Sunset Country Family Health Team

Quarterly Report

Q2 Highlights: July, August, September 2021

Issue 13
October 2021

Inspiring a healthier Kenora

SCFHT COVID-19 Update

After 18+ months of supporting patients during the COVID-19 pandemic, the SCFHT extends our appreciation to our staff and partners for your hard work and dedication to keeping our patients and 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.

Thank you!

Acute & Episodic Care Program

Program Goal

To provide high quality acute care.

Stats

In Q2, **2,643 patients** were seen, and **4,437 visits** were provided by the team under acute and episodic care.

- 53.8% were in-office visits;
- 45% were phone visits;
- 0.2% other visits (home or virtual visits);
- 1 ER diversion from LWDH.

Health Promotion & 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.

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

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

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, **82 patients** were seen, resulting in **105 visits**.

Stats

96.55% of Asthma and COPD patients have a spirometry confirmed diagnosis.

81.48% of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention.

60% of COPD patients have received a yearly flu shot, and 68.6% of COPD patients have received a one-time pneumococcal vaccine.

Highlight

The Asthma & COPD Program continues to have a significant wait time for spirometry testing. There is currently a ~10 month wait for an appointment.

Urgent referrals can be sent to the SCFHT, and will be expedited to LWDH. The Asthma & COPD Team will follow-up with results.

Cancer Screening Program

Program Goal

Maintain or improve rates of cancer screening of eligible FHN patients according to current evidence-based clinical practice guidelines.

**Please note that SAR values are different from our EMR values; we are continuing to work on reconciling EMR data.*

Stats

32.8% (EMR) / 48% (SAR) of FHN patients are up to date for **cervical cancer screening**.

50.9% (EMR) / 51% (SAR) of FHN patients are up to date for **breast cancer screening**.

49.9% (EMR) / 60% (SAR) of FHN patients are up to date for **colorectal cancer screening**.

Highlight

Cancer screening education videos and resources are available in English and Ojibwe: https://tbrhsc.net/sflmedia/

Reminder for providers to check operative reports and relabel as colonoscopy where needed.

Cancer screening doesn't stop for COVID-19!

It is important for patients to stay up-to-date with their cancer screening!
Our NPs are seeing patients who are overdue for their Pap test. Patients can book their Pap tests through their doctor's office.

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 provide custom foot orthotics to patients who require offloading.

Access

In Q2, **158 patients** were seen, resulting in **246 visits** at the **SCFHT Program**.

97 patients were seen and **134 visits** at the **LWDH Wound Care Clinic**.

Stats

0% of patients had a hospitalization due to an unstable wound since their last visit.

93% of patients in the program with wounds have controlled or improved their results.

Highlight

The SCFHT Chiropodist provides services related to biomechanics, orthotics, foot care callous debridement for those living with an ulceration.

Patients must be referred into the program and patients must be rostered to a FHN Physician.

When to refer to the Chiropody Program:

- Foot pain
- Bunions
- Leg length discrepancies (heel or full lifts)
- Chronic ingrown nails requiring surgery
- Custom-made Foot Orthotics
- ABPI testing

Diabetes Management Program

Program Goal

To 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, **230 patients** were seen, resulting in **451 visits**.

Stats

94.26% of patients with Type 1 or Type 2 diabetes had an A1C in the last year.

83.91% of all patients with Type 1 or Type 2 diabetes had their blood pressure measured in the last six months.

70.33% of patients with Type 1 or Type 2 diabetes had a validated foot screen in the last year.

40.19% of patients had a retinal exam within the last two years.

73.91% of patients set a SMART goal within the last six months.

Highlight

Stats have improved since the last quarter!

Orphaned patients who have a confirmed diagnosis of Diabetes are able to be seen by the DMP team.

Cindy has an InBody composition machine which measures overall body stats.

The DMP team hosted a POC testing day in Keewatin (offered a BP check, POCA1c test, foot screen, and a goodie bag).

Foot Care Services

Program Goal

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

Access

In Q2, **188 patients** were seen, resulting in **300 visits**.

Stats

95.35% of patients with diabetes have had a 60 second foot screen within the last year.

96.28% of patients have an action plan who follow-up with the foot care nurse on an annual basis.

96.77% of patients with chronic problems have their conditions now under control with regular clinic visits.

Highlight

The SCFHT Foot Care Nurses provide foot care for at risk individuals, and/or persons living with diabetes with a history of ulceration, injury or infection, requiring foot care in the prevention of foot injury, ulceration and infection. The SCFHT Foot Care Nurses also provide foot care education and diabetic foot screening.

A reminder to providers that patients who do not have a history of diabetes or ulceration are not eligible for foot care services at the SCFHT and can be referred to a private foot care nurse in the community.

When to refer patients for Foot Care Services:

- Foot assessments for diabetic peripheral neuropathy
- Ingrown nails or possible deformities of nails
- Calluses/corns
- Thickened nails

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 Q2, **145 patients** were seen, resulting in **282 visits**.

Stats

71.70% of patients in the program have improved their blood pressure readings to target after 3 months.

57.55% of patients have set a new lifestyle goal after 3 months.

Highlight

Welcome to Diane Debbo! Diane will be covering for Jill's maternity leave.

The hypertension team continues to be above target for patients in the program to have improved BP readings after their most recent visit.

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 Q2, **124 patients** were seen, resulting in **513 visits**.

Stats

64.76% of tests given were within INR target range.

1 INR patient experienced a stroke in Q2, keeping the SCFHT below their 2% target.

1 INR patient experienced a major bleeding event in Q2, which keeps the SCFHT below their 2% target.

Highlight

The INR team is able to do home visits for INR patients who have trouble leaving their home.

Lactation Consultation Program

Program Goal

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 Q2, **34 patients** were seen, resulting in **104 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 Q2, **9 patients** were seen, resulting in **12 provider contacts**. 1 clinic was held in Q2.

Stats

100% of patients surveyed in Q2 are satisfied with the service.

66.67% of patients reported an increased understanding about their condition.

Highlight

Please be advised that there has been an increase in our wait time for Memory Clinic appointments, and are estimating a 9-10 month wait based on our current wait list.

If you have an urgent referral to the Memory Clinic, or if patients are requiring an urgent follow-up, please send a message to Brittan Amell, OT in PS Suite.

Nutritional Counselling

Program Goal

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 Q2, **130 patients** were seen, resulting in **215 visits**.

Stats

86.21% of follow-up patients have achieved their most recent SMART goal.

86.36% of dyslipidemia patients had a documented Framingham risk assessment.

Highlight

The SCFHT Social Worker and Dietitian will be offering the **Mindful Eating: Emotional Eating and Food Craving Management 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.

Occupational Therapy

Program Goal

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 Q2, **37 patients** were seen, resulting in **79 visits**.

Stats

6 home assessments were completed in Q2.

52.94% 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

Pharmacist Services

Program Goal

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 **Q2** there were **142 patients**, resulting in **168 visits**.

Stats

14 patients had a medication review completed in Q2.
108 patients had their medications updated in the EMR.
19 patients had a medication reconciliation.
47 patients had drug information questions answered.
15 patients received assistance with drug navigation (forms, etc.)
85 patients had hospital discharge medication follow-up.
5 patients from the Cardiac Rehab Program.

Highlight

The SCFHT Pharmacist would like to continue focusing on elderly patients who are needing a medication review.

Please refer any of those patients being seen to the SCFHT Pharmacist.

Primary Care Outreach Program

Program Goal

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 Q2, **157 patients** were seen, resulting in **390 visits**.

Stats

15 patients were seen for trauma/injury.
312 patients were seen for acute illness.
3 patients were seen for chronic illness.
7 patients were seen for mental health.
Patients seen for substances:
0 – alcohol, **17** – drugs
Other: 36

105 connections and referrals to All Nations Health Partners programs and services were made.
1 patient self-reported they would have sought care from the LWDH Emergency Department.
7 referrals to the LWDH Emergency Department were made.

Highlight

The Primary Care Outreach team, is conducting a **Hepatitis C micro-elimination project** in Kenora, funded through AbbVie Care.

For those of you who don't know who we are or what we do, the Primary Care Outreach team provides low-barrier primary care in both walk-in settings, located across from the surgeon's office, and in an Outreach setting via a mobile clinic accessing hard to reach patients. On Tuesday afternoons (1-5) and Friday mornings (9-2) Dr. Grek works with us to support our Outreach patients.

We are reaching out to all of you in regards to addressing, monitoring, and treating the current rates of Hepatitis C in the region.

To help with this process, we have created a form in the EMR titled "**SCFHT Hepatitis C Form**" to help streamline the process regarding HCV treatment, and the various blood work needed and treatment requirements.

When identifying a patient with Hepatitis C, please add this form to the patient's chart, and make it a "**special note**". This will ensure that the form will appear automatically every time the patient's chart is accessed, to ensure that patients' treatment plans and monitoring requirements are met and being monitored.

Outreach is available to help with this process, especially if patients are difficult to reach. In order to do so, we would require a referral. This can be done by calling us directly regarding a patient, a multi-agency referral form, or even an EMR message.

To support everyone in this process, a representative from AbbVie is prepared to answer any emails, phone calls, or schedule Zoom meetings to help out regarding treatment coverage plans, i.e., Trillium or NHIB. Her contact info is embedded in the Hep C form.

Please don't hesitate to message us with any comments, questions, or concerns.

Jen Carlson, RN and Becky Shorrock, RN
SCFHT Primary Care Outreach Program

Smoking Cessation

Program Goal

Provide education, ongoing support, and appropriate pharmacotherapy, if needed, to assist patients in becoming smoke-free.

Stats

28.6% 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 team is working hard with patients to help them quit smoking.

New referrals to the Smoking Cessation program are welcome.

Access

In Q2 there were **73 patients**, resulting in **158 visits**.

Social Work

Program Goal

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

Access

In Q2, **49 patients** were seen, resulting in **99 visits**.

Highlight

The SCFHT Social Worker is able to see patients virtually or in-person – whatever is the patients preference.

Your Opinion Matters!
Help us further develop our programs by sending your ideas or comments to:
Lindsay Kinger, Clinical Coordinator
lkinger@scfht.ca | 468-6321 x327

The Team

Executive Director – Colleen Neil
Finance Manager – Stephanie Evenden
QIDSS – Melonie Young
***New* Administrative Assistant – Programs** – Carly Freund
Administrative Assistant – Communications & Executive – Lindsay Whitaker
Administrative Assistant – Jenna Mattson *(casual)*
***New* Reception** – Toni Maenpaa
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)*
***New* Registered Nurse** – Diane Debbo *(temporary)*
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)
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

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