Sunset Country Family Health Team
Quarterly Report
Inspiring a healthier Kenora

Issue 10
January 2021

Q3 Highlights - *October, November, December 2020*

SCFHT COVID-19 Update

Throughout the COVID-19 Pandemic and the stay-at-home order issued in January 2021, the SCFHT has remained **open** and continues to offer programs and services to their patients.
The SCFHT is always accepting new referrals for their 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 Q3, 3,156 patients were seen by the Sunset Country Family Health Team and 5,207 visits were provided by the team under acute and episodic care.

- 59.97% were in-office visits.
- 39.10% were phone visits.
- 1% other visits (home or virtual visits).
- 5 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. The SCFHT is transitioning events and support groups to a virtual platform where possible.*
Highlight: The SCFHT has created 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: 53% of FHN patients are up to date for cervical screening.
Breast Cancer Screening: 55% 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 have resumed. 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 Q3, 189 were patients seen resulting in 392 contacts.

Stats:

- 94.92% of patients with Type 1 or Type 2 diabetes had an A1C in the last year.
- 76.19% of all patients with Type 1 or Type 2 diabetes had their blood pressure measured in the last six months.
- 65.54% of patients with Type 1 or Type 2 diabetes had a validated foot screen in the last year.
- 53.44% of patients had a retinal exam within the last two years.
- 69.84% of patients set a SMART goal within the last six months.

Highlight: **Canadian Adult Obesity Clinical Practice Guidelines**

The Diabetes Management Program team is continuing to offer services throughout the COVID-19 pandemic by phone appointments or virtual visits, as well as seeing new patients and urgent referrals in-office.

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 Q3, 216 patients were seen resulting in 492 visits.

Stats:

- 62.5% 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 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.

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 Q3, 126 patients were seen resulting in 518 visits.

Stats:

- 73.72% of tests given were within INR target range.
- 0 INR patients experienced a stroke in Q3, 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 has continued to provide services throughout the COVID-19 pandemic. The INR team offers home visits or 'car visits' to 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 Q3 69 patients were seen, resulting in 128 visits.

No SRS surveys were completed in Q3, as the majority of visits were completed virtually.

Highlight: The SCFHT Social Worker is available to see patients virtually which has been a great alternative for access to services during the COVID-19 pandemic. 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 Q3, 13 patients were seen resulting in 31 visits.
Highlight: Patients who are struggling with breastfeeding, have low milk-supply, or are struggling with supplemental feedings, or infants with poor weight gain or who are always hungry, please send a message or referral to the SCFHT Lactation Program as soon as possible. In-person appointments are ideal, but the Lactation Nurse can also offer support through phone or virtual visits.
New referrals for lactation consultations are always welcome and the SCFHT will ensure they are scheduled 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 Q3 there were 134 patients, resulting in 157 visits.
Stats:

- 99.03% of Asthma and COPD patients have a spirometry confirmed diagnosis.
- 86.05% 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.
- 70.24% of COPD patients received a yearly flu shot and 67.86% of COPD patients received a one-time pneumococcal vaccine.

Highlight: Services are continuing through the pandemic; the SCFHT is offering follow-up phone calls and check-ins with patients. Spirometry tests have resumed at the SCFHT and the SCFHT has been working to book patients that had their appointments cancelled or postponed in spring 2020. LWDH is also assisting with the spirometry referral backlog. The SCFHT is accepting new referrals for spirometry; please continue to send them to SCFHT.

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 Q3 there were 146 patient visits and 230 office visits at the SCFHT program; and 110 patients and 150 visits to the LWDH Wound Care program.
Stats:

- 0% 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: 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 Q3 there were 107 patients, resulting in 130 visits.
Stats:

- 92.13% of patients with diabetes have had a 60 second foot screen within the last year.
- 87.85% of patients have an action plan who follow-up with the foot care nurse on an annual basis.
- 94.19% of patients with chronic problems have their conditions now under control with regular clinic visits.

Highlight: The SCFHT is pleased to announce their new Foot Care nurse, Shannon Matheson. She will be in the clinic and offering appointments 3 days per week; Sue McLeod will continue offering appointments 1 day per week. The SCFHT is able to offer more foot care appointments with a shorter wait time with having Shannon on the team.

Smoking Cessation

Program Goal: Provide education, ongoing support, and appropriate pharmacotherapy, if needed, to assist patients in becoming smoke-free.
Access: In Q3 there were 51 patients, resulting in 89 patient visits.
Stats:

- 45% of patients in the program have quit smoking at 12 months.
- 98.04% of patients in the program have smoking status documented in Risk Factors.

Highlight: The Smoking Cessation program is open; during the stay-at-home order the team is offering the program through phone or virtual visits. Please send new referrals for patients who would like assistance in their journey to quit smoking.

Pharmacy 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 Q3 there were 164 patients, resulting in 188 visits.
Stats:

- 17 patients had a medication review completed in Q3.
- 134 patients had their medications updated in the EMR.
- 57 patients had a medication reconciliation.
- 37 patients had drug information questions answered.
- 28 patients received assistance with drug navigation (forms, etc.)
- 87 patients had hospital discharge medication follow-up.

Highlight: Access for pharmacy services increased in Q3. The Pharmacist is no longer doing spirometry testing which allows more time to dedicate to pharmacy services and medication reviews. Please continue to send referrals to the SCFHT 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 Q3, there were 87 patients, resulting in 154 visits.
Stats:

- 97.14% 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, in collaboration with the Social Worker, ran a group session in the fall of 2020 called Mindful Eating: Emotional Eating and Food Craving Management, which were 2-hour sessions one night a week for 6 weeks. The group was well attended and approximately 75% of patients who signed up for the course attended throughout.

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: 21 patients were seen in Q3 resulting in 31 provider contacts.
Stats:

- 27 patients had a documented MOCA in Q2; 16 were performed by Memory Clinic.
- 100% of patients are satisfied with the service (5/5).
- 100% of patients reported an increased understanding about their condition (5/5).

Highlights: Memory Clinic is open and will continue to remain open during the lockdown. 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: 42 patients were seen in Q3 resulting in 72 patient visits.
Home Visits: 17 home assessments completed.
Falls Assessments: 70.83% of patients over 65 had falls assessments.
Highlight: Occupational Therapy services are available throughout the lockdown 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 Q3, 163 patients were seen, resulting in 425 visits.
Stats:

- 14 patients were seen for trauma/injury.
- 89 patients were seen for acute illness.
- 7 patients were seen for chronic illness.
- 11 patients were seen for mental health.
- Patients seen for substances: 3 – alcohol, 22 drugs
- Uncategorized: 279
- 124 connections and referrals to All Nations Health Partners programs and services were made.
- 25 patients 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 Program has been successful in its' first quarter, even considering the significant challenges from the COVID-19 pandemic and the changes in the clinical space and downtown location.
The Outreach 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.

Upcoming Events

Hypertension Education Group Session: TBD

Jill, Alanna, and Janet 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 in the works!

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
***NEW* Reception** – Jenna Nowak *(casual)*
Clinical Coordinator– Lindsay Kinger
Chiropodist – Andrea Clemmens
Diabetes Dietitian – Cindy Van Belleghem
Diabetes RN – Carolyn Hamlyn
***NEW* 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 Van Belleghem
Pharmacist – June Dearborn
Registered Dietitian – Therese Niznowski *(part time)*
Registered Dietitian – Janet Gilfix *(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** – 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