Sunset Country Family Health Team

Annual Report 2022-2023

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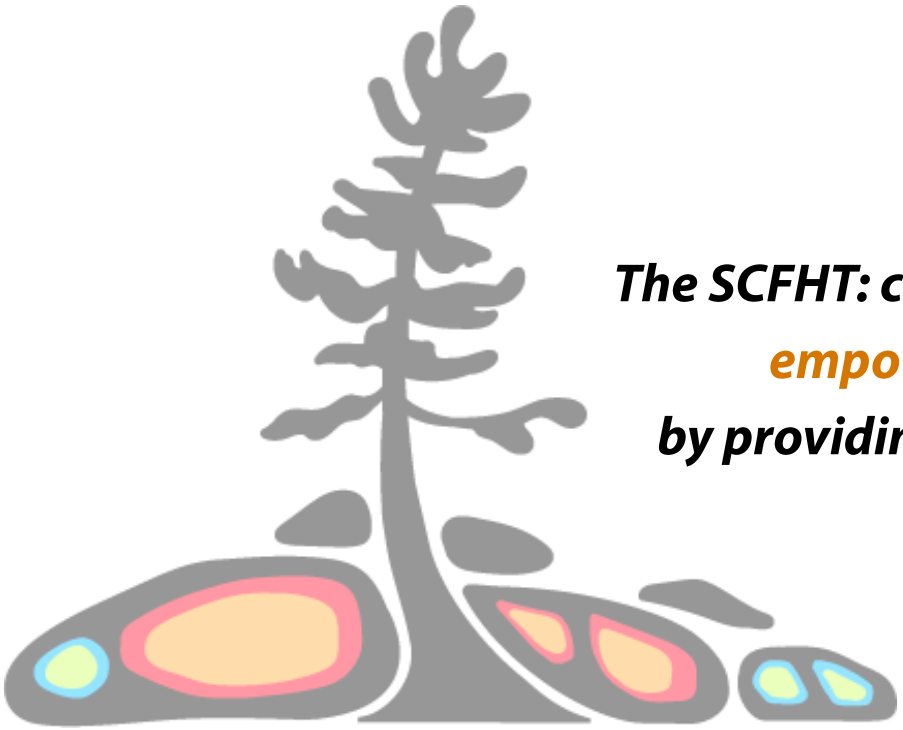


The SCFHT: collaborating as a team to empower a healthy community by providing comprehensive quality primary care.

About the SCFHT

A *Family Health Team* is an approach to primary health care that brings together family physicians, nurse practitioners, registered nurses, registered practical nurses, dietitians, pharmacists, occupational therapists, and other health care professionals to coordinate the highest possible quality of primary care for our patients. Our team of interdisciplinary health care providers at the SCFHT work in our services and programs to assess patients' needs, provide preventative care for chronic conditions, and coordinate health care with local community health and social services sectors and other partners and agencies.

Vision	Mission	Values
Inspiring a healthier community together.	Collaborating as a team to empower a healthy community by providing comprehensive quality primary care.	Quality. Team Care. Accountability. Patient Focused. Excellence. Collaboration.

SCFHT Board of Directors, 2022-2023

SCFHT Board Members:

KMA Representative: Dr. Jonny Grek

Keewatin Clinic Representative: Dr. Meghan Olson

Docside Clinic Representative: Dr. Stephane Foidart

Community Partner Physician: Dr. Kerry Anderson

Community Partner IHP: Roberta Giesbrecht

Community Partner: Paul Derouard

Community Partner: *Vacant*

SCFHT Board Executive

Chair: Dr. Jonny Grek

Vice Chair: Roberta Giesbrecht

Secretary/Treasurer: Paul Derouard

SCFHT Lead Physician

Dr. Shannon Wiebe

Message from the SCFHT Lead Physician


Dr. Shannon Wiebe
SCFHT Lead Physician, 2022-2023

There have been a lot of important and visionary projects under way at the SCFHT this year. I was overwhelmingly impressed by the enthusiasm and passion of staff, physician representatives, and board members at the strategic planning sessions in the fall. It's impressive to see so many of the goals already being actioned.

During a time when all service providers are feeling stretched and inadequate in number, the team has also put a lot of work and thought into identifying new ways to support physicians in a way that improves the volume and speed of patient access. These included trials of digital and inbox support, tracking of cancer screening, and supporting the application of Ocean for online booking and email communication. The support of SCFHT leadership was essential to getting this project off the ground, and was the focus of the preceding Quality Improvement goal from the QI committee.

Upcoming changes are a result of serious dedicated reflection on ways to support staff in working to their full capacity in a supported environment, and to truly expand access for patients in and eventually outside of the FHN roster who are having difficulty accessing care.

There is a lot of change in progress through the All Nations Health Partners OHT at the level of primary care, and the SCFHT has been a great leader in efforts to align partner agencies in working together, improving communication and eventually simplifying access and reducing redundancies in service delivery.

Despite the overwhelm experienced by providers at both the FHN and FHT, I'm very excited by the ongoing dedication of the SCFHT and the positive developments we've seen in 2022-23.

- Dr. Shannon Wiebe

Message from the Executive Director

Dear Members of the Board and Valued Staff,

Colleen Neil, SCFHT Executive Director

As we come together to reflect on another remarkable year at the Sunset Country Family Health Team, I am filled with a deep gratitude and admiration for each of you. With immense pleasure, I extend my heartfelt appreciation and thanks for your commitment, passion, and relentless efforts in advancing our mission and serving our community.

The Annual Report allows us to celebrate our achievements, milestones, and collective impact. It is a testament to the dedication and collaboration that have defined our organization over the past year. Through our combined efforts, we have continued to uphold our core values, deliver exceptional healthcare services, and make a positive difference in the lives of those we serve.

To our esteemed Board of Directors, your guidance, wisdom, and strategic vision have been instrumental in shaping our path forward. Your commitment to our mission and tireless efforts in ensuring the success of our organization has been truly remarkable. Your collective expertise and steadfast support have helped us navigate challenges and seize opportunities, allowing us to thrive despite adversity. Please accept my sincerest gratitude for your leadership and dedication to our shared cause.

To our incredible staff, you are the heart and soul of our Family Health Team. Day in and day out, you demonstrate an commitment to excellence and compassion in delivering exceptional care to our patients. Your dedication, expertise, and professionalism are a constant source of inspiration for me and for the entire community. Each one of you plays a crucial role in creating a welcoming and supportive environment where patients can receive comprehensive, patient-centred care. Thank you for your hard work, resilience, and compassion.

Continued...

To our patients, your willingness to entrust us with your health is a responsibility we do not take lightly. It is our highest priority to ensure that you receive the highest quality care in a safe and welcoming environment.

Over the past year, we have strived to continually improve our services, expand our offerings, and enhance the patient experience. Your valuable feedback and input have played a crucial role in shaping the care we provide. We are constantly seeking opportunities to grow and evolve, driven by our unwavering commitment to delivering comprehensive, patient-centered healthcare.

As we move forward, we want to assure you that your well-being remains at the forefront of our priorities. We will continue to explore new ways to improve access to care, leverage technology to enhance communication, and foster an environment where you feel heard, respected, and supported.

Together, we have achieved remarkable milestones over the past year. We have expanded our outreach programs, implemented innovative strategies to enhance patient care, and fostered collaborative partnerships with other healthcare providers and community organizations. Our commitment to continuous improvement has driven us to embrace new technologies, optimize our workflows, and embrace evidence-based practices. These accomplishments are a testament to the collective efforts of our board and staff, and I am truly humbled to lead such an exceptional team.

As we move forward, let us renew our commitment to our shared purpose. Let us continue to push the boundaries of excellence, challenge ourselves, and be at the forefront of interdisciplinary primary care. By working together, we can overcome obstacles and build a healthier, more vibrant community for all.

Once again, I extend my deepest gratitude to each and every one of you. Your dedication, passion, and commitment to our mission inspire me and reaffirm my belief in the transformative power of teamwork. I look forward to our continued collaboration and to the incredible achievements that lie ahead.

With warmest regards,

Colleen Neil
Executive Director
Sunset Country Family Health Team

Our Medical Community

Our allied health professionals work in collaboration with the physicians of the **Sunset Country Family Health Network** to provide primary care, chronic disease management, health promotion and disease prevention.

The SCFHT works closely with our affiliated doctor's offices and have staff embedded to support the clinical and patient needs' of our valued affiliated physicians' clinics. Patients of our affiliated doctor offices have access to the programs and services offered by the SCFHT to support their overall health.

Our Partner Clinics:

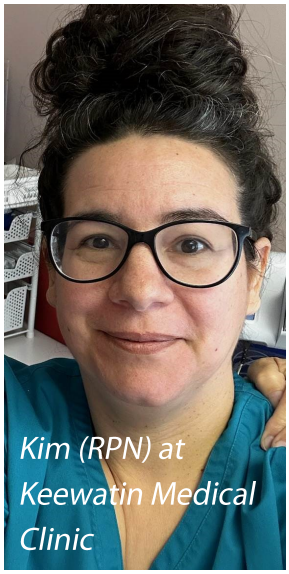
Kenora Medical Associates (KMA)
1-45 Wolsley Street, Kenora, ON, P9N 3W7

Docside Clinic
524 First Avenue South, Kenora, ON, P9N 1W5

Keewatin Medical Clinic
904 Ottawa Street, Keewatin, ON, P0X 1C0

RPNs at KMA! Megan, Kendra, and Rachel

Our NPs! (L-R) Holly, Maggie, Meg, Mike, Angela and Barb. Missing from this photo: Cass and Kate



Kim (RPN) at Keewatin Medical Clinic

Cass (NP) at Docside Clinic

Our COVID-19 Journey

The COVID-19 pandemic has tested the resilience and adaptability of healthcare providers worldwide. In the midst of this global crisis, the Sunset Country Family Health Team played a crucial role in supporting our local communities. This is the SCFHT's journey of the COVID-19 pandemic, highlighting the challenges we faced, the innovative solutions we implemented, and the lessons we learned along the way.

As news of the emerging pandemic reached us, we quickly recognized the need to develop a robust response strategy. We established a coordinated approach, including implementing additional infection control measures, training staff on proper protocols, and procuring essential personal protective equipment (PPE) to ensure the safety of both patients and staff.

As lockdown measures and social distancing restrictions were enforced, we had to adapt our primary care services to meet the evolving needs of our patients. Embracing telehealth technology became imperative for providing continuous care. We swiftly implemented virtual consultation platforms, enabling patients to receive care from the safety and comfort of their homes.

Like many healthcare providers, we faced the challenge of securing an adequate supply of PPE. We explored alternative suppliers, collaborated with local organizations, and leveraged community support to bridge the gap. Our resourcefulness and dedication helped us maintain a safe environment for both patients and staff.

Recognizing the importance of collaboration during a crisis, we strengthened our relationships with local partners. This allowed us to share resources, exchange best practices, and coordinate efforts to address the evolving needs of our patients effectively. Together, we supported mass immunization clinics, assisted in staffing the COVID-19 Assessment Centre, and supported vulnerable populations.

The pandemic taught us invaluable lessons that will shape the future of healthcare delivery at the SCFHT and beyond. Our journey through the COVID-19 pandemic as a small primary care clinic tested our resolve, but it also highlighted our strength and resilience. We embraced innovation, adapted to new realities, and prioritized the health and well-being of our patients and staff. As we move forward, we carry with us the lessons learned, knowing that our dedication to providing compassionate care remains unwavering, regardless of the challenges that lie ahead.

Celebrations & Achievements

April 2022: The SCFHT joined the Rapid Antigen Test public distribution program and have supplied thousands of COVID-19 Rapid Antigen Test kits to partners and community members.

June 2022: Events are resuming! SCFHT staff set up a table at the Matiowski Farmer's Market, promoting cancer screening, email consent forms, and online appointment booking.

July/August 2022: The SCFHT partnered with the Lake of the Woods District Hospital to provide dedicated ER Diversion appointment spots. The SCFHT also shared Nurse Practitioner resources to support the temporary CTAS 4 & 5 Urgent Care Clinic at the LWDH ER.

August 2022: The SCFHT launched Ocean, the eReferral platform, and continues to support all users as the eReferral system expands.

September 2022: Three new Nurse Practitioners joined the team to fill all vacant NP positions!

September/October 2022: Strategic planning engagement sessions with the public and staff. Read more about our journey on page 10.

November 2022: The SCFHT participated in the EXPLORE Career Expo at St. Thomas Aquinas High School.

January 2023: Participated at Beaver Brae Secondary School's *Ignite Your Future 2023* event.

New! Online Appointment Booking: Offering an easy way to book appointments online at your convenience! Appointment email reminders also accompany online appointment booking.

Scan to book online!

Rachel @ BBSS Ignite Your Future

Students & Learners: The SCFHT has welcomed many medical and nursing students, and community paramedics throughout the year to support the completion of their clinical placements.

Joint Health & Safety: 0 incident reports for the year!

SCFHT Strategic Plan 2023-2026

At the SCFHT, we recognize the critical importance of strategic planning to ensure the delivery of high-quality healthcare services to our community. To chart a course for the future and address the evolving needs of our patients and our community, we conducted a comprehensive strategic planning process in the fall of 2022 that embraced community and staff engagement at its core.

Understanding the significance of collaboration and inclusivity, we initiated a series of community engagement sessions. These sessions provided an opportunity for us gather valuable feedback to understand the unique healthcare needs, concerns, and aspirations of our community members. Through public engagement sessions, we gathered valuable insights and feedback, which served as a foundation for our strategic planning efforts.

Equally important was the active involvement of our dedicated staff in shaping the future direction of the SCFHT. We recognize that our employees, who work tirelessly to provide compassionate care, possess invaluable knowledge and expertise. To harness this collective wisdom, we organized a staff and board engagement session that encouraged open dialogue, idea sharing, and innovative thinking. By involving our staff and board in the planning process, we ensured that their perspectives were heard, fostering a sense of ownership and commitment to our shared vision.

The strategic planning process encompassed various key aspects, including:

Needs Assessment: A thorough needs assessment was conducted in spring 2022 to identify the specific healthcare challenges faced by our community. We analyzed data and gathered insights from community survey responses to gain a comprehensive understanding of the current and future healthcare needs.

Goal Setting: Guided by the feedback from the needs assessment report, and public and staff engagement sessions, we established strategic goals and objectives to guide the SCFHT's growth and development. These goals encompassed areas such as enhancing access to care, health human resource recruitment and retention strategies,

access to care, health human resource recruitment and retention strategies, community engagement, and health system guidance.

Action Planning, Monitoring and Evaluation: We translated our strategic goals into actionable initiatives and projects. To ensure the success of our strategic plan, we are developing mechanisms for ongoing monitoring and evaluation.

The SCFHT is committed to leveraging this strategic plan as a guide, continuously adapting and evolving to meet the changing healthcare landscape and delivering exceptional care that our patients deserve.

Staff Strategic Planning Engagement Session—Brainstorming, team building, and creative thinking!

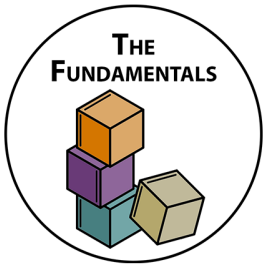
Sunset Country Family Health Team
2023-2026 Strategic Plan

STRATEGIC PRIORITIES

- Evaluate clinic staffing resource allocation
- Develop and submit a funding request for an Urgent Care Clinic
- Evaluate what FHT programs can be open to all patients
- Strategic collaboration with physicians to increase patient access
- Explore alternative hours of operation for better patient access

- Recruitment strategies
- Retention strategies
- Health Human Resource planning
- Wage parity for health providers through advocacy
- Promote/nuture staff engagement

- Increase community awareness of the SCFHT programs, services, and the differences between the FHT and FHN



- Review and update organizational values and standard operating principals
- Improve internal communication
- Develop centralized support and utilization
- Impove technical support and utilization
- Start one community health record
- Collaborate on a searchable database of community resources

- Create a care coordinator program
- Evaluate what the SCFHT's role is in participating in existing or new partnered programs
- Improve collaboration between primary care and home and community care
- Collaborate with partner agencies, re: complex care cases

SCFHT Programs & Services

The SCFHT promote health and wellness by supporting our patients' needs through our array of programs and services:

- **Acute & Episodic Care**
- **Asthma/COPD Management**
- **Cancer Screening**
- **Diabetes Management**
- **Hypertension Clinic**
- **INR Clinic**
- **Lactation Consultations**
- **Memory Clinic**
- **Nutritional Counselling**
- **Occupational Therapy**
- **Pharmacist Services**
- **Primary Care Outreach**
- **Smoking Cessation**

The Team, 2023

2022-2023 Program Access & Statistics

Access to Care *(across all SCFHT programs for the 2022-2023 fiscal year)*:			
Total # of Patients:	8,572	**Total # of Visits:**	29,123

Acute & Episodic Care

Acute and episodic care services at the SCFHT is the provision of core primary care services in response to an acute or episodic illness. Services may include, but are not limited to: wound care, suture removal, immunizations, pre-operative visits, annual health exams, well baby checks, patient education, health promotion and disease prevention.

Total # of patients seen:	**7,207**
Total # of visits:	**17,332**
Total rate of same day / next day appointments	**49.62%**

In Partnership with LWDH: Physiotherapy & Rehabilitation Services

Total # of patients seen:	**1,739**

In partnership with the Lake of the Woods District Hospital Rehabilitation and Physiotherapy Department, the SCFHT contributes staffing dollars to subsidize and increase availability and patient access to physiotherapy services at LWDH to decrease the cost to patients by providing OHIP covered services that were not previously offered in Kenora. Together, the LWDH and WNHAC plan and implement physiotherapy and rehabilitative programs for individuals and groups, and coordinate services and care for clients.

2022-2023 Program Access & Statistics

Asthma / COPD Management Program

The Asthma / COPD Management Program at the SCFHT aims to provide spirometry screening to patients with breathing issues, and to provide assessment, education, and support to patients and their families with a diagnosis of Asthma or COPD. Treatment, education and day-to-day management of asthma and/or COPD symptoms are offered through initial and follow-up visits with our providers to help patients take control of their conditions.

The SCFHT has successfully caught up on the spirometry referral backlog, which was on hold during the peak of the COVID-19 pandemic. We extend our gratitude to our partner, Lake of the Woods District Hospital, for their assistance in supporting spirometry testing for the SCFHT.

Total # of patients seen:	**274**
Total # of visits:	**522**

Program Goals	Annual Outcomes
85% of Asthma/COPD patients seen in the program will have **a spirometry confirmed diagnosis.**	**97.11%**
85% of current patients in the program who smoke have received **a smoking cessation intervention.**	**80.6%**
75% of COPD patients have received **flu** and **pneumovax vaccines.**	**43.86% flu vaccine** **66.67% pneumovax**
75% of patients in the Asthma/COPD Program have received their **COVID-19 vaccine.**	**82.16%**

2022-2023 Program Access & Statistics

Cancer Screening Program

The SCFHT's Cancer Screening Program offers prevention and early detection of cervical, breast, and colorectal cancer to eligible patients according to the Ontario Cancer Care screening guidelines. This program intends to maintain or improve rates of cancer screening of eligible FHN patients according to current evidence-based clinical practice guidelines.

Total # of patients seen:	**926**
Total # of visits:	**1,035**

Program Goals	Annual Outcomes
69% of eligible patients screened for **cervical cancer** within the recommended timelines	**50.3% EMR** **56% SAR***
67% of eligible patients screened for **breast cancer** within the recommended timelines	**59.5% EMR** **61% SAR***
68% of eligible patients screened for **colorectal cancer** within the recommended timelines	**57.8% EMR** **66% SAR***

**Screening Activity Report (SAR) is an online tool available to primary care physicians and provides screening data for breast, cervical, and colorectal cancers. The SAR often differs from the SCFHT's Electronic Medical Records (EMR) data due to incoming reports not being automatically categorized correctly. The SCFHT and clinic staff continue to work to narrow the gap.*

The SCFHT participated in **Pap-a-Palooza** (April 2022), a campaign to promote cervical cancer screening and encourage individuals to book their Pap test.

Total # of rostered patients seen:	**85**
Total # of unattached patients seen:	**27**

2022-2023 Program Access & Statistics

Diabetes Management Program (DMP)

The SCFHT's Diabetes Management Program is a multidisciplinary team approach to education, intervention, and clinical management for all community members with diabetes to reduce the burden of diabetes and improve the quality of life of those affected by diabetes.

Our DMP Team provides patient-centred, accessible, and evidence-based care with screening, early diagnosis, and treatment of diabetes aimed at preventing or delaying disease progression or complications.

Total # of patients seen:	**571**
Total # of visits:	**2,025**

Program Goals	Annual Outcomes
90% of patients with Type 1 or Type 2 diabetes who received an A1c **within the last year**.	**91.47%**
80% of patients in the program will have their blood pressure measured within the **last six months**.	**69.0%**
60% of patients with Type 1 or Type 2 diabetes with a **validated foot screen** performed in the last year.	**46.63%**
60% of patients with Type 1 or Type 2 diabetes with a retinal exam performed **within the last two years**.	**69.25%**
60% of patients setting a **SMART goal** within the last 6 months.	**88.62%**

2022-2023 Program Access & Statistics

Foot Care Services

The SCFHT's Foot Care services provides 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. Our foot care nurses provide foot care education and diabetic foot screening.

Total # of patients seen:	**101**
Total # of visits:	**359**

Program Goals	Annual Outcomes
90% of patients with diabetes with a **60-second foot screen** completed **within the last 1 year**.	**91.49%**
80% of patients with **an Action Plan** who follow up with the foot care nurse on an annual basis.	**86.14%**
90% of patients with a **chronic problem whose condition is under control** at their most recent follow-up visit.	**98.68%**

2022-2023 Program Access & Statistics

Hypertension (HTN) Program

The SCFHT's Hypertension Program is designed for individuals with high blood pressure to learn the skills needed for the daily management of their condition. Our Registered Nurses assess and monitor patients of suspected or diagnosed hypertension using both in-office and ambulatory blood pressure monitoring, and provide patients with hypertension ongoing monitoring, education, and self-management skills.

Jill, Colleen S., and Alanna, RNs

Total # of patients seen:	**494**
Total # of visits:	**1,908**

Program Goals	Annual Outcomes
60% of patients with hypertension have individualized **blood pressure (BP) target set** within 3 months of their initial visit.	**100%**
65% of patients in the program to have **improved BP readings to target** after 3 months.	**62.31%**
80% of patients set **a lifestyle goal** after 3 months.	**92.31%**
Collect baseline on % of patients in for screening who receive **an in-office automated BP**; and % provided **education or resources** on proper BP technique.	**92.49%** received an in-office reading; **98.12%** received education / resources

2022-2023 Program Access & Statistics

INR Program

Warfarin is an oral anticoagulant that comes in tablets that are taken by mouth. It prevents individuals' blood from clotting in blood vessels, and stops existing clots from getting larger. The amount of Warfarin that a person needs is based on a blood test called the INR (International Normalized Ratio) which is tested using a CoaguChek machine.

The SCFHT's INR Program provides ongoing INR monitoring of a patient's Warfarin treatment to maintain patients at target range to reduce the risk of adverse events. Appropriate patients may be transitioned to newer medications (e.g., DOACs—Direct-acting Oral Anti Coagulants). In general, DOACs are safer and more effective than Warfarin, especially when it comes to serious bleeding events. DOACs cause half as much life-threatening bleeding than Warfarin, and doesn't require frequent blood monitoring and can be given safely in fixed doses.

Total # of patients seen:	**106**
Total # of visits:	**1,463**

Program Goals	Annual Outcomes
70% of point of care **INR tests in range**.	**71.5%**
<2% of patients in the INR program with **a recent stroke event**.	**2.8%**
<2% of patients in the INR program with **a recent major bleeding event** (requiring ER visit or hospitalization).	**3.8%**

2022-2023 Program Access & Statistics

Lactation Consultation Services

The SCFHT has an International Board Certified Lactation Consultant to assist new moms with breastfeeding. This program provides expectant and new parents with education and support to exclusively breastfeed to 6 months and beyond.

Parents who are struggling with breastfeeding, have low milk supply or are struggling with supplemental feedings; infants with poor weight gain or who are always hungry can receive support from the SCFHT's lactation consultant.

Baby Rest Stop @ the Farmer's Market

Total # of patients seen:	**72**
Total # of visits:	**232**

Program Goals	Annual Outcomes
85% of parents attending prenatal sessions or individualized consultations will report **increased confidence, knowledge, and skill** in breastfeeding through a post-session survey.	**100%**
75% of patients who **feel confident with the knowledge provided** at their appointment **to accomplish their breastfeeding plan**.	**80.95%** indicated increased confidence; **76.19%** increased confidence in oral exercises
Number of SCFHT and community partner staff who have **completed the 20-hr lactation course**.	**3** FHT staff, **2** students, **12** community partner staff

2022-2023 Program Access & Statistics

Primary Care Collaborative Memory Clinic Program

The Memory Clinic is comprised of a multi-disciplinary team including representatives from pharmacy, nursing, dietitian, family medicine, and the Kenora Rainy River District Alzheimer's Society for early diagnosis, treatment, and support of problems associated with memory loss.

The team uses a clinical reasoning model and assess possible related issues such as delirium, depression, and reversible causes. Functional and cognitive impairment is also assessed. The team also looks at considerations in fitness to drive. Interventions include (but are not limited to) medication changes, referrals to programs and supports, and driving status. A study exploring the cost-effectiveness analysis of MINT Memory Clinics found net cost savings of $51,500 per patient as compared to those in Ontario without the service, with improvement in quality of life for those living with dementia.

Total # of patients seen:	**64**
Total # of visits:	**159**

MINT MEMORY CLINIC
Collaborative primary care

Program Goals	Annual Outcomes
80% of patients/caregivers who are **satisfied with the service**.	**100%**
80% of patients/caregivers who report an **increased understanding about their condition**.	**92.31%**
60% of patients are **contacted after 2 weeks**; 60% **understand their care plan recommendations**	**51.7%** received call; **51.7%** understood recommendations
70% of patients who have **implemented 1 or more care plan recommendation(s)** at their follow-up visit; **number of recommendations** completed.	**82%; 133** recommendations
80% of patients with **advanced care planning (ACP) education** at an initial visit; 80% of patients with an **ACP and power of attorney (POA)** at follow-up visit.	**62%** ACP at initial visit; **47%** ACP & POA at follow-up visit

2022-2023 Program Access & Statistics

Nutritional Counselling Program


Therese, RD

The SCFHT's registered dietitian 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.

Total # of patients seen:	**330**
Total # of visits:	**733**

Program Goals	Annual Outcomes
90% of follow up patients will have achieved their **most recent SMART goal**.	**88.07%**
90% of dyslipidemia patients will have a **documented Framingham risk assessment**.	**81.58%**
Offer the **Mindful Eating: Emotional Eating and Food Craving Management Group** three times a year.	**3** workshops ran; **11** sessions completed

2022-2023 Program Access & Statistics

Occupational Therapy Program

Occupational Therapy (OT) focuses on promoting and maintaining a person's function an independence. Occupational Therapists work with individuals to help create goals and problem solve barriers that may be preventing them from participating in their chosen and meaningful self-care, productivity, and leisure activities.

The SCFHT's OT program offers and provides appropriate OT-based assessments and individualized interventions and educations to patients living in the community who are experiencing limitations to their function. The SCFHT's OT assists community members to remain as safe and independent as possible in their community.

Total # of patients seen:	**53**
Total # of visits:	**91**

Program Goals	Annual Outcomes
90% of home OT assessments with completed **Home Safety**	**75%**
80% of patients ages 65+ have a **completed falls assessment**.	**62.96%**
Collect baseline on number of patients in the program who are currently prescribed **opioid medication for pain management**.	**7.55%**
80% of patients who receive follow up and report an **improved understanding of their primary concern** and **ability to self-manage**.	**54.5%**

**The OT Program is currently on hold due to a temporary staff absence. The above reported stats are for Q1 only.*

2022-2023 Program Access & Statistics

Primary Care Outreach Services

Primary Care Outreach is an evidence-based approach that is effective in expanding access to programs and services for those most adversely affected by the social determinants of health. The SCFHT Primary Care Outreach program offers primary care services through outreach in various community settings for difficult to reach populations and those who have barriers in accessing these services through formal channels. Primary Care Outreach is a method to help ensure equitable access to those facing barriers in accessing primary care programs and services. The SCFHT extends our gratitude to the Kenora District Services Board for their generous and innovative collaboration with the SCFHT to bring this program to fruition.

Total # of patients seen:	**528**
Total # of visits:	**3,066**

Program Goals

Collect **baseline on housing as a social determinant of health**; **changes to housing status**; and **reason for homelessness**.

Annual Outcomes

Unsheltered: **86**
Emergency Shelter: **21**
At-risk: **12**
Provisionally sheltered: **192**
Sheltered: **183**
Incomplete: **34** Changes to housing status: **11** negative, **14** positive

Reason for homelessness:
52.3% navigation;
24.6% wait-listed;
7.7% housing debt or restriction;
9.2% patient choice;
1.6% unable to live in home community;

2022-2023 Program Access & Statistics

Program Goals *(continued)*	Annual Outcomes
Track number of unique individuals served, number of encounters (above); and **reason for encounter**.	Primary Care: **1,988** Trauma/Injury: **63** Acute Illness: **148** Chronic Illness: **114** Mental Health: **311** Substances-Alcohol: **53** Substances-Drugs: **296** Social Services: **52** Basic Needs: **14** Other: **27**
Number of **connections / referrals to other All Nations Health Partners (ANHP)** and **community services**.	**186** referrals to ANHP partners; **13** community referrals
Track **ER diversions**, based on patient-self reported use.	**9** patients self-reported ER diversion; **75** referrals from Lake of the Woods District Hospital

Becky & Jen from our Outreach Team

2022-2023 Program Access & Statistics

Pharmacist Services

A pharmacist provides the SCFHT with experience and support regarding medication related issues and drug information. Our pharmacist works alongside the FHN physicians, SCFHT Nurse Practitioners and nursing teams, and other allied health professionals to ensure that the most appropriate medicine is used to improve patients' health.

The SCFHT's pharmacist provides services that includes comprehensive medication reviews by assessing a patients' medications (prescriptions, non-prescriptions, supplements, traditional, and alternative medications) to determine if each medication is necessary, effective, safe, and realistic for the patient to take. Our pharmacist also identifies and helps solve possible drug therapy problems (DTPs), and medication related problems following hospital-discharge to help minimize the risk of re-admittance to hospital.

Total # of patients seen:	**533**
Total # of visits:	**771**

Program Goals	Annual Outcomes
400 visits for the following services: **Medication Reviews**; **medication updates** in the EMR; **drug information questions**; **prescription samples**; **drug navigation** (forms, etc.); **hospital discharge medication follow up**; and other services provided.	**66** medication reviews; **518** medication updates; **109** medication reconciliations; **114** drug info questions; **16** Rx samples; **80** drug navigation; **413** hospital discharges; **12** cardiac rehab; **2** Memory Clinic
50 patients will have **a medication review completed**.	**62** medication reviews

2022-2023 Program Access & Statistics

Pharmacist Services

Program Goals *(continued)*	Annual Outcomes
55% of **DTPs identified** at a medication review **get resolved**.	**58.94%**
250 **hospital discharge attempts**; 130 **patients contacted**; 200 **charts updated**.	**328** attempts; **156** patients contacted; **313** charts updated

11 pharmacy newsletters were created and distributed to community pharmacy partners.

June, SCFHT Pharmacist

2022-2023 Program Access & Statistics

Smoking Cessation Program

The Smoking Cessation Program at the SCFHT provides a systematic approach to assist patients who are interested in quitting smoking. An initial in-office appointment analyzes smoking and quitting history, smoking cessation medication options, and quit plans are developed. Follow-up supportive care counselling is provided by phone.

The SCFHT participates in the STOP with FHTs Smoking Cessation Program. With funding from the Ministry of Health Promotion, the SCFHT has the opportunity to offer free nicotine replacement therapy (NRT) to smokers who wish to quit.

Total # of patients seen:	**130**
Total # of visits:	**534**

Program Goals	Annual Outcomes
30% of patients in the program who have **quit smoking at 6 months**.	**32.3%**
25% of patients in the program who have **quit smoking at 12 months**.	**25.0%**
90% of smoking cessation program patients have **smoking status documented** in Risk Factors in the EMR.	**99.23%**

All Nations Health Partners OHT Involvement

The Sunset Country Family Health Team is a proud partner of the All Nations Health Partners Ontario Health Team (ANHP OHT). The establishment of OHTs represents a transformative approach to healthcare delivery, emphasizing collaboration, integration, and patient-centered care. Through our involvement with the ANHP OHT, the SCFHT is dedicated to advancing these principles and fostering a healthier community.

ALL NATIONS
HEALTH PARTNERS

By partnering with other healthcare providers, community and municipal organizations, and social service agencies, we recognize the immense potential to enhance the overall health and well-being of our patients. As a Primary Care Service Provider, we understand the vital role the SCFHT plays in coordinating care, promoting preventive measures, and managing chronic conditions. Through our involvement in the ANHP OHT, we are able to align our efforts with a broader network of healthcare professionals, enabling us to provide comprehensive, integrated care to our patients.

Key aspects of our involvement in the ANHP OHT include:

1. **Secondment of Leadership and Administrative Services for the ANHP OHT**: Services included, but were not limited to the following:
    - Present as the active executive champion for the All Nations Health Partners Ontario Health Team;
    - Be accountable to the ANHP OHT Direct Core Partners for supporting the working groups to achieve approved outcomes;
    - Be accountable to the ANHP OHT Direct Core Partners to provide strategic support to advance the objectives of the working groups in alignment with and support the ANHP OHT vision and to develop the strategic and operational plans;
    - Work collaboratively with the working group leads to ensure work plans are/ remain aligned with the overall OHT objectives;
    - Provide executive support and oversight to the development and execution of the group's work plan, ensuring alignment with approved timelines, objectives and outcomes;
    - Work within their capacity and with other system leaders to remove barriers for their working groups;

All Nations Health Partners OHT Involvement

- Identify and advocate for resources required to achieve outcomes (i.e., human and financial) and ensure secured resources are optimized to support the working groups' objectives;
- Remain current regarding the initiative status and provide progress updates to the ANHP OHT Steering Committee;
- Promote and advance the strategy of the ANHP OHT at the organization and system level;
- Support the development and execution of the overall implementation plans of the ANHP OHT.

2. Collaboration and Communication: We actively engage in regular meetings and communication channels established by the ANHP OHT, fostering strong relationships with fellow healthcare providers. By sharing insights, best practices, and clinical expertise, we collectively strive for better health outcomes and improved patient experiences. This collaboration also facilitates effective care transitions, ensuring that patients receive seamless and coordinated care across various healthcare settings—the right service, at the right time, in the right setting, for everyone in the Kenora region.

3. Integrated Care Planning: Within the ANHP OHT framework, we actively participate in integrated care planning initiatives. This involves working collaboratively with other ANHP members to develop care pathways, protocols, and shared guidelines that streamline care delivery, reduce fragmentation, and improve the patient journey. By aligning our efforts with other healthcare partners, we can optimize the use of resources, enhance care coordination, and ultimately deliver better health outcomes for our patients.

4. Data Sharing and Technology Integration: Through our involvement in the ANHP OHT, we have access to shared health information systems and platforms that facilitate secure data exchange and interoperability. This enables us to access comprehensive patient information, share relevant clinical data, and collaborate on care plans more effectively. The integration of technology also enhances our ability to deliver virtual care, remote monitoring, and telehealth services, ensuring accessibility and convenience for our patients.

Continued...

All Nations Health Partners OHT Involvement

5. Leadership of the Data & Quality Improvement, and Privacy & Security Working Groups: The ANHP OHT offers opportunities for quality improvement initiatives through shared learning and best practice sharing. We actively participate in quality improvement projects, leveraging the collective expertise within the ANHP OHT to enhance our clinics' processes, patient outcomes, and overall healthcare delivery. By learning from each other's experiences, we can continually innovate and adapt our approaches to deliver the highest standard of care. The SCFHT provided leadership for the Data & Quality Improvement and Privacy & Security Working Groups:

- The SCFHT Quality Improvement Decision Support Specialist (QIDSS) has been instrumental to the planning of the cQIP (collaborative quality improvement plan), tracking metrics and supporting the subgroups for each cQIP indicator;
- The SCFHT Finance Manager and Clinical Coordinator have co-chaired the Privacy & Security Working Group, ensuring that privacy policies are in alignment amongst the ANHP Partners, ensuring that Partners are up-to-date with the latest in health privacy law, and managing data-sharing agreements.

Our involvement with the ANHP OHT reflects our commitment to advancing integrated care, collaboration, and patient-centeredness. By working together within the ANHP OHT framework, we are confident that we can make a meaningful difference in the health and well-being of our community. As we continue this journey, we remain dedicated to providing comprehensive, coordinated, and compassionate care that meets the evolving needs of our patients and fosters a healthier future for all.

The ANHP Partners:

Our Privacy Commitment

At the SCFHT, we take your privacy seriously. The SCFHT is a part of data-sharing agreements with our partners: **Kenora Chiefs Advisory (KCA)**, **Kenora District Services Board (KDSB)**, **Lake of the Woods District Hospital (LWDH)**, **Northwestern Health Unit (NWHU)**, and **Waasegiizhig Nanaandawe'iyewigamig (WNHAC)** (the team members).

As a health service provider, we are committed to safeguarding the privacy and confidentiality of any personal information we collect.

Any personal health information provided to KCA, KDSB, LWDH, the NWHU, the SCFHT or WNHAC, or any information we receive from our health care partners can only be collected, used, or disclosed (meaning shared) in accordance with the **Freedom of Information and Protection of Privacy Act (FIPPA)** and/or the **Personal Health Information Protection Act (PHIPA)** which is Ontario law.

KCA, KDSB, LWDH, the NWHU, the SCFHT and WNHAC employees are bound by confidentiality and have established policies and practices that further ensure all client health information is kept private and confidential. We are required by law to notify clients if there is a privacy breach.

Clients have the right to make choices and control how their health information is collected, used, and disclosed. It is assumed that when clients receive health care from KCA, KDSB, LWDH, the NWHU, the SCFHT or WNHAC, the client has given their consent (permission) to use their information, unless they tell KCA, KDSB, LWDH, the NWHU, the SCFHT or WNHAC otherwise; clients have the right to ask that KCA, KDSB, LWDH, the NWHU, the SCFHT, or WNHAC does not share some or all of their health information with one or more of the team members, or their external health care providers (such as a specialist).

Continued...

In some situations, KCA, KDSB, LWDH, the NWHU, the SCFHT or WNHAC will be required to ask for a client's permission to share information, the client may choose to say no. If the client says yes, they may change their mind at any time. However, there may be some cases where KCA, KDSB, LWDH, the NWHU, the SCFHT or WNHAC may collect, use, or disclose a client's health information without their permission, as permitted or required by law.

Clients have the right to request a copy of their health record; the request must be in writing and sent to the respective agency.

Questions, concerns, or requests for more information about the SCFHT privacy policies and practices can be directed to our Privacy Officers (Clinical Coordinator and Finance Manager), or to the Executive Director.

If, after contacting any of the above agencies the client feels that their concerns have not been addressed to their satisfaction, they have the right to complain to the Information and Privacy Commissioner of Ontario:

Information and Privacy Commissioner of Ontario
2 Bloor Street East, Suite 1400, Toronto, ON M4W 1A8
or visit the IPC website: www.ipc.on.ca

Your Privacy Matters!

Learn more about your privacy rights:
www.ipc.on.ca/privacy-individuals/your-privacy-rights/

Our Team

Executive Director – Colleen Neil
Finance Manager – Stephanie Evenden
Clinical Coordinator– Lindsay Kinger
Quality Improvement Decision Support Specialist – Melonie Young
Administrative Assistant – Patient Services – Toni Maenpaa
Administrative Assistant – Communications & Executive – Lindsay Whitaker
Administrative Assistant – IT & Programs Services – Suzanne Langlois
Administrative Assistant – Jenna Mattson *(casual)*
Diabetes Dietitian – Cindy Van Belleghem
Diabetes Educator, Registered Nurse – Carolyn Hamlyn
Foot Care Nurse – Crystal Cadieux
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 *(Kenora Medical Associates)*
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
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)*

Audited Financial Statements, 2022-2023

Sunset Country Family Health Team
Statement of Financial Position

March 31	2023	2022
Assets		
Current		
Cash and bank	**$1,001,957**	$995,152
Account receivable	**95,141**	85,430
Prepaid expenses	**46,172**	19,532
	1,143,270	1,100,114
Capital assets	**220,956**	253,054
	$1,364,226	$1,353,168
Liabilities and Net Assets		
Current		
Accounts payable and accrued liabilities	**$249,619**	$433,904
Government contributions repayable	**356,458**	289,596
Deferred revenue	**293,068**	179,120
	899,145	902,620
Net Assets		
Net assets invested in capital assets	**220,956**	253,053
Unrestricted	**244,125**	197,495
	465,081	450,548
	$1,364,226	$1,353,168

On behalf of the Board:

Colleen Neil

Jonathan Grek

Audited Financial Statements, 2022-2023

Sunset Country Family Health Team
Statement of Operations

For the year ended March 31	2023	2022
Revenue		
Ministry of Health and Long Term Care	**$3,712,782**	$3,539,752
Family Health Network (Salary contribution)	**25,000**	25,000
Primary Care Asthma program	**37,250**	39,350
Other	**103,276**	29,476
Waasegiizhig Nanaandawe'iyewigamig	**49,047**	52,438
Kenora District Services Board	**252,850**	400,429
Ontario Health Quality Council	**74,954**	-
	4,255,159	4,086,445
Expenses		
Human Resources		
Salaries	**2,369,393**	2,556,694
Benefits	**504,334**	500,912
Contract Labour	**203,267**	203,137
Sessionals	**45,084**	45,864
General Overhead		
Advertising	**24,370**	8,173
Communication equipment and materials	**11,120**	10,012
Membership fees	**13,708**	12,307
Library materials	**39**	88
Medical equipment, supplies and waste	**40,339**	33,525
Office equipment and supplies	**17,887**	10,687
Program supplies—QIDSS	**6,186**	5,857
Printing/courier	**6,304**	6,527
Other—board expenses	**4,384**	1,942
Other—Equipment Calibration	**2,174**	1,661
Other	**14,341**	1,364

Continued...

Audited Financial Statements, 2022-2023

Sunset Country Family Health Team
Statement of Operations (continued)

For the year ended March 31	2023	2022
Expenses		
Information Technology		
IT hardware/software	**12,016**	18,816
EMR Expenses	**91,443**	28,626
Equipment lease contracts	**2,789**	2,820
Ongoing Overhead		
Audit fees and other accounting fees	**22,589**	19,459
General Consulting	**41,041**	10,274
Insurance	**19,982**	17,444
Legal fees	**6,780**	6,242
Physician consulting	**33,000**	33,000
Professional fees	**41,074**	36,784
Recruitment and retention	**4,405**	3,810
Premises—rent	**142,205**	169,139
Travel	**9,165**	2,409
Common area maintenance	**54,546**	59,263
Approved one-time expenditures	**241,589**	130,349
	3,985,554	3,937,185
Excess of revenues over expenses	**269,605**	149,260
Government contributions repayable	**(222,975)**	(100,992)
Excess of revenues over expenses	**$46,630**	$48,268

Sunset Country Family Health Team
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