful skills to help manage tough food cravings
- find balance and heal their relationship with food

The Mindful Eating group is a 6-week program, with 2-hour sessions once a week for the 6-week duration. Dates for the upcoming group sessions will be announced soon.

All other public events are on hold due to the ongoing COVID-19 pandemic and provincial Stay at Home order.

Your opinion matters!

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

Colleen Neil
Executive Director
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468-6321 ext.269

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

Please contact Lindsay Whitaker, SCFHT Administrative Assistant with your content or suggestions: lwhitaker@scfht.ca

Sunset Country Family Health Team

The Team

Executive Director – Colleen Neil
Finance Manager – Stephanie Evenden
QIDSS – Melonie Young
Administrative Assistant – Lindsay Whitaker
Reception – Addyson Kasprick
Reception – Jenna Mattson *(casual)*
Clinical Coordinator– Lindsay Kinger
Chiropodist – Andrea Clemmens
Diabetes Dietitian – Cindy Van Belleghem
Diabetes RN – Carolyn Hamlyn
Foot Care Nurse – Shannon Matheson
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
Nurse Practitioner – Michèle Berthiaume *(Docside Clinic + Minaki Nursing Station)*
Occupational Therapist – Brittan Amell
Pharmacist – June Dearborn
Registered Dietitian – Therese Niznowski *(part time)*
Registered Nurse – Alanna Mutch *(part time)*
Registered Nurse – Colleen Snyder
Registered Nurse – Jillian Faulds
Registered Nurse – Becky Shorrock (Outreach)
Registered Nurse – Jen Carlson (Outreach)
NEW **Registered Practical Nurse –** Megan Vieira
Registered Practical Nurse – Jay Lee Bais *(casual)*
Registered Practical Nurse – Breanne Becker *(casual)*
Registered Practical Nurse – Carleigh Edie *(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 Clinic)*
Social Worker – Kati Heinrich