SUNSET COUNTRY FAMILY HEALTH TEAM ANNUAL REPORT 2024/2025

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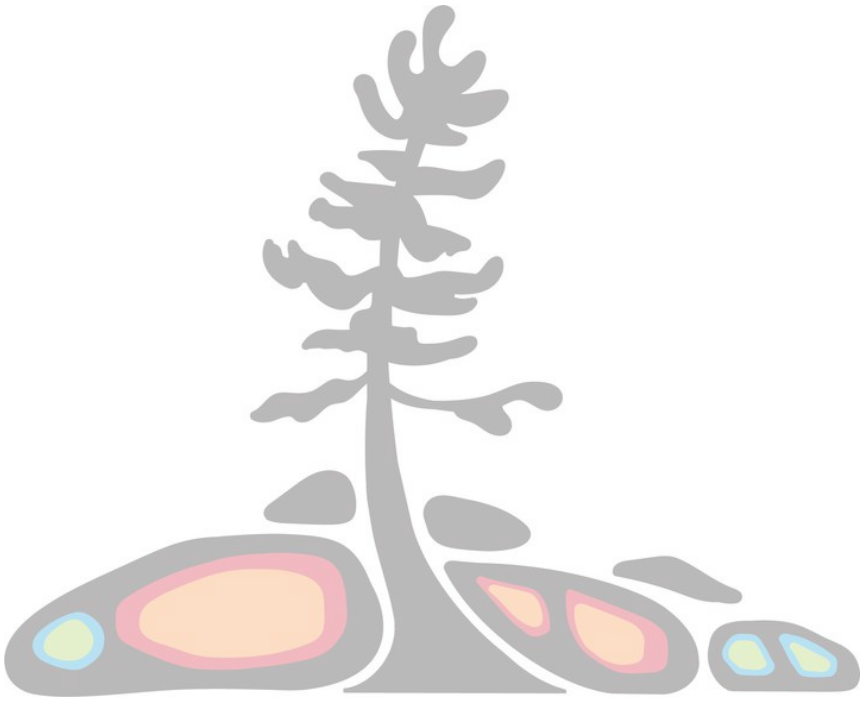


About the Sunset Country Family Health Team

We are proud partners of the All Nations Health Partners Ontario Health Team and staff an interdisciplinary team of physicians, nurse practitioners, registered nurses, registered practical nurses, occupational therapists, pharmacists, dietitians, and other healthcare professionals. Together we strive for a healthier community, offering quality comprehensive primary care to collaborate with the members of our community on their healthcare journey.

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.

SCFHT Board of Directors, 2024-2025

We extend our gratitude to our Board of Directors for their shared expertise and passion for upholding the values, mission and vision of the Sunset Country Family Health Team.

SCFHT Board Members:

KMA Representative: Dr. Michelle Thomas
Keewatin Clinic Representative: Dr. Meghan Olson
Docside Clinic Representative: Dr. Emily Drake
Docside Clinic Representative: Dr. Stephane Foidart
Community Partner Physician: Dr. Kerry Anderson
Community Partner IHP: Roberta Giesbrecht
Community Partner: Paul Derouard
Community Partner: Whitney Van Belleghem-Morrison

SCFHT Board Executive:

Chair: Dr. Kerry Anderson
Vice Chair: Roberta Giesbrecht
Secretary / Treasurer: Paul Derouard

SCFHT Lead Physician:

Dr. Shannon Weibe

A Message from the SCFHT Lead Physician: **Shannon Wiebe**

For family physicians, major changes were in the final stages of being formalized in the spring of this year. The Family Health Network was in the process of being terminated, and all community family physicians were preparing to transition to work for the All Nations Health Partners Rural Generalist Council. The SCFHT has been a key leader in guiding this transition, and will continue as the manager of physician clinics. This transition is intended to remove the administrative burden of office management from physicians, increasing time for patient care, while recognizing clinical administrative work.

The formalized leadership also aims to support consistent standards for staff and bring significant changes in scheduling and team function. All SCFHT clinics were preparing to implement a centralized booking team and advanced access booking, with the goal of significantly shortening wait times for members of previously over-rostered clinics. A Pod system for shared care was in development, which should further support coverage when physicians or nurse practitioners are out of office, and share administrative burdens. Physicians and nurse practitioners were beginning to provide appointments for currently "unattached" patients, with the intention of offering meaningful ongoing and preventative care until we are able to recruit adequately to allow each patient to be attached to a primary care provider.

The call centre staff experienced a steep learning curve, but one of their early skills has been in identifying the "right provider, right time," meaning that all staff will be maximizing their scope of practice and that patients are being provided appointments with the FHT member who can best meet their needs — SCFHT program, RPN, nurse practitioner, or family physician.

Physician recruitment had not been as rapid as hoped, partly due to the Ministry of Health maintaining an embargo on information about the new physician services model. A new physician, part of the Practice Ready Ontario program, was set to begin with Dr. Foidart, and we remain optimistic that the model will allow for increased recruitment in the near future. It has already begun to provide improved access to locum coverage and increased interest in work in our emergency department. Overall, community physicians worked through major changes in clinic function, time tracking, and autonomy, but reported satisfaction with the model and a sense of pride in the evolution of access to care in which they will be able to play a part.

The SCFHT's efforts to improve staff retention (e.g., formalization of the 4-day work week) created a positive atmosphere and provided some additional availability for staff to work in other agencies in need of health human resources, without impacting the number of patient interactions at SCFHT. Recent staff expansion meant that SCFHT will now, with variations in work weeks and length of day, provide 5-day-per-week coverage to clinics.

continued…

A Message from the SCFHT Lead Physician: **Shannon Wiebe**

The opening of remaining SCFHT programs to all patients regardless of roster status is a significant improvement in access to care for our community members. SCFHT have demonstrated great flexibility and problem solving in bringing this into action. Medical Directives have been updated to reflect the access to all OHT referring providers. SCFHT Nurse Practitioners have really stepped up in alignment with the changes to physician practices, seeing unattached patients, and formalizing connections with SCHT services so that staff have a designated provider to which they can reach out for unattached patients in their programs.

SCFHT staff and leadership have played a major role in supporting local development of Integrated Clinical Pathways. These provincial initiatives provide guidance, programs, and pathways for key clinical concerns. The last year has seen the expansion of our COPD program to all community members, with steps to provide access to lung function testing and programming in First Nations Communities. The Congestive Heart Failure Clinic is a new program implemented this year, and will significantly improve education and care for these patients. In its infancy, this program has been currently focussing on access for patients previously unattached to a primary care provider.The Wound Care Pathway is also in early stages, targeting improved access to wound care and intravenous antibiotics outside of the hospital setting.

We truly appreciate SCFHT leadership continues to take a major role in OHT leadership and in the development of strong linkages with other community Service Provider Organizations. This is highly reassuring in ensuring we are up to date on developments, and that the primary care voice is strong. A primary focus is the digital strategy, including the development of a primary care module for Meditech Expanse, the hospital electronic medical record (EMR), which will allow for a single EMR across our region. The work on unattached patient access will advance with a shift in Health Care Connect data to a more local level, and places us well ahead on the provincial target for attaching all patients to care.

The Goals and projects of the SCFHT Quality Improvement Committee overlap with OHT cQIP Committee. This is focused on community-wide assessments and improvements in care.

Respectfully submitted, Shannon Wiebe
June 2025

A Message from the SCFHT Executive Director: **Colleen Neil**

As we reflect on the 2024–2025 year, I am filled with gratitude and admiration for the incredible individuals who comprise the Sunset Country Family Health Team.

To our dedicated healthcare providers, thank you. You are the heart and soul of this organization. Your compassion, clinical excellence, and dedication to patient care inspire us all. To our administrative team, your tireless work behind the scenes ensures that we continue to function smoothly, adapt to change, and meet the growing administrative demands of a complex healthcare system. Your contributions are essential and deeply valued.

To our patients, thank you for placing your trust in us. You are at the centre of everything we do.

We are also grateful to our partners in primary care, Waasegiizhig Nanaandawe'iyewigamig and Kenora Chiefs Advisory. Your ongoing collaboration has been vital as we work together to strengthen primary care services and build a unified system that meets the needs of our entire community—First Nations and non-First Nations, on and off reserve.

Throughout the pages of this report, you will see the impressive and wide-reaching work of our team. What may not be as visible, but is profoundly felt, is the unwavering commitment to our patients and the remarkable spirit of our Family Health Team. It is this passion and dedication that make our team so special.

To our Board of Directors—thank you for your generous gift of time, your guidance, and your leadership. Your perspective helps shape the direction of our work and keeps us grounded in the needs of the community we serve.

As we look ahead to 2025–2026, the Sunset Country Family Health Team enters a new phase of growth and opportunity. We will support our physicians and patients through the implementation of a new model of primary care, with an expanded interprofessional team and renewed objectives that align with the evolving needs of our community. It will be a year of progress, challenge, and promise—and I am confident that together, we are ready.

Thank you all.

Our Medical Community

The Sunset Country Family Health Team (SCFHT) collaborates with partners to provide a range of primary care services. Working alongside allied health professionals and physicians from the community, we offer primary care, manage chronic conditions, promote health, and prevent illnesses for our patients. Achieving our goals of collaboration, integration, and patient-centred care are made possible through these partnerships.

Megan (left) and Kendra (right), RPN's at the Kenora Medical Associates and Rika (centre), RPN at the Keewatin Clinic

Our Affiliated Clinics

Docside Clinic
525 First Avenue South
Kenora ON P9N 1W5

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

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

SCFHT in the Community

WE HOSTED

7 PRENATAL BREASTFEEDING SESSIONS IN COLLABORATION WITH THE NWHU

12 FITNESS FOR BREATH SESSIONS

5 MINDFUL EATING SESSIONS

2 DIABETES EDUCATION SESSIONS (PINECREST AND WOMENS PLACE)

8 BABY BEGINNINGS SESSIONS IN COLLABORATION WITH EARLYON CENTRE

3 MEDICINE CABINET CLEAN-UP EVENTS AT SENIORS HOMES

1 BLOOD PRESSURE CLINIC AT WOMEN'S PLACE AND **1** DROP IN HYPERTENSION CLINIC

BABY FRIENDLY PINK TENT AT 8 FARMERS MARKETS

2 MONTH LONG COPD FOLLOW UP CLINICS

7 WEEKLY WALKING WEDNESDAY SESSIONS

WE ATTENDED

MAY 2024

9 - Palliative Care Community Event in Dryden
29 - Health Fair at Evergreen School

JUNE 2024

3-4 - Palliative Care Conference in Dryden
12 - Matiowski Farmers Market
13 - Alzheimer's Society's Learning Series for Care Partners of Persons Living with Dementia
24 - Process Mapping Improvement Bootcamp

SEPTEMBER 2024

13 - Empower 2 Recover
17 - Park Meadows Open House

JANUARY 2025

14 - Career Fair at Beaver Brae Secondary School
30 - SNAP Community Information Session (hosted by Firefly)

FEBRUARY 2025

5 - Career Expo at St Thomas Aquinas
13 - MINT Memory Clinic Training (virtual)

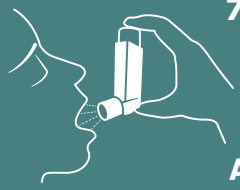
MARCH 2025

3 - Palliative Care Expo in Kenora
20 - BLS Recertification

Access to all SCFHT programs

2024/2025 Total #of patients: 14,880	**2024/2025 Total # of visits: 33,036**
2023/2024 Total #of patients: 8,934	**2023/2024 Total # of visits: 35,249**

17,335 visits to the Acute and Episodic Care Services



729 visits to the Certified Respiratory Educator for Asthma / COPD

709 visits to the Cancer Screening program

83 patient encounters with the Community Health Worker

1,877 visits to the Diabetes Management program

1,373 visits to the Foot Care nurses

2,358 visits to the Hypertension team

1,524 visits to the INR program

293 visits to the International Board Certified Lactation Consultant (IBCLC)

78 Memory Clinic patients

677 visits to the Registered Dietitian

192 visits to the Obesity Management Program

269 visits to the Occupational Therapist

667 visits to the SCFHT Pharmacist including Minor Ailments

4,953 visits to the Physiotherapy / Rehab program at LWDH

Strategic Plan 2023 - 2026

Strategic planning is crucial for delivering high-quality healthcare services. At SCFHT, we aim to ensure patients have timely access to care and are aware of their healthcare options. A needs assessment conducted in Spring 2022 identified gaps in healthcare access through community surveys. This data guided our strategic planning process in Fall 2022, focusing on community and staff engagement to develop actionable initiatives. Over the past year, we have made significant strides towards our goals. We take pride in our achievements and are committed to further expanding healthcare access in the future.

Priority One: Access for All

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

During the 2023/2024 fiscal year, planning was completed to enhance accessibility across SCFHT programs. As a result, effective April 1, 2025, 12 out of 15 programs became available to all patients—regardless of whether they have an attached primary care provider.
Throughout the 2024/2025 fiscal year, additional planning was undertaken to attach each SCFHT Nurse Practitioner with specific SCFHT programs. This ensures unattached patients receive support in managing chronic conditions, medication renewals, and related referrals.
By the final quarter of the 2024/2025 fiscal year, the remaining two programs were also opened to all patients, completing the transition to fully accessible programming.

Priority Two: Recruitment & Retention

Recruitment strategies | Retention strategies |Health Human Resource planning | Wage parity for health providers through advocacy |Promote/nurture staff engagement.

Recruitment, retention, and wage equity are priorities in SCFHT's 2023–2026 Strategic Plan. To address challenges like wage disparities and staff burnout, SCFHT trialed a 32-hour workweek from January to August 2024. The trial showed stable recruitment, improved staff satisfaction and efficiency, reduced burnout, and maintained productivity while enhancing job satisfaction and work-life balance. Access to programs expanded, and staff contributed over 600 hours to the healthcare system. Based on positive outcomes, SCFHT plans to maintain the 32-hour workweek while transitioning back to five-day operations. The Board approved a revised full-time equivalency of 1,664 hours per year. Following the trial, SCFHT focused on staffing to support this transition.

Priority Three: Community Engagement

Increase community awareness of the SCFHT programs, services, and the differences between the SCFHT and the Family Health Network (FHN).

In the 2024/2025 fiscal year, the Sunset Country Family Health Team (SCFHT) focused on community engagement to enhance access and awareness of local health services. They launched a postcard campaign to inform every household about SCFHT programs and services, alongside a social media campaign for updates and health promotion. SCFHT staff also participated in community events like farmers' markets and job fairs. These initiatives led to increased public awareness and a rise in self-referrals and program inquiries.

Priority Four: The Fundamentals

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

In 2024/2025, the Sunset Country Family Health Team (SCFHT) focused on enhancing its digital infrastructure for efficient care. Key initiatives included:

- Advancing the Ocean eReferral Network
- Expanding online appointment booking
- Enabling secure patient messaging
- Improving reminder systems via email and text
- Exploring AI-powered scribing tools to reduce administrative workload

Additionally, SCFHT worked on EMR data cleanup and standardization to ensure accurate health information, supporting quality improvement and care coordination. These efforts demonstrate SCFHT's commitment to using digital tools to improve access and system efficiency.

Priority Five: Health System Guidance

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.

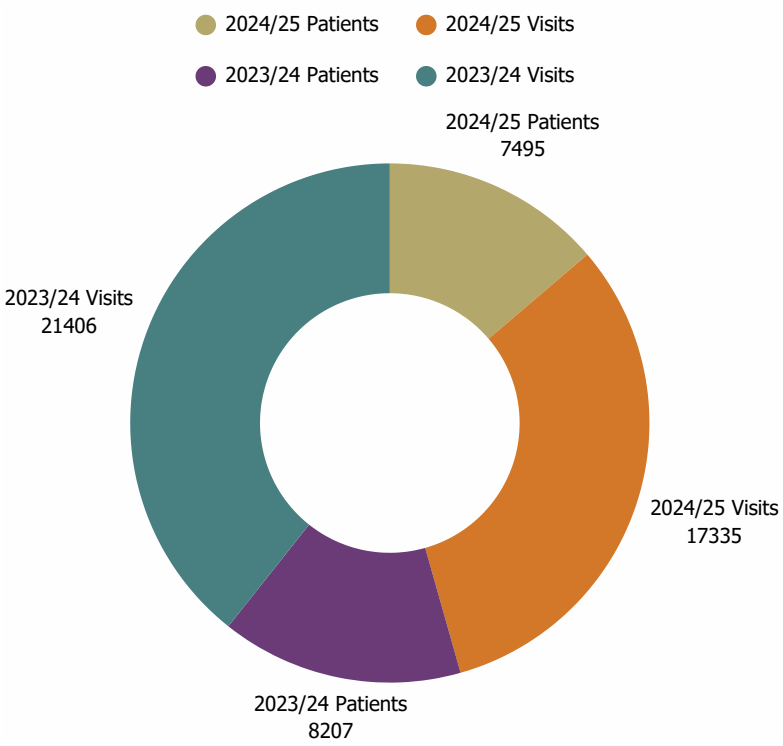
The Community Health Worker role at SCFHT expanded significantly during the 2024/2025 fiscal year, focusing on aiding patients in navigating the complex healthcare landscape. Key developments included:

- Strengthened partnerships with community organizations.
- Enhanced support for patients in accessing services and understanding care pathways.
- Leadership of the SCFHT Memory Clinic Program, improving service coordination for those with cognitive changes and their families.

Initial planning for an Advance Care Planning initiative to assist chronic condition patients in preparing for future care preferences, aiming for integration into the Chronic Disease Management program.

- AHE
- Well baby checks
- Patient education
- Wound care
- Suture removal
- Immunizations
- Pre-op care
- Health promotion
- Disease prevention

ACUTE AND EPISODIC CARE
SERVICES



What is the program?

The SCFHT Acute and Episodic Care Services aim to provide high quality core primary care services in response to an acute or episodic illness.

What can we help with?

- Primary care treatment of wounds and sutures
- Education, assessment and support to patients with an acute or episodic illness, a pending operation, or questions around immunizations or disease prevention

Program Goals

Annual Outcomes

	2024 - 2025	2023 - 2024
15,000 visits offered. Office visits, emails, home visit, community / hospital, virtual visits	**15,174** office visits **2037** phone visits **72** email contacts **0** home visits **33** community / hospital **29** virtual visits	**16,640** office visits **4,636** phone visits **99** email contacts **16** home visits **10** community / hospital **5** virtual visits
50% of appointments are same day or next day	**32.52%**	**43.36%**
Track number of ER diversions	**3**	**22**

ASTHMA MANAGEMENT
PROGRAM

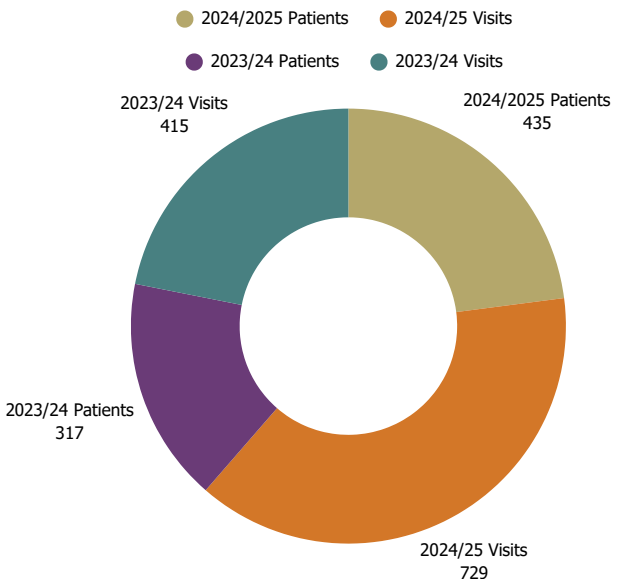
- Provide spirometry screening to test patients for asthma
- Provide asthma education and support for patients and their families
- Management and treatment of asthma symptoms
- Day-to-day lifestyle skills for asthma management

What is the program?

The SCFHT Asthma Management Program has Certified Respiratory Educators (CRE) to help improve the overall health and well-being of individuals with asthma.

What can we help with?

- Provide spirometry screening to patients
- Education, assessment and support to patients and their families with an asthma diagnosis

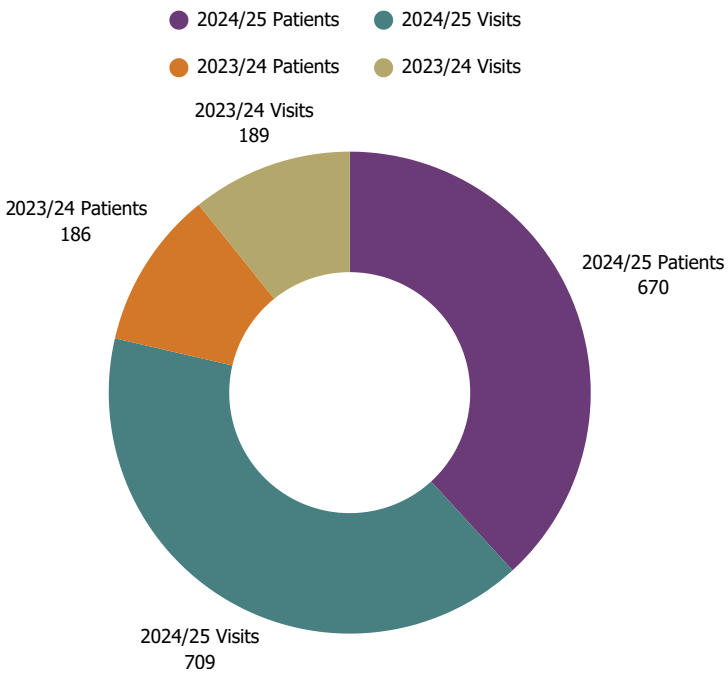


Program Goals

	Annual Outcomes 2024 - 2025	2023 - 2024
95% of Asthma / COPD patients seen in the program w have a **spirometry confirmed diagnosis.**	**96.48%**	**98.15%**
85% of current patients in the program who smoke hav received a **smoking cessation intervention.**	**79.54%**	**62.93%**
75% of COPD patients have received **flu*** and **pneumovax** vaccines.**	**45.54%*** **79.81%****	**49.59%*** **67.48%****
75% of patients in the Asthma / COPD Program have received their **Covid-19 vaccine.**	**71.03%**	**80.44%**

- Provide education and cancer screening
- Community based events to provide cancer screening awareness and education
  Examples: Pap tests, prostate tests, lung screening, FIT tests, and mammogram information
- Host screening clinics for patients to access Cervical Cancer Screening
- Provide support with cancer screening navigation and follow up

CANCER SCREENING
PROGRAM



What is the program?

The SCFHT Cancer Screening program offers preventative cancer screening according to Ontario Cancer Care Screening Guidelines.

What can we help with?

- Provide education and increased access to cancer screening based on Cancer Care Ontario guidelines
- Provide information and support for how to access and book cancer screening testing

Program Goals

Annual Outcomes

	2024 - 2025	2023 - 2024
69% of eligible patients screened for **cervical cancer** within the recommended timelines	**EMR: 58.6%** **SAR: 62.2%**	**EMR: 60.1%** **SAR: 63%**
67% of eligible patients screened for **breast cancer** within the recommended timelines	**EMR: 57.9%** **SAR: 62.5%**	**EMR: 60.1%** **SAR: 61%**
68% of eligible patients screened for **colorectal cancer** within the recommended timelines	**EMR: 59.7%** **SAR: 66.7%**	**EMR: 59.8%** **SAR: 68%**

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

HEALTH SYSTEM NAVIGATION
PROGRAM

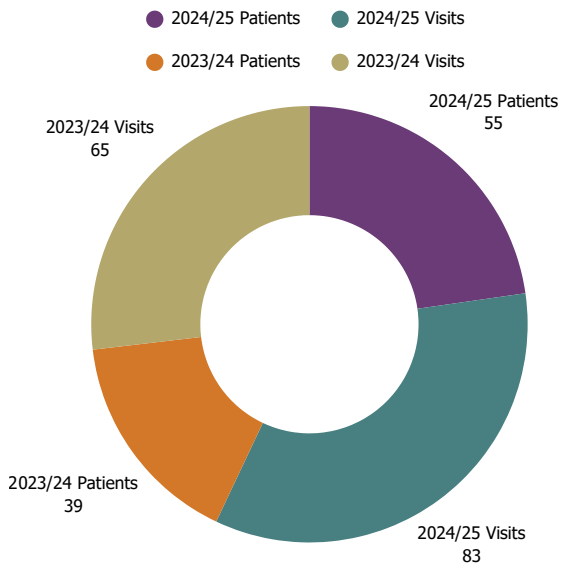
- Assistance with Health Forms/Health Funding Applications
  e.g.) ODSP applications, Disability Tax Credit, obtaining OHIP cards etc.
- Health System Navigation
- Support completing referrals & intake forms
- Providing information for local services & community resources
- Health Service Coordination
  e.g.) Support when communicating with multiple service providers

What is the program?

The SCFHT's Community Health Worker Program assists patients and caregivers in navigating our local healthcare system.

What can we help with?

- Connecting patients with local supports and resources
- Helping patients to reduce barriers preventing them from accessing healthcare
- Encouraging patient empowerment

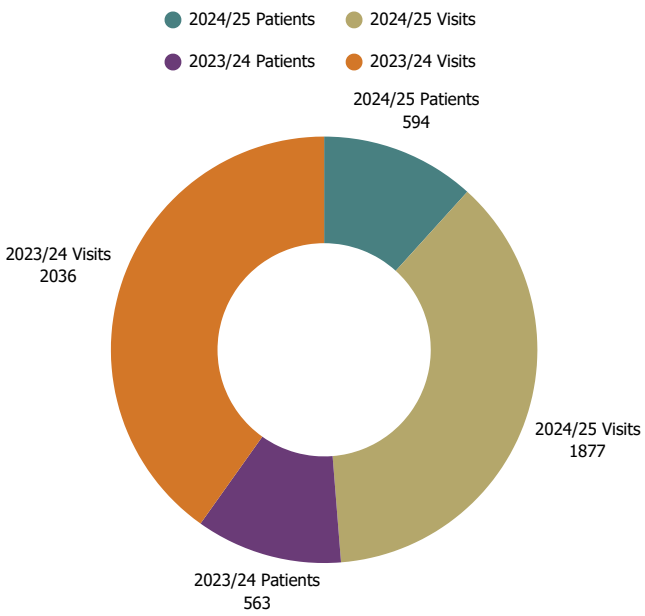


Annual Outcomes

Program Goals	2024 - 2025	2023 - 2024
Collect baseline on unique patients accessing CHW (rostered and unrostered)	**59 unique patients** **48 rostered** **4 attached** **5 unattached**	**41 unique patients** **36 rostered** **3 attached** **2 unattached**
Collect baseline on patient encounters (phone, in-office, virtual and services with no encounter)	**83 patient encounters;** **52 phone** **30 office** **1 home** **2 service, no encounter**	**66 patient encounters;** **43 phone** **16 office** **1 virtual** **6 service, no encounter**
Encounters/connections to other agencies (housing, mental health, legal, ODSP, etc.)	**42 connections / referrals to other agencies**	**5 connections / referrals to other agencies**

- Individualized education, screening and treatment of Type 1 diabetes, Type 2 diabetes and gestational diabetes
- Referrals for preventative health care
- Diabetes community screening events to screen and identify at-risk community members
- Treatments can include: nutrition, weight management, foot care, medications (including insulin starts), blood glucose monitoring, and more

DIABETES MANAGEMENT PROGRAM



What is the program?

The SCFHT Diabetes Management Program provides patient-centered education, screening, diagnosis and treatment of diabetes.

What can we help with?

- Education about day-to-day lifestyle management skills for patients and their family
- Treatment of diabetes aimed at preventing or delaying disease progression and complications

Program Goals

	Annual Outcomes 2024 - 2025	2023 - 2024
90% of patients with Type 1 or Type 2 diabetes who recieved an A1c **within the last year.**	**96.82%**	**97.99%**
80% of patients in the program will have their blood pressure measured **within the last six months.**	**78.62%**	**90.80%**
60% of patients with Type 1 or Type 2 diabetes with a **validated foot screen** performed in the last year.	**38.88%**	**46.76%**
60% of patients with Type 1 or Type 2 diabetes with a retinal exam performed **within the last two years.**	**45.23%**	**54.87%**
60% of patients setting a **SMART goal** within the last 6 months.	**69.2%**	**76.72%**

FOOT CARE
PROGRAM

- Preventative care and treatment for chronic foot conditions

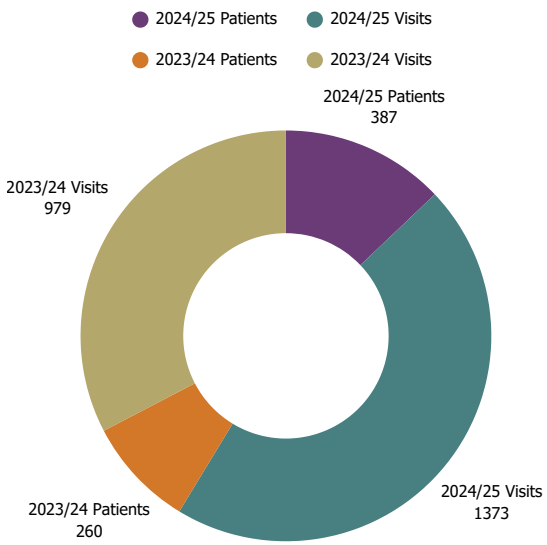
  Examples of chronic foot conditions: corns/calluses, chronic ingrown/involuted toenails, toenail fungus, and lower limb wounds
- Treatment and referrals for acute conditions
- Provide education on lower limb injury prevention and self-management techniques
- Diabetic foot screens
- Ankle-brachial index (ABI) testing

What is the program?

The SCFHT Foot Care Program provides foot care and education services for at-risk individuals to prevent or delay complications.

What can we help with?

- Provide care and treatment for acute and chronic conditions
- Foot assessments for diabetic peripheral neuropathy



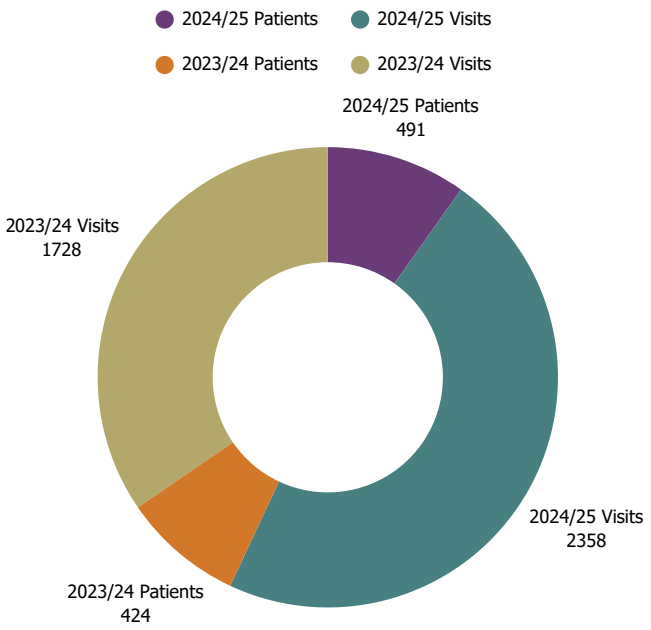
Program Goals

Annual Outcomes

	2024 - 2025	2023 - 2024
90% of patients with diabetes with a **60 second foot screen** performed **within the last 1 year**	**91.21%**	**88.30%**
90% of patients with a **chronic problem whose condition is under control** at their most recent follow-up visit	**90.16%**	**92.61%**
New: Collect baseline on number of **patients eligible for Onyfix** treatment and success rate	**127** eligible patients	-
New: Collect baseline % of follow up patients reporting less discomfort since treatment started	**58.49%**	-
New: Collect baseline % of follow up patients where provider reports nail management has improved	**52.83%**	-
New: Collect baseline of patients reporting they are satisfied with treatment at the treatments end.	**21** patients	-

- Provide screening for suspected hypertension using in office and at home monitors
- Provide education and support for self-management of hypertension through nutrition and lifestyle
- Provide medication reviews and support with the SCFHT Pharmacist as needed

HYPERTENSION
PROGRAM



What is the program?

The SCFHT Hypertension Program provides education and support to patients living with high blood pressure.

What can we help with?

- Provide blood pressure assessments and monitoring for patients with a hypertension diagnosis or suspected hypertension
- Education and support for patients experiencing high blood pressure

Program Goals

Annual Outcomes

Program Goals	2024 - 2025	2023 - 2024
65% of patients in the program to have **improved BP readings to target** after 3 months	**58.96%**	**73.52%**
80% of patients set a **lifestyle goal** after 3 months	**91.79%**	**77.51%**
New: Collect baseline on number of **patients with HTN with an RD visit as part of their care.**	**20.6%**	-
New: Collect baseline on patients identified as missing 2 or more doses of medication per week at 2 or more visits or patients on 3+ anti-hypertensive medications whose BP is not at target **who are referred to pharmacist for a med review.**	**5 patients referred to pharmacist**	-

INR
PROGRAM

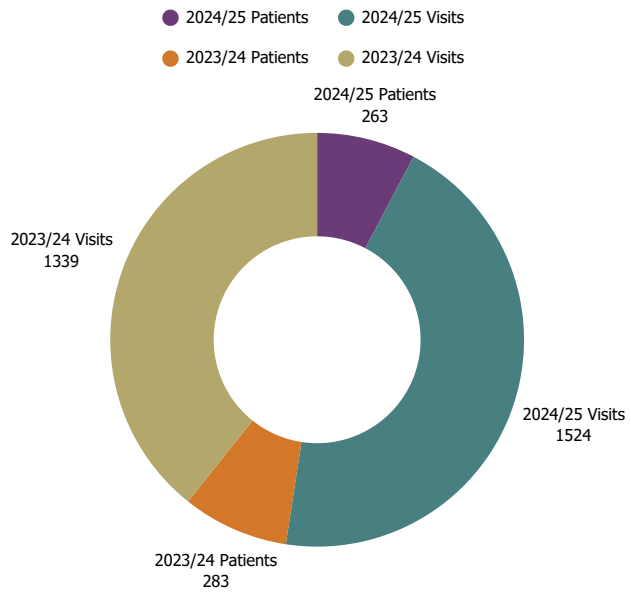
- Regular monitoring to maximize time in therapeutic range and minimize the risk of stroke or severe bleeding
- Multidisciplinary team including a Pharmacist and Registered Nurses working in conjunction with Physicians and Nurse Practitioners

What is the program?

The SCFHT INR Program team supports patients taking warfarin through point-of-care testing and lab monitoring to ensure that their INR is maintained within a therapeutic range.

What can we help with?

- Regular INR monitoring
- Education on optimal nutrition, exercise, and medication interactions
- Adjustments of warfarin as needed



Program Goals

Annual Outcomes

Program Goals	2024 - 2025	2023 - 2024
70% of point of care INR tests in range	**71.07%**	**67.86%**
<2% of patients in the INR program with a recent stroke event	**0.0%**	**0.3%**
<2% of patients in the INR program with a recent major bleeding event (requiring ER visit or hospitalisation)	**2.7%**	**0.7%**
New: % of patients eligible for a DOAC who are successfully transferred to a DOAC. % of pts in program not eligible for DOAC	**0.38%** transferred **1.89%** eligible **98.1%** ineligible	-

- Support for breastfeeding parents

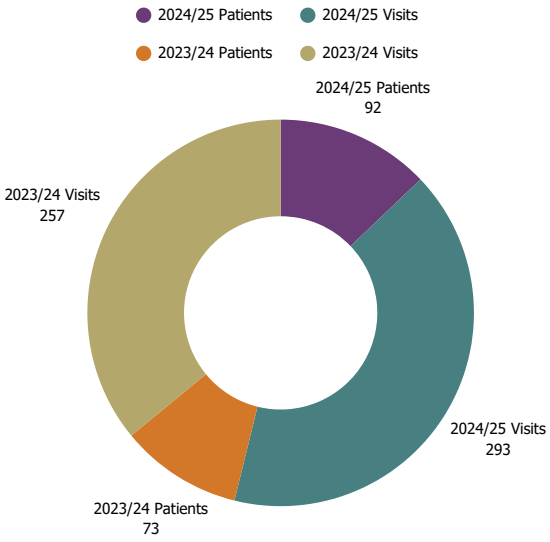
e.g.) trouble latching, pain during and/or after feeding, sore nipples, poor weight gain, unusually fussy baby, short feedings, and pumping issues

- Support for bottle feeding parents

e.g.) poor weight gain, unusually fussy baby, short feedings, exclusively pumping, supplementing feeding and bottle feeding issues

- Provide assessment and support for babies with suspected tongue or lip tie or other feeding difficulties
- Virtual & phone supports available

LACTATION CONSULTATION PROGRAM



What is the program?

The SCFHT International Board Certified Lactation Consultant (IBCLC) provides expectant and new parents with education and support for healthy infant feeding including breastfeeding, bottle feeding, or a combination.

What can we help with?

- Healthy infant feeding support and education for all new parents
- Pre-natal support and education

Program Goals

Annual Outcomes

	2024 - 2025	2023 - 2024
New: # Family Visits to the program	**293 visits**	-
New: Collect baseline on number of referrals from Kenora and number from outside of Kenora	**56** referrals from Kenora/Keewatin **28** referrals from outside of Kenora **8** referrals not recorded	-
75% of patients who feel confident with the knowledge provided at their appointment to accomplish their breastfeeding plan	**68.13%** indicated increased confidence; **69.41%** increased confidence in oral exercise	**77.30%** indicated increased confidence; **69.82%** increased confidence in oral exercise
Number of SCFHT and community partner staff who have completed the 20hr lactation course	**0 events hosted this year due to HHR challenges.**	**5** misc. attendees **25** community partner staff

MEMORY CLINIC
PROGRAM

- Patient care is supported by a team of specially trained health care professionals

Health care team includes: doctors, nurses, pharmacists, community health workers, occupational therapists and community agencies

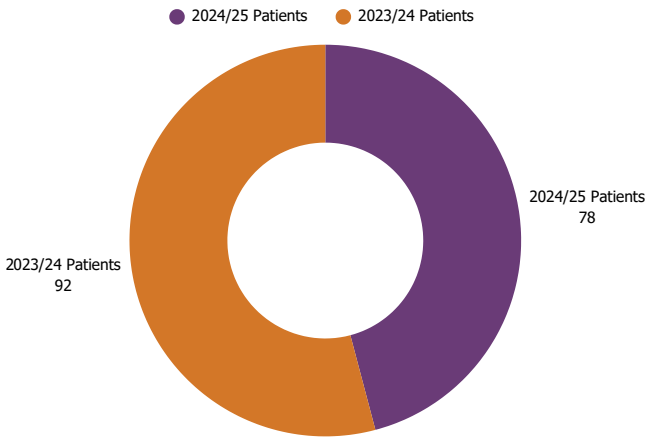
- Provide medication reviews and education for patients and their families
- Functional and cognitive impairment assessment

What is the program?

The SCFHT Memory Clinic Program provides optimized access, diagnosis and care for patients and their family navigating memory concerns.

What can we help with?

- Diagnosis and treatment for memory difficulties
- Support and education for patients and caregivers
- Comprehensive care for conditions involving memory loss



Program Goals

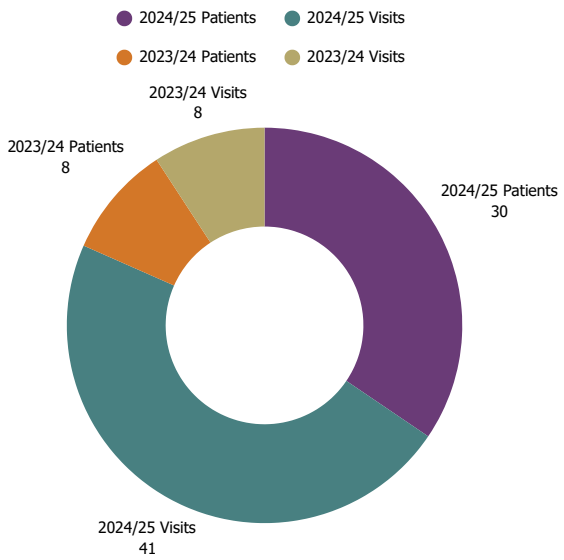
Annual Outcomes

Program Goals	2024 - 2025	2023 - 2024
80% of patient/caregivers are satisfied with service	**100%**	**96.29%**
80% patient/ caregivers who report increased understanding about their condition.	**95%**	**100%**
60% of patients are contacted 4 weeks (14-45 days) 60% understand their care plan reccommendations	**75.14%** contacted **88.67%** understand	**78.35%** contacted **84%** understand
70% of patients who have implemented 1 or more care plan recommendation(s) at their MC follow up visit; 70% Number of recommendations completed	**81.81%** implemented **61.40%** completed	**92.30%** implemented **67.62%** completed
100% of patients without an ACP and POA will have education at their initial visit; 75% without ACP & POA at their initial visit will have them completed by their follow up visit	**92.60%** initial ACP **78.94%** initial POA **45.45%** follow up ACP **75.75%** follow up POA	**92.60%** initial **62.79%** follow up
75% of patients with medications successfully deprescribed/adjusted at their follow up visit	**75.75%**	-

MINOR AILMENTS PROGRAM

- Minor Ailments include:

- Canker sores & cold sores
- Eczema & allergic skin rash
- Heartburn and indigestion
- Joint & muscle pain
- Pinworms & threadworms
- Vaginal yeast infection
- Nausea & vomiting (of pregnancy)
- Pink eye (due to allergies or bacteria)
- Thrush (fungal infection of the mouth)
- Bacterial skin infection (impetigo)
- Urinary tract infection (uncomplicated)
- Tick bites (Lyme disease prevention)



What is the program?

The SCFHT Pharmacist is available to assess and prescribe medications for minor ailments, which are health conditions that can be managed with minimal treatment and/or self-care strategies.

What can we help with?

- Timely assessment of minor ailments in person or by phone depending on the nature of the patient's condition
- Provide treatment for minor ailments including prescriptions and/or self-care strategies

Program Goals

Annual Outcomes

	2024 - 2025	2023 - 2024
Collect baseline of patients diverted from the ED	**10**	**8**
Collect baseline of % of total visits per presenting ailment type	**10%** dermatitis **12%** tick bites **14%** eye infections **17%** misc.* **46%** UTI	**25%** Cold Sores **12.5%** Dermatitis **50%** Pinworms **12.5%** UTI

*(acne, cold sores, impetigo, vaginal yeast infections, hemorrhoids)

NUTRITIONAL COUNSELLING
PROGRAM

Provide nutritional counselling for:

- People of all ages with challenges meeting their nutritional requirements
- Those trying to reduce their risk of developing a new or chronic health condition
- People who would like support in developing a healthy relationship with food
- People with a new or chronic health condition who would like nutritional support

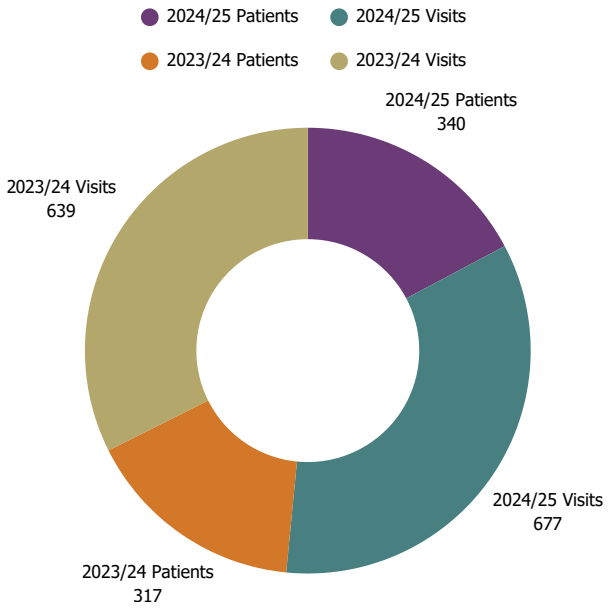
Examples of health conditions:
high cholesterol, hypertension (high blood pressure), stroke, cancer, eating disorders, and diabetes

What is the program?

The SCFHT Registered Dietitian provides nutritional counselling to assist patients in achieving optimal health.

What can we help with?

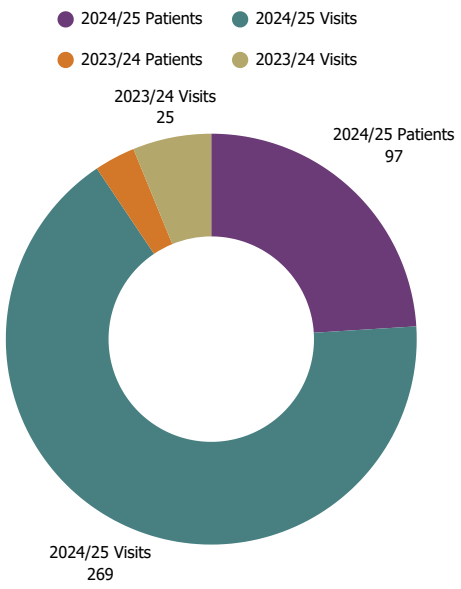
- Provide tools and nutrition education to help patients improve quality of life
- Help patients manage their nutritional components of living with a chronic health condition
- Provide education and support to reduce the risk of developing a chronic health condition such as diabetes, heart disease or stroke



Program Goals	Annual Outcomes 2024 - 2025	Annual Outcomes 2023 - 2024
90% of follow up patients will have achieved their **most recent SMART goal**	**67.86%**	**76.02%**
90% of dyslipidemia patients will have a **documented Framingham risk assessment**	**93.55%**	**90.32%**
Run two 6-week group sessions during the year. Mindful Eating: Emotional Eating and Food Craving Management Group and Healthy You	**1** workshop ran, **5** sessions completed **35** attendances	**2** workshops ran, **6** sessions completed

- Home environment safety assessments (within pre-determined boundary)
- Fall risk prevention and management
- Chronic pain and chronic disease management (non-pharmacological interventions)
- Mobility aids/adaptive equipment assessments and support
- Assistive Devices Program (ADP) authorizer for mobility equipment
- Functional assessments and recommendations
- Brain injury rehabilitation
- Cognitive assessments and interventions
- Return to work and ergonomic assessments

OCCUPATIONAL THERAPY
PROGRAM



What is the program?

The SCFHT Occupational Therapy Program focuses on promoting and maintaining a person's function and independence.

What can we help with?

- Problem solve barriers that may prevent participating in self-care, productivity, and leisure activities
- Work with patients to create goals and a plan to improve and/or maintain function and independence

Program Goals

Annual Outcomes

	2024 - 2025	2023 - 2024 Q4
90% of home OT assessments with completed **Home Safety**	**89.47%**	**100%**
80% of patients ages 65+ have a **completed falls assessment**	**74.35%**	**72.73%**
1-2 cognitive stimulation therapy workshops in the year. (7 bi-weekly sessions for each workshop)	**3** workshops, **22** sessions, **46** attendances	-
80% of patients who receive follow up and report an **improved understanding of their primary concern** and **ability to self manage.**	**58.97%**	**77.8%**

PHARMACIST SERVICES
PROGRAM

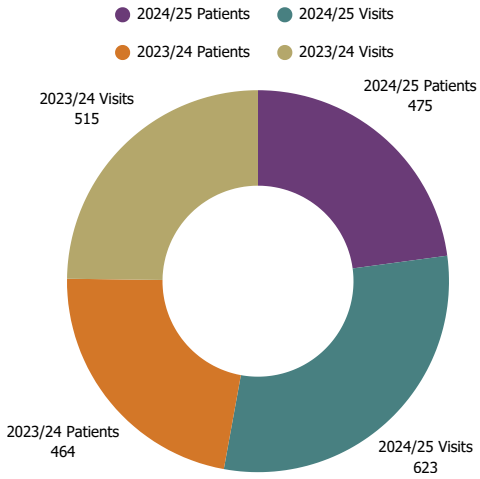
- Answer medication related questions and concerns
- Conduct comprehensive medication reviews:
- Provide information about the purpose of each medication, side effects to watch out for, and manage potential drug interactions
- Simplify daily medication schedules
- Discuss opportunities to "de-prescribe" or stop medications which may no longer be needed

What is the program?

The SCFHT Pharmacist provides education and support relating to the use of medication.

What can we help with?

- Ensure that a patient's medications are safe, effective and working well
- Prevent and resolve medication-related issues in conjunction with the patient's primary care provider
- Connect with patients after a hospital stay to review medication changes



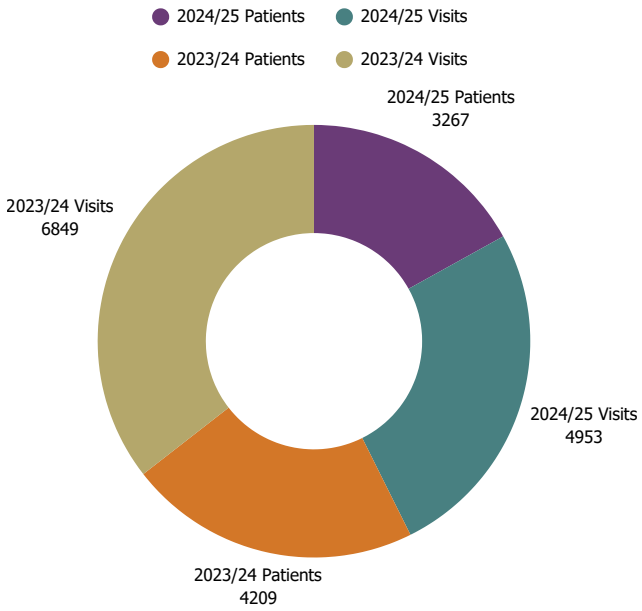
Program Goals	2024 - 2025	Annual Outcomes 2023 - 2024
NEW: Collect baseline number of **medication discrepancies identified during hospital discharge** follow up.	**46**	-
NEW: Collect baseline number of **patients diverted from the emergency room for a minor ailment or COVID assessment.**	**10**	-
NEW: Collect baseline percentage of identified drug therapy problems (DTPs) **resolved within 1 month**	**86.72%**	-
NEW: Collect baseline percentage of **Hospital discharge medication follow up within 7 days**	**85.71%**	-
Collect baseline # of visits for: **Medication reviews** **Medication updates** in the EMR **Drug information questions** **Drug navigation** (forms, etc)	**? visits across** **53** medication reviews **221** medication updates **12** medication reconciliations **73** drug info questions **61** drug navigation	**515 visits across** **44** medication reviews **336** medication updates **57** medication reconciliations **68** drug info questions **59** drug navigation

PHYSIOTHERAPY AND REHAB PROGRAM

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 with the intention of fulfilling the objectives as listed here.

LWDH continues to offer full comprehensive PT services to all FHT patients, including value added programs such as cardiac and pulmonary rehab, Glad classes, total hip and knee replacement classes, pelvic health, amputees, and lymphoedema management.

LWDH physio has been short 2 PTs for 2 years now – both have now been hired; one has already started at the time of publication, and the second set to begin in just two months post publication of this report.



Program Objectives

- To decrease number of pain medications from physicians for conditions that would benefit from treatment.
- Decrease unnecessary visits to physicians that are best seen by a physiotherapist.
- Decrease cost to patients by providing services covered by OHIP that were not previously offered in Kenora prior to this program start.
- Decrease wait times for physio appointments.

Annual Outcomes

	2024 - 2025	2023 - 2024
Referrals for conditions best served by Physiotherapist	1,119	1,331
# of Patients	3,267	4,209
# of Attendances	4,953	6,849

SMOKING CESSATION PROGRAM

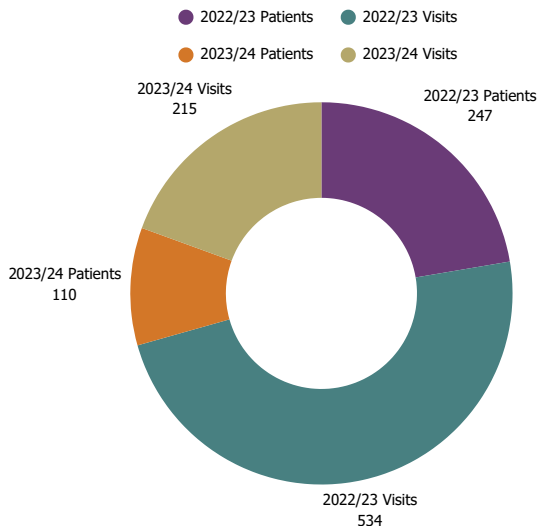
In the 2023/2024 fiscal year Smoking Cessation was embedded within the SCFHT existing Programs. Access to this program is available to patients already enrolled in one or more of SCFHT's existing programs. Due to the high demand for resources, we encourage eligible patients to utilize STOP on the NET (SOTN) when possible. You can access it at the SOTN website: https://intrepidlab.ca/en/stop/stop-on-the-net

What is the program?

The Smoking Cessation Program at the Sunset Country Family Health Team is for all patients 18 years of age and older who are rostered to a SCFHT physician. This program provides a systematic approach to assist patients who are interested in quitting smoking.

What can we help with?

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.



Program Goals

Annual Outcomes

	2024 - 2025	2023 - 2024
30% of patients in the program who have **quit smoking at 6 months**	**20%**	**28.5%**
25% of patients in the program who have **quit smoking at 12 months**	**31.3%**	**50%**
90% of smoking cessation program patients have smoking status documented in Risk Factors in the EMR	**95%**	**100%**

Strengthening Integrated Care Through Partnership: SCFHT and the ANHP Ontario Health Team (ANHP OHT)

The Sunset Country Family Health Team (SCFHT) continues to play a vital leadership role in advancing the All Nations Health Partners Ontario Health Team (ANHP OHT), contributing to the collaborative work that is transforming the way care is delivered across our region.

Throughout 2024–2025, SCFHT has remained fully engaged in planning, designing, and implementing key initiatives that support more integrated and patient-centred care. This includes the secondment of our Executive Director, Colleen Neil, as the Executive Lead for the ANHP OHT, providing system-level leadership and strategic guidance to advance our collective vision.

SCFHT has been instrumental in the co-design and rollout of Integrated Clinical Pathways for Chronic Obstructive Pulmonary Disease (COPD), Heart Failure (HF), and Wound Care—work that brings together interdisciplinary providers across the system to improve continuity, outcomes, and patient experience. We are proud to provide leadership to the ANHP OHT's Privacy and Security Working Group, ensuring that shared information systems and collaborative care models are underpinned by strong governance, ethical practice, and respect for data sovereignty. In parallel, SCFHT has also co-led the Collaborative Quality Improvement and Data Working Group, helping to drive performance measurement, health equity, and quality improvement initiatives across the OHT.

Our team has also actively contributed to efforts to improve the quality of cancer screening, engaging in work to strengthen early detection and ensure equitable access to preventive care across the ANHP region. Additionally, SCFHT played a key role in planning and developing the administrative infrastructure to support the Rural Generalist Model of Care, which is scheduled to be implemented in 2025–2026. This work includes supporting integrated scheduling, billing, performance measurement, and system coordination functions that will underpin the successful delivery of this model across hospital, primary care, and community settings.
The SCFHT takes great pride in partnering with the ANHP OHT to build a more collaborative, connected, and culturally responsive primary care system. These efforts reflect our ongoing commitment to collaborating with our communities to address their needs and enhance health outcomes throughout Northwestern Ontario.

Canadian Mental Health Association Kenora — Mental health for all
District of Kenora Homes & Community Support Services
FIREFLY
Grand Council Treaty #3
Lake of the Woods KENORA
KDSB — Kenora District Services Board
Lake of the Woods District Hospital
Métis Nation of Ontario
Northwestern Health Unit — www.nwhu.on.ca
Sunset Country Family Health Team
Township of Sioux Narrows - Nestor Falls
WIIGWAS
DoK URA — District of Kenora Unincorporated Areas Ratepayers Association
Kenora Association for Community Living — A Meaningful and Satisfying Life
KENORA CHIEFS ADVISORY — OGIMAAWABIITONG — Our Strengths are Our People

Our Privacy Commitment

Questions, concerns, or requests for more information about the Partners privacy policies and practices can be directed to a Privacy Officer.

SCFHT
(807) 468 6321

Sunset Country Family Health Team

KCA
(807) 467 8144

KENORA CHIEFS ADVISORY
OGIMAAWABIITONG
Our Strengths are Our People

KDSB
(807) 468 5372

KDSB
KENORA DISTRICT SERVICES BOARD

LWDH
(807) 468 9861

Lake of the Woods District Hospital

NWHU
(807) 468 3147

Northwestern Health Unit
www.nwhu.on.ca

WNHAC
(807) 699 6422

WAASEGIIZHIG
NANAANDAWE'IYEWIGAMIG

The SCFHT understands the value of, and the importance of, our clients privacy. We only collect personal health information needed for specific purposes related to our client's health care. The SCFHT and 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), (referred to hereinafter as "the Partners"), have a data-sharing agreement which allows a comprehensive circle of care. Each partner is committed to protecting the privacy and confidentiality of any personal health information collected from our clients.

Any personal health information provided to the Partners, 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.

The Partners 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 the Partners, the client has given their consent (permission) to use their information, unless they tell the Partners otherwise; clients have the right to ask that the Partners do 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.)

In some situations, the Partners 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 min at any time. However, there may be some cases where the Partners may collect, use, or share 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 may be in writing and sent to the respective agency.

If, after contacting any of the listed 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
2 Bloor Street East, Suite 1400
Toronto, ON M4W 1A8
T: 1-800-387-0073 F: 1-416-325-9195
or visit the IPC website: www.ipc.on.ca

Audited Financial Statements, 2024 - 2025

Sunset Country Family Health Team
Statement of Financial Position

March 31		**2025**		**2024**
Assets				
Current				
Cash and bank	$	**1,591,558**	$	1,531,594
Account receivable (note 2)		**131,230**		24,205
Prepaid expenses		**8,789**		--
	$	**1,731,577**		1,555,799
Capital assets (Note 3)		**305,924**		199,264
	$	**2,037,501**	$	1,755,063
Liabilities and Net Assets				
Current				
Accounts payable and accrued liabilities (Note 4)	$	**291,184**	$	249,230
Governments contributions repayable (Note 5)		**752,703**		482,096
Deferred revenue (Note 6)		**-**		372,834
	$	**1,043,887**	$	1,104,160
Net Assets				
Net assets invested in capital assets		**305,924**		199,264
Unrestricted		**687,690**		451,639
		993,614	$	650,903
	$	**2,037,501**	$	1,755,063

2024 Salary Declaration

Employee	**Position**		**Salary**		**Benefits**
Evenden, Stephanie	Finance Manager & Acting Executive Director	$	139,565.35	$	1,009.19
Neil, Colleen	Executive Director & ANHP OHT Executive Lead		241,214.22		1,282.04
Reid, Michael	Nurse Practitioner		125,295.80		250.80
Rose, Holly	Nurse Practitioner		128,975.07		1,374.31
Sharp, Susan	Pharmacist		103,167.74		1,323.28

Audited Financial Statements, 2024-2025

Sunset Country Family Health Team
Statement of Operations

For the year ended March 31		**2025**		**2024**
Revenue				
Ministry of Health	$	**-**	$	1,802,975
Ontario Health		**3,657,417**		1,935,872
Ministry of Health - Primary Care Asthma program		**57,250**		37,250
Family Health Network (salary contribution)		**18,247**		25,000
Kenora Chiefs Advisory - ANHP OHT		**397,081**		-
Kenora Chiefs Advisory		**44,100**		-
Other		**59,096**		62,972
Kenora Medical Associates		**28,507**		-
Waasegiizhig Nanaadawe'iyewigamig		**49,047**		49,047
Kenora District Services Board		**-**		294,559
Ontario Health Quality Council		**-**		102,746
	$	**4,310,745**	$	4,310,421
Expenses				
Human Resources	$	**3,027,924**	$	3,092,781
Physician consulting		**39,156**		33,200
Sessionals		**47,265**		47,265
General Overhead		**133,141**		102,739
Information Technology		**91,694**		112,643
Ongoing Overhead				
Audit fees and other accounting fees	$	**24,187**	$	23,899
Project management		**-**		30,422
Insurance		**17,863**		21,188
Legal fees		**7,937**		7,765
Professional fees		**37,232**		31,457
Recruitment and retention		**12,158**		2,799
Premises - rent		**131,180**		133,441
Travel		**12,048**		16,961
Common area maintenance		**58,903**		83,359
Approved one-time expenditures		**163,399**		111,963
	$	**3,804,087**	$	3,851,881
Excess of revenues over expenses	$	**506,658**	$	458,540
Government contributions repayable		**(270,607)**		(251,026)
Excess of revenues over expenses	$	**236,051**	$	207,514

Sunset Country Family Health Team
1-35 Wolsley Street | Kenora, ON | P9N 0H8
T: (807) 468 6321 | F: (807) 468 3978
info@scfht | www.scfht.ca