



Sunset Country Family Health Team

2025-2026 Annual Report



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About the Sunset Country Family Health Team

As a proud partner of the All Nations Health Partners Ontario Health Team, we are fortunate to have a diverse team of healthcare professionals—including Physicians, Nurse Practitioners, Registered Nurses, Registered Practical Nurses, Occupational Therapists, Pharmacists, Dietitians, and more—working together to care for our community. We are committed to providing compassionate, comprehensive primary care and supporting individuals and families as partners in their health and wellness 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 2025-2026

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

SCFHT Board Executive:

Chair: Dr. Kerry Anderson

Vice Chair: Roberta Giesbrecht

Secretary / Treasurer: Jennifer McPhearson

SCFHT Lead Physician:

Lead: Dr. Shannon Wiebe

SCFHT Board Members:

RGC Representative: Dr. Michelle Thomas

RGC Representative: Dr. Meghan Olson

RGC Representative: Dr. Stephane Foidart

Community Partner Physician: Dr. Kerry Anderson

Community Partner IHP: Roberta Giesbrecht, RN

Community Partner: Jennifer McPhearson

Community Partner: Whitney Van Belleghem-Morrison





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

SCFHT has continued to lead and take on major new roles in the evolution of Family Medicine and Primary Care in Kenora over the last year. This has continued in alignment with our own goal to improve access to care for all patients in our region, as well as Ontario Health's priority of increased attachment of patients to primary care.

SCFHT staff and administration have put significant work into community-wide clinical pathway planning, increasing knowledge of and access to our programming for all patients. Work is underway for a centralized digital intake process for referrals to Chronic Disease Management Programs and primary care attachment. We continue to encounter some questions about appropriate next steps for patients without a current primary care provider who have issues identified while under SCFHT staff care, but having the process in place for unattached patients to be seen by a primary care provider has been a helpful outlet. Nurse Practitioners are providing support to each program for urgent requests, and the lead physician is also available for consultation or trouble-shooting. SCFHT has been filling some major community gaps in care - not just in opening to all unattached patients, but for specific programming such as spirometry and lactation consultancy. Recent retirements have left us with gaps in these areas, but recruitment has been strategically directed to fill these roles.

The successful funding application to add the Sioux Narrows Clinic Site to the Family Health Team has been efficiently put into action, and is a meaningful support for providers and community members in that area. It's meant a shift in NP staffing, but also attached additional physicians and allowed some re-balancing of patients previously travelling to Kenora or with our formal attachment who are now able to receive primary care in their own community.

For family physicians, the major transition to the Rural Generalist Council (RGC) model of care, which was formalized last April, has continued to mature over the last year. Contracts are set to be finalized in the near future. There are ongoing delays with the Ministry of Health regarding billing processes, but the RGC team has managed some great work-arounds. The SCFHT has been a key leader during this transition, and stepped in efficiently last April as the manager of physician clinics. This removed the administrative burden of office management from physicians, increasing time for patient care, while recognizing clinical administrative work. All SCFHT clinics are now using a centralized booking team, and advanced access booking, significantly shortening wait times for members of previously over-rostered clinics - although access is still less than ideal, as most practices are over-attached at this time, and the need for care from currently unattached patients continues to outstrip capacity. The SCFHT Nurse Practitioners are currently providing significant support to over-attached physician practices and unattached patients, and there is work in progress to ensure a more consistent practice roster for these team members.

Physician recruitment has not been as rapid as hoped, partly due to Ministry of Health information and contract delays related to the new physician services model. One of last year's new recruits, however, is filling a longterm gap with a local sports medicine clinic. We have also had two additional Practice Ready Ontario physicians join the community, one physician return to the emergency department, and some new graduates committing to stay. We have also seen improved access to locum coverage. Overall, community physicians have worked through some major changes in clinic function and autonomy, but are satisfied with the model and feel good about the evolution in access to care in which they are able to play a part.

The Primary Care Network (comprised of all physicians and nurse practitioners working in primary care) has become formalized and more established over the last year. Primary care providers are now represented on all OHT committees, and have started a task group related to values of care and collaboration. We continue to appreciate SCFHT leadership takes 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.

Respectfully submitted, Shannon Wiebe

A Message from the
SCFHT Executive
Director:
Colleen Neil



This past year has been one of the most transformative in the history of the Sunset Country Family Health Team (SCFHT). Together, we have expanded our role from a primary care provider to a robust, integrated support system for the Kenora primary care landscape—playing a central role in the successful launch of the Rural Generalist Council model of care.

This evolution did not happen by chance. It is the result of an extraordinary commitment from a team that has demonstrated, day in and day out, what true dedication to improvement looks like. Across all levels of the organization, we have seen individuals step forward with purpose, adaptability, and a shared belief in building a better system of care for our community.

The scale and pace of change over the past year have been significant. We have strengthened our operational capacity, expanded our teams, and taken on new responsibilities to support a more coordinated and equitable primary care system. In doing so, we have helped lay the groundwork for a model that better meets the needs of patients, providers, and partners across our region.

These achievements were not without challenge. There were difficult moments and complex issues that required thoughtful navigation, resilience, and trust in one another. What stands out most is how our team responded—with professionalism, collaboration, and an unwavering focus on solutions.

And to our community—thank you for your patience, your feedback, and your trust. Your voices continue to shape our work and keep us grounded in what matters most.

The changes we have made this year, and the team we have built, have created a strong foundation for the future. As we look ahead to 2026–2027, our focus will be on refining and maximizing this model's full potential. We will also embark on developing a new strategic plan, and we look forward to engaging our partners, staff, and community in shaping what comes next.

Together, we are building something meaningful—and we are just getting started.

Colleen Neil

A handwritten signature in black ink, appearing to read 'Colleen Neil'.





Our Medical Community

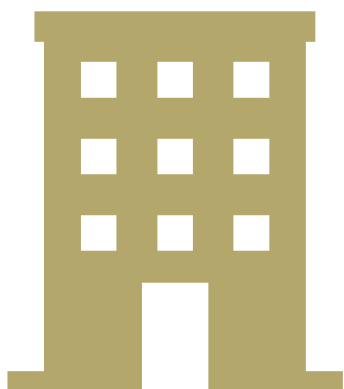
At the Sunset Country Family Health Team, we believe great care happens when we work together. By partnering with physicians, allied health professionals, and community organizations, we provide a wide range of primary care services, including chronic disease management, health promotion, and illness prevention. These collaborations help us deliver connected, patient-centred care and support the health and well-being of the individuals and families we serve.

Left to right - Katelyn, Kim, Kendra, Rika

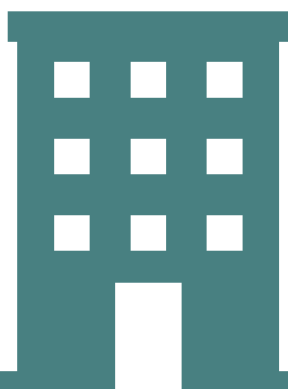


Our Clinics

New!



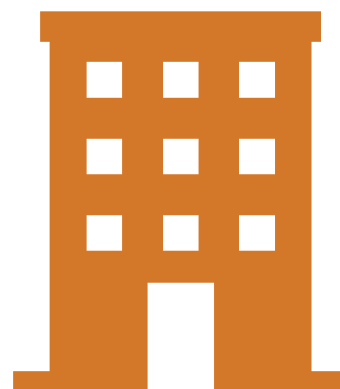
Lakeside Site
524 First Avenue South
Kenora ON P9N 1W5



Kenora Site
1-45 Wolsley Street,
Kenora ON P9N 3W7



Keewatin Site
904 Ottawa Street,
Keewatin ON P0X 1C0



**Sioux Narrows
Nestor Falls Site**
10 Fickas Road,
Sioux Narrows ON P0X 1N0

SCFHT in the Community



WE HOSTED

We are proud to host a variety of health and wellness events throughout the year, bringing our community together to learn, connect, and support healthier lives.



4 FOOT SCREENING CLINICS



14 COGNITIVE STIMULATION SESSIONS



3 RESPIRATORY CLINICS



2 MONTH LONG COPD EXERCISE CLASSES



10 WEEKLY WALKING WEDNESDAY SESSIONS



8 MINDFUL EATING SESSIONS

WE ATTENDED

We are proud to participate in community health events, connecting with residents, sharing health information, and supporting wellness across our region.



2 MATIOWSKI FARMERS MARKETS



1 RESOURCE SESSION AT WOMEN'S PLACE



6 PRENATAL SESSIONS WITH LWDH



1 OLDER ADULTS EXPO



8 LACTATION SUPPORT SESSIONS AT EARLYON CENTRE



8 BABY STOP/REST TENTS



1 PALLIATIVE CARE EXPO



3 SCHOOL EXPOS

Access to all SCFHT programs

2025/2026 Total # of patients: 15,492

2025/2026 Total # of visits: 34,951

2025/2026 Total # of referrals scheduled: 1,607

2025/2026 Total completed referrals: 1,010

2024/2025 Total # of patients: 14,880

2024/2025 Total # of visits: 33,036



17,771 visits to the Acute and Episodic Care Services



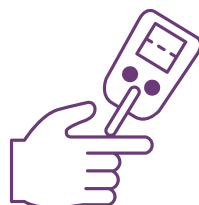
466 visits to the Certified Respiratory Educator for Asthma / COPD



1,084 visits to the Cancer Screening program



71 patient encounters with the Community Health Worker



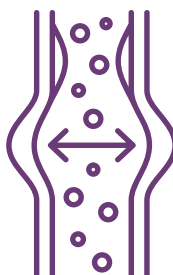
1,806 visits to the Diabetes Management program



1,272 visits to the Foot Care nurses



2,548 visits to the Hypertension team



1,636 visits to the INR program



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



68 Memory Clinic patients



661 visits to the Registered Dietitian



226 visits to the Obesity Management Program



372 visits to the Occupational Therapist



672 visits to the SCFHT Pharmacist including Minor Ailments



6,036 visits to the Physiotherapy / Rehab program at LWDH

Strategic Plan 2023 - 2026

Strategic planning is essential to delivering high-quality healthcare services. At Sunset Country Family Health Team (SCFHT), we are committed to ensuring patients have timely access to care and are well informed about the healthcare services available to them. A community needs assessment conducted in Spring 2022 identified gaps in access to healthcare through community surveys and stakeholder feedback. The findings informed our strategic planning process in Fall 2022, which focused on meaningful engagement with both the community and our staff to identify priorities and develop actionable initiatives. Over the past year, we have made significant progress toward achieving our strategic goals. We are proud of the accomplishments of our team and partners and remain committed to continuously improving and expanding access to high-quality, patient-centred healthcare for our community.



Priority One: Access for All

Recruitment and retention strategies | Health human resource planning | Advocacy for wage parity across the healthcare sector | Staff engagement and organizational culture | Evaluation of clinic staffing and resource allocation | Expansion of SCFHT programs to improve access for all patients | Strategic collaboration with physicians to increase patient access | Exploration of alternative clinic hours to improve access

The 2025–2026 fiscal year marked a significant milestone in improving access to primary care services at the Sunset Country Family Health Team (SCFHT). Effective April 1, 2025, SCFHT expanded access to comprehensive primary care for residents who were previously considered unattached and did not have a regular primary care provider.

Prior to this expansion, unattached patients had access primarily to SCFHT's interprofessional programs and services but were unable to routinely access physician or Nurse Practitioner appointments. Through strategic collaboration with physician partners, SCFHT established dedicated appointment capacity across physician and Nurse Practitioner practices, enabling unattached patients to receive comprehensive, longitudinal primary care.

Patients now have improved access to routine medical assessments, chronic disease management, preventative care, medication renewals, and specialist referrals when required. This expansion significantly improved continuity of care, reduced barriers to accessing services, and advanced SCFHT's commitment to equitable, patient-centred healthcare for all residents of the region.



Priority Two: Recruitment & Retention

Recruitment and retention strategies | Health human resource planning | Wage parity advocacy | Staff engagement and workplace wellness

Recruitment, retention, and staff engagement remained key organizational priorities throughout the 2025–2026 fiscal year. Building on the success of the balanced workweek initiative and ongoing health human resource planning, SCFHT continued to foster an innovative, flexible, and supportive workplace while advocating for wage parity across the healthcare sector.

The effectiveness of these strategies was demonstrated during the organization's role with the Rural Generalist Council and a significant expansion on April 1, 2025. SCFHT successfully recruited and onboarded an additional 20.25 full-time equivalent (FTE) positions, allowing the organization to substantially stabilize primary care capacity while maintaining high standards of patient care.

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As a result, SCFHT entered this period of growth with a stable, engaged workforce capable of supporting expanded services and increased patient access. The organization remains committed to investing in innovative recruitment and retention initiatives to ensure a sustainable workforce that can meet the evolving healthcare needs of the communities it serves.

Priority Three: Community Engagement



Increase community awareness of SCFHT programs and services | Improve understanding of the roles of the SCFHT

Community engagement was a major focus throughout the 2025–2026 fiscal year as SCFHT implemented significant changes to improve access to care. Recognizing the importance of clear and consistent communication, the organization developed a comprehensive outreach strategy to ensure residents understood the expanded services available, how to access care, and the evolving role of SCFHT in delivering interprofessional primary care.

Attention was given to educating individuals who had historically lacked access to a primary care provider. Through targeted social media campaigns, public education initiatives, community presentations, and local media, SCFHT informed residents about new opportunities to receive comprehensive primary care as unattached patients and how to connect with appropriate programs and providers.

Staff also participated in community events, including farmers' markets and job fairs, providing opportunities to engage directly with residents, answer questions, and promote available services. These efforts increased public awareness of SCFHT's role within the local healthcare system and contributed to measurable growth in self-referrals, program inquiries, and community engagement.



Priority Four: The Fundamentals

Review organizational values and operating principles | Improve internal communication | Enhance centralized administrative supports | Improve technology utilization and technical support | Advance the vision of one community health record

During the 2025–2026 fiscal year, SCFHT continued to strengthen its operational foundation by advancing digital infrastructure, improving internal processes, and leveraging technology to enhance patient care.

Key accomplishments included continued implementation of the Ocean eReferral Network, expansion of online appointment booking, increased use of secure patient messaging, and enhanced appointment reminder systems utilizing both email and text messaging. These initiatives improved communication with patients while supporting appointment attendance and overall patient engagement.

SCFHT also began exploring the responsible use of emerging technologies, including artificial intelligence, to improve administrative efficiency, streamline workflows, and reduce workload pressures for both clinical and administrative staff. Planning continued for additional electronic medical record (EMR) enhancements and greater integration with partner healthcare organizations to improve information sharing and coordinated care. Significant efforts were also directed toward EMR data cleanup and standardization, improving the accuracy, consistency, and usability of clinical information to support quality improvement initiatives and better care coordination.

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Collectively, these initiatives strengthened organizational operations, enhanced internal communication, and reinforced SCFHT's commitment to delivering high-quality, technology-enabled, patient-centred care.



Priority Five: Health System Guidance

Evaluation of SCFHT's role in existing and emerging partnership initiatives | Strengthen collaboration between primary care service providers across the All Nations Health Partners | Improve coordination and access to care for patients with complex care needs

Throughout the 2025–2026 fiscal year, SCFHT continued to strengthen its leadership role in helping patients navigate an increasingly complex healthcare system through enhanced care coordination, interdisciplinary collaboration, and strategic partnerships.

A major area of focus was the continued development of the SCFHT Memory Clinic Program. Efforts centred on improving interdisciplinary communication and implementing a designated contact person model, providing patients and families with a consistent point of contact to improve continuity of care, system navigation, and access to appropriate supports.

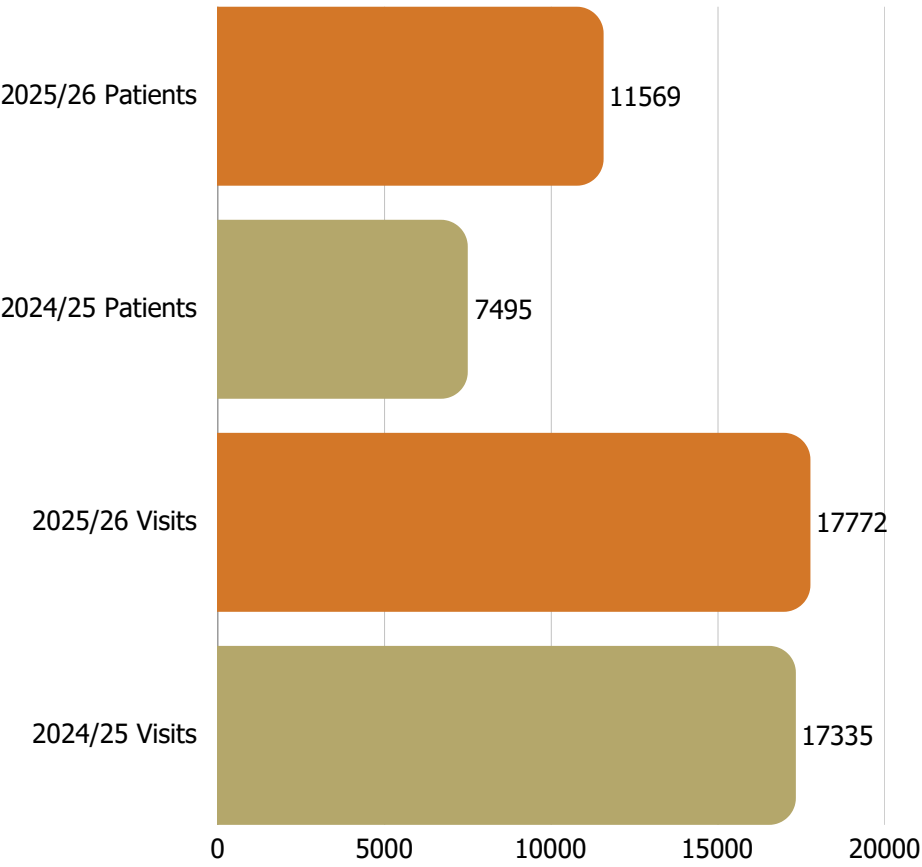
SCFHT also strengthened partnerships with healthcare providers and community organizations to improve care coordination for patients with complex health needs. Collaboration with the Palliative Care Clinical Coach expanded opportunities for shared learning and enhanced the organization's capacity to support patients with Advance Care Planning, ensuring individuals and families receive timely information and guidance when making important healthcare decisions.

Recognizing the growing need for integrated mental health services within primary care, SCFHT continued investing in workforce development. During the year, the Community Health Worker pursued a Master of Arts in Counselling Psychology, with the goal of introducing psychotherapy services in 2026 following completion of the program.

Together, these initiatives demonstrate SCFHT's commitment to improving patient navigation, strengthening partnerships across the healthcare system, and delivering coordinated, person-centred care that supports patients throughout their healthcare journey.



ACUTE AND EPISODIC CARE



What is the program?

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

What can we help with?

- Education, assessment and support to patients with an acute or episodic illness, a pending operation, or questions around immunizations or disease prevention
- Provision of core primary care services in response to an episodic illness or chronic conditions. Services may include, but are not limited to, wound care, suture removal, immunizations, pre-op, periodic health exam, well baby checks and patient education, health promotion, and disease prevention

Program Goals

	2024 - 2025	2025 - 2026
15,000 visits offered. Office visits, emails, home visit, community / hospital, virtual visits	15,174 office visits 2,037 phone visits 72 email contacts 0 home visits 33 community / hospital 29 virtual visits	15,432 office visits 2,042 phone visits 196 email contacts 0 home visits 96 community / hospital 5 virtual visits
40% of appointments are same day or next day	32.52%	38.37%
Patients attached to an NP for longitudinal care	N/A	85



ASTHMA MANAGEMENT

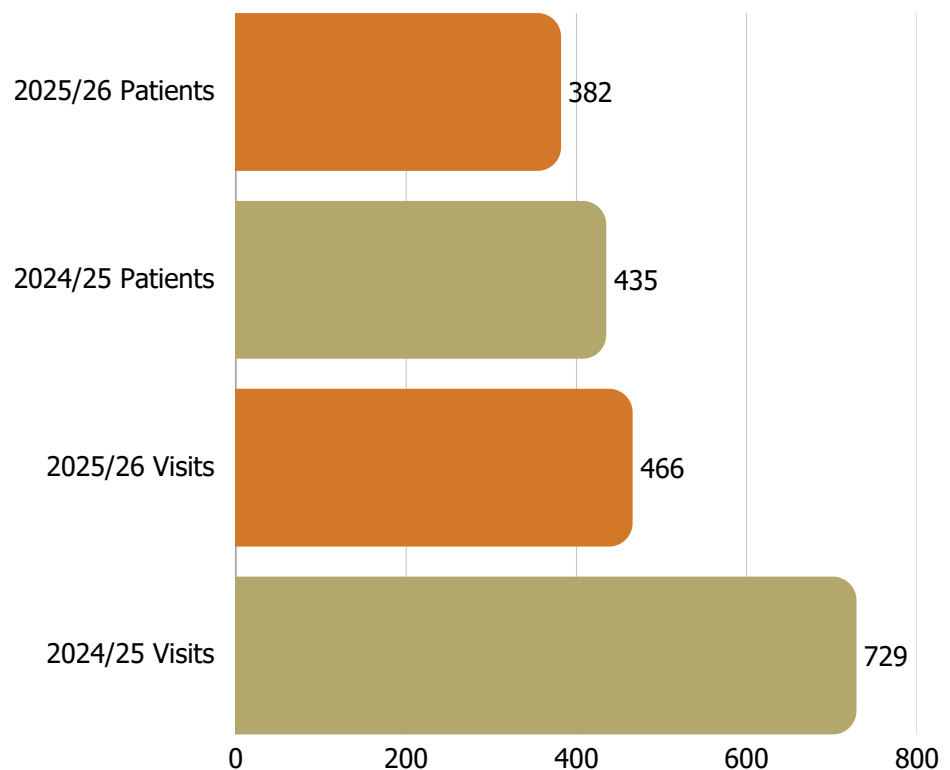


What is the program?

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

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

2024 - 2025

2025 - 2026

95% of Asthma / COPD patients seen in the program will have a **spirometry confirmed diagnosis**

96.48%

95.20%

85% of current patients in the program who smoke have received a **smoking cessation intervention**

79.54%

80.72%

75% of COPD patients have received **flu*** and **pneumovax** vaccines**

45.54%*

79.81%**

61.32%*

83.02%**

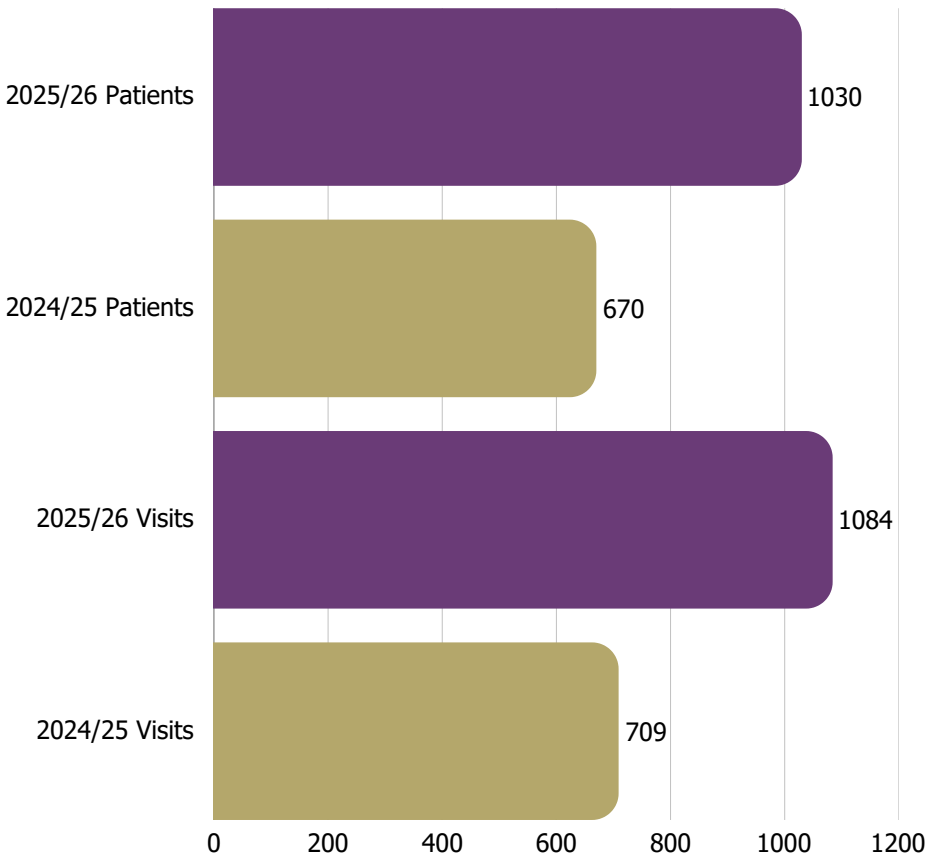
75% of patients in the Asthma / COPD Program have received their **Covid-19 vaccine**

71.03%

65.99%



CANCER SCREENING



What is the program?

The Cancer Screening Program maintains & improves the rates of cancer screening of eligible patients according to current evidence-based clinical practice guidelines.

What can we help with?

- Prevention and early detection of cervical, breast, and colorectal cancer to eligible patients according to Ontario Cancer Care screening guidelines.
- Provide information and support for how to access and book cancer screening testing

Program Goals	2024 - 2025	2025 - 2026
65% of eligible patients screened for cervical cancer within the recommended timelines	EMR: 58.6% SAR: 62.2%	EMR: 50.6% SAR: N/A
65% of eligible patients screened for breast cancer within the recommended timelines	EMR: 57.9% SAR: 62.5%	EMR: 49.6% SAR: N/A
68% of eligible patients screened for colorectal cancer within the recommended timelines	EMR: 59.7% SAR: 66.7%	EMR: 56.3% SAR: N/A



HEALTH SYSTEM NAVIGATION

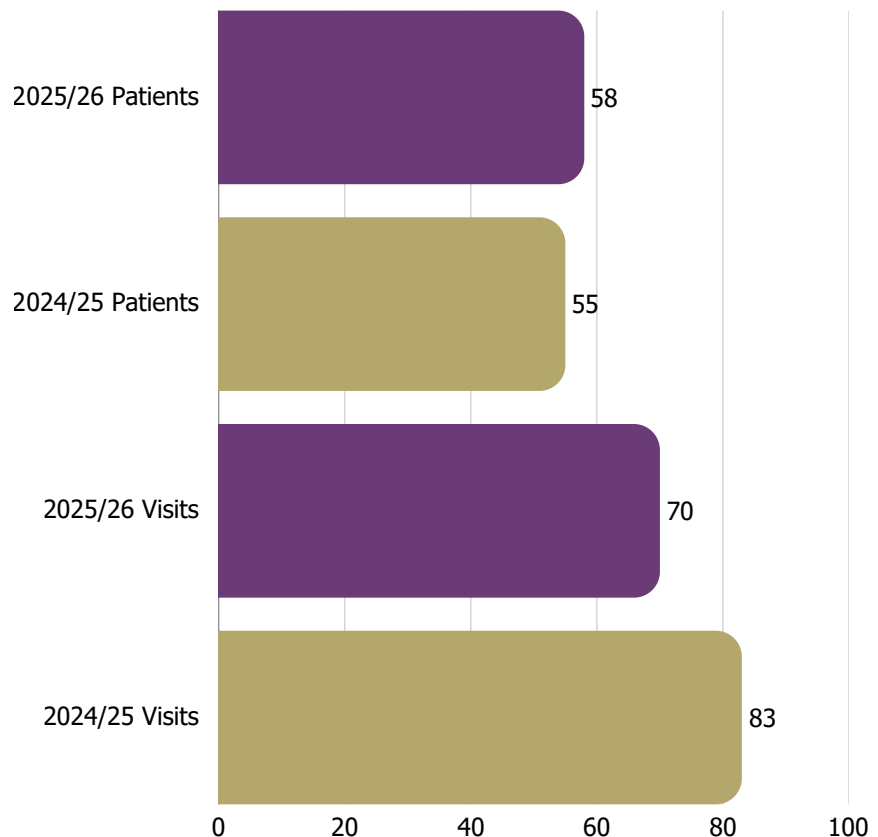


What is the program?

The Community Health Worker (CHW) Program assists patients and caregivers in navigating our local healthcare system.

What can we help with?

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



Program Goals

2024 - 2025

2025 - 2026

Collect baseline on unique patients accessing CHW (attached and unattached)

59 unique patients
52 attached
5 unattached

59 unique patients
49 attached
10 unattached

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

83 patient encounters;
52 phone
30 office
1 home
2 service, no encounter

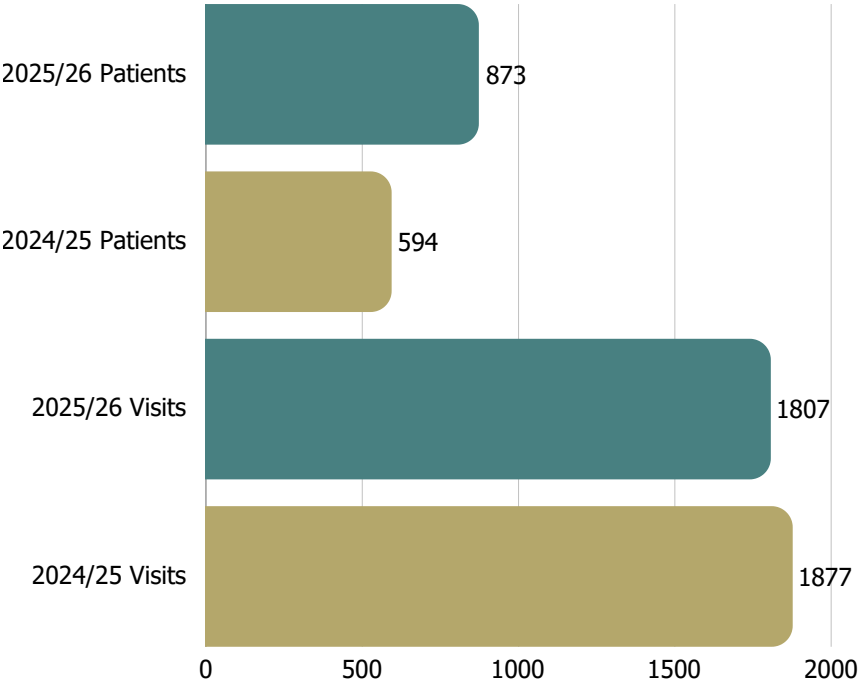
71 patient encounters;
10 health forms
37 navigation visits
19 coordination visits
5 service, not recorded

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

42 connections / referrals to other agencies

34 connections / referrals to other agencies

DIABETES MANAGEMENT



What is the program?

The 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	2024 - 2025	2025 - 2026
90% of patients with Type 1 or Type 2 diabetes who recieved an A1c within the last year	96.82%	96.20%
80% of patients in the program will have their blood pressure measured within the last six months	78.62%	90.56%
60% of patients with Type 1 or Type 2 diabetes with a validated foot screen performed in the last year	38.88%	51.54%
60% of patients with Type 1 or Type 2 diabetes with a retinal exam performed within the last two years	45.23%	41.05%
100% of patients setting a SMART goal within the last 6 months	69.2%	70.30%



FOOT CARE

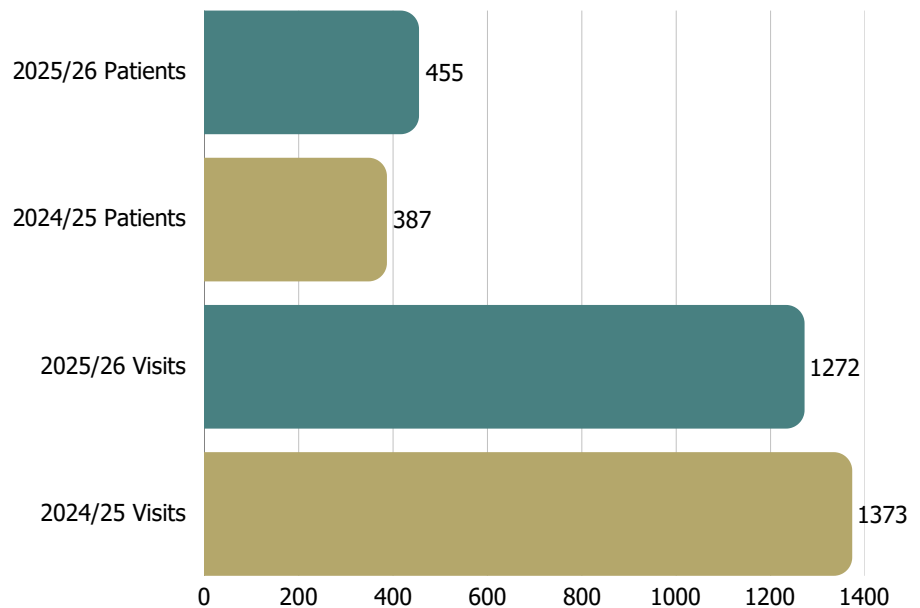


What is the program?

The 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

2024 - 2025

2025 - 2026

95% of patients with diabetes with a **60 second foot screen** performed **within the last 1 year**

91.21%

78.36%

95% of patients with a **chronic problem whose condition is under control** at their most recent follow-up visit

90.16%

89.08%

Baseline on number of **patients eligible for Onyfix** treatment and success rate

127 eligible patients

118 eligible patients

75% of follow up patients reporting less discomfort since treatment started

58.49%

59.09%

75% of follow up patients where provider reports nail management has improved

52.83%

50%

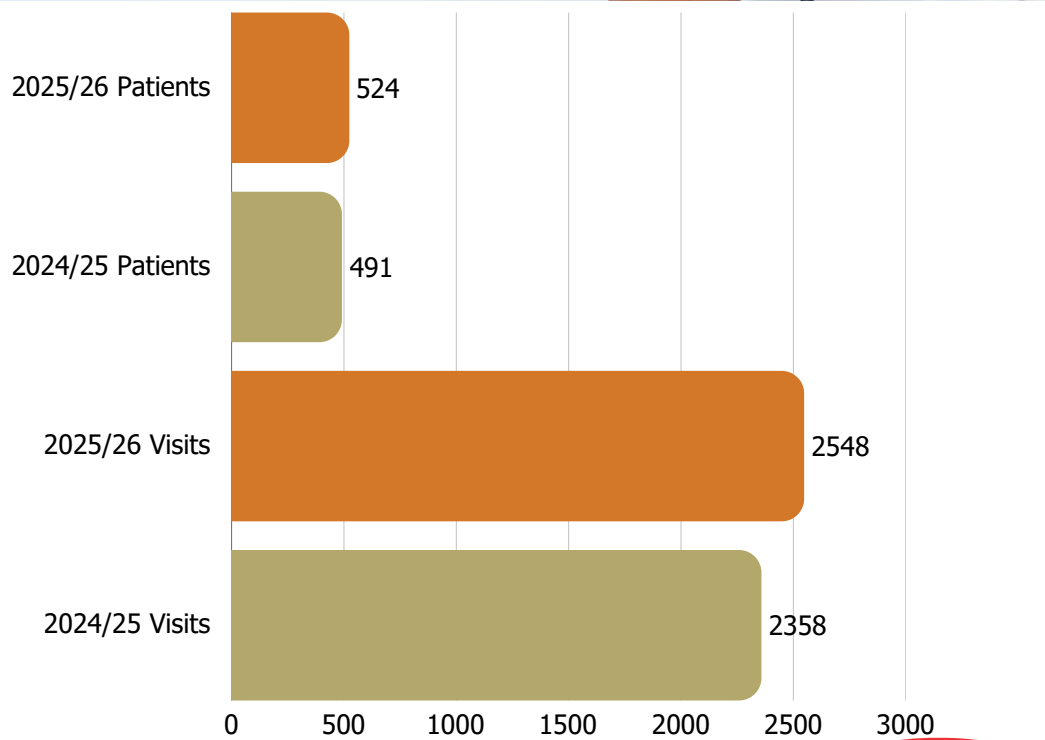
Baseline / % of patients reporting they are satisfied with treatment at the treatments end.

21 patients

57.14%



HYPERTENSION



Program Goals	2024 - 2025	2025 - 2026
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65% of patients in the program to have improved BP readings to target after 3 months	58.96%	66.86%
80% of patients set a lifestyle goal after 3 months	91.79%	89.71%
Baseline on number of patients with HTN with a Registered Dietician visit as part of their care.	20.60%	12.70%
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	8 patients referred to pharmacist

What is the program?

The Hypertension Program provides education and support to patients living with high blood pressure (BP).

What can we help with?

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



NEW

HEART FAILURE CLINIC

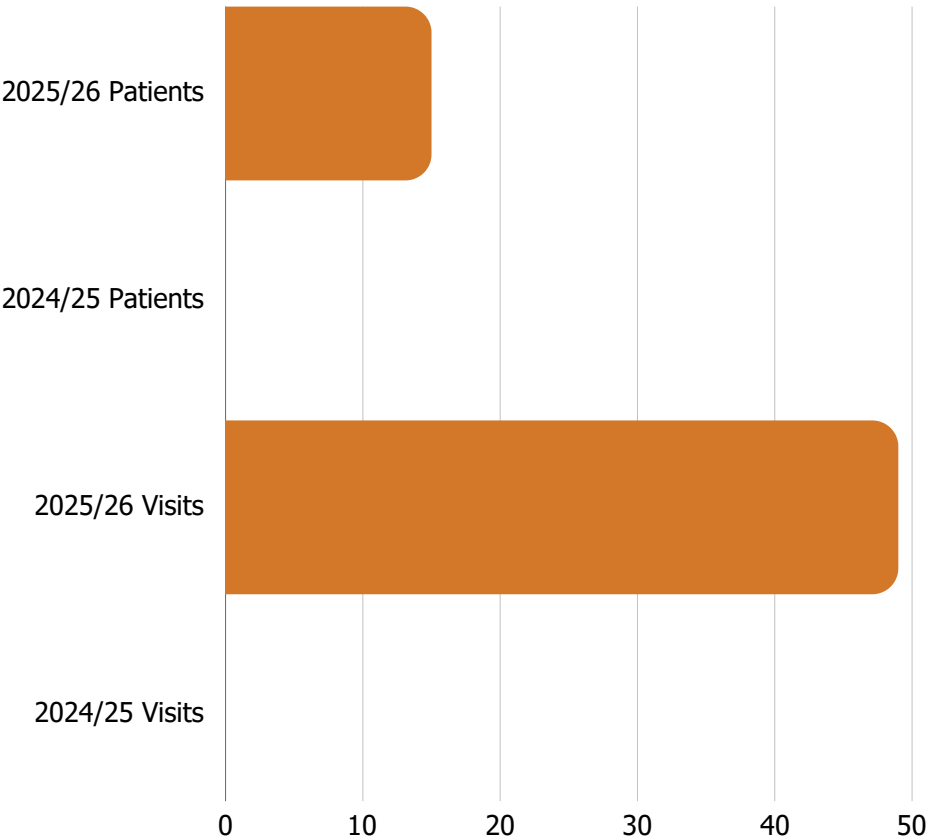


What is the program?

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.

What can we help with?

- Improve equitable access to heart failure health care close to home
- Access for all patients with heart failure, who would benefit from a interdisciplinary approach



Program Goals

2024 - 2025

2025 - 2026

New: Collect baseline on patient encounters including in-office, virtual and intake only

27 encounters

New: Collect baseline on number of visits including in-office and phone contacts

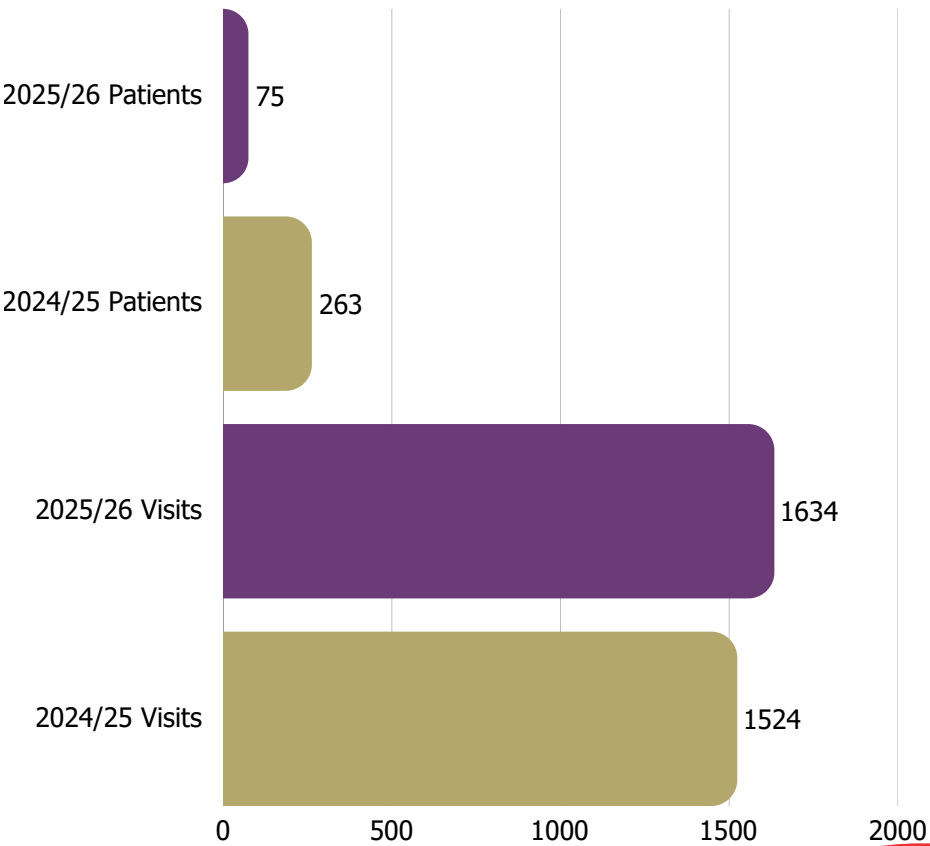
49 visits

New: Collect baseline on number of community exercise program sessions held

2 8-week program sessions held



INR



What is the program?

The 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	2024 - 2025	2025 - 2026
70% of point of care INR tests in range	71.07%	66.78%
<2% of patients in the INR program with a recent stroke event	0.0%	5.30%
<2% of patients in the INR program with a recent major bleeding event (requiring ER visit or hospitalisation)	2.7%	9.30%
New: % of patients with a bleed who were in range at their most recent visit	---	85.70%



LACTATION CONSULTATION

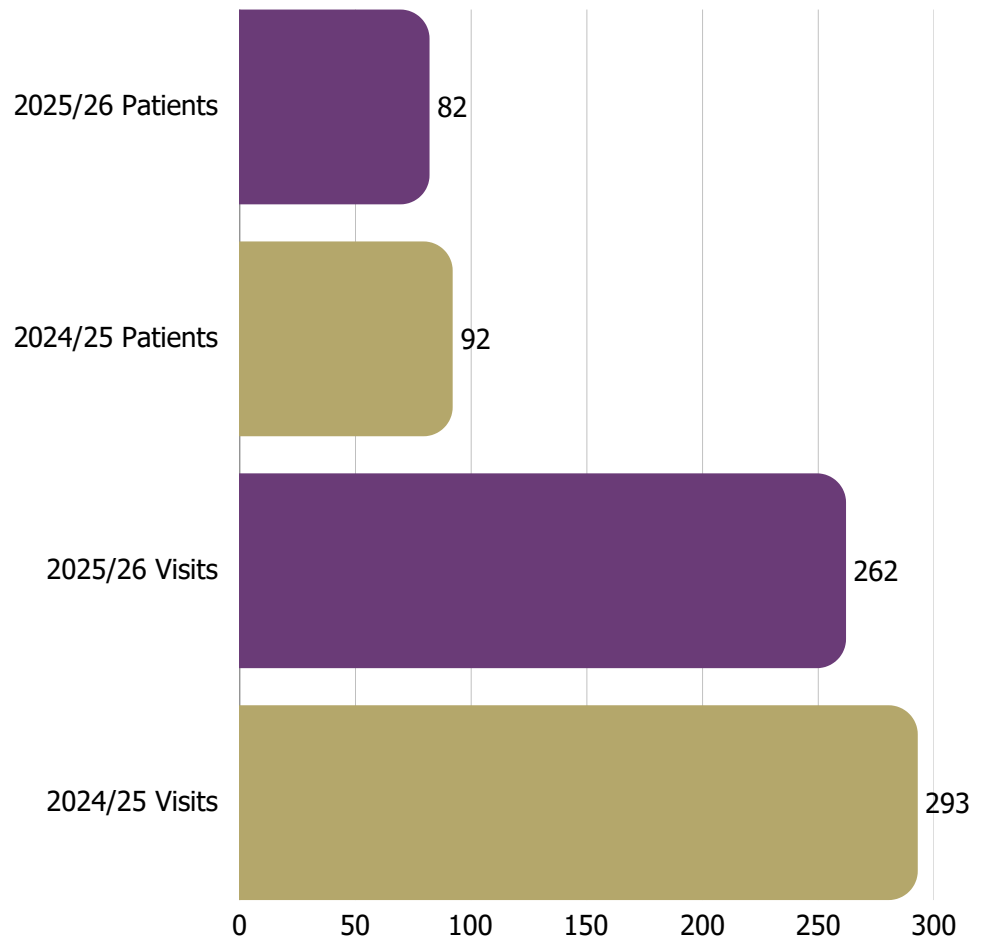


What is the program?

The 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

2024 - 2025

2025 - 2026

Family Visits to the program

293 visits

262 visits

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

48 referrals from Kenora/Keewatin
12 referrals from outside of Kenora
4 referrals not recorded

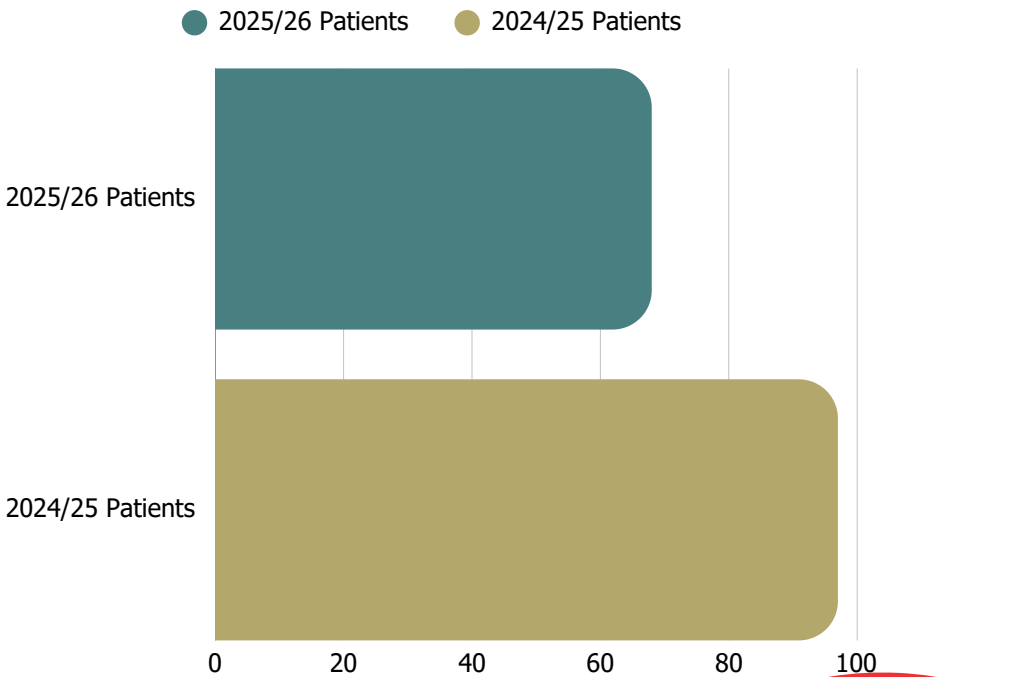
75% of patients who feel confident with the knowledge provided at their appointment to accomplish their breastfeeding plan

68.13% indicated increased confidence

80.65% indicated increased confidence



MEMORY CLINIC



Program Goals	2024 - 2025	2025 - 2026
80% patient/caregivers who report increased understanding about their condition	95%	86.96%
80% of patients are contacted after 4 weeks (14-45 days) 60% understand their care plan recommendations	75.14% contacted 88.67% understand	36.51% contacted 86.96% understand
70% of patients who have implemented 1 or more care plan recommendation(s) at their MC follow up visit	81.81% implemented	76.47% implemented
65% of patients without an ACP and POA will have education at their initial visit; 65% without ACP & POA at their initial visit will have them completed by their follow up visit	92.60% initial ACP 78.94% initial POA 75.75% follow up POA 45.45% follow up ACP	86.05% initial ACP 100% initial POA 71.43% follow up POA 23.81% follow up ACP
75% of patients with medications successfully deprescribed/adjusted at their follow up visit	75.75%	61.54%

Program Goals	2024 - 2025	2025 - 2026
80% patient/caregivers who report increased understanding about their condition	95%	86.96%
80% of patients are contacted after 4 weeks (14-45 days) 60% understand their care plan recommendations	75.14% contacted 88.67% understand	36.51% contacted 86.96% understand
70% of patients who have implemented 1 or more care plan recommendation(s) at their MC follow up visit	81.81% implemented	76.47% implemented
65% of patients without an ACP and POA will have education at their initial visit; 65% without ACP & POA at their initial visit will have them completed by their follow up visit	92.60% initial ACP 78.94% initial POA 75.75% follow up POA 45.45% follow up ACP	86.05% initial ACP 100% initial POA 71.43% follow up POA 23.81% follow up ACP
75% of patients with medications successfully deprescribed/adjusted at their follow up visit	75.75%	61.54%

What is the program?

The 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

Legend:

- Memory Clinic = MC
- Advance Care Planning = ACP
- Power of Attorney = POA



OBESITY MANAGEMENT

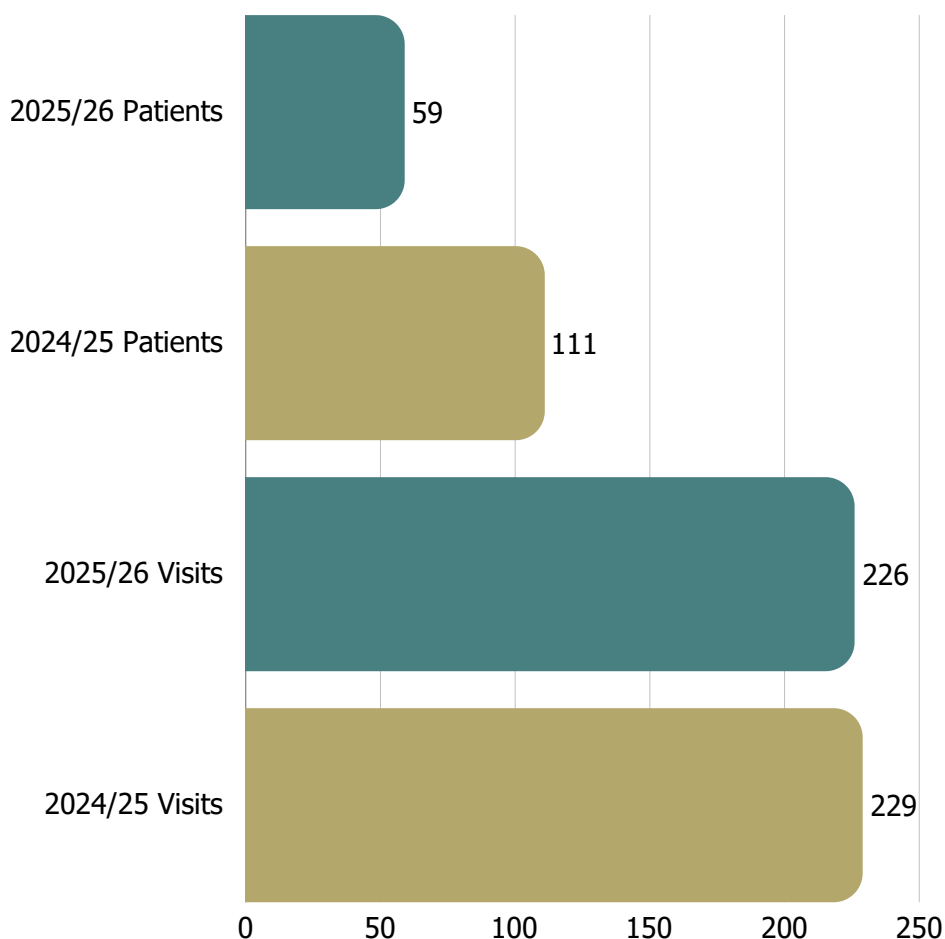


What is the program?

The Obesity Management Program provides patient centered, accessible evidence-based care to increase self-management capacity, confidence and overall quality of life for those living with obesity, according to the best practice as outlined by the 2020 Canadian Obesity Guidelines.

What can we help with?

- Provides relevant education and resources to support management of obesity
- Aiming to improve quality of life and reducing obesity related complications



Program Goals

2024 - 2025

2025 - 2026

80% of patients with SMART goals discussed and documented

87.10%

89.83%

80% of patients with an initial program visit less than 4 weeks after the initial referral

48.65%

66.67%

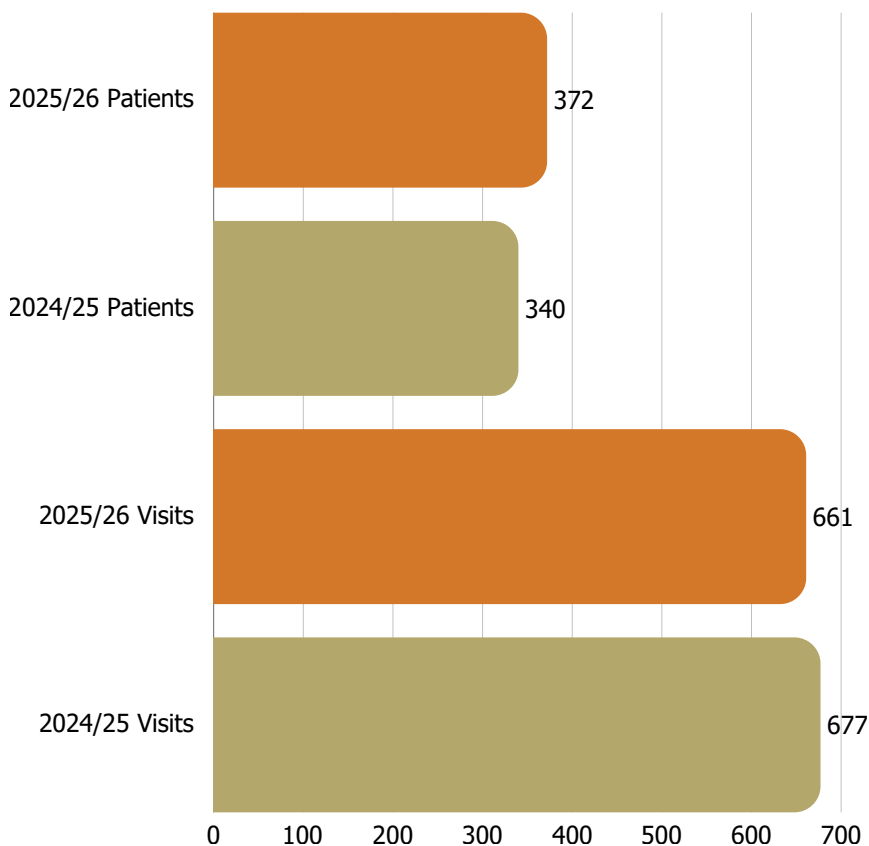
80% of patients reporting improved knowledge and confidence in managing their obesity

80.65%

88.14%



NUTRITION COUNSELLING



What is the program?

The 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

2024 - 2025

2025 - 2026

85% of follow up patients will have achieved their **most recent SMART goal**

67.86%

68.84%

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

93.55%

94.74%

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 workshop ran,
8 sessions completed
25 attendances



OCCUPATIONAL THERAPY

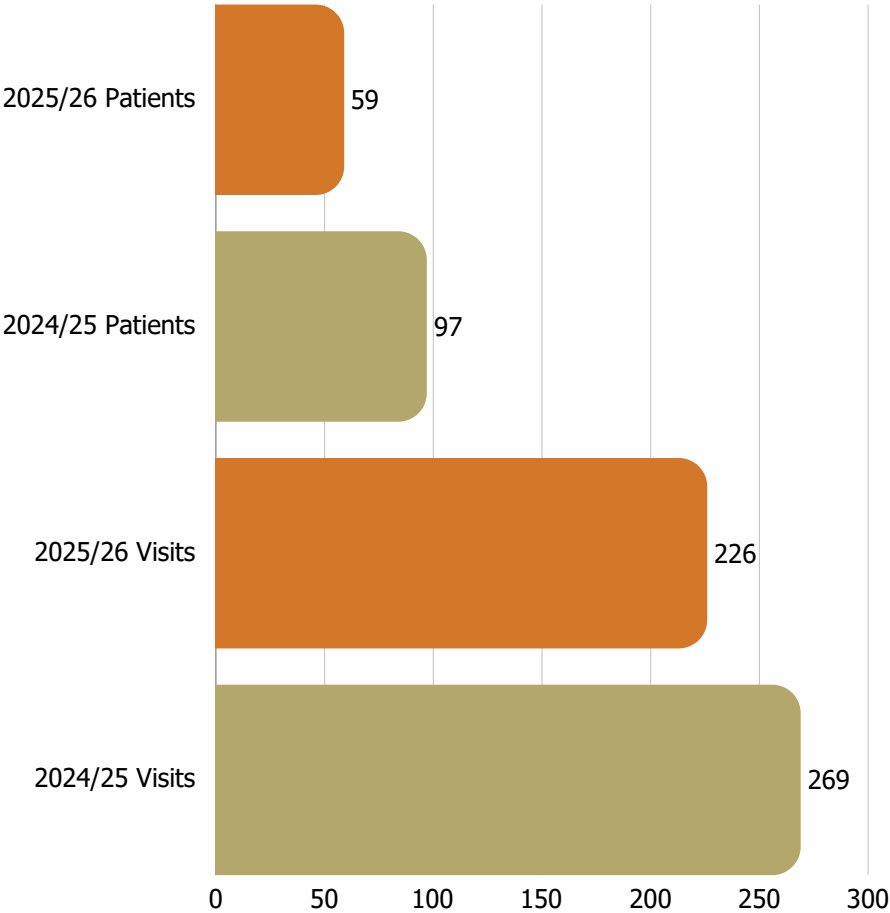


What is the program?

The 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

2024 - 2025

2025 - 2026

90% of home OT assessments with completed **Home Safety**

89.47%

90%

80% of patients ages 65+ have a **completed falls assessment**

74.35%

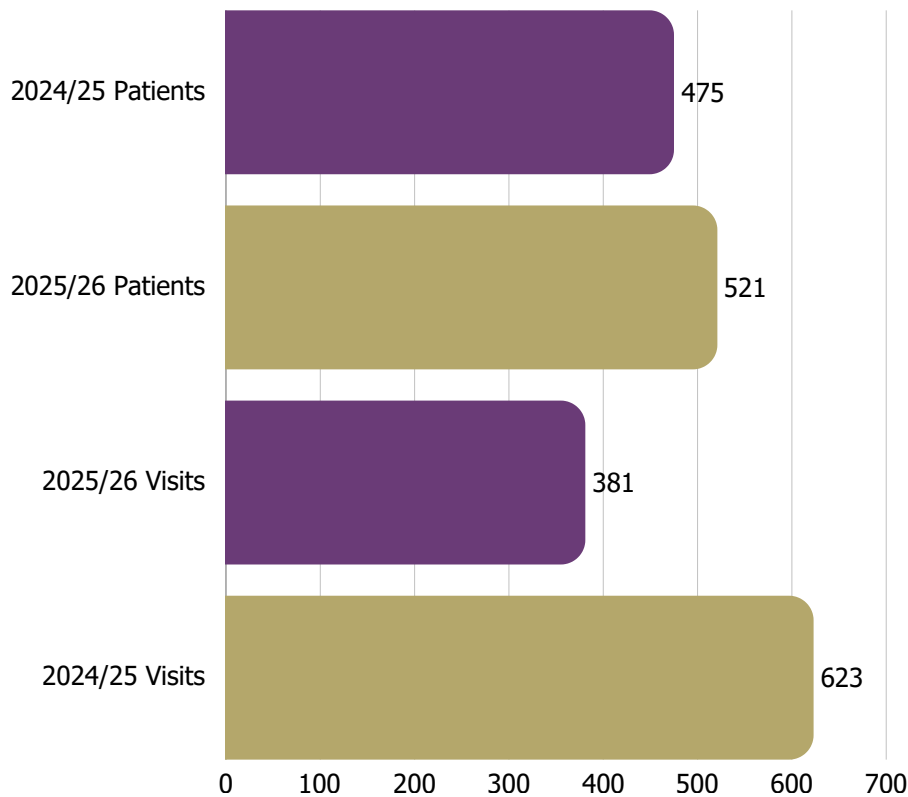
81%

1-2 cognitive stimulation therapy workshops in the year. (7 bi-weekly sessions for each workshop)

3 workshops
22 sessions
46 attendances

2 workshops
14 sessions
33 attendances

PHARMACIST SERVICES



What is the program?

The 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

2025 - 2026

Baseline number of patients diverted from the emergency room for a minor ailment or COVID assessment

10

1

Baseline percentage of identified drug therapy problems (DTPs) resolved within 1 month

86.72%

87.74%

Collect baseline number of drug information and drug navigation/coverage requests addressed

61 Drug navigation
73 Drug information

73 Drug navigation
41 Drug information

Collect baseline # of visits for:

Medication reviews

53 medication reviews

97 medication reviews

Medication updates in the EMR

221 medication updates

287 medication updates

12 medication reconciliations

13 medication reconciliations

Patients assessed for a minor ailment or COVID assessment

38

35



PHYSIOTHERAPY AND REHABILITATION

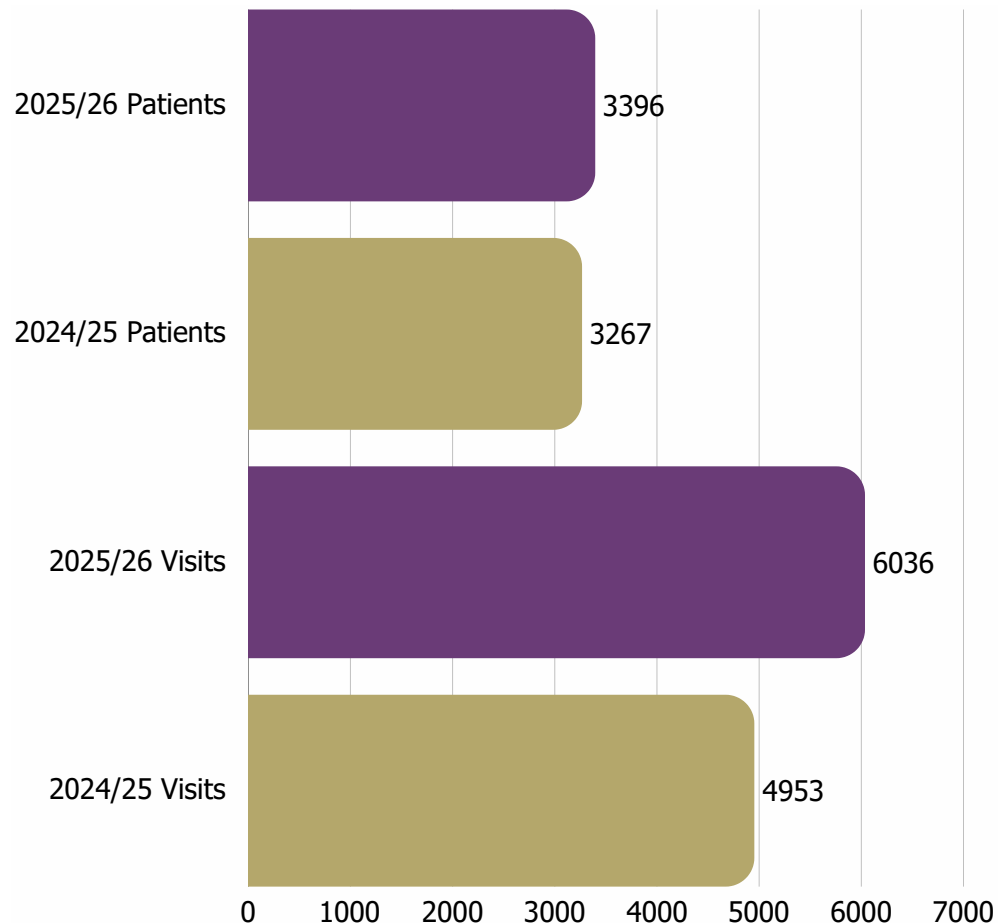


What is the program?

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 (PT) 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.

Program Objectives

- 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



Program Goals

2024 - 2025

2025 - 2026

Referrals for conditions best served by Physiotherapist

1,119

1,014

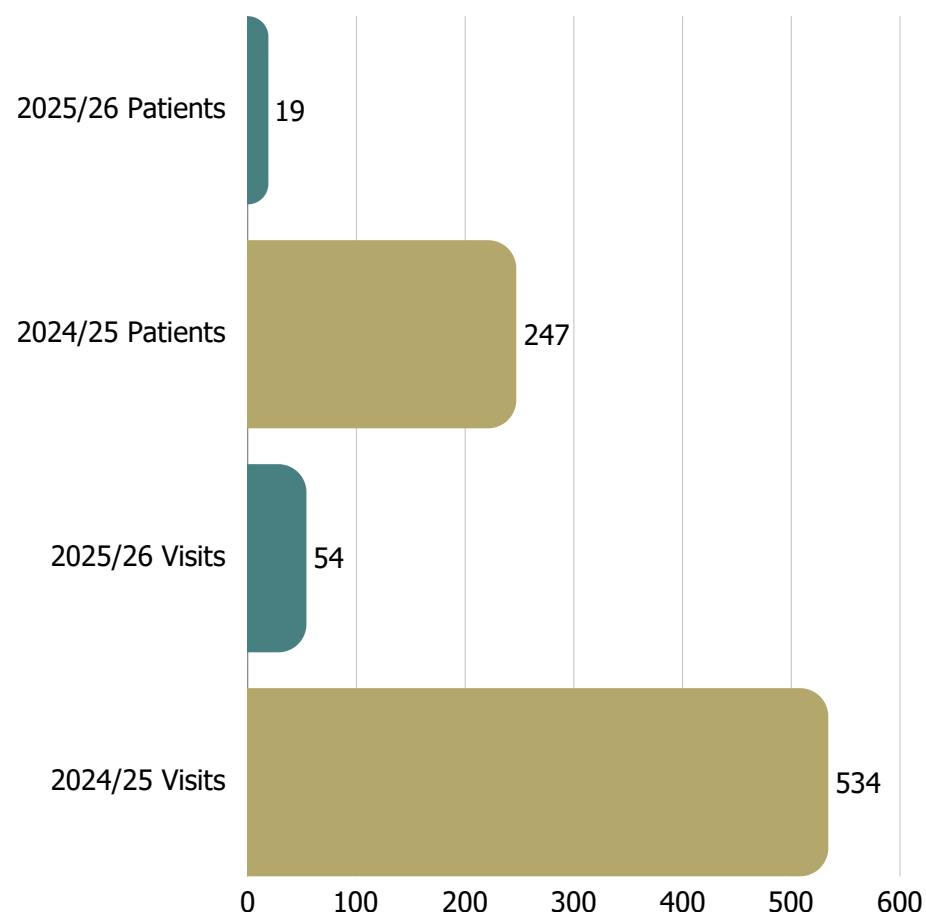
New: Number of referrals awaiting appointments

352



SMOKING CESSATION

Embedded in programs throughout the SCFHT



Program Objectives

Starting 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 programs.

Smoking Cessation Resources

- We encourage eligible patients to utilize STOP on the NET (SOTN) when possible through the SOTN website: <https://intrepidlab.ca/en/stop/stop-on-the-net>
- Smokers' Helpline offers help by phone, text, and through an online community forum
- Talk Tobacco is an Indigenous quit smoking and vaping support program which can be accessed online or by phone

Program Goals	2024 - 2025	2025 - 2026
30% of patients in the program who have quit smoking at 6 months	20%	25%
25% of patients in the program who have quit smoking at 12 months	31.3%	15.4%
90% of smoking cessation program patients have smoking status documented in Risk Factors in the EMR	95%	85.77%



PALLIATIVE MODEL OF CARE



What is the program?

This resource focuses on improving access to high-quality palliative care by supporting healthcare organizations, enhancing provider competencies, promoting quality improvement initiatives, and fostering collaboration among healthcare partners.

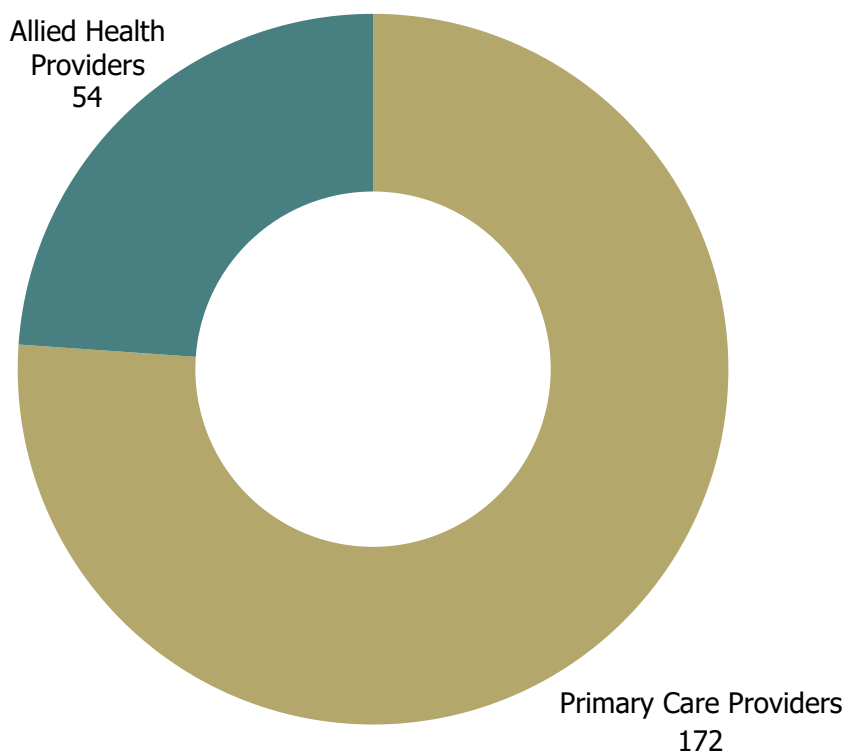
What can we help with?

- Strengthens the delivery of palliative care across community settings by building the knowledge, skills, and confidence of healthcare providers delivering primary-level palliative care
- Prevent and resolve medication-related issues in conjunction with the patient's primary care provider
- The key deliverables are: clinical coaching / mentorship, regional collaboration and system integration, education and capacity building, and quality improvement with clinical support



Number of Educational Training Sessions to Providers

Primary Care Providers Allied Health Providers



Program Goals

2024 - 2025

2025 - 2026

Community events and resources

2 Palliative care expos - **65 attendees**

Number of coaching/case mentoring

Primary care and allied health providers: **10**

Number of presentations to the public

82

Rural Generalist Care Model (RGC)

The Rural Generalist Council (RGC) is an innovative, locally designed healthcare model developed through the collaboration of the All Nations Health Partners (ANHP) Ontario Health Team, physician leaders, Indigenous partners, healthcare organizations, and the Ministry of Health. Created specifically to address the unique healthcare needs of the Kenora region and surrounding communities, the RGC supports a sustainable physician workforce while ensuring residents have access to high-quality primary care, emergency medicine, and other essential physician services.

As a key partner in the RGC, Sunset Country Family Health Team (SCFHT) plays an integral role in supporting implementation of the model by providing administrative and operational infrastructure, advancing physician recruitment and retention initiatives, and expanding access to comprehensive team-based primary care. Working collaboratively with physician partners and ANHP OHT organizations, SCFHT helps create a more coordinated, sustainable, and patient-centred healthcare system.

For residents who do not currently have a primary care provider, the RGC model creates new opportunities to improve access to ongoing primary care closer to home while strengthening continuity of care and reducing barriers to timely healthcare services.

Where Does the Family Health Team Fit in?

Since adopting the Rural Generalist Council (RGC) model, the Sunset Country Family Health Team (SCFHT) has assumed responsibility not only as the employer of all staff working within Kenora's primary care clinics, but also for the day-to-day management of the business operations that were previously administered by individual physician-owned practices.

Under the previous model, physicians were responsible for operating independent medical practices, requiring them to dedicate significant time to human resources, business operations, and other administrative responsibilities. These demands reduced the time available for direct patient care.

Through the RGC model, SCFHT now provides centralized operational leadership and administrative management across the clinics. By consolidating these functions under one organization, physicians are no longer required to manage the complexities of running independent businesses and can instead focus their expertise where it is most valuable: providing high-quality patient care.

This integrated approach has created a more cohesive and collaborative primary care system. Standardized processes, centralized staffing, and shared resources have improved efficiency, strengthened teamwork, and increased consistency across clinic sites. It has also enhanced alignment between Physicians, Nurse Practitioners, Care Teams, and the Health Care Connect (HCC) program, improving coordination of care, supporting physician recruitment and retention, and increasing access and attachment to primary care services for patients throughout the community.

The transition represents a significant shift from independent clinic operations to a unified, team-based model of care, allowing healthcare providers to spend more time caring for patients while ensuring the operational needs of the clinics are managed efficiently and sustainably.

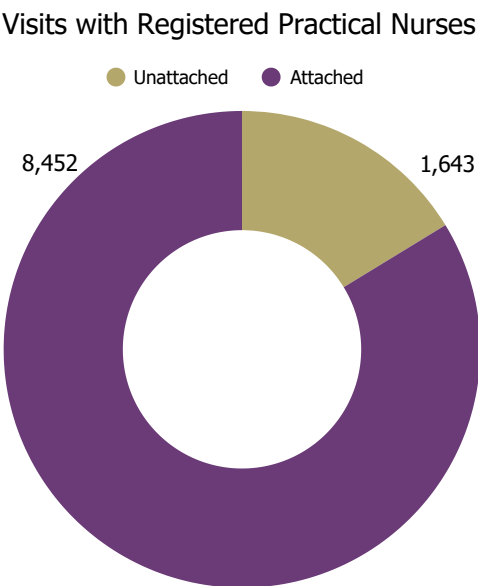
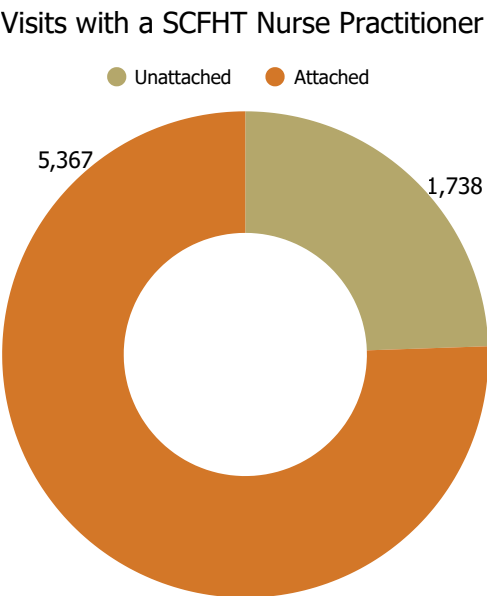
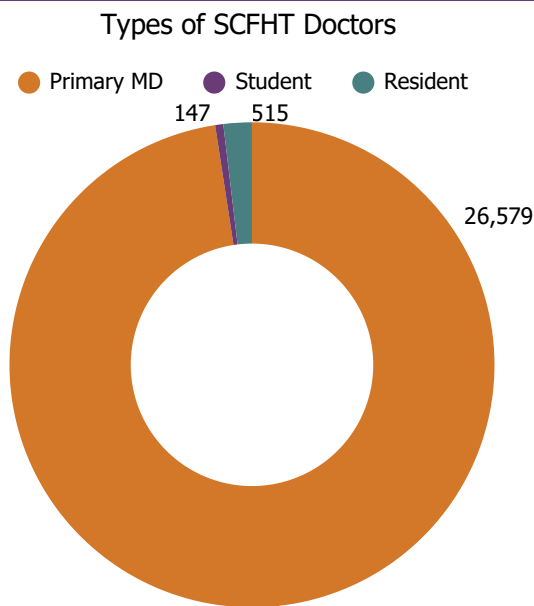
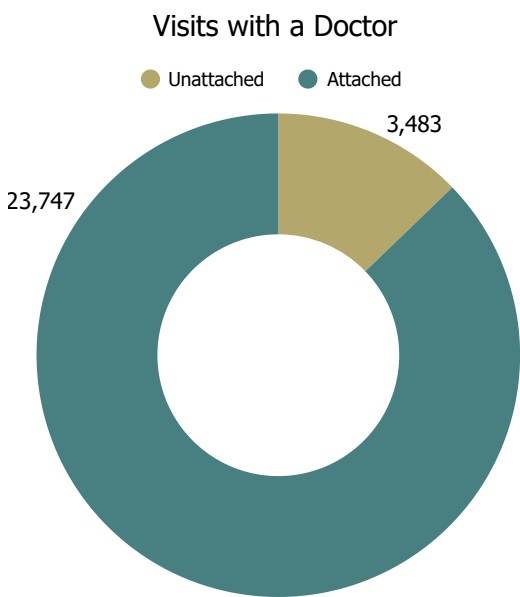
INCREASED ACCESS TO PATIENTS



About Us

The RGC model has enabled SCFHT to create a more integrated, sustainable, and team-based approach to primary care. By bringing physicians, care teams, and operational supports together under one model, we have expanded access to care for both attached and unattached patients.

Increased Access for Patients



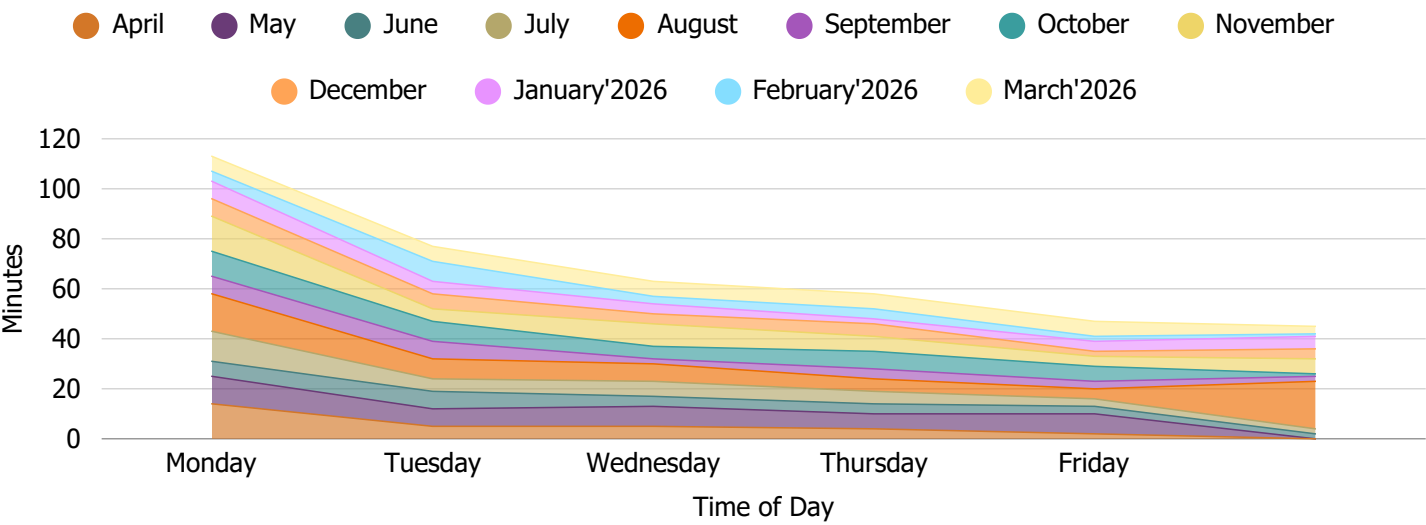
CENTRALIZED CALL CENTRE



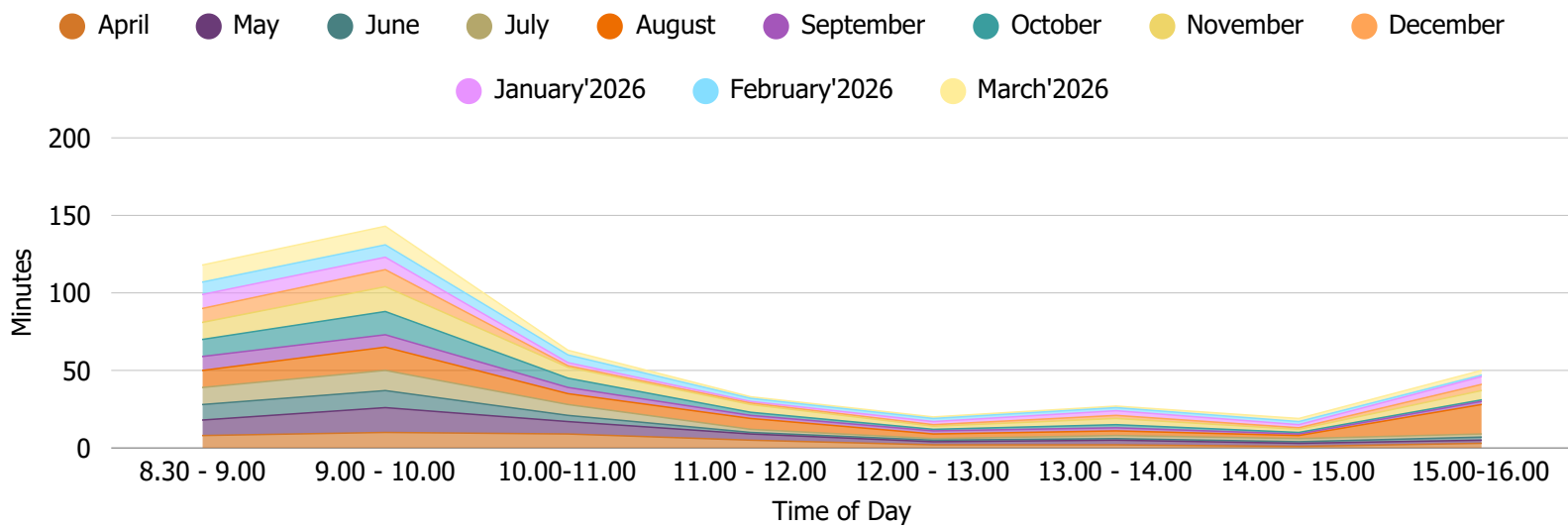
About Us

Every appointment begins with a call, and our Call Centre team makes that connection possible. Managing thousands of calls each week, they help ensure patients receive the right care, from the right provider, at the right time. Our Call Centre is located at the SCFHT Kenora Site, with team members who are connected to our clinics and community. All Call Centre staff are cross-trained in reception services, allowing them to provide seamless coverage across our clinic locations. This flexible staffing model strengthens continuity, supports clinic operations, and helps ensure patients have timely access to care.

Average Call Wait Times per Weekday



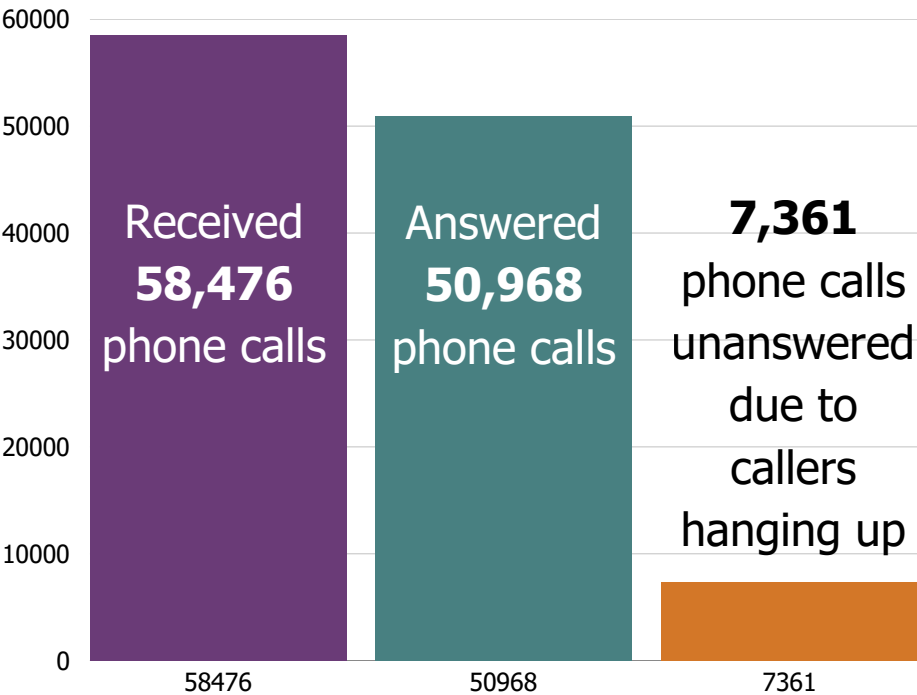
Average Call Wait Times per Hour



CENTRALIZED CALL CENTRE



Yearly Phone Statistics

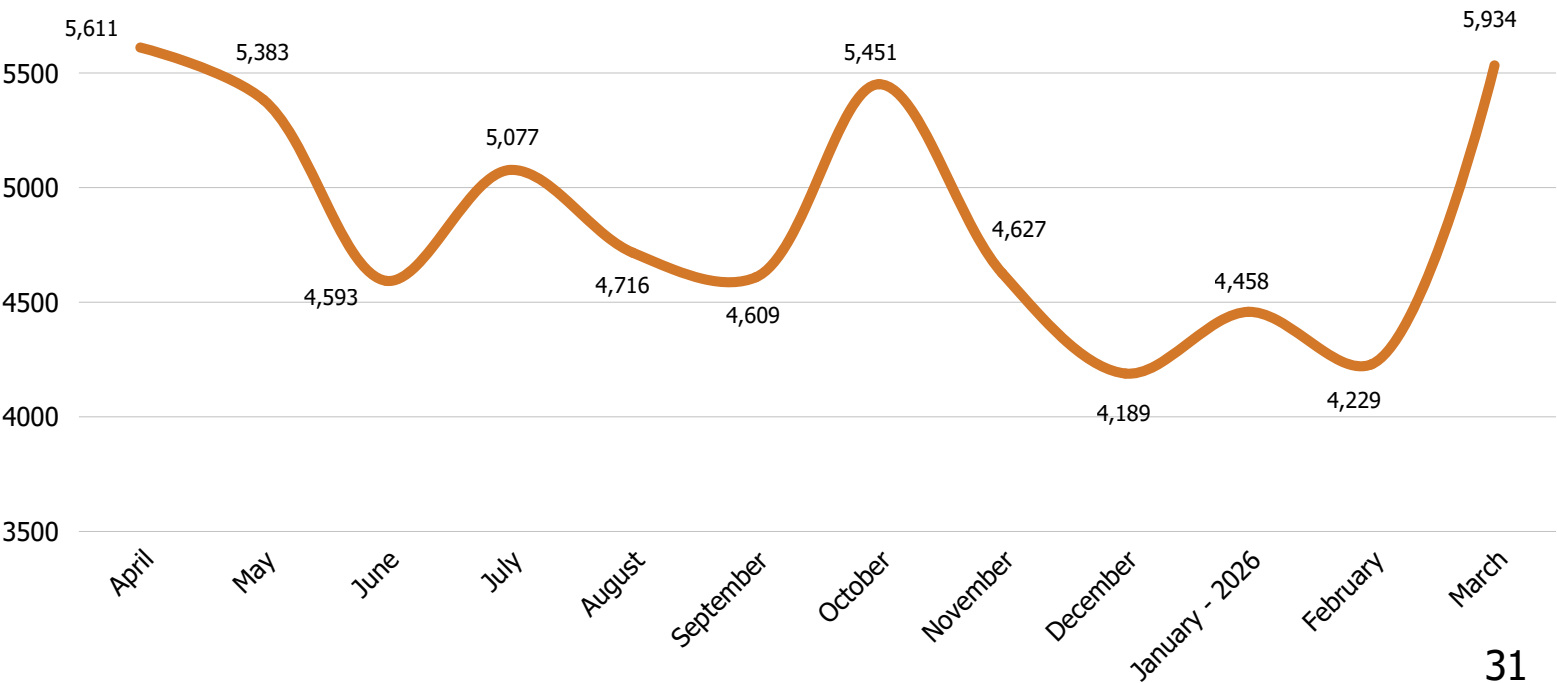


Objectives

To further support our communities medical needs, the SCFHT introduced a centralized call centre.

- This new model was designed to improve availability and reduce wait times
- Our centralized call centre team is trained in specific procedure and booking methodology to ensure accurate and efficient bookings for patients and providers
- By scheduling appointments for all four medical clinics and for patients without a primary care physician, our call centre plays a key role in expanding access to care throughout our community

Monthly breakdown of incoming calls for the 2025-2026 fiscal year



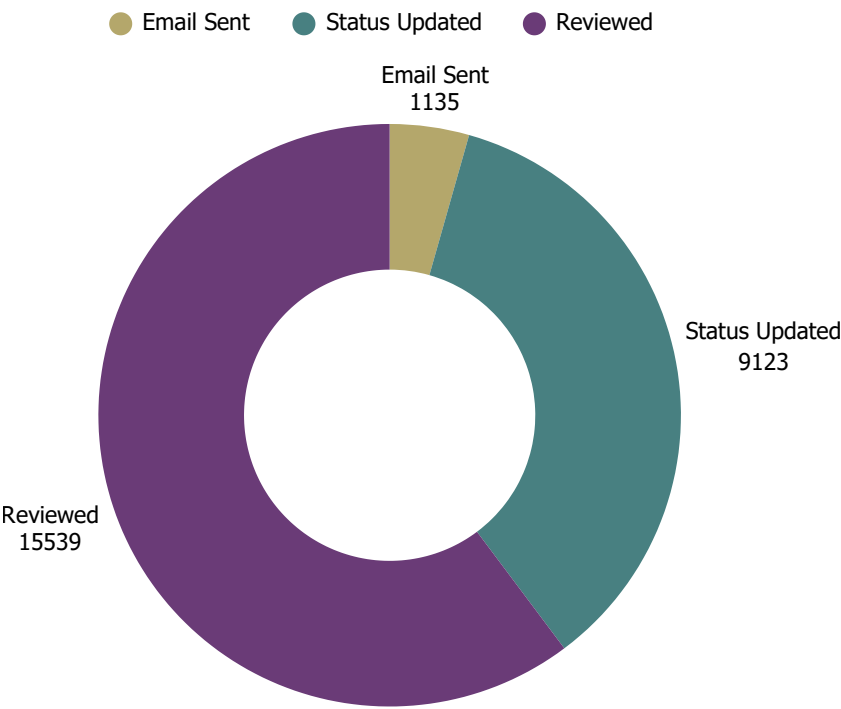


About Us

SCFHT’s Medical Records Department ensures patient information is managed with accuracy, confidentiality, and in accordance with privacy regulations. The team oversees chart updates, information requests, outgoing referrals, and medical record processes across all clinic locations, providing a consistent and coordinated approach to records management. This centralized model was designed to improve efficiency, standardize processes, and ensure patient information is handled with the highest level of care and respect.

Centralized Medical Records

Referral Progress



Our Medical Records department had 4,791 incoming calls in the 2025-2026 fiscal year!

Referral Statistics

Number of attachments sent from a patient’s chart	1,331
Number of forms sent to a patient by Medical Records	188
Number of alterations made to a referral that had required a review	15,447

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



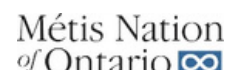
The Sunset Country Family Health Team (SCFHT) continues to play a vital leadership role in advancing the All Nations Health Partners Ontario Health Team (ANHP OHT), contributing to the collaborative work that is transforming the way care is delivered across our region.

Throughout 2025–2026, 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 Council model of care, which was 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.



Privacy Commitment

The Sunset Country Family Health Team (SCFHT), Kenora Chiefs Advisory (KCA), Kenora District Services Board (KDSB), Lake of the Woods Hospital (LWDH), Northwestern Health Unit (NWHU), and Waasegiizhig Nanaandawe'iyewigamig (WNHAC), (hereafter referred to as "the organizations") are committed to protecting the privacy and confidentiality of any personal information we collect from our clients.

The primary purpose for which we collect, use and disclose personal health information is to deliver health care. We may also use and disclose your information for administrative and planning purposes, risk management and quality improvement activities, research, and teaching, to comply with our legal and regulatory requirements, or as otherwise permitted or required by law.

Any personal health information provided to the organizations, 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 organizations' employees are bound by confidentiality and have established policies and practices that 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 organizations, the client has given their consent (permission) to use their information, unless they tell the organizations, otherwise; clients have the right to ask that the organizations 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 organizations will be required to ask for a client's permission to share information, and 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 organizations may collect, use, or share a client's health information without their permission, as permitted or required by law.

Additional Information for KCA, LWDH, SCFHT, or WNHAC

KCA, LWDH, SCFHT and WNHAC are committed to providing patient focused, comprehensive and results-driven health care. Pursuant to this commitment, our systems are designed to enable the efficient sharing of personal health information when required to deliver our health care services. This means that when you visit one of our locations, your health care provider will have access to information relating to the health care services you have received at other locations within our network. We've implemented administrative, technical, and physical measures to safeguard the information you provide us. We restrict access to personal health information on a need-to-know basis to personnel who require access to fulfil their job requirements. We retain personal health information only for as long as necessary to carry out the purposes discussed in this Privacy Commitment or to meet our legal or organizational requirements. Personal health information that forms part of your medical record will be retained in accordance with Provincial retention guidelines.

Clients have the right to request a copy of their health record; the request must be in writing and sent to the respective agency. Questions, concerns, or requests for more information about our privacy policies and practices can be directed to a **Privacy Officer**:

SCFHT	KCA	KDSB	LWDH	NWHU	WNHAC
807-468-6321	807-467-8144	800-461-5766	807-468-9861	807-468-3147	888-699-6422

If, after contacting any of the above organizations 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 or visit the IPC website: www.ipc.on.ca



Statement of Financial Position

March 31	2026	2025
Assets		
Current		
Cash and bank	2,016,649	1,591,558
Account receivable (Note 2)	517,726	131,230
Prepaid expenses	34,381	8,789
	2,568,756	1,731,577
Tangible capital assets (Note 3)	383,282	305,923
	2,952,038	2,037,500
Liabilities		
Current		
Accounts payable and accruals (Note 4)	308,257	291,182
Governments contributions repayable (Note 5)	1,042,287	752,703
Deferred contributions (Note 6)	32,083	-
	1,382,627	1,043,885
Net Assets		
Invested in tangible capital assets	383,282	305,923
Net assets, end of year	1,186,129	687,692
	1,569,411	993,615
	2,952,038	2,037,500

2025 Salary Declaration

Employee	Position	Salary	Benefits
Boyko, Jennifer	Operations Manager	120,415.12	1,162.84
Campbell, Caitlin	Nurse Practitioner	124,772.33	247.16
Evenden, Stephanie	Finance Manager	136,147.20	883.66
	& Acting Executive Director		
Mascotto, Charity	Nurse Practitioner	124,845.76	242.59
Neil, Colleen	Executive Director	261,368.16	1,290.46
	& ANHP OHT Executive Lead		
Rose, Holly	Nurse Practitioner	124,662.16	1,392.39
Sharp, Susan	Pharmacist	99,456.57	1,341.55
Simpkin, Svea	Nurse Practitioner	124,515.32	247.16

Statement of Operations

For the year ended March 31

2026

2025

Revenue

Ontario Health	4,396,064	3,657,417
Ministry of Health - Primary Care Asthma program	57,250	57,250
Family Health Network (salary contribution)	1,648	18,247
Kenora Chiefs Advisory - ANHP OHT	290,390	397,081
Kenora Chiefs Advisory	-	44,100
Kenora Medical Associates	-	28,507
Waasegiizhig Nanaadawe'iyewigamig	-	49,047
Lake of the Woods District Hospital	2,119,139	-
Other	170,689	59,096
	7,035,180	4,310,745

Expenses

Human Resources	4,570,943	3,027,981
Physician consulting	33,000	39,156
Sessionals	53,674	47,265

General Overhead

Advertising	23,596	14,735
Board / staff meetings	10,376	3,871
Communication equipment and materials	50,606	17,854
Consulting	15,000	-
Equipment calibration and cleaning	4,778	500
Interest and bank charges	13,935	1,157
Library materials	-	137
Medical equipment, supplies and waste	167,566	49,353
Membership fees	23,393	10,499
Office equipment and supplies	82,018	22,260
Printing/courier	20,323	6,211
Program Supplies - QIDSS	5,905	5,565

Information Technology

IT hardware/software	25,889	24,612
EMR expenses	168,197	65,541
Equipment lease contracts	6,150	1,542
IT support	69,232	1,000

Ongoing Overhead

Audit fees and other accounting fees	28,708	24,187
Insurances	15,101	17,864
Legal fees	5,909	7,937
Professional development	76,855	40,207
Recruitment and retention	34,398	12,158
Premises - rent	316,753	131,179
Travel	3,671	9,015
Common area maintenance	119,355	58,903
Approved one-time expenditures	78,853	163,399

6,024,184 **3,804,088**

Excess of revenue over expenses before other items

1,010,996 **506,657**
(512,559) (270,607)

Excess of revenue over expenses

498,437 **236,050**



Sunset Country Family Health Team

1-45 Wolsley Street | Kenora, ON | P9N 3W7

T: (807) 468 6321 | F: 1 (844) 212 0817

info@scfht | www.scfht.ca



Cover Art: "Coney Island" 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