Q3

Sunset Country Family Health Team

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Q3 Quarterly Report

October-December 2025

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glossary of common medical abbreviations

A&E	Acute and Episodic
COPD	Chronic Obstructive Pulmonary Disorder
DTP	Drug Therapy Problem
EMR	Electronic Medical Record
ER	Emergency Room
FIT	Fecal Immunochemical Test
FHN	Family Health Network
FHT	Family Health Team
HTN	Hypertension
INR	International Normalised Ratio
MRP	Most Responsible Provider
NP	Nurse Practitioner
PCP	Primary Care Provider
RD	Registered Dietitian
RN	Registered Nurse
RPN	Registered Practical Nurse
SAR	Screening Activity Report

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 Family Health Network (FHN) patients.

Stats:

In Q3, **2812 patients** were seen, and **4348 visits** were provided by the team under acute and episodic care.

- **85.7%** were in **office visits**
- **12.2%** were **phone visits**
- **1.3%** other (**email, home, or virtual visits**)

Asthma & COPD Program

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

Stats:

In Q3, **126 patients** were seen, and **179 visits** were provided.

- **98.61%** of Asthma and COPD patients have a **spirometry confirmed diagnosis**
- **70.97%** of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention. **smoking interventions not consistently documented on new spirometry form**
- **74.24%** of COPD patients have **received a yearly flu shot**
- **87.8%** of COPD patients have **received a pneumococcal vaccine**
- **58** spirometry tests done
- **125** follow-ups completed

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:

In Q3, **206 patients** were seen, and **212 visits** were provided.

- **49.9% (EMR)** of FHN patients are **up to date for cervical cancer screening.**
- **46.6% (EMR)** of FHN patients are **up to date for breast cancer screening.**
- **56% (EMR)** of FHN patients are **up to date for colorectal cancer screening.**

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, **14 patients** were seen, and **16 visits** were provided

- **71.4%** of patients were **rostered**
- **9** visits were navigation
- **6** visits were coordination
- **6** events attended **1** community exercise class supported

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, **279 patients** were seen, and **365 visits** were provided.

- **97.68%** of patients with Type 1 or Type 2 diabetes had an **A1C** in the last year
- **90.32%** of patients with Type 1 or Type 2 diabetes had their **blood pressure** measured in the last six months
- **46.72%** of patients with Type 1 or Type 2 diabetes had a **validated foot screen** in the last year
- **48.26%** of patients with Type 1 or Type 2 diabetes had a **retinal exam** within the last two years
- **55.91%** 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, **253 patients** were seen, and **326 visits** were provided.

- **72.47%** of patients with diabetes had a **60 second foot screen** within the last year
- **88.54%** 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, **229 patients** were seen, and **611 visits** were provided.

- **73.33% of patients** in the program have **improved their blood pressure readings** to target after 3 months.
- **68.57% of patients** have set a **new lifestyle goal** after 3 months
- **15.7% of patients** with HTN who have been **offered** to visit with a Registered Dietitian as part of their care plan

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, **68 patients** were seen, and **405 visits** were provided

- **65.87%** of point of care INR tests given were in range
- **1.5%** INR patients experienced a stroke in Q3
- **2.9%** INR patients experienced a major bleeding event in Q3; the SCFHT remains below their 2% target
- **2** INR patients eligible for a DOAC (Direct Oral Anticoagulant)

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, **37 patients** were seen, and **97 visits** were provided

- **76%** report increased confidence in feeding
- **3 LC visits** to EarlyON Baby drop in sessions

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, **26 patients** were seen, and **6 clinics** were hosted

- **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
- **100%** of patients **received a post-visit call** after 4 weeks
- **100%** of those contacted **understood their care plan recommendation**s

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, **5 patients** were seen, and **5 visits** were provided

- **1** patient diverted from ER visit

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, **79 patients** were seen, and **111 visits** were provided

- **65.71%** of follow-up patients have **achieved** their most recent **SMART goal**
- **88.89%** of dyslipidemia patients have a documented **Framingham risk assessment**
- **0** Mindful Eating workshops in Q3 were done

Obesity Management Program

PROGRAM GOAL: To provide relevant education and resources to support the clinical management of obesity aimed at improving quality of life and reducing obesity related complications.

Stats:

In Q3, **32 patients** were seen, and **49 visits** were provided

- **78.13%** of patients with **SMART goals discussed and documented**
- **60%** of patients with an initial program visit **less than 4 weeks after the initial referral**
- **71.88%** of patients reporting **improved knowledge and confidence** in managing their obesity

Reminder: To refer patients to the Obesity Management Program, you can use the eternal referral form found in *Ocean.*

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.

Stats:

In Q3, **53 patients** were seen, and **81 visits** were provided

- **87.5%** of OT assessments with completed Home Safety Assessment Form with recommendations
- **89.47%** of patients 65 or older have completed a falls assessment
- **100%** of patients requiring screening at the inital visit completed screening

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, **151 patients** were seen, and **67 visits** were provided

- **92.75%** of identified drug therapy problems (DTP's) resolved within 1 month
- **56** drug information and drug navigation/coverage requests addressed
- **5** assessed for a minor ailment or COVID assessment
- **1** minor ailment diverted from ER visit
- **15** medication reviews provided
- **87** medication updates provided
- **7** medication reconciliations provided

STOP on the Net

Smoking Cessation: Refer to "STOP on the Net" for smoking cessation inquiries.