Sunset Country Family Health Team

Quarterly Report

Q1 Highlights: April, May, June 2023

Issue 19
July 2023

Inspiring a healthier Kenora

Acute & Episodic Care Program

Program Goal

To provide high quality acute care to FHN patients.

Stats

In Q1, **3,713 patients** were seen, and **5,772 visits** were provided by the team under acute and episodic care.

- 79.3% were in-office visits;
- 20.4% were phone visits;
- 0.2% other (email, home, or virtual visits);
- 14 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 Q1:

- **Pap-a-Palooza** held in April 2023; 86 patients given a Pap test
- **1 Prenatal Group session held**
- **1 Community Career Fair** at Seven Generations Education Institute
- **1 Farmer's Market** event

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, **84 patients** were seen, resulting in **102 visits**.

Stats

93.62% of Asthma and COPD patients have a spirometry confirmed diagnosis.

66.67% of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention.

32.35% of COPD patients have received a yearly flu shot, and **67.65%** 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.

Planning for an Asthma/COPD follow-up clinic in the fall is underway.

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

57.3% (EMR) / 60% (SAR) of FHN patients are up to date for **cervical cancer screening**.

60.9% (EMR) / 62% (SAR) of FHN patients are up to date for **breast cancer screening**.

58.5% (EMR) / 67% (SAR) of FHN patients are up to date for **colorectal cancer screening**.

Highlight

Through a combination of education and awareness, we encourage all providers to champion the importance of cancer screening, and encourage all patients to stay up-to-date with their screenings.

Fun and engaging activities to promote cancer screening and awareness is underway.

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, **293 patients** were seen, resulting in **510 visits**.

Stats

97.76% of patients with Type 1 or Type 2 diabetes had an A1C in the last year.

92.15% of all patients with Type 1 or Type 2 diabetes had their blood pressure measured in the last six months.

44.4% of patients with Type 1 or Type 2 diabetes had a validated foot screen in the last year.

52.24% of patients had a retinal exam within the last two years.

71.33% of patients set a SMART goal within the last six months.

Highlight

The SCFHT Diabetes Management Team is planning a Diabetes Day at Keewatin Clinic in Q2.

At the Diabetes Days, patients can receive point-of-care testing, blood pressure checks, and foot screenings.

Do you have content you would 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 and high-risk patients in order to prevent or delay complications.

Access

In Q1, **114 patients** were seen, resulting in **163 visits**.

Stats

93.27% of patients with diabetes have had a 60 second foot screen within the last year.

86.52% of patients with chronic problems have their conditions now under control with regular clinic visits.

Highlight

The SCFHT Foot Care program now accepts referrals for the treatment of chronic ingrown and involuted toenails with nail bracing and/or Onyfix for all patients with a FHN physician.

With the increased capacity for foot care services, Crystal has expanded her services to offer lower-limb wound care, and treatment for calluses, and corns for non-DM patients.

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, **207 patients** were seen, resulting in **426 visits**.

Stats

77.14% of patients in the program have improved their blood pressure readings to target after 3 months.

91.43% of patients have set a new lifestyle goal after 3 months.

92.56% of patients referred for screening received education or resources on proper BP technique.

Highlight

In Q2, there will be a provider shortage until maternity leave coverage begins in September. We are anticipating a brief increase in wait times for appointments during this time.

If you have an urgent referral, please flag this and we will prioritize booking urgent requests.

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, **74 patients** were seen, resulting in **298 visits**.

Stats

74.1% of tests given were within INR target range.

0 INR patients experienced a stroke in Q4.

1 INR patient experienced a major bleeding event in Q1; the SCFHT remains 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 Q1, **30 patients** were seen, resulting in **86 visits**.

Highlight

Patients who are struggling with breastfeeding, have low milk-supply, or are struggling with supplemental feedings, or infants with poor weight gain or who are always hungry, please send a message or referral to the SCFHT Lactation Program as soon as possible.

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, **37 patients** were seen; **12 clinics** were held (including half-day clinics).

Stats

94.44% of patients surveyed in Q1 are satisfied with the service.

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

Highlight

The Memory Clinic team had a busy quarter, offering 12 clinics. Additional half-day clinics have been helpful to reduce the waitlist for initial appointments.

Wait time for an initial appointment is now only 6 months. Urgent referrals are encouraged to be flagged for the team to prioritize booking.

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, **112 patients** were seen, resulting in **178 visits**.

Stats

83.78% of follow-up patients have achieved their most recent SMART goal.

94.74% of dyslipidemia patients had a documented Framingham risk assessment.

Highlight

Therese is planning on offering another Mindful Eating: Emotional Eating and Food Craving Management group in October. The Mindful Eating group is a 6-week program, with 2-hour sessions once a week for the 6-week duration.

Referrals for the next Mindful Eating session are welcome.

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.

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 **88 patients** seen, resulting in **94 visits**.

Stats

7 patients had a medication review completed in Q1.
63 patients had their medications updated in the EMR.
11 patients had a medication reconciliation.
12 patients had drug information questions answered.
9 patients received assistance with drug navigation (forms, etc.)
43 patients had hospital discharge medication follow-up.
3 patients from the Cardiac Rehab Program.

Highlight

The SCFHT has a new pharmacist, Susan Sharp, on the team. She is currently accepting referrals to provide a range of comprehensive medication services aimed at improving patient outcomes.

Suggestions for additional areas where she can contribute to the well-being of our patients As Susan settles into her new role are welcome.

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

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** seen, resulting in **121 visits**.

Stats

44.4% of patients in the program have quit smoking at 6 months.

25% 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

The Smoking Cessation Program has seen success rates for patients enrolled in the program.

Please note is currently on hold for new referrals due to provider shortage.

Social Work

The SCFHT is pleased to share we have new staff on our team: Taylor Alcock, Community Health Worker, who has been developing her program in Q1. Working closely with our clinical team, Taylor will help guide and navigate patients through the healthcare system, identifying and overcoming obstacles to ensure that patients receive the care and treatment they require.

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
Administrative Assistant – IT & Programs Services – Suzanne Langlois
Administrative Assistant – Jenna Mattson
***New* Community Health Worker** – Taylor Alcock
Diabetes Dietitian – Cindy Van Belleghem
Diabetes RN – Carolyn Hamlyn
Foot Care Nurse – Crystal Cadieux
Foot Care Nurse – Sue McLeod
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
***New* Pharmacist** – Susan Sharp
Registered Dietitian – Therese Niznowski
Registered Nurse – Alanna Scribilo
Registered Nurse – Colleen Snyder
Registered Nurse – Jillian Faulds
Registered Practical Nurse – Breanne Becker *(Kenora Medical Associates)*
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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