Sunset Country Family Health Team

Quarterly Report

Issue 15
August 2022

Q1 Highlights: April, May, June 2022

Inspiring a healthier Kenora

Acute & Episodic Care Program

Program Goal

To provide high quality acute care.

Stats

In Q1, **2,262 patients** were seen, and **3,560 visits** were provided by the team under acute and episodic care.

- 73.4% were in-office visits;
- 26.1% were phone visits;
- 0.4% other (email, home or virtual visits);
- 0 ER diversions 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

101 patients were screened during a Pap-a-palloza screening event.

1 Mindful Eating Group Session was held in Q1.

All other 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.

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, **88 patients** were seen, resulting in **104 visits**.

Stats

99.43% of Asthma and COPD patients have a spirometry confirmed diagnosis.

65% of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention.

31.5% of COPD patients have received a yearly flu shot, and **60.5%** of COPD patients have received a one-time pneumococcal vaccine.

Highlight

The Asthma team has gotten through the 2020/2021 Spirometry wait list! Now working on this year's referrals. LWDH is currently only accepting urgent spirometry referrals.

Pulmonary Rehabilitation program is open for patients with moderate to severe asthma or COPD; a referral from the patient's Primary Care Provider is required.

The STOP Program is available for all patients who smoke.

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

48.2% (EMR) / 53% (SAR) of FHN patients are up to date for **cervical cancer screening**.

57.8% (EMR) / 58% (SAR) of FHN patients are up to date for **breast cancer screening**.

543.9% (EMR) / 65% (SAR) of FHN patients are up to date for **colorectal cancer screening**.

Highlight

Rika and Carly were at the Farmer's Market June 22nd providing info about cancer screening and promoting SCFHT programs and services.

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.

Stats

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

90% of patients in the program with wounds have controlled or improved their results.

Access

In Q1, **117 patients** were seen, resulting in **172 visits** at the **SCFHT Program**.

Highlight

Please note the Chiropody program is currently on hold.

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 Q1, **223 patients** were seen, resulting in **451 visits**.

Stats

92.6% of patients with Type 1 or Type 2 diabetes had an A1C in the last year.

70.4% of all patients with Type 1 or Type 2 diabetes had their blood pressure measured in the last six months.

62.9% of patients with Type 1 or Type 2 diabetes had a validated foot screen in the last year.

35.6% of patients had a retinal exam within the last two years.

72.2% of patients set a SMART goal within the last six months.

Highlight

The Diabetes team hosted Diabetes Days at the Keewatin Clinic in July. Patients received POCT, BP check and foot screenings. Patients were very pleased with the services. The team plans to host another clinic in the Fall.

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

Contact Carly Freund, Administrative Assistant with your content or suggestions: cfreund@schft.ca

Foot Care Services

Program Goal

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

Access

In Q1, **71 patients** were seen, resulting in **93 visits**.

Stats

93.9% of patients with diabetes have had a 60 second foot screen within the last year.

96.6% of patients with chronic problems have their conditions now under control with regular clinic visits.

Highlight

Patients are following their action plans and have been more involved in their own care. Sue will be doing Onyfix training soon! Hoping to start treatments this Fall.

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, **223 patients** were seen, resulting in **517 visits**.

Stats

73.2% of patients in the program have improved their blood pressure readings to target after 3 months.

78.8% of patients have set a new lifestyle goal after 3 months.

Highlight

Wait times for an appointment with the Hypertension Management team are low; the SCFHT can accommodate HTN referrals within 1-2 weeks.

Please highlight urgent referrals and we will ensure these patients are seen quickly.

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, **101 patients** were seen, resulting in **397 visits**.

Stats

70.8% of tests given were within INR target range.

0 INR patients experienced a stroke in Q1, keeping the SCFHT below their 2% target.

2 INR patients experienced a major bleeding event in Q1, which keeps the SCFHT below their 2% target.

Highlight

In Q1, **5** patients transitioned to DOACs (Direct-Acting Oral Anticoagulants). Patients with non-valvular trial fibrillation and good renal function may be candidates for DOACs.

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 Q1, **25 patients** were seen, resulting in **53 visits**.

100% of parents attending prenatal sessions or individualized consultations reported increased confidence, knowledge, and skill in breastfeeding in the post session evaluation

Highlight

Colleen Snyder did presentations for NWHU & LWDH Nursing staff. A survey was completed by participants who reported increased knowledge and confidence to assist/guide patients.

Patients may self-refer. Any patient with a valid OHIP card can book online at scfht.ca or call SCFHT reception.

Memory Clinic

Program Goal

A multidisciplinary approach for early diagnosis, treatment and support of problems associated with memory loss. The FHT team members work collaboratively with physicians to provide comprehensive care for conditions involving memory loss.

Access

In Q1, **17 patients** were seen, resulting in **45 provider contacts**. 6 clinics were held in Q1.

Stats

100% of patients surveyed in Q1 are satisfied with the service.

33.3% of patients reported an increased understanding about their condition.

Highlight

90% of follow-up patients implemented recommendations made from Memory Clinic care team.

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 Q1, **107 patients** were seen, resulting in **168 visits**.

The Mindful Eating group sessions is becoming popular! The SCFHT is holding a wait list for interested patients for future sessions.

Stats

94.8% of follow-up patients have achieved their most recent SMART goal.

80.9% of dyslipidemia patients had a documented Framingham risk assessment.

Highlight

The SCFHT Dietitian and LWDH Social Worker will be offering the **Mindful Eating: Emotional Eating and Food Craving Management Group October 2022.** 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

To maintain or improve quality of life and function for patients experiencing limitations to their overall function. Assist community members to remain as safe and independent as possible in their community.

Access

In Q1, **53 patients** were seen, resulting in **91 visits**.

Stats

9 home assessments were completed in Q1.

62.9% of patients over 65 had fall assessments completed.

Highlight

Please note the Occupational Therapy Program is currently on hold.

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 Q1 there were **144 patients**, resulting in **178 visits**.

Stats

11 patients had a medication review completed in Q1.
110 patients had their medications updated in the EMR.
20 patients had a medication reconciliation.
30 patients had drug information questions answered.
19 patients received assistance with drug navigation (forms, etc.)
101 patients had hospital discharge medication follow-up.
2 patients from the Cardiac Rehab Program.

Highlight

Insights4Care (i4c) dashboard is a great tool that features a medication management indicator to help manage/monitor patient medications. Please notify June if you have any patients requiring med review or help managing their meds -she would love to help!

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

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 Q1, **262 patients** were seen, resulting in **738 visits**.

Stats

15 patients were seen for trauma/injury.
46 patients were seen for acute illness.
21 patients were seen for chronic illness.
56 patients were seen for mental health.
Patients seen for substances:
17 – alcohol, **88** – drugs
Other: 1

17 connections and referrals to All Nations Health Partners programs and services were made.
2 patients self-reported they would have sought care from the LWDH Emergency Department.

Highlight

The Outreach team did a Naloxone Training Refresher for all staff in May. It was very informative and appreciated by those who attended. Big thanks to Jen & Becky!

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 **64 patients**, resulting in **143 visits**.

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

In Q1 **20%** of patients in the program have quit at 6 months! Reminder that all patients with a FHN physician can self-refer. Appointments can be booked online at scfht.ca or by calling SCFHT reception.

Social Work

Program Goal

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

Highlight

The SCFHT Social Worker went on extended leave in October 2021 and resigned in January 2022. Currently, the SCFHT is not actively looking to fill this position until we receive the results of the third-party service delivery review.

Access

During this time, referrals for social work services may be directed to external programs and services:

Adult referrals:

- **LWDH Mental Health and Addictions Program (807) 467-3555**: staff are available daily to respond to inquiries for counselling and can deal with more urgent referrals. The youth program there is also available for youth ages 12+.
- **Canadian Mental Health Association-Kenora Branch (807) 468-1838**: can provide individual counselling services for 18+.
- **Canadian Mental Health Association-Fort Frances Branch (807) 468-4699**: has the Older Adults Program age 60+.
- **WNHAC (807) 467-8770**: offers emotional health and wellness programs for their clients.

Child referrals:

- **Firefly (807) 467-5437**: is the primary agency for children's mental health. There is a Firefly referral form in PS Suite custom forms.
- **24/7 Crisis Line: 1-866-888-8988**
- **Kenora Mobile Crisis Response Team: 1-888-310-1122** (non-emergent line) or **911**

Please also refer to the '**Kenora Mental Health Interagency Referral Form 2021**' found in PS Suite Custom Forms to refer a patient to an external service.

SCFHT Quality Improvement Committee – Update

The SCFHT Quality Improvement Committee has been working on the Quality Improvement Plan for the 2022/23 year.

improvement concepts and methods which we have begun implementing in our work with the Quality Improvement Plan.

Through guidance and mentorship from the SCFHT QIDSS, Melonie has been working with the team to utilize our training and become more familiar with the quality improvement process and implementation.

The Team

Executive Director – Colleen Neil
Finance Manager – Stephanie Evenden
Clinical Coordinator– Lindsay Kinger
QIDSS – Melonie Young
Administrative Assistant – Programs – Carly Freund
Administrative Assistant – Communications & Executive – Lindsay Whitaker
Administrative Assistant – Jenna Mattson *(maternity leave)*
Reception – Toni Maenpaa
Diabetes Dietitian – Cindy Van Belleghem
Diabetes RN – Carolyn Hamlyn
Foot Care Nurse – Sue McLeod *(part time)*
Nurse Practitioner – Angela Jung *(Kenora Medical Associates)*
Nurse Practitioner – Barb Pernsky *(Keewatin Medical Clinic)*
Nurse Practitioner – Holly Rose *(Kenora Medical Associates)*
Nurse Practitioner – Kate McEachern *(Kenora Medical Associates)*
Nurse Practitioner – Michael Reid *(Kenora Medical Associates)*
Occupational Therapist – Brittan Amell *(maternity leave)*
Pharmacist – June Dearborn
Registered Dietitian – Therese Niznowski *(part time)*
Registered Nurse – Diane Debbo *(temporary)*
Registered Nurse – Alanna Mutch
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 – Breanne Becker *(casual)*
Registered Practical Nurse – Kendra Madussi
Registered Practical Nurse – Kim Loranger
Registered Practical Nurse – Rika Schadek-Parson *(Keewatin Medical Clinic)*

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