# Sunset Country Family Health Team

Quarterly Report

**Q4 Highlights: January, February, March 2023**

**Issue 18**
**April 2023**

*Inspiring a healthier Kenora*

## Acute & Episodic Care Program

### Program Goal

To provide high quality acute care to FHN patients.

### Stats

In Q4, **3,389 patients** were seen, and **5,371 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.

### Stats

In Q4:

- **1 prenatal session** was held; 11 couples attended
- **1 Mindful Eating** group session was held; 5 patients attended

In-person events are slowly resuming as restrictions from the COVID-19 pandemic have eased.

## 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 Q4, **89 patients** were seen, resulting in **107 visits**.

### Stats

**85.19%** of Asthma and COPD patients have a spirometry confirmed diagnosis.

**61.9%** of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention.

**52.5%** of COPD patients have received a yearly flu shot, and **60%** of COPD patients have received a one-time pneumococcal vaccine.

### Highlight

The referral waitlist for spirometry screening is manageable. All referrals for Asthma and/or COPD education are welcome and should be sent to the SCFHT.

31 responses were received from the Client Experience Survey – Respiratory Education Program.

- **80.65%** rated the overall care received in the program as 'Excellent'; **12.90%** as 'Very Good' and **6.45%** as 'Good';
- **100%** would recommend this education program to their friends and family.

Full survey results can be found **here**.

# 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

**50.3% (EMR)** / 56% (SAR) of FHN patients are up to date for **cervical cancer screening**.

**59.5% (EMR)** / 61% (SAR) of FHN patients are up to date for **breast cancer screening**.

**57.8% (EMR)** / 66% (SAR) of FHN patients are up to date for **colorectal cancer screening**.

## Highlight

**FIT Testing**
Please advise any patient who is eligible and completing their FIT testing to drop off FIT kits to LifeLabs directly. This will help alleviate the issue of FIT kits getting lost in the mail.

Watch for the next *Integrated Cancer Screening Newsletter* being released in July for a chance to win a prize!

# 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 Q4, **301 patients** were seen, resulting in **569 visits**.

## Stats

**96.36%** of patients with Type 1 or Type 2 diabetes had an A1C in the last year.

**88.04%** of all patients with Type 1 or Type 2 diabetes had their blood pressure measured in the last six months.

**46.55%** of patients with Type 1 or Type 2 diabetes had a validated foot screen in the last year.

**53.09%** of patients had a retinal exam within the last two years.

**77.74%** of patients set a SMART goal within the last six months.

## Highlight

The SCFHT Diabetes Management Program Team have had great success in partnering with the KDSB's Community Paramedicine Program.

Partnering with the community paramedics will allow for enhanced coordination of care and ensuring that medications are properly managed and connections for further follow-up and/or education are arranged.

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

**Contact Lindsay Whitaker, Administrative Assistant with your content or suggestions:**
**lwhitaker@schft.ca | (807) 468-6321 x329**

## Foot Care Services

### Program Goal

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

### Access

In Q4, **70 patients** were seen, resulting in **87 visits**.

### Stats

**93.65%** of patients with diabetes have had a 60 second foot screen within the last year.

**100%** of patients with chronic problems have their conditions now under control with regular clinic visits.

### Highlight

The Foot Care Program is welcoming the addition of Crystal. During Q4, Crystal successfully completed her training to provide foot care services.

The team is currently training to provide Onyfix (a painless and non-invasive nail correction system designed to treat chronic ingrown and involuted toenails).

## 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 Q4, **189 patients** were seen, resulting in **469 visits**.

### Stats

**43.06%** of patients in the program have improved their blood pressure readings to target after 3 months.

**88.89%** of patients have set a new lifestyle goal after 3 months.

**98%** of patients referred for screening received education or resources on proper BP technique.

### Highlight

The Hypertension Management Program team is meeting several of the intended outcomes.

24hr ABPMs and 7-day BID BP monitors are available to further support screening for hypertension.

## 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 Q4, **74 patients** were seen, resulting in **347 visits**.

### Stats

**74.76%** of tests given were within INR target range.

**0** INR patients experienced a stroke in Q4.

**2** INR patients experienced a major bleeding event in Q4, which keeps the SCFHT below their 2% target.

### Highlight

INR program providers continue to look for patients who may be appropriate DOAC candidates. Patients who may be possible candidates for DOACs are patients with non-valvular atrial fibrillation and good renal function.

INR program providers will consult with MDs regarding any patient who may be an appropriate DOAC candidate.

## 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 Q4, **18 patients** were seen, resulting in **48 visits**.

### Highlight

The SCFHT Lactation Consultant held a virtual prenatal breastfeeding group, with 11 couples attended from across the region.

New referrals for lactation consultations are always welcome!

## 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 Q4, **33 patients** were seen, resulting in **64 provider contacts**. **7 clinics** were held in Q4.

### Stats

**100%** of patients surveyed in Q4 are satisfied with the service.

**100%** of patients reported an increased understanding about their condition.

### Highlight

The Memory Clinic team had a busy quarter; additional half-day clinics were added between January-June 2023 to help reduce the waitlist for initial appointments.

A SCFHT Nurse Practitioner will be joining future clinics to support Memory Clinic after training is completed.

## 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 Q4, **115 patients** were seen, resulting in **200 visits**.

### Stats

**70.83%** of follow-up patients have achieved their most recent SMART goal.

**80%** of dyslipidemia patients had a documented Framingham risk assessment.

### Highlight

This program provides nutritional counselling to patients who are struggling with healthy eating, and who may need to change and monitor their diet in regards to chronic diseases such as dyslipidemia, obesity, diabetes, hypertension, and eating disorders. Our dietitian will provide 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.

## Occupational Therapy

**Please note:** this 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:** Firefly referral form in PS Suite custom forms.

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## 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 Q4 there were **183 patients** seen, resulting in **219 visits**.

### Stats

**23 patients** had a medication review completed in Q4.
**159 patients** had their medications updated in the EMR.
**41 patients** had a medication reconciliation.
**28 patients** had drug information questions answered.
**32 patients** received assistance with drug navigation (forms, etc.)
**113 patients** had hospital discharge medication follow-up.
**3 patients** from the Cardiac Rehab Program.

### Highlight

There are new recommendations from the Ministry of Health Ontario that involves prescribing biosimilars for certain insulin and other disease modifying biologics (like Enbrel, Remicade); June will be circulating a Pharmacist Newsletter in the upcoming months about those new processes for prescribing those medications to assist with keeping the pharmacy faxes and/or messages to a minimum during the transition.

**Your Opinion Matters!**

**Help us further develop our programs and services 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 Q4, **249 patients** were seen, resulting in **888 visits**.

## Stats

**26 patients** were seen for trauma/injury.
**46 patients** were seen for acute illness.
**37 patients** were seen for chronic illness.
**92 patients** were seen for mental health.
Patients seen for substances:
**13** – alcohol; **64** – drugs
**Other: 12**

**7 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 Primary Care Outreach team has been working closely with the NWHU to offer HIV point of care testing with incentives for testing to increase uptake. Communications have been sent to community partners to advise of the increase in HIV cases and to increase testing offered.

The Outreach team continues to provide HIV care in partnership with Winnipeg HSC, who is guiding them though the process of supporting a newly diagnosed patient at the onset of diagnosis and working to connect them with the appropriate treatment and follow up as quickly as possible.

# Smoking Cessation

## Program Goal

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

## Access

In Q4, there were **67 patients** seen, resulting in **159 visits**.

## Stats

**44%** of patients in the program have quit smoking at 6 months.

**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

Individuals who quit smoking have substantial gains in life expectancy, compared with those who continue to smoke.

All providers are reminded to continue to discuss smoking at primary care appointments, and continue to refer patients who are interested in quitting smoking to the SCFHT.

# Social Work

**Please note:** the Social Work 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.

## The Team

**Executive Director** – Colleen Neil
**Finance Manager** – Stephanie Evenden
**Clinical Coordinator**– Lindsay Kinger
**QIDSS** – Melonie Young
**Administrative Assistant – Patient Services** – Toni Maenpaa
**Administrative Assistant – Communications & Executive** – Lindsay Whitaker
***new* Administrative Assistant – IT & Programs Services** – Suzanne Langlois
**Administrative Assistant** – Jenna Mattson *(maternity leave)*
**Diabetes Dietitian** – Cindy Van Belleghem
**Diabetes RN** – Carolyn Hamlyn
***new* Foot Care Nurse** – Crystal Cadieux *(in training)*
**Foot Care Nurse** – Sue McLeod *(part time)*
**Nurse Practitioner** – Angela Jung *(Kenora Medical Associates)*
**Nurse Practitioner** – Barb Pernsky *(Keewatin Medical Clinic)*
**Nurse Practitioner** – Cassandra Boutwell *(Docside Clinic)*
**Nurse Practitioner** – Holly Rose *(Kenora Medical Associates)*
**Nurse Practitioner** – Kate McEachern *(maternity leave)*
**Nurse Practitioner** – Maggie Williams *(Kenora Medical Associates)*
**Nurse Practitioner** – Meg Scully *(Kenora Medical Associates)*
**Nurse Practitioner** – Michael Reid *(Kenora Medical Associates)*
**Occupational Therapist** – Brittan Amell *(maternity leave)*
**Pharmacist** – June Dearborn
**Registered Dietitian** – Therese Niznowski
**Registered Nurse** – Alanna Scribilo
**Registered Nurse** – Diane Debbo *(part time)*
**Registered Nurse** – Colleen Snyder
**Registered Nurse** – Jillian Faulds
**Registered Nurse** – Becky Shorrock (Outreach)
**Registered Nurse** – Jen Carlson (Outreach)
**Registered Practical Nurse** – Breanne Becker *(casual)*
**Registered Practical Nurse** – Kendra Madussi (*Kenora Medical Associates)*
**Registered Practical Nurse** – Kim Loranger *(Keewatin Medical Clinic)*
**Registered Practical Nurse** – Megan Viera (*Kenora Medical Associates)*
**Registered Practical Nurse** – Rachel Wykes (*Kenora Medical Associates)*

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