Q3

Sunset Country Family Health Team

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Q3 Quarterly Report

October-December 2023

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mission

"Collaborating as a team to empower a healthy community by providing comprehensive quality primary care."

vision

"Inspiring a healthier community together."

values

Quality. Team Care. Accountability. Patient Focused. Excellence. Collaboration.

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Sunset Country Family Health Team

Acute & Episodic Care Program

PROGRAM GOAL: To provide high quality acute care to FHN patients.

Stats:

In Q3, **3333 patients** were seen, and **5064 visits** were provided by the team under acute and episodic care.

- **81%** were in **office visits**
- **17%** were **phone visits**
- **0.09%** other (**email, home, or virtual visits**)
- **1** ER **diversion** from LWDH

Asthma & COPD Program

PROGRAM GOAL: To improve the overall health & wellbeing of individuals with Asthma and COPD.

Stats:

In Q3, **127 patients** were seen, and **191 visits** were provided.

- **100%** of Asthma and COPD patients have a **spirometry confirmed diagnosis**
- **62%** of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention. **smoking interventions not consistently documented on new spirometry form**
- **69%** of COPD patients have **received a yearly flu shot**
- **71%** of COPD patients have **received a pneumococcal vaccine**

Cancer Screening Program

PROGRAM GOAL: 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.

Stats:

- **60.5% (EMR)** / 63% (SAR) of FHN patients are **up to date with for cervical cancer screening.**
- **60.5% (EMR)** / 61% (SAR) of FHN patients are **up to date with for breast cancer screening.**
- **60.5% (EMR)** / 61% (SAR) of FHN patients are **up to date with for colorectal cancer screening.**

*Please note that SAR values are different from our EMR values; we are continuing to work on reconciling EMR data.

Community Health Worker Program

PROGRAM GOAL: Support patients to navigate the healthcare system, coordinate between service providers, and empower patients to become their own strongest advocate.

Stats:

In Q3, **15 patients** were seen, **27 visits** were provided, and **4 system navigation**

- **93%** of patients were **rostered**
- **7%** of patients were **unrostered**
- **77.7%** of visits were in **office visits**
- **22.2%** of visits were **phone visits**

Diabetes Management Program

PROGRAM GOAL: Multidisciplinary team approach to education, intervention and clinical management for all community members with diabetes to reduce the burden of diabetes and prediabetes and improve the quality of life of those affected by diabetes.

Stats:

In Q3, **303 patients** were seen, and **524 visits** were provided.

- **98.57%** of patients with Type 1 or Type 2 diabetes had an **A1C** in the last year
- **90.1%** of patients with Type 1 or Type 2 diabetes had their **blood pressure** measured in the last six months
- **46.95%** of patients with Type 1 or Type 2 diabetes had a **validated foot screen** in the last year
- **54.85%** of patients with Type 1 or Type 2 diabetes had a **retinal exam** within the last two years
- **59.08%** of patients set a **SMART goal** within the last six months

Foot Care Program

PROGRAM GOAL: To screen for and treat diabetic foot conditions and high-risk patients in order to prevent or delay complications

Stats:

In Q3, **189 patients** were seen, and **318 visits** were provided.

- **84.46%** of patients with diabetes had a **60 second foot screen** within the last year
- **96.15%** of patients with **chronic problems have their conditions now under control** with regular clinic visits

Hypertension Management Program

PROGRAM GOAL: Assessment and monitoring of suspected or diagnosed hypertension using both in office and ambulatory blood pressure monitoring. Provide patients with hypertension ongoing monitoring, education and self-management skills. Provide screening for suspected hypertension with Ambulatory Blood Pressure Monitor to help in diagnosis of HTN.

Stats:

In Q3, **156 patients** were seen, and **434 visits** were provided.

- **65.38% of patients** in the program have **improved their blood pressure readings** to target after 3 months.
- **82.69% of patients** have set a **new lifestyle goal** after 3 months
- **78.82% of patients** referred for screening have **received education or resources** on proper BP technique

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:

- **168 patients** seen at **11 full or part day flu clinics** – **101** flu vaccines, **126** covid vaccines.
- **3 prenatal group sessions** with **16 attendees**

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 required hospitalizations.

Stats:

In Q3, **71 patients** were seen, and **355 visits** were provided

- **67.29%** of point of care INR tests given were in range
- **0** INR patients experienced a stroke in Q3
- **0** INR patients experienced a major bleeding event in Q2; the SCFHT remains below their 2% target

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.

Stats:

In Q3, **23 patients** were seen, and **54 visits** were provided

- **84.21%** report increased confidence in feeding
- **1** Lactation education event in Q3 with **5 attendees**
- **3** prenatal sessions with **16** attendees

Memory Clinic Program

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.

Stats:

In Q3, **27 patients** were seen, and **5 clinics** were provided

- **100%** of patients/caregivers surveyed in Q3 were **satisfied with the service**
- **100%** of patients surveyed in Q3 reported an **increased understanding** about their condition

Minor Ailments Program

PROGRAM GOAL: The Minor Ailments program will provide timely access to care for the treatment of self-limiting illnesses for individuals without a primary care provider.

Stats:

In Q3, **7 patients** were seen, 6 unattached, 1 enrolled

- **1** patient reported ER diversion
- **28.6%** of visits were cold sores
- **14.3%** of visits were dermatitis
- **57.1%** of visits were pinworms/threadworms

Nutritional Counselling Program

PROGRAM GOAL: Provide nutrition tools and education to help patient improve quality of life and decrease likelihood of developing a chronic disease or to help patients manage the nutritional component of dealing with a chronic disease to decrease possibility of adverse events. To improve lipid levels in patients with dyslipidemia to decrease risk of cardiovascular events.

Stats:

In Q3, **86 patients** were seen, and **151 visits** were provided

- **61.29%** of follow-up patients have **achieved** their most recent **SMART goal**
- **84.62%** of dyslipidemia patients have a documented **Framingham risk assessment**
- **1** Mindful Eating workshop, **2** sessions, **22** attendances

Obesity Management Program

PROGRAM GOAL: This program is currently in development.

Stats:

In Q3, **31 patients** were seen, and **64 visits** were provided

- **12.9% of patients** with InBody testing

Occupational Therapy Program

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

Program on hold - provider on leave.

Pharmacist Services Program

PROGRAM GOAL: Assist patients in a review of their current medication regime. Assist primary care providers in identifying drug therapy problems (DTPs) and identifying potential solutions, updating the EMR medication module and completing paperwork required for Exceptional Access Program Provide phone follow up to post hospital discharge patients to identify and help to resolve DTPs that can occur in a patient's transition from hospital to home, and update the EMR medication module.

Stats:

In Q3, **131 patients** were seen, and **143 visits** were provided

- **13 patients** had a medication review completed in Q3
- **90 patients** had their medications updated in the EMR
- **16 patients** had a medication reconciliation
- **24 patients** had drug information questions answered
- **25 patients** received assistance with drug navigation (forms etc.)
- **35 patients** had hospital discharge medication follow-up
- **1 patient** were seen from the Cardiac Rehab Program