Q1

Sunset Country Family Health Team

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Q1 Quarterly Report

April - June 2026

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glossary of common medical abbreviations

A&E	Acute and Episodic
ACP	Advance Care Plan
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 primary care to patients.

Stats:

In Q1, **2870 patients** were seen, and **4466 visits** were provided by the team under acute and episodic care.

- **83.7%** were in **office visits**
- **15.6%** were **phone visits**
- **0.7%** other (**email, home, or virtual visits**)
- **29** community/hospital vists

Asthma & COPD Program

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

Stats:

In Q1, **50 patients** were seen, and **57 visits** were provided.

- **96%** of Asthma and COPD patients have a **spirometry confirmed diagnosis**
- **30%** of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention. **smoking interventions not consistently documented on new spirometry form**
- **43.18%** of COPD patients have **received a yearly flu shot**
- **90.91%** 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:

In Q1, **353 patients** were seen, and **387 visits** were provided.

- **47.8%** of eligible patients are **up to date for cervical cancer screening.**
- **56.4%** of eligible patients are **up to date for breast cancer screening.**
- **56%** of eligible patients are **up to date for colorectal cancer screening.**

* Changes to the FIT testing process may negatively impact screening results over the next period. Completion time frame has changed from 6 months to 1 year.

Community Health Worker Program

PROGRAM GOAL: Provide service coordination and system navigation to SCFHT patients. Increase access to and understanding of local healthcare, encourage patient empowerment, nurture partnerships, and strengthen patient relationships**.**

Stats:

In Q1, **9 patients** were seen, **10 visits** were provided

- **100%** of patients were **rostered**
- **55.6%** of patients were **attached, 44.4%** of patients were **unattached**
- **70%** of visits were for navigation
- **10%** of visits were for coordination
- **20%** of visits were not recorded

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 Q1, **264 patients** were seen, and **365 visits** were provided.

- **98.4%** of patients with Type 1 or Type 2 diabetes had an **A1C** in the last year
- **93.56%** of patients with Type 1 or Type 2 diabetes had their **blood pressure** measured in the last six months
- **52.4%** of patients with Type 1 or Type 2 diabetes had a **validated foot screen** in the last year
- **47.2%** of patients with Type 1 or Type 2 diabetes had a **retinal exam** within the last two years
- **88.64%** 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 Q1, **263 patients** were seen, and **358 visits** were provided.

- **86.36%** of patients with diabetes had a **60 second foot screen** within the last year
- **87.5%** of patients with **chronic problems have their conditions now under control** with regular clinic visits

Hypertension Management Program

PROGRAM GOAL: To reduce the risk of heart disease and stroke by working with patients to achieve and maintain healthy blood pressure through monitoring, education, and treatment support. To provide screening for suspected hypertension with Ambulatory Blood Pressure Monitor or Home BP monitoring to help in diagnosis of HTN.

Stats:

In Q1, **266 patients** were seen, and **634 visits** were provided.

- **80.95%** of patients in the program have **improved their blood pressure readings** to target after 3 months.
- **83.81%** of patients have set a **new lifestyle goal** after 3 months
- **29.01%** of patients seen for a screening visit whose BP was above target

Heart Function Clinic

PROGRAM GOAL: The Heart Failure Integrated Clinic aims to enhance patient outcomes by providing a standardized, evidence-based approach to managing heart failure that is culturally appropriate and builds local capacity. Improve equitable access to heart failure health care close to home.

Stats:

In Q1, **8 patients** were seen, and **12 visits** were provided.

- **41.6%** visits were **in office**
- **58.3%** vists were **phone or email**
- **6 medication updates** were made

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 Q1, **65 patients** were seen, and **390 visits** were provided

- **56.92%** of point of care INR tests given were in range
- **0** INR patients experienced a recent stroke event in Q1
- **0** INR patients experienced a major bleeding event in Q1; the SCFHT remains below their 2% target
- **3** INR patients eligible for a DOAC (Direct Oral Anticoagulant)

Physiotherapy & Rehabilitation

PROGRAM GOAL: Lake of the Woods District Hospital **(**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.

Stats:

In Q1, there were **1573 attendances**, and **286 referrals** were provided

- **52 days** is the average wait time for an initial appointment
- **189 referrals** awaiting appointments

Memory Clinic Program

PROGRAM GOAL: To provide early and accurate assessment and compassionate culturally sensitive care to individuals with memory concerns and to support these patients and families through diagnosis, treatment, and long-term planning.

Stats:

In Q1, **21 patients** were seen, and **23 vists** were provided

- **10.53%** had a post visit call
- **100%** of patients contacted **understood their care plan recommendations**
- **15.79%** of patients had a post visit contact with their PCP. ***NEW***
- **100%** of patients who have received ACP education have an ACP documented at follow-up visit

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 Q1, **12 patients** were seen, and **12 visits** were provided

- **2** patients reported ER diversion

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 Q1, **109 patients** were seen, and **193 visits** were provided

- **74.55%** of follow-up patients have **achieved** their most recent **SMART goal**
- **1 workshop**, 2 sessions, 9 attendees in Q1

Obesity Management Program

PROGRAM GOAL: Support patients with obesity to improve overall health, enhance quality of life, and reduce the risk of chronic, obesity-related complications.

Stats:

In Q1, **21 patients** were seen, and **36 visits** were provided

- **75%** of patients with an initial program visi**t less than 4 weeks after the initial referral**
- **52.94%** of patients **maintained or decreased their initial weight**
- 0**%** of patients with obesity who had an **improvement of weight related complications *NEW***

Occupational Therapy Program

PROGRAM GOAL: To strengthen functional ability and quality of life while empowering community members to remain safe, independent, and actively engaged in the community.

Stats:

In Q1, **49 patients** were seen, and **86 visits** were provided

- **66.7%** of OT assessments with completed Home Safety Assessment Form with recommendations
- **3.7%** of fall risk patients have a **follow up screening in 1 year**
- **84.2%** of patients **completed frailty screening and are offered interventions / referrals *NEW***
- **100%** of patients have **1 or more occupational documented goals *NEW***

Pharmacist Services Program

PROGRAM GOAL: Provide comprehensive medication review that involves assessing a patient's medications (prescription, non-prescription, supplements, traditional, and alternative medications) to determine if each medication is necessary, effective, safe and realistic for the patient to take. Communicate with the patient and primary care provider in identifying and helping to solve DTPs.

Stats:

In Q1, **139 patients** were seen, and **66 visits** were provided

- **86.99%** of identified drug therapy problems (DTP's) resolved within 1 month
- **8** drug navigation and **10** drug information requests addressed
- **26** medication reviews provided
- **75** medication updates provided
- **2** medication reconciliations provided