Sunset Country Family Health Team
Quarterly Report
Inspiring a healthier Kenora

Issue 12
July 2021

Q1 Highlights – *April, May, June 2021*

SCFHT COVID-19 Update

The SCFHT would like to thank all of our staff, patients and partners for their diligence and dedication to keeping our community healthy and safe.
The SCFHT is always accepting new referrals for programs and have modified the way these services are provided where necessary, ensuring that both patients and staff stay safe.

Acute & Episodic Care Program

Program Goal: To provide high quality acute care to FHN patients.
Stats: In Q1, 3,008 patients were seen by the Sunset Country Family Health Team and 5,354 visits were provided by the team under acute and episodic care.

- 53.73% were in-office visits.
- 44% were phone visits.
- 2% other visits (home or virtual visits).
- 2 ER diversions from LWDH.

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 122 patients, resulting in 159 visits.
Stats:

- 99.01% of Asthma and COPD patients have a spirometry confirmed diagnosis.
- 92.86% of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention.
    - 14% of the patients who smoke have joined the STOP program.
- 64.5% of COPD patients have received a yearly flu shot and 69.4% of COPD patients have received a one-time pneumococcal vaccine.

Highlight:
Please note there is currently a 6 month wait for spirometry testing.
Spirometry testing has resumed and the SCFHT is working through the wait list for scheduling appointments. Referrals triaged as moderate urgency will be prioritized for booking.
We appreciate your patience and understanding as we work diligently to catch up on the backlog for spirometry testing.

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: 36% (EMR) / 49% (SAR) of FHN patients are up to date for cervical screening.
Breast Cancer Screening: 49.9% (EMR) / 49% (SAR) of FHN patients are up to date for breast screening.
Colorectal Cancer Screening: 47.1% (EMR) / 67% (SAR) of FHN patients are up to date for colorectal screening.
**Please note that SAR values are different from our EMR values; we are working on reconciling EMR data.*
Highlight: A reminder for all providers to check operative reports and relabel as colonoscopy where needed (see Mel or Jen B if you don't know how to). Please review cancer screening stats each time you see a patient or open a chart. Colposcopy is now available in Kenora at Lake of the Woods District Hospital.

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 Q1 there were 177 patient visits and 251 office visits at the SCFHT program; and 95 patients and 143 visits to the LWDH Wound Care program.
Stats:

- 0% of patients had a hospitalization due to an unstable wound since their last visit.
- 96% 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 and must be referred into the program. Continue to send referrals through PS Suite.

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, 220 patients were seen resulting in 505 contacts.
Stats:

- 92.68% of patients with Type 1 or Type 2 diabetes had an A1C in the last year.
- 70.45% of all patients with Type 1 or Type 2 diabetes had their blood pressure measured in the last six months.
- 62.93% of patients with Type 1 or Type 2 diabetes had a validated foot screen in the last year.
- 35.61% of patients had a retinal exam within the last two years.
- 72.27% of patients set a SMART goal within the last six months.

Highlight:
Obesity Management at SCFHT
Globally, approximately 650 million people are currently living with obesity; the number of people living with obesity has tripled since 1975. The latest available data from the LHIN reports locally 62% of residents are living with either being overweight or obese. Obesity is a disease and like all disease,

management is available. The cornerstones of obesity management include behavioural support (lifestyle, psychological), medication and surgery options. The Sunset Country Family Health team is currently offering obesity management behavioural support. Cindy Van Belleghem, SCFHT Registered Dietitian has been focusing on obesity management as part of her role in diabetes. She is a member of Obesity Canada and has received specialized obesity care training including mentorship by an obesity specialist from Ottawa, Ontario. An acceptance and commitment therapy for obesity, including education regarding obesity management, is being offered on an individual basis for those living with diabetes, prediabetes or at risk of developing diabetes.

To refer a patient for this obesity programming, please complete the SCFHT Referral Form 2020, checking "Diabetes Program" and under reason for referral write *obesity behavioural therapy* or *obesity management*. If you have any questions about this service, please contact Cindy.

Foot Care Services

Program Goal: To screen for and treat diabetic foot conditions in order to prevent or delay complications.
Access: In Q1, 197 patients were seen, resulting in 295 visits.
Stats:

- 96.34% of patients with diabetes have had a 60 second foot screen within the last year.
- 96.95% of patients have an action plan who follow-up with the foot care nurse on an annual basis.
- 90.65% of patients with chronic problems have their conditions now under control with regular clinic visits.

Highlight: Shannon, part of our Foot Care Team, is now offering Onyfix – a new, pain-free, non-invasive nail correction treatment system. The Onyfix system provides treatment for ingrown and involuted nails which corrects the nail through natural nail growth and helps prevent relapse. The Onyfix treatment uses a thin layer of liquid polymer resin on the nailbed, shaped and customized to the specific needs of the patient's nail, which helps prevent the nail from bending and growing inwards.

The Onyfix system has evidence-based studies proving efficacy, provides quick, lasting pain relief, is safe, fast and easy to use and is an excellent option for high-risk and patients with diabetes.

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 Q1, 197 patients were seen resulting in 433 visits.
Stats:

- 71.07% of patients in the program have improved their blood pressure readings to target after 3 months.
- 40.1% of patients have set a new lifestyle goal after 3 months. *(Changes to program tracking in Q1 mean that this number is understated. Corrected in Q2.)*

Highlight: The Hypertension Team is accepting new referrals and are able to see patients in-person or over the 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.
Please note that one of our nurses on the Hypertension Management Team is on maternity leave. The SCFHT has been unsuccessful in filling her temporary position, and will anticipate a longer wait for an initial appointment for new hypertension referrals.
We will continue to schedule new referrals as quickly as possible and appreciate your patience and understanding.

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 Q1, 122 patients were seen resulting in 541 visits.
Stats:

- 68.98% of tests given were within INR target range.
- 1 INR patients experienced a stroke in Q1, keeping the SCFHT below their 2% target.
- 1 INR patients experienced a major bleeding event, which keeps the SCFHT below their 2% target.

Highlight: The INR team is continuing to look for patients on Warfarin therapy who may be eligible for DOAC treatments.
In 2020/21 36 patients were discharged from the program:

- 17 patients transitioned to a DOAC
- 5 deceased
- 1 put on ASA
- 8 moved/transferred care
- 3 stopped warfarin
- 2 home machines

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 Q1, 29 patients were seen resulting in 87 visits.
Highlight: New referrals for lactation consultations are always welcome and the SCFHT will ensure they are scheduled in quickly. Colleen is happy to see mothers/babies in person, and will also provide support through phone consults and virtual visits where needed.

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 Q1, 22 patients were seen, resulting in 43 provider contacts. 4 clinic days.
Stats:

- 90% of patients are satisfied with the service.
- 82% of patients reported an increased understanding about their condition.

Highlights: Memory Clinic is on hold for the summer and will resume services in September 2021. Referrals for Memory Clinic are still being accepted, but please be aware that patients will need to wait until the fall for their appointment.

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 Q1, there were 97 patients, resulting in 161 visits.
Stats:

- 89.74% of follow-up patients have achieved their most recent SMART goal.
- 70% of dyslipidemia patients had a documented Framingham risk assessment.

Highlight: The SCFHT will be offering full time dietitian services beginning in early August. The dietitian offers services and supports for healthy eating and lifestyle, cardiovascular disease management, dyslipidemia or hyperlipidemia, eating disorders, irritable bowel syndrome or any GI issues, kidney, liver disease, prediabetes, hypertension, or celiac disease.
The dietitian is able to see patients in person, and continues to offer services through phone or virtual visits.

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: In Q1, 39 patients were seen resulting in 86 patient visits.
Home Visits: 8 home assessments completed.
Falls Assessments: 39% of patients over 65 had falls assessments. (71% of patients with in person visits.)
Highlight: FHT Occupational Therapy Services are available to all patients in the Kenora area who are rostered with a primary care provider. Services available include:

- Functional/Daily Living Skills Assessments
- Fall Prevention
- Home Safety Assessments
- Mobility Aid Assessment & Prescription (ADP Authorizer)
- Chronic Disease & Chronic Pain Management
- Cognition and Visual Perception Assessments
- Brain Injury Rehabilitation
- Community Stroke Rehab
- Coping Skills
- Sensory Processing
- Return to Work
- Ergonomic Assessments

Providers are also welcome to contact our OT directly for specific inquiries about the types of services Brittan provides.

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 Q1 there were 203 patients, resulting in 246 visits.
Stats:

- 22 patients had a medication review completed in Q1.
- 158 patients had their medications updated in the EMR.
- 31 patients had a medication reconciliation.
- 51 patients had drug information questions answered.
- 13 patients received assistance with drug navigation (forms, etc.)
- 88 patients had hospital discharge medication follow-up.
- 10 patients from the Cardiac Rehab Program.
- 10 patients received prescription samples

Highlight: Pharmacist services continue to be available at the SCFHT. Please send referrals to the SCFHT for patients to see the Pharmacist for medication reviews or questions for managing their medication lists.

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 Q1, 201 patients were seen, resulting in 502 visits.
Stats:

- 6 patients were seen for trauma/injury.
- 373 patients were seen for acute illness.
- 1 patient was seen for chronic illness.
- 16 patients were seen for mental health.
- Patients seen for substances: 2 – alcohol, 25 – drugs
- Other: 79
- 185 connections and referrals to All Nations Health Partners programs and services were made.
- 8 patients self-reported they would have sought care from the LWDH Emergency Department.
- 13 referrals to the LWDH Emergency Department were made.

Highlight: The Primary Care Outreach Program Team is available to try to connect with difficult to contact patients – please contact Becky Shorrock and Jen Carlson and they'd be happy to assist. Please note that sometimes it can take some time tracking down patients.
A note of success for the PCO Team is they are seeing patients return to them for care when they otherwise wouldn't access care through conventional means.

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 85 patients, resulting in 160 visits.
Stats:

- 33.3% 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: The Smoking Cessation program is open and accepting new referrals. The STOP program is developing a virtual platform for patients to enroll and submit forms prior to their initial appointment which will streamline the enrollment process.

Social Work

Program Goal: To improve the overall wellbeing and mental health of patients served by the SCFHT.
Access: In Q1, 93 patients were seen, resulting in 223 visits.
Highlight: The SCFHT Social Worker is available to offer services through virtual visits. The SCFHT is accepting new referrals for the social work program.
Please note that the Social Worker will be out of office for the month of August 2021. Any referrals may be redirected to external agencies during this time, or wait until Kati has returned.

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 COVID-19 pandemic restrictions. The SCFHT is transitioning events and support groups to a virtual platform where possible.*

Upcoming Events

Mindful Eating: Emotional Eating and Food Craving Management Group

This virtual group, offered by the SCFHT Social Worker and Dietitian, has created a wait list for 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.

The next Mindful Eating group will begin **September 8, 2021**.

All other public events are on hold due to the COVID-19 pandemic.

Your opinion matters!

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

Colleen Neil
Executive Director
cneil@scfht.ca
468-6321 ext.269

Sunset Country Family Health Team

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

Please reach out to Lindsay Whitaker, Administrative Assistant with your content or suggestions: lwhitaker@scfht.ca

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 *(Keewatin Medical Clinic)*
Nurse Practitioner – Carol Wilson *(Kenora Medical Associates)*
Nurse Practitioner – Holly Rose *(Kenora Medical Associates)*
Nurse Practitioner – Kate McEachern *(Kenora Medical Associates)*
Nurse Practitioner – Michael Reid *(Kenora Medical Associates)*
Nurse Practitioner – Michèle Berthiaume *(Docside Clinic)*
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 *(maternity leave)*
Registered Nurse – Becky Shorrock (Outreach)
Registered Nurse – Jen Carlson (Outreach)
NEW **Registered Practical Nurse** – Josh Oliver *(temporary)*
Registered Practical Nurse – Jay Lee Bais *(casual)*
Registered Practical Nurse – Breanne Becker *(casual)*
Registered Practical Nurse – Kendra Madussi
Registered Practical Nurse – Vanessa Trent *(part time)*
Registered Practical Nurse – Kim Loranger *(maternity leave)*
Registered Practical Nurse – Rika Schadek-Parson *(Keewatin Medical Clinic)*
Social Worker – Kati Heinrich
Summer Student – Ethan Belrose
Summer Student – Paige Stevenson