

SUNSET COUNTRY FAMILY HEALTH TEAM ANNUAL REPORT 2023/2024



Table of Contents

1	About the SCFHT; SCFHT Board of Directors, 2023-2024
2	A Message from the SCFHT Lead Physician
3	A Message from the SCFHT Executive Director
4	Our Medical Community
5	Strategic Planning
8	Overview of SCFHT Programs, Access and Statistics
27	All Nations Health Partners Ontario Health Team (ANHP OHT) Involvement
30	Our Privacy Commitment
31	Our Team
32	Audited Financial Statements



About the SCFHT

Founded in 2007, the Sunset Country Family Health Team consists of nurse practitioners, registered nurses, registered practical nurses, registered dietitians, a pharmacist, occupational therapist, and other healthcare professionals. In partnership with the affiliated family physicians, we offer comprehensive primary care across various disciplines to ensure high-quality healthcare for our patients. At the SCFHT, our providers work closely with patients throughout their healthcare journey.

VISION

Inspiring a healthier community together.

MISSION

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

VALUES

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

SCFHT Board of Directors, 2023 - 2024

Our Board of Directors are a phenomenal group of members with a wealth of experience and expertise, all of whom guide the SCFHT' to uphold the vision, mission and values.

Our sincere thanks to Dr. Stephane Foidart and Dr. Jonny Grek, who have completed their terms on the board.

SCFHT Board Members:

KMA Representative: Dr. Michelle Thomas

Keewatin Clinic Representative: Dr. Meghan Olson

Docside Clinic Representative: Dr. Emily Drake

Community Partner Physician: Dr. Kerry Anderson

Community Partner IHP: Roberta Giesbrecht

Community Partner: Paul Derouard

Community Partner: Whitney Van Belleghem

SCFHT Board Executive:

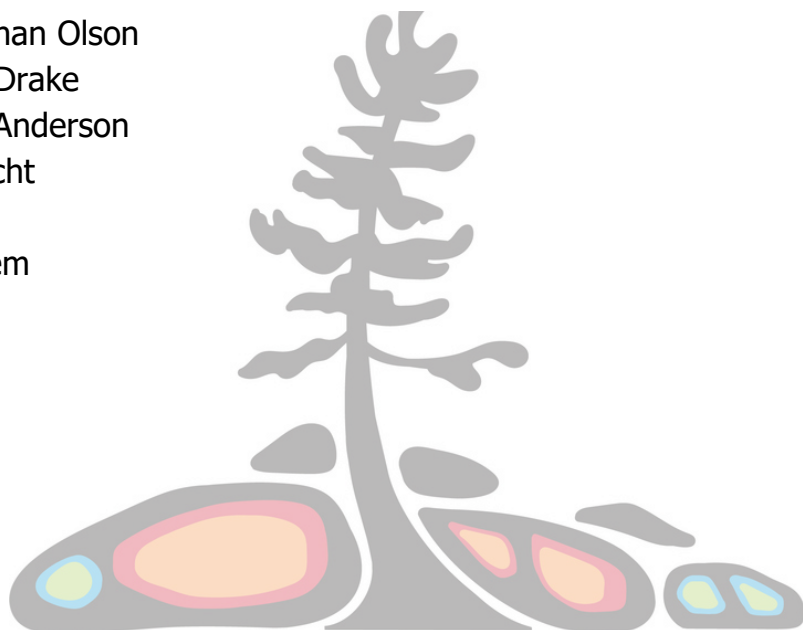
Chair: Dr. Kerry Anderson

Vice Chair: Roberta Giesbrecht

Secretary / Treasurer: Paul Derouard

SCFHT Lead Physician:

Dr. Shannon Weibe



A Message from the SCFHT Lead Physician

SCFHT has continued to make great progress on the strategic plan generated last year. 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.

SCFHT leadership has taken a major role in OHT leadership and in the development of strong linkages with other community Service Provider Organizations. With the goal of improving care across all community members and communities, SCFHT has developed a workflow with KCA staff to facilitate access to cancer screening and education in on-reserve communities, with tests ordered under the care of the patients' primary care provider. KCA staff have been on-boarded to SCFHT EMR, leading to improvement in information access and communication for shared patients.



Dr. Shannon Wiebe
SCFHT Lead Physician

The Goals and projects of the SCFHT Quality Improvement Committee overlap with OHT cQIP Committee, which is now established with SCFHT leadership. Again, this is focused on community-wide assessments and improvements in care.

The SCFHT efforts to improve staff retention (ex. 4 day work week) have 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.

The Family Health Network (physician group) recognizes the significant support provided by the SCFHT in both day-to-day patient care and visionary work. Unfortunately, we remain under staffed. One FHN doc left for focussed practice earlier this year; one is planning a move away, and another retirement is anticipated in coming months. This has already resulted in a decline in funding which flows to FHT administration, despite the fact that it contribute to ongoing and increased work by that leadership. There are no new Recruits at this time, but OHT and FHT leadership have been instrumentally supporting Primary Care Physicians in design and negotiation of a new Rural Generalist Model, which is intended to improve recruitment, streamline patient access to care, and allow more equitable access to care (including First Nation Communities and to Currently Unattached Patients).

Respectfully submitted,

Shannon Wiebe



A Message from the SCFHT Executive Director

As we reflect on the past year, I am filled with a deep sense of pride and gratitude for the achievements of the Sunset Country Family Health Team. The 2023-2024 year brought significant challenges and incredible opportunities for growth, collaboration, and innovation. Our dedicated team of healthcare professionals, staff, and community partners worked tirelessly to deliver high-quality, patient-centered care across the Kenora region. One of the year's highlights was our continued focus on improving access to primary care services. Through our partnerships with local hospitals, Indigenous health organizations, and community agencies, we expanded our service delivery to better meet the evolving needs of our diverse population. Whether through expanding support behind the scenes, enhancing chronic disease management, expanding scopes of practice or offering virtual care options, our team's unwavering commitment to the health and well-being of the community was always at the forefront.



Colleen Neil
SCFHT Executive Director

Our collaboration with our All Nations Health Partners Ontario Health Team was a cornerstone of this year's success. By working together with our OHT partners, we supported a shared vision of integrated, holistic care for our communities. Our team contributed to healthcare transformation efforts that prioritize the voices and needs of patients, families, and providers.

In addition to service improvements, we have made significant strides in supporting the development of a sustainable healthcare workforce. Recruiting and retaining skilled healthcare providers remains a top priority, and we are actively engaged in the All Nations Health Partners' Recruitment Committee to address regional needs. That being said, the current Sunset Country Family Health Team staff are some of the most dedicated and kind people I have ever had the pleasure of spending my work life with.

I want to extend my sincere thanks to our Board of Directors for their leadership and guidance throughout the year. Their unwavering support and strategic direction have enabled us to navigate complex challenges and seize new opportunities. To our staff, thank you for your dedication, professionalism, and compassion—your work has made a real difference in the lives of so many.

Finally, I want to express my gratitude to the community for your trust and partnership. The care we provide reflects the relationships we build, and I look forward to continuing to work together to improve the health of our region.

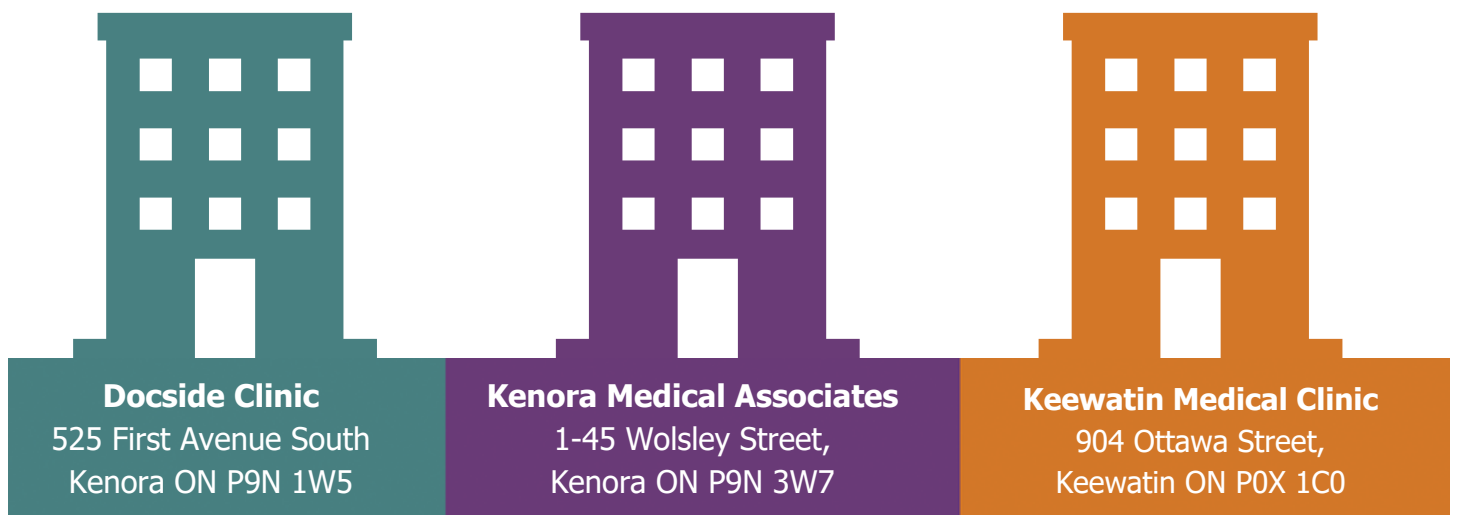
As we move into the next year, we remain focused on strengthening our services, advancing our partnerships, and ensuring that every patient has access to the care they need, when and where they need it. We are building a healthier, stronger future for the Sunset Country Family Health Team.

Sincerely,
Colleen Neil

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.

Our Affiliated Clinics



Strategic Plan 2023 - 2026

The importance of strategic planning when it comes to the delivery of high-quality healthcare services to our community cannot be overstated, and would not be overlooked. At the SCFHT, we strive with every action to ensure that our patients have the access they need, to the care they need, when they need it, and that our community knows what their options are when it comes to receiving healthcare in a time where access can seem so limited.

In the Spring of 2022, a thorough needs assessment was conducted to determine gaps in our community's healthcare access. In order to better understand the specific challenges faced by our community members and our current and future healthcare needs, we collected and analyzed data and insights gained from community survey responses. Guided by this data, in the fall of 2022 we conducted a comprehensive strategic planning process, with community and staff engagement at its core. Through this engagement, we developed strategic goals and objectives which would become actionable initiatives and projects to address the needs outlined in our needs assessment.

Over the last year, we have made phenomenal strides towards each of our goals. We have expanded program access, allowing more clients without primary care providers to self refer to a number of our programs and services. We have introduced a community health worker to improve system navigation and understanding of health care access. As we look back over the year, we are extraordinarily proud of our team and the challenge they have risen to in helping to enact this strategic plan, and we look forward to continuing this path over the coming years in further pursuit of expanding health care access for all.



Strategic Plan 2023 - 2026

Identified Priorities and 2023/2024 Progress Updates

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.



Planning for increased accessibility was completed during the 2023/24 fiscal year. As a result, 12 of 15 programs became accessible to all patients (with or without primary care providers) on April 1, 2024. Updated program posters and guidelines have been displayed in the SCFHT hallway, shared on social media, and circulated to healthcare partners.

Priority Two: Recruitment and Retention

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



During the 2023/24 fiscal year, planning and process changes were implemented to launch a six-month trial of an innovative recruitment and retention strategy. SCFHT joined an accredited study through Boston College, aiming to improve staff retention and morale while attracting new clinicians to the community. The initiative progressed well and positively impacted staff morale.

continued...

Strategic Plan 2023 - 2026

Priority Three: Community Engagement

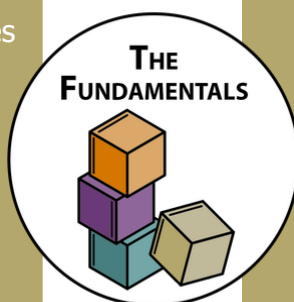
- Increase community awareness of the SCFHT programs, services, and the differences between the SCFHT and the Family Health Network (FHN).



Our focus for the 2023/24 fiscal year was to expand the community's awareness of the programs and services offered by SCFHT. Increased social media activity has successfully captured public attention, and branding efforts have been completed. The Strategic Plan has been publicly posted, and our offices have been repainted with SCFHT colors, reinforcing our presence and commitment to the community.

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 the 2023/24 fiscal year, we implemented several key initiatives to enhance operational efficiency and patient experience. This included eReferrals, Ocean, online appointment bookings, patient messaging, and email and text reminders. The Auto Scribe pilot for Nurse Practitioners began in May. We completed an EMR data cleanup, introduced Ocean automated tasks, and standardized EMR onboarding and training for SCFHT, WNHAC, and KCA staff.

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.



During the 2023/24 fiscal year, a Community Health Worker (CHW) was hired, and the CHW program was developed and advertised. In addition to helping patients navigate the health care system and providing support in accessing resources, the CHW now leads the Memory Clinic Program and provides follow-up support to patients after clinic visits.

SCFHT Programs & Services

- Asthma Management
- COPD Management
- Cancer Screening
- Health System Guidance* (NEW)
- Diabetes Management
- Foot Care
- Hypertension
- INR
- Lactation Consultant
- Memory Clinic
- Minor Ailments* (NEW)
- Nutritional Counselling
- Nurse Practitioner Services
- Occupational Therapy
- Pharmacist Services
- Smoking Cessation

As part of our strategic plan, emphasis was placed on access for all and health system guidance. In furthering that, this year we proudly expanded program access for a number of our services - making it easier for clients without a primary care provider to access and receive the care they need.

We introduced the role of Community Health Worker to help clients navigate external health systems - including clients needing assistance understanding and completing health forms and health funding applications, to help make health system navigation more accessible within our community.



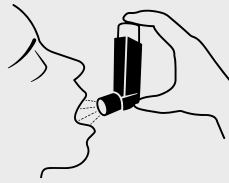
2023 - 2024 Program Access & Statistics

Access to all SCFHT programs	
2023/2024 Total #of patients: 8,934	2023/2024 Total # of visits: 50,725
2022/2023 Total #of patients: 8,572	2022/2023 Total # of visits: 29,123

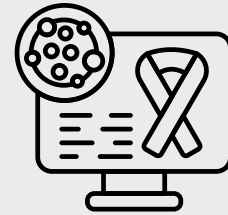
SCFHT Program Access



21,406 visits
to the Acute
and Episodic
Care Services



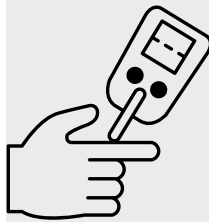
415 visits to the
Certified
Respiratory
Educator for
Asthma / COPD



1,045 visits to
the Cancer
Screening
program



66 patient
encounters with
the Community
Health Worker



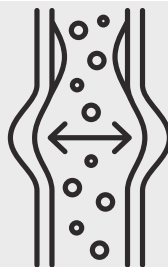
2,036 visits to
the Diabetes
Management
program



980 visits to
the Foot Care
nurses



1,728 visits
to the
Hypertension
team



1,339 visits
to the INR
program



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



76 patients
seen in **27**
Memory
Clinics



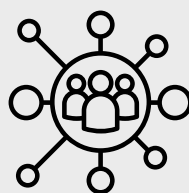
639 visits to
the
Registered
Dietitian



523 visits to the
SCFHT
Pharmacist
including Minor
Ailments



6,952 visits to
the
Physiotherapy /
Rehab program
at LWDH

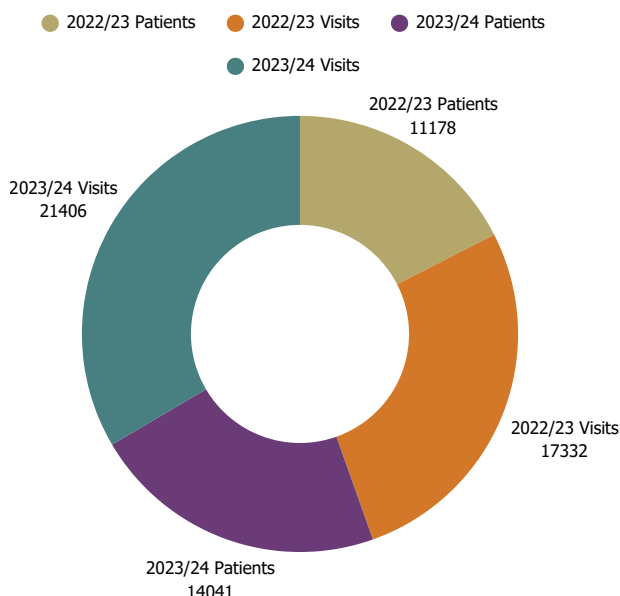


480
encounters
with the
Primary Care
Outreach
program



215 visits to
the Smoking
Cessation
program

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

Services & Supports

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

Program Goals

15,000 visits offered.
Office visits, emails, home visit, community / hospital, virtual visits

50% of appointments are same day or next day

Track number of ER diversions

Annual Outcomes

2023 - 2024 2022 - 2023

16,640 office visits	13,605 office visits
4,636 phone visits	3,670 phone visits
99 email contacts	24 email contacts
16 home visits	24 home visits
10 community / hospital	5 community / hospital
5 virtual visits	4 virtual visits

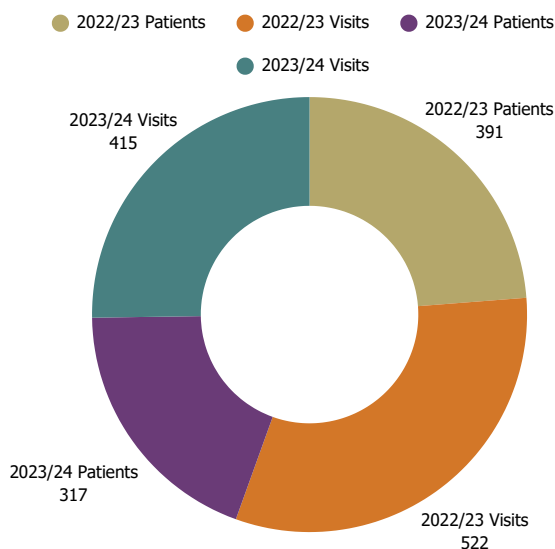
43.36%

49.62%

22

8

ASTHMA MANAGEMENT PROGRAM



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

Services & Supports

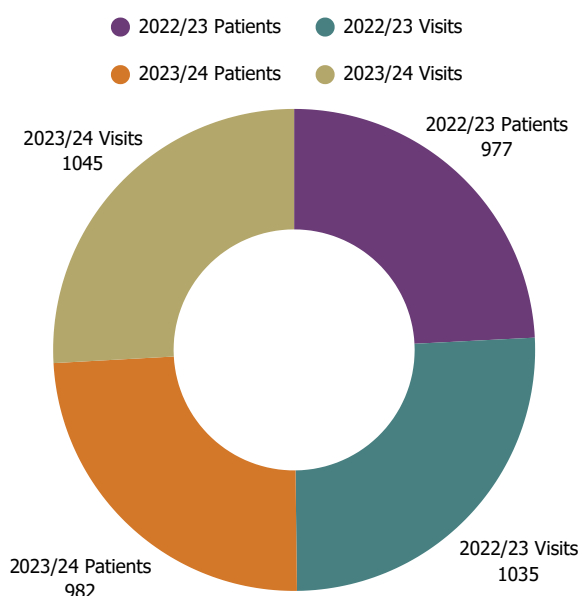
- Provide spirometry screening to test patients for asthma
- Provide asthma education and support for patients and their families
- Management and treatment of asthma symptoms
- Day-to-day lifestyle skills for asthma management

Program Goals

Annual Outcomes 2023 - 2024 2022 - 2023

95% of Asthma / COPD patients seen in the program will have a spirometry confirmed diagnosis.	98.15%	97.11%
85% of current patients in the program who smoke have received a smoking cessation intervention.	62.93%	80.6%
75% of COPD patients have received flu* and pneumovax** vaccines.	49.59%* 67.48%**	43.86%* 66.67%**
75% of patients in the Asthma / COPD Program have received their Covid-19 vaccine.	80.44%	82.16%

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

Services & Supports

- Provide education and cancer screening

Examples: Pap tests, prostate tests, lung screening, FIT tests, and mammogram information

- Host screening clinics for patients to access Cervical Cancer Screening (Pap)
- Community based events to provide cancer screening awareness and education
- Provide support with cancer screening navigation and follow up

Program Goals

69% of eligible patients screened for **cervical cancer** within the recommended timelines

67% of eligible patients screened for **breast cancer** within the recommended timelines

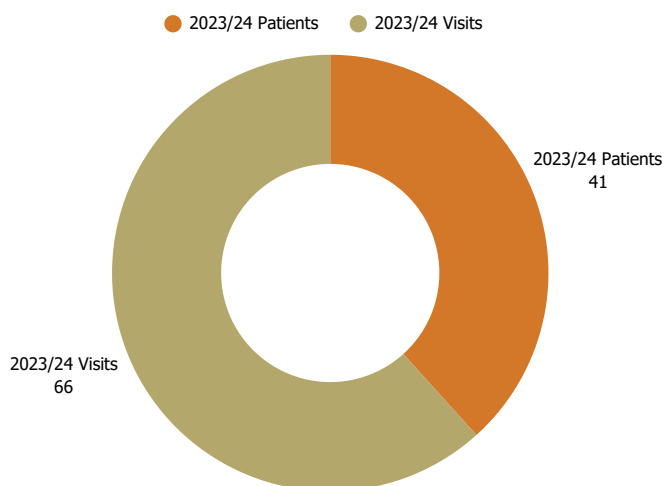
68% of eligible patients screened for **colorectal cancer** within the recommended timelines

Annual Outcomes

	2023 - 2024	2022 - 2023
69% of eligible patients screened for cervical cancer within the recommended timelines	60.4% EMR 63% SAR	50.3% EMR 56% SAR
67% of eligible patients screened for breast cancer within the recommended timelines	60.1% EMR 61% SAR	59.5% EMR 61% SAR
68% of eligible patients screened for colorectal cancer within the recommended timelines	59.8% EMR 68% SAR	57.8% EMR 66% SAR

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 work on narrowing the gap.

HEALTH SYSTEM NAVIGATION PROGRAM



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

Services & Supports

- 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

Program Goals

Collect baseline on unique patients accessing CHW (rostered and unrostered)

Collect baseline on patient encounters (phone, in-office, virtual and services with no encounter)

Encounters/connections to other agencies
(housing, mental health, legal, ODSP, etc.)

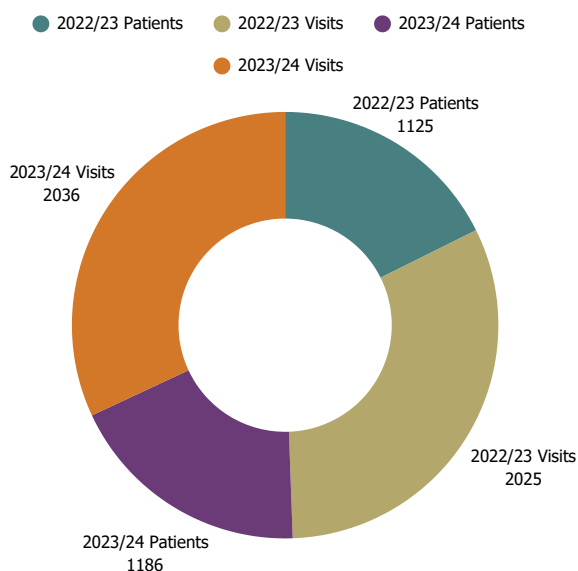
Annual Outcomes 2023 - 2024

41 unique patients
36 rostered
3 attached
2 unattached

66 patient encounters;
43 phone
16 office
1 virtual
6 service, no encounter

5 connections / referrals to other agencies

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

Services & Supports

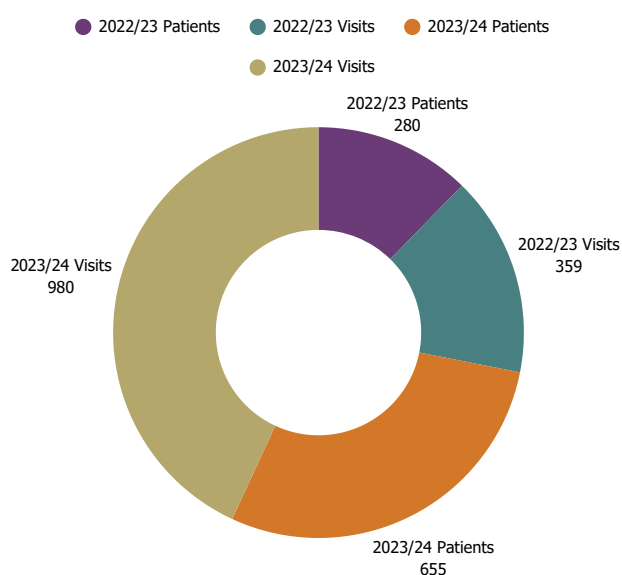
- Individualized education, screening and treatment of Type 1 diabetes, Type 2 diabetes and gestational diabetes
- Treatments can include: nutrition, weight management, foot care, medications (including insulin starts), blood glucose monitoring, and more
- Referrals for preventative health care
- Diabetes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

Program Goals

Annual Outcomes 2023 - 2024 2022 - 2023

90% of patients with Type 1 or Type 2 diabetes who recieved an A1c within the last year.	97.99%	91.47%
80% of patients in the program will have their blood pressure measured within the last six months.	90.80%	69.0%
60% of patients with Type 1 or Type 2 diabetes with a validated foot screen performed in the last year.	46.76%	46.63%
60% of patients with Type 1 or Type 2 diabetes with a retinal exam performed within the last two years.	54.87%	69.25%
60% of patients setting a SMART goal within the last 6 months.	76.72%	88.62%

FOOT CARE PROGRAM



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

Services & Supports

- 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

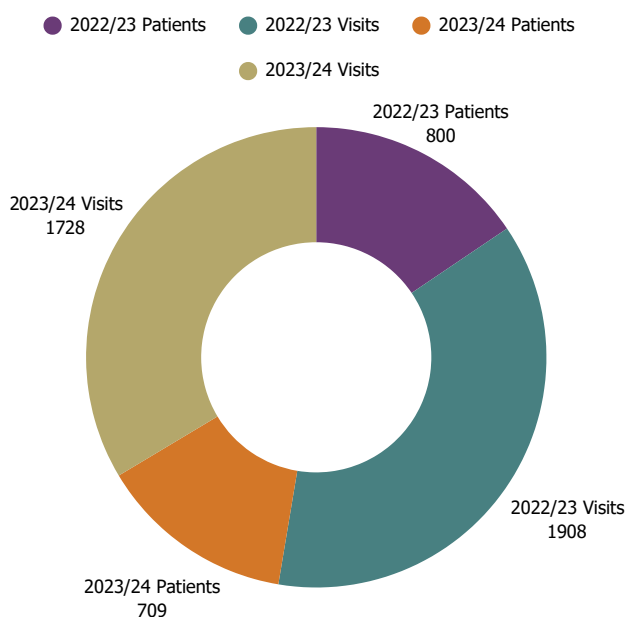
- Treatment and referrals for acute conditions
- Provide education on lower limb injury prevention and self-management techniques
- Diabetic foot screens
- Ankle-brachial index (ABI) testing

Program Goals

Annual Outcomes 2023 - 2024 2022 - 2023

90% of patients with diabetes with a 60 second foot screen performed within the last 1 year	88.30%	91.49%
80% of patients with an Action Plan who follow up with the foot care nurse on an annual basis	92.97%	86.14%
90% of patients with a chronic problem whose condition is under control at their most recent follow-up visit	92.61%	98.68%

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

Services & Supports

- 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

Program Goals

60% of patients with hypertension have individualised **blood pressure (BP) target set** within 3 months of their initial visit

65% of patients in the program to have **improved BP readings to target** after 3 months

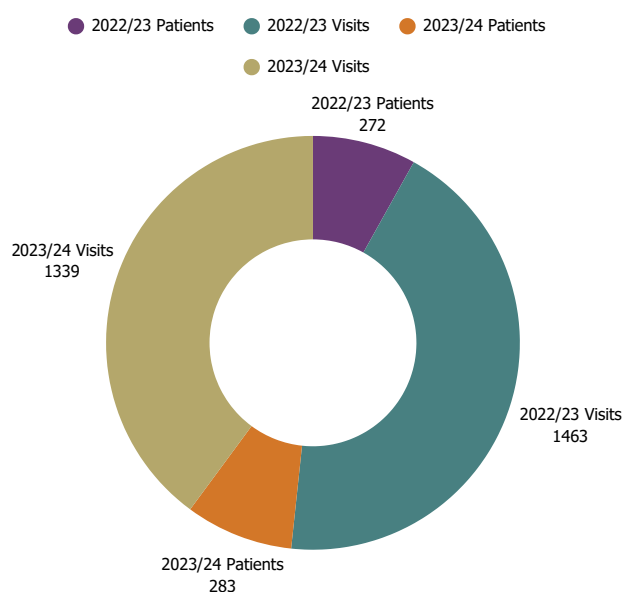
80% of patients set a **lifestyle goal** after 3 months

80% of patients receiving BP screening **provided education or resources** on proper BP technique

Annual Outcomes 2023 - 2024 2022 - 2023

60% of patients with hypertension have individualised blood pressure (BP) target set within 3 months of their initial visit	100%	100%
65% of patients in the program to have improved BP readings to target after 3 months	73.52%	62.31%
80% of patients set a lifestyle goal after 3 months	77.51%	92.31%
80% of patients receiving BP screening provided education or resources on proper BP technique	85.97%	98.12%

INR PROGRAM



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

Services & Supports

- 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

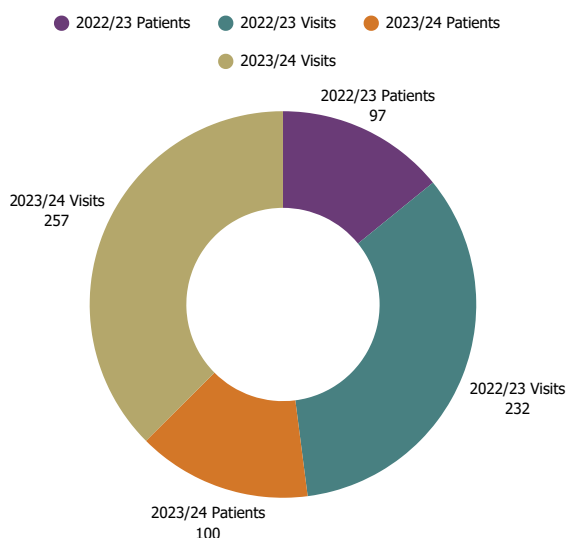
Program Goals

Annual Outcomes 2023 - 2024 2022 - 2023

70% of point of care INR tests in range	67.86%	71.5%
<2% of patients in the INR program with a recent stroke event	0.3%	2.8%
<2% of patients in the INR program with a recent major bleeding event (requiring ER visit or hospitalisation)	0.7%	3.8%

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

Services & Supports

- 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

Program Goals

85% of parents attending prenatal sessions or individualised consultations will report increased **confidence, knowledge, and skill** in breastfeeding through a post session survey.

75% of patients who feel confident with the knowledge provided at their appointment to accomplish their breastfeeding plan

Number of SCFHT and community partner staff who have completed the 20hr lactation course

Annual Outcomes

	2023 - 2024	2022 - 2023
100% of those surveyed reported increased knowledge and confidence	100% of those surveyed reported increased knowledge and confidence	100% of those surveyed reported increased knowledge and confidence
77.30% indicated increased confidence; 69.82% increased confidence in oral exercise	80.95% indicated increased confidence; 76.19% increased confidence in oral exercise	
5 misc. attendees 25 community partner staff	3 FHT staff 2 students 12 community partner staff	

100% of those surveyed reported increased knowledge and confidence

77.30% indicated increased confidence;
69.82% increased confidence in oral exercise

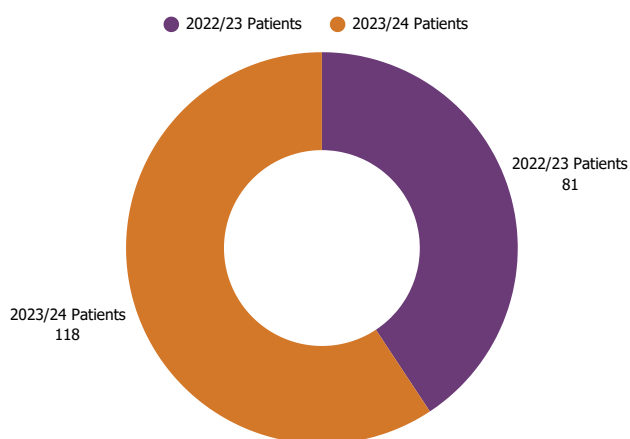
5 misc. attendees
25 community partner staff

100% of those surveyed reported increased knowledge and confidence

80.95% indicated increased confidence;
76.19% increased confidence in oral exercise

3 FHT staff
2 students
12 community partner staff

MEMORY CLINIC PROGRAM



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

Services & Supports

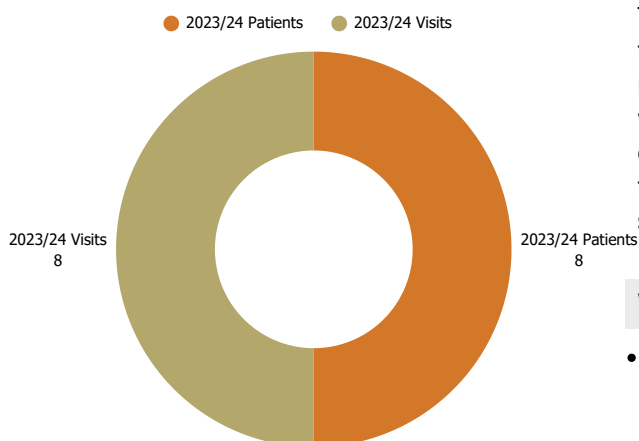
- Patient care is supported by a team of specially trained health care professionals
Health care team includes: doctors, nurses, pharmacists, community health workers, occupational therapists and community agencies
- Provide medication reviews and education for patients and their families
- Functional and cognitive impairment assessment

Program Goals

Annual Outcomes 2023 - 2024 2022 - 2023

80% of patient/caregivers are satisfied with service	96.29%	100%
80% patient/ caregivers who report increased understanding about their condition.	100%	92.31%
60% of patients are contacted 4 weeks (14-45 days)	78.35% contacted	51.67% contacted
60% understand their care plan recommendations	84% understand	51.67% understand
70% of patients who have implemented 1 or more care plan recommendation(s) at their MC follow up visit;	92.30%	83.33%
70% Number of recommendations completed	67.62%	64.88%
80% of patients with advanced care planning education at initial visit;	92.60%	62.79%
80% of patients with an ACP and POA at follow up visit.	62.79%	47.22%

MINOR AILMENTS PROGRAM



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

Services & Supports

- **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)

Program Goals

Collect baseline of unattached patients diverted from the ED

Collect baseline of % of total visits per presenting ailment type

% of patients referred to other services, internal or external to SCFHT

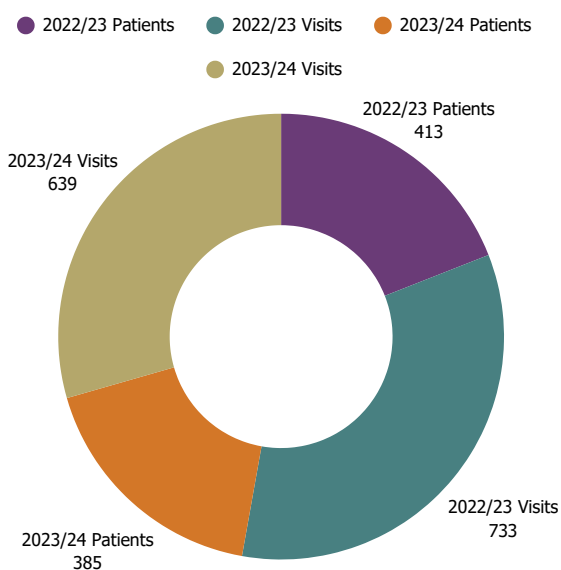
Annual Outcomes 2023 - 2024

7 unattached
1 enrolled

25% Cold Sores
12.5% Dermatitis
50% Pinworms
12.5% UTI

0 internal
0 external

NUTRITIONAL COUNSELLING PROGRAM



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

Services & Supports

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 with a new or chronic health condition who would like nutritional support
- People who would like support in developing a healthy relationship with food

Examples of health conditions:

high cholesterol, hypertension (high blood pressure), stroke, cancer, eating disorders, and diabetes

Program Goals

90% of follow up patients will have achieved their **most recent SMART goal**

90% of dyslipidemia patients will have a **documented Framingham risk assessment**

Offer the **Mindful Eating: Emotional Eating and Food Craving Management Group** three times a year

Annual Outcomes 2023 - 2024 2022 - 2023

76.02%

88.07%

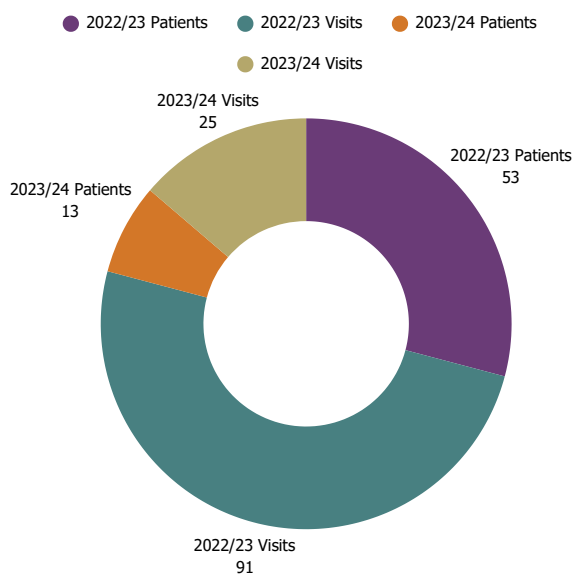
90.32%

81.58%

**2 workshops ran,
6 sessions completed**

**3 workshops ran,
11 sessions completed**

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

Services & Supports

- 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

Program Goals

Annual Outcomes 2023 - 2024 Q4 2022 - 2023

90% of home OT assessments with completed Home Safety	100%	75%
80% of patients ages 65+ have a completed falls assessment	72.73%	62.96%
Collect baseline on number of patients in the program who are currently prescribed opiod medication for pain management.	15.38%	7.55%
80% of patients who recieve follow up and report an improved understanding of their primary concern and ability to self manage.	77.8%	54.5%

PHARMACIST SERVICES PROGRAM



What is the program?

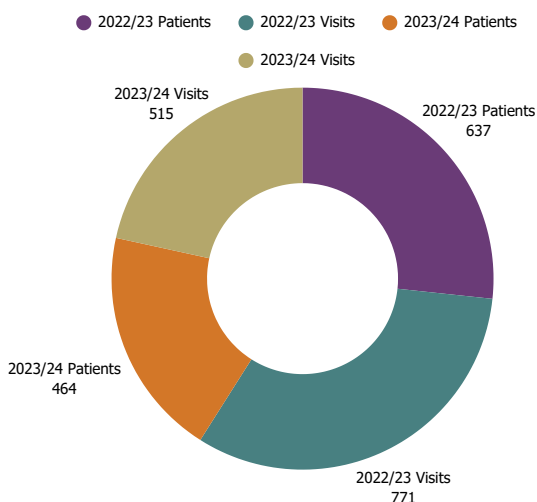
The SCFHT Pharmacist provides education and support relating to the use of medication.

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

Services & Supports

- 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



Program Goals

400 visits for:

Medication reviews

Medication updates in the EMR

Drug information questions

Prescription samples

Drug navigation (forms, etc)

Hospital discharge medication follow up and other services provided

2023 - 2024

515 visits across
44 medication reviews
336 medication updates
57 medication reconciliations
68 drug info questions
5 Rx samples
59 drug navigation
126 hospital discharges
9 cardiac rehab
2 memory clinic

Annual Outcomes

2022 - 2023

66 medication reviews
518 medication updates
109 medication reconciliations
114 drug info questions
46 Rx samples
80 drug navigation
413 hospital discharges
12 cardiac rehab
2 memory clinic

50 patients will have a **med review completed**

44 medication reviews

62 medication reviews

55% of **DTPs identified** at a med review **get resolved**

28.96%

58.94%

250 **hospital discharge attempts;**

130 **patients contacted;**

200 **charts updated**

118 attempts,

70 patients contacted

115 charts updated

328 attempts,

156 patients contacted

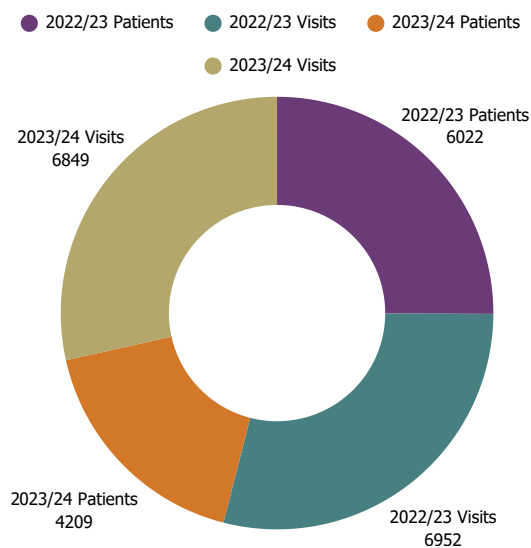
313 charts updated

Pharmacy newsletters created and distributed to community pharmacy partners

6 newsletters

11 newsletters

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.

After a PT resignation in July, 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.

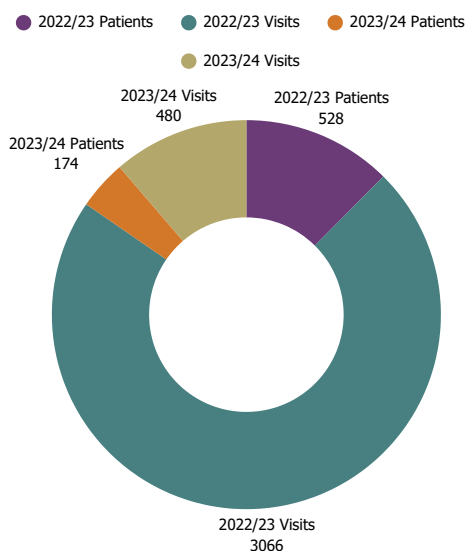
Program Objectives

- 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 2023 - 2024 2022 - 2023

Referrals for conditions best served by Physiotherapist	1,331	1,739
# of Patients	4,209	6,022
# of Attendances	6,849	6,952

PRIMARY CARE OUTREACH PROGRAM



What is the program?

Primary Care Outreach is an evidence-based approach effective in expanding access to programs and services for those most adversely affected by the social determinants of health. The SCFHT is proud to offer this primary care outreach to the vulnerable sector in collaboration with the Kenora District Services Board, Kenora Chiefs, CMHA, KACL, Ne Chee Friendship Centre, OPP, WNHAC, RAAM, NWHU, SafeBeds, Clarissa Manor and Del Art Manor. Through the program, we aim to increase access to primary care, mental health and addictions services for underserved populations in Kenora, leading to improved health outcomes and quality of life and reduced emergency room visits and hospitalizations.

This program was transferred to WNHAC as of June 07, 2023.

Program Goals

Track number of unique individuals served, number of encounters (both total encounters and encounters per individual), and reason for encounter.

Collect baseline on Housing SDOH, changes to housing status, and reason for homelessness.

Number of connections/referrals to other ANHP partners and community services.

Track ER diversions, based on patient self-reported use. Track direct referrals to ER/Hospital.

2023 - 2024

174 patients
Primary Care - 362
Trauma/injury - 3
Acute Illness - 10
Chronic Illness - 11
Mental Health - 35
Alcohol - 4
Substance-Drugs - 44
Social Services - 8
Basic Needs - 0
Other - 3

Reason for Homelessness:
60.9% navigation,
30.4% waited listed, 8.7%
housing debt or restriction,
0% patient choice,
0% unable to live in home
community (BCR)
0% other

0 referrals recorded
in Q1.

0 patients self-reported ER diversion,
0 referrals from LWDH

Annual Outcomes 2022 - 2023

Primary Care - 1988
Trauma/injury - 63
Acute Illness - 148
Chronic Illness - 114
Mental Health - 311
Substance-Alcohol - 53
Substance-Drugs - 296
Social Services - 52
Basic Needs - 14
Other - 27

Reason for Homelessness:
52.3% system navigation,
24.6% waitlisted,
7.7% housing debt or
restriction,
9.2% by patient choice,
1.5% BCR,
4.7% other

186 referrals to ANHP
partners,
13 to community partners

9 patients self reported they would
have otherwise received care at ER,
75 referrals from LWDH.

SMOKING CESSATION PROGRAM



What is the program?

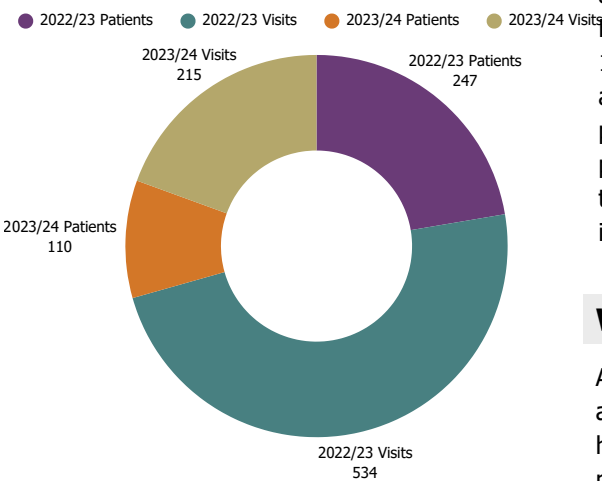
The Smoking Cessation Program at the Sunset Country Family Health Team is for all patients 18 years of age and older who are rostered to a SCFHT physician. This program provides a systematic approach to assist patients who are interested in quitting smoking.

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.

Services & Supports

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>



Program Goals

Annual Outcomes		
	2023 - 2024	2022 - 2023
30% of patients in the program who have quit smoking at 6 months	28.5%	32.3%
25% of patients in the program who have quit smoking at 12 months	50%	25.0%
90% of smoking cessation program patients have smoking status documented in Risk Factors in the EMR	100%	99.23%

Supporting the All Nations Health Partners Ontario Health Team (ANHP OHT)

The Sunset Country Family Health Team (SCFHT) has been a key partner in advancing integrated, collaborative healthcare across our region by actively participating in and leading several working groups within the ANHP OHT. This work is driven by our commitment to our partners and the collaborative efforts to enhancing patient-centered care, improving health outcomes, and promoting equitable access to healthcare services.



Leadership and Participation in Key Working Groups

- **ANHP Partner Table:** SCFHT engages in strategic decision-making and fostering partnerships with health organizations to support the ANHP OHT's vision of collaborative care in our region.
- **ANHP Governance and Incorporation Working Group:** Providing leadership in guiding the formal governance and incorporation structure of the OHT, ensuring a collaborative model that represents all partners.
- **Primary Care Network / ANHP OHT Clinical Advisory:** SCFHT actively supports the work of our care providers in shaping care delivery models and best practices for primary care delivery across the OHT.
- **Rural Generalist Council (RGC Negotiations):** Advocating for solutions to ensure consistent rural healthcare delivery models tailored to the unique needs of our communities.
- **Primary Care Working Group:** Developing integrated care approaches to enhance service delivery for primary care providers across the region.
- **Integrated Clinical Pathways:** Contributing to the creation and implementation of the following pathways to standardize care for chronic diseases:
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Heart Failure (HF)
 - Cancer Screening
 - Wound and Vascular Care
- **Home Care Working Group:** SCFHT played a pivotal role in developing Phase 3 of the Local Home Care Delivery Business Model, aligning home care services with regional needs.
- **ANHP OHT Digital Strategy:** Leading efforts to enhance digital health tools and strategies to support integrated care and improve patient access to services.
- **Health Care Recruitment:** Addressing regional healthcare workforce challenges by working with ANHP OHT Partners on strategies to attract and retain skilled healthcare professionals.
- **ANHP OHT Privacy and Security Working Group:** Ensuring that patient data privacy and security are prioritized while enabling information sharing across healthcare providers.
- **ANHP OHT Collaborative Quality Improvement and Data Working Group (cQIP):** Supporting the continuous improvement of healthcare services through data-driven quality improvement initiatives.

This highlights SCFHT's integral role in the ongoing development of the ANHP OHT, underscoring our commitment to building a healthier, more resilient healthcare system for the region.

Our Privacy Commitment

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 mind 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.

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

SCFHT	KCA	KDSB	LWDH	NWHU	WNHAC
(807) 468 6321	(807) 467 8144	(807) 468 5372	(807) 468 9861	(807) 468 3147	(807) 699 6422

If, after contacting any of the above 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

The SCFHT Team

Executive Director

Finance Manager

Clinical Coordinator

Quality Improvement Decision Support Specialist

Administrative Assistant: Patient Services

Administrative Assistant: Communications & Executive

Administrative Assistant

Administrative Assistant

Colleen Neil
Stephanie Evenden
Kim Loranger
Melonie Young
Toni Trepanier-Maenpaa
Kate Charlebois
Owen Doerkson (casual)
Emily Tella (casual)

Community Health Worker

Taylor Alcock

Registered Diabetes Educator, Registered Nurse:

Registered Diabetes Dietitian:

Carolyn Hamlyn
Cindy Van Belleghem

Registered Dietitian

Therese Niznowski

Foot Care Nurses:

Crystal Cadieux
Sue McLeod

Nurse Practitioners:

Kenora Medical Associates:
Kenora Medical Associates:
Kenora Medical Associates:
Keewatin Medical Clinic:

Angela Jung
Holly Rose
Michael Reid
Svea Simpkin

Occupational Therapist

Brittan Amell

Pharmacist

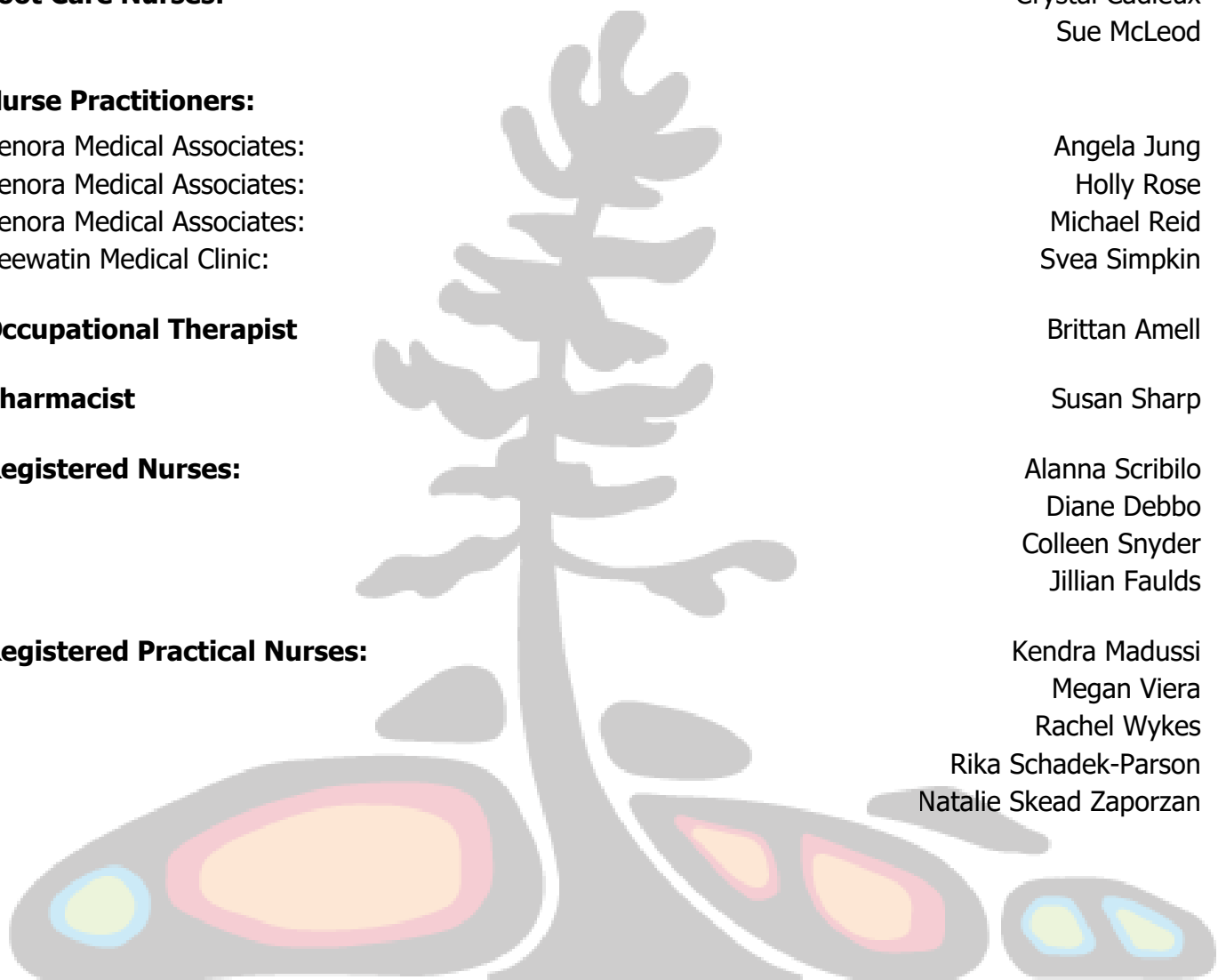
Susan Sharp

Registered Nurses:

Alanna Scribilo
Diane Debbo
Colleen Snyder
Jillian Faulds

Registered Practical Nurses:

Kendra Madussi
Megan Viera
Rachel Wykes
Rika Schadek-Parson
Natalie Skead Zaporzan



Audited Financial Statements, 2023 - 2024

Sunset Country Family Health Team Statement of Financial Position

March 31

2024

2023

Assets

Current

Cash and bank	\$	1,531,594	\$	1,001,957
Account receivable (note 2)		24,205		95,141
Prepaid expenses		--		46,172

	\$	1,555,799		1,143,270
--	----	------------------	--	-----------

Capital assets (Note 3)

		199,264		220,956
--	--	----------------	--	---------

	\$	1,755,063	\$	1,364,226
--	----	------------------	----	-----------

Liabilities and Net Assets

Current

Accounts payable and accrued liabilities (Note 4)	\$	249,230	\$	249,619
Governments contributions repayable (Note 5)		482,096		356,458
Deferred revenue (Note 6)		372,834		293,068

	\$	1,104,160	\$	899,145
--	----	------------------	----	---------

Net Assets

Net assets invested in capital assets		199,264		220,956
Unrestricted		451,639		244,125

		650,903	\$	465,081
--	--	----------------	----	---------

	\$	1,755,063	\$	1,364,226
--	----	------------------	----	-----------

On behalf of the Board:



Paul Derouard
3E483825CCE47A...

Audited Financial Statements, 2023 - 2024

Sunset Country Family Health Team Statement of Operations

For the year ended March 31

2024

2023

Revenue

Ministry of Health	\$	1,802,975	\$	3,712,782
Ontario Health		1,935,872		-
Ministry of Health - Primary Care Asthma program		37,250		37,250
Family Health Network		25,000		25,000
Other		62,972		103,276
Waasegiizhig Nanaadawe'iyewigamig - HR Sharing		49,047		49,047
Kenora District Services Board - Outreach		294,559		252,850
Ontario Health Quality Council		102,746		74,954

\$	4,310,421	\$	4,255,159
----	------------------	----	-----------

Expenses

Human Resources	\$	3,092,781	\$	3,076,994
Physician consulting		33,200		33,000
Sessionals		47,265		45,084
General Operating		102,739		140,852
Information Technology		112,642		106,248
Professional Fees				
Audit fees and other accounting fees	\$	23,899	\$	22,589
Project management		30,422		41,041
Insurance		21,188		19,982
Legal fees		7,765		6,780
Professional fees		31,457		41,074
Recruitment and retention		2,799		4,405
Premises - rent		133,441		142,205
Travel		16,961		9,165
Common area maintenance		83,359		54,546
Approved one-time expenditures		111,963		241,589

\$	3,851,881	\$	3,985,554
----	------------------	----	-----------

Excess of revenues over expenses

\$	458,540	\$	269,605
----	----------------	----	---------

Government contributions repayable

	(251,026)		(222,975)
--	------------------	--	-----------

Excess of revenues over expenses

\$	207,514	\$	46,630
----	----------------	----	--------

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



Cover Art: "Whitefish Bay" by Kenora artist, Melissa Jean. We'd like to extend our sincere appreciation to Melissa for her generosity in allowing us to feature her work in this year's annual report; we are honoured to showcase her talent alongside our reflection of the year. Melissa captures the wild beauty of Lake of the Woods and Northwestern Ontario in her vivid paintings. Represented in galleries across Canada and collected worldwide by both private and corporate collectors, she lives and works year-round in her Keewatin studio, where her deep connection to the lakes and forests in the region continues to inspire her art on a daily basis. Find out more at melissajeart.com