Sunset Country Family Health Team

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Quarterly Report

Issue 16
November
2022

Q2 Highlights: July, August, September 2022

Inspiring a healthier Kenora

Acute & Episodic Care Program

Program Goal

To provide high quality acute care to FHN patients.

Stats

In Q2, **2,370 patients** were seen, and **3,479 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);
- 13 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.

Objective

Provision of core primary care services in response to an acute or episodic illness. Services may include but not limited to wound care, suture removal, immunizations, pre-op, AHE, well baby checks and patient education, -health promotion and disease prevention.

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, **86 patients** were seen, resulting in **99 visits**.

Stats

94.9% of Asthma and COPD patients have a spirometry confirmed diagnosis.

63.1% of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention.

32.3% of COPD patients have received a yearly flu shot, and **58.8%** of COPD patients have received a one-time pneumococcal vaccine.

Highlight

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.

Reminder: patients experiencing post-covid symptoms requiring a spirometry test should be referred to the hospital.

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

48.9% (EMR) / 55% (SAR) of FHN patients are up to date for **cervical cancer screening**.

58.5% (EMR) / 59% (SAR) of FHN patients are up to date for **breast cancer screening**.

56.4% (EMR) / 66% (SAR) of FHN patients are up to date for **colorectal cancer screening**.

Highlight

Rika and Carly were at the Farmer's Market again on September 14th providing info about cancer screening and promoting SCFHT programs.

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 or online at www.scfht.ca.

Chiropody Program

Please note: the program is currently on hold. Referrals for Chiropody services may be directed to external agencies where possible:

- **Lake of the Woods Chiropody (807) 547-2420**: ("The Foot Clinic" in Keewatin with Lou Swancar). They provide chiropody services and orthotics casting and adjustments. Note: they are a private clinic and cannot bill OHIP or other personal extended health care benefits plans.
- **Kenora Physiotherapy and Sports Injury Centre (807) 468-3631**: can provide assessment and casting for orthotics. Note: they are a private clinic and cannot bill OHIP or other personal extended health care benefits plans.
- **Waasegiizhig Nanaandawe'iyewigamig Health Access Centre 1-888- MYWNHAC (699-6422)**: offers Chiropody and foot care services to eligible clients.

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, **276 patients** were seen, resulting in **506 visits**.

Stats

94% of patients with Type 1 or Type 2 diabetes had an A1C in the last year.

83.9% of all patients with Type 1 or Type 2 diabetes had their blood pressure measured in the last six months.

70% of patients with Type 1 or Type 2 diabetes had a validated foot screen in the last year.

40.1% of patients had a retinal exam within the last two years.

73.9% of patients set a SMART goal within the last six months.

Highlight

November is Diabetes Awareness Month! This year, the theme is **"Education to Protect Tomorrow".**

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

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Foot Care Services

Program Goal

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

Access

In Q2, **70 patients** were seen, resulting in **97 visits**.

Stats

93.7% 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

Sue will be taking Onyfix training soon! Hoping to start offering treatments in Q4.

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, **185 patients** were seen, resulting in **414 visits**.

Stats

68.6% of patients in the program have improved their blood pressure readings to target after 3 months.

85% of patients have set a new lifestyle goal after 3 months.

Highlight

The team has received more 7-day monitors to assist with wait times.

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 Q2, **91 patients** were seen, resulting in **373 visits**.

Stats

71% of tests given were within INR target range.

2 INR patients experienced a stroke in Q2.

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

Highlight

In Q2, **6** 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 Q2, **30 patients** were seen, resulting in **59 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 facilitated the BABY STOP tent events at the Farmer's Market throughout the Summer. Offering support for new moms with the NWHU staff.

Reminder: 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 Q2, **17 patients** were seen, resulting in 27 **provider contacts**. **5** clinics were held in Q2.

Stats

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

10% of patients reported an increased understanding about their condition.

Highlight

80% of patients/caregivers reported an increased understanding about their condition.

Please note: Wait times for initial appointments are 6-12 months for non-urgent cases. Follow-up appointments are a 12-15 month wait for non-urgent cases. If you have a patient who needs to be seen urgently, please reach out to the MC 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 Q2, **99 patients** were seen, resulting in **179 visits**.

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

Stats

91.6% of follow-up patients have achieved their most recent SMART goal.

75% of dyslipidemia patients had a documented Framingham risk assessment.

Highlight

Mindful Eating: Emotional Eating and Food Craving Management Group will be offered again in Spring 2023. 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

Please note: the program is currently on hold. Referrals for Occupational services may be directed to external agencies where possible:

Adult referrals:
- **Wellwise by Shoppers (Keewatin) (807) 468-4244**: available to assist with ordering and setting up mobility aids/adaptive equipment.
- **Kenora Physiotherapy & Sports Injury Centre (807) 468-3631**: available to support chronic pain management, and staff a kinesiologist who offers ergonomic assessments. Note: they are a private clinic and cannot bill OHIP or other personal extended health care benefits plans.

Child referrals (ages 0-18):
- **Firefly (807) 467-5437**; there is a Firefly referral form in PS Suite custom forms.

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 **141 patients**, resulting in **178 visits**.

Stats

11 patients had a medication review completed in Q2.
120 patients had their medications updated in the EMR.
12 patients had a medication reconciliation.
28 patients had drug information questions answered.
17 patients received assistance with drug navigation (forms, etc.)
109 patients had hospital discharge medication follow-up.
6 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 Q2, **220 patients** were seen, resulting in **703 visits**.

Stats

14 patients were seen for trauma/injury.
21 patients were seen for acute illness.
35 patients were seen for chronic illness.
86 patients were seen for mental health.
Patients seen for substances:
13 – alcohol, **93** – drugs
Other: 6

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

Highlight

57.2% of the population served experienced criminalization and **68.6%** of patients served have indigenous heritage. Reflecting the team's ability to create a safe space where vulnerable citizens are willing to access primary care services.

Smoking Cessation

Program Goal

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

Access

In Q2 there were **66 patients**, resulting in **132 visits**.

Stats

32% of patients in the program have quit smoking at 12 months.

98% of patients in the program have smoking status documented in Risk Factors.

Highlight

STOP program is now being offered without the research component.

What's new?
A new online patient registration option that includes a patient portal for registration, consent, surveys and access to online resources.

Who's eligible?
Current smokers, or those who have recently quit (within the last 30 days) and are an Ontario resident.

How to refer?
Send the patient information along with an updated email address if they have one via the SCFHT referral form found on OCEAN. Patients can receive up to 26 weeks of free NRT treatment.

Social Work

Please note: the program is currently on hold. Referrals for Social Worker services may be directed to external agencies where possible:

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 *(maternity leave)*
Nurse Practitioner – Michael Reid *(Kenora Medical Associates)*
Nurse Practitioner – Meg Scully *(Kenora Medical Associates)*
Nurse Practitioner – Maggie Williams *(Kenora Medical Associates)*
Nurse Practitioner – Cassandra Boutwell *(Docside Clinic)*
Occupational Therapist – Brittan Amell *(maternity leave)*
Pharmacist – June Dearborn
Registered Dietitian – Therese Niznowski
Registered Nurse – Diane Debbo *(part time)*
Registered Nurse – Alanna Scribilo
Registered Nurse – Colleen Snyder
Registered Nurse – Jillian Faulds *(maternity leave)*
Registered Nurse – Becky Shorrock (Outreach)
Registered Nurse – Jen Carlson (Outreach)
Registered Practical Nurse – Megan Viera (*Kenora Medical Associates)*
Registered Practical Nurse – Breanne Becker *(casual)*
Registered Practical Nurse – Kendra Madussi (*Kenora Medical Associates)*
Registered Practical Nurse – Rachel Wykes (*Kenora Medical Associates)*
Registered Practical Nurse – Kim Loranger *(Keewatin Medical Clinic)*