Sunset Country Family Health Team

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Quarterly Report
Inspiring a healthier Kenora

Issue 8
November 2019

Q2 Highlights - *July, August, September 2019*

Acute & Episodic Care Program

Program Goal: To provide high quality acute care to FHN patients.
Access: In Q2, 42.36% of NP patients received a same or next day appointment.
Stats: In Q2, 5674 patients were seen by the Sunset Country Family Health Team and 9583 visits were administered by the team under acute episodic care.

Health Promotion and Disease Prevention Program

Program Goal: To increase access to Health Promotion services within the community as part of a comprehensive Primary Care delivery model.
Stats: We hosted the following events in Q2:

- 6 Baby Stop Tent at the Farmers Market (28 moms and babies)
- 1 Prenatal Group Session (8 couples attended)
- 1 Prediabetes Group Session (2 evenings, 8 attendees)
- 1 Bariatric Group sessions (5 attendees)
- 2 Falls Prevention Groups (33 attendees)

Highlight: The Falls Prevention Program was a success, providing valuable information to 33 attendees!

Cancer Screening Program

Program Goal: Maintain or improve rates of cancer screening of eligible FHN patients according to current evidence-based clinical practice guidelines.
Cervical Cancer Screening: 63.64% of our patients are up to date for cervical screening.
Colorectal Cancer Screening: 66.33% of our patients are up to date for colorectal screening.
Breast Cancer Screening: 62.02% of our patients are up to date for breast screening.
Lindsay Kinger has begun the process of becoming a Local Registration Authority for Ehealth. She will soon be able to assist physicians in managing their SAR.
Highlight: Paptastic was a success; Barb and Carol completed 55 paps. In addition, 2 flu shots, 20 Tdap, 3 pneumovax, 7 FIT, 3 mammograms arranged, 3 smoking cessation counselling, STI testing, 3 medication lists reviewed, and bloodwork ordered for 8 patients were completed during pap appointments.

Diabetes Management Program

Program Goal: Provide patient-centered, accessible, evidence-based care with screening, early diagnosis, and treatment of diabetes aimed at preventing or delaying disease progression and complications, according to best practice as outlined by the Diabetes Canada 2018 Clinical Practice Guidelines.

- *Multidisciplinary team approach to education, intervention and clinical management for all community members with diabetes to reduce the burden of diabetes and prediabetes and improve the quality of life of those affected by diabetes.*

Access: In Q2 there were 378 patients seen and 645 visits to the Diabetes Management Program.

Stats:

- 94.97% of patients with Type 1 or Type 2 diabetes who have received an A1c within the last year.
- 92.06% of patients with Type 1 or Type 2 diabetes most recent blood pressure measured within one year.
- 52.29% of patients had a monofilament in the last year.
- 51.59% of patients had a retinal exam in the last year.
- 32.80% of patients setting a SMART goal within the last six months.
- 98.73% of patients with chronic foot issues seen by the foot care nurse had their problem under control at their most recent visit.

Highlight: *Did you know?* People who are living with diabetes mellitus are covered by OHIP for a major eye exam once every 12 months and any follow-up appointments related to the condition.

Hypertension Management Program

Program Goal: Assess patients for hypertension and cardiovascular risk factors, provide education and tools to manage and improve lifestyle and blood pressure.

- *Assessment and monitoring of suspected or diagnosed hypertension using both in office and ambulatory blood pressure monitoring. Provide patients with hypertension ongoing monitoring, education and self-management skills.*
- *Provide screening for suspected hypertension with Ambulatory Blood Pressure Monitor to help in diagnosis of HTN.*

Access: 203 patients were seen by the program in Q4, resulting in 381 patient visits.

Stats:

- 73.29% of patients in the program have improved their blood pressure readings to target after 3 visits.
- 52.46% of initials have a documented med review
- 56.25% of patients with a med review had an update documented in EMR.

Highlight: 73% of patients have reached their target after three visits!

INR Program

Program Goal: To reduce the cost to the healthcare system by providing point-of-care INR testing and minimizing adverse events of warfarin therapy that cause harm and/or hospitalization.

- *Provide ongoing INR monitoring of a patient's warfarin treatment to maintain patients at target range to reduce the risk of adverse events.*
- *Improve clinical efficiency and patient outcomes by using a multidisciplinary approach to monitoring anticoagulant therapy.*

Access: 161 patients were seen by the SCFHT in Q2 resulting in 694 visits.

Stats:

- 70.1% of tests given were within INR target range.
- 0% INR patients experienced a stroke in Q2, keeping us below our 2% target.
- One INR patient experienced a major bleed resulting in an ER visit or hospitalization keeping us below our 2% target.

Highlight: 48 patients were seen over 93 visits. 5 patients were transitioned to DOAC.

Social Work

Program Goal: To improve the overall wellbeing and mental health of patients served by the SCFHT.

Access: 97 patient visits occurred in Q2.

Stats: The Session Rating Scale is a four-item scale survey designed to assess the patient's relationship with their mental health program in terms of respect and understanding, relevancy, client-practitioner fit, and overall alliance. Our Social Work program scored 92.82%.

Highlight: Michael Reid is now the program lead for CAPACITI to enhance patient experience in palliative care. Please direct questions regarding this program to Michael Reid or Dr. Grek.

Lactation Consultation Program

Program Goals:

- Provide individual patient sessions with expectant parents and mother/baby dads for support, education and strategies to establish, maintain or continue exclusive breastfeeding until 6 months.
- Provide expectant and new parents with education and support to exclusively breastfeed to 6 months and beyond.
- To raise awareness in Kenora of the normalcy of breastfeeding in healthy infant nutrition.
- Increase the presence of Baby Friendly initiatives within the Kenora area.
- Provide specialized care to mothers currently breastfeeding and babies experiencing difficulties.

Access: 18 patients were seen in Q2 resulting in 24 patient visits.
Stats: 52.2% of babies seen for lactation in Kenora are still exclusively breastfed at 6 months.
Highlight: The Kenora Baby Friendly Coalition received funding from the Community Foundation to purchase the Pink Tent which as been brought to the farmers market, home show, and other local events. The tent provides chairs, a change table, supplies, and books and toys for older children. This encourages young families to stop and take a break with their little ones. The goal of this program is to promote healthy infant feeding regardless of choice, but also to normalize breastfeeding in the community. This summer there was a great turnout at the farmer's markets with most families reporting that they appreciated a clean and calm place to change and feed their babies while visiting the market.

Asthma & COPD Program

Program Goal: To improve the overall health and wellbeing of individuals with asthma and moderate to severe COPD. To provide Spirometry screening to patients with breathing issues. To provide assessment, education, and support to patients and their families with diagnosis of asthma or COPD.
Access: In Q2 there were 119 patients and 130 patient visits.
Stats:

- 76.92% of patients with confirmed Asthma/COPD have an action plan.
- 81.82% of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention.
    - 25% of the patients offered the STOP Smoking Cessation program have joined.
- 75.0% of COPD patients received a yearly flu shot and 79.17% of COPD patients received a one-time pneumococcal vaccine.

Highlight: *Due to the volume of referrals to this program, wait times can be upwards of two months.*

Chiropody Program

Program Goals:

- To reduce amputations or adverse events related to foot care and manage those patients who already have a condition and prevent further problems and delay disease progression.
- To provide custom foot orthotics to patients who require offloading
- To assess patient's feet, provide preventative footcare and education, and treat existing foot conditions.
- Weekly wound clinic held 1 day/week to assess and treat patients with open wounds, to avert those patients from accessing care in the Emergency Department.
- Interprofessional knowledge sharing
- Establish interagency bi-annual communication for Kenora are footcare providers

Access: In Q2 there were 208 patient visits and 321 office visits at the SCFHT program. In Q2 there were 130 patients and 184 visits to the LWDH Wound Care program.

Stats:

- 87.37% of patient referrals received in Q2 were for high-risk patients.
- 95.24% of patients in the program with wounds have controlled or improved their results.

Foot Care Services

Program Goal: To screen for and treat diabetic foot conditions in order to prevent delay or complications. Initial assessment, patient education, and foot care.

Access: This program started August 28, 2019 and has had 20 patients and 21 visits in Q2.

Stats:

- 84.62% of patients have had a 60 second foot screen within the last year.
- 95% of patients have an action plan who follow up with foot care nurse on an annual basis (19/20).
- 88.24% of patients with chronic problems have their conditions now under control with regular clinic visits.

Highlight: We are pleased to announce that Chris Anderson has joined our foot care team. Chris is located in the NP Clinic and will be seeing FHN patients. Also, a new Chiropody referral tool has been added to your computer notice board and emailed to all doctors and nurse practitioners. This new tool will enable you to refer patients to the correct individual and will cut down on chiropody/foot care visit wait times.

Smoking Cessation

Program Goal: Provide education, ongoing support, and appropriate pharmacotherapy, if needed, to assist patients in becoming smoke-free.

Access: In Q2 there were 84 patients, resulting in 149 patient visits.

Stats:

- 19.0% of patients in the program have quit smoking at 12 months.
- 90.48% of patients in the program have smoking status documented in Risk Factors.

Please continue to document smoking status. In the new EMR, smoking status is found on the toolbar in the patient's chart.

Pharmacist Services

Program Goals:

- To improve patient and provider education about drug therapy and to ensure medications are working effectively and are not negatively impacting the patient's wellbeing.
- To identify and help solve possible medication related problems soon after discharge to help minimize risk of re-admittance to hospital.
- Assist patients in a review of their current medication regimes
- Assist Primary care providers in identifying drug-related problems and identifying potential solutions
- Provide phone follow up to post hospital discharge patients to identify and help to resolve medication problems that can occur in a patient's transition from hospital to home.

Access: There were 99 patients seen in Q2.

Stats: 82.8% of patients in the program had a medication reconciliation process completed.

22 Drug Information requests were completed and 25 hospital discharge medication follow ups were completed.

Highlight: Deprescribing resources can be found at: https://deperscribing.org/

Nutritional Counselling

Program Goals:

- Provide tools and education to help patients improve quality of life and decrease likelihood of developing a chronic disease or to help patients manage the nutritional component of dealing with a chronic disease to decrease possibility of adverse events.
- To improve lipid levels in patients with dyslipidemia to decrease risk of cardiovascular events
- Provision of nutrition and lifestyle education and counselling.

Access: 42 patient visits occurred in Q2.

Stats:

- 61.5% of follow-up patients have achieved their most recent SMART goal.
- 70.0% of dyslipidemia patients who completed a repeat lipid assessment showed improved results 1 year after appointment.

Highlight: Therese is continuing Dyslipidemia Program in Kate's absence and will continue setting up Dyslipidemia Groups. Janet Gilfix, RD will be joining our team two days a week to help improve access to program services.

Memory Clinic

- *A multidisciplinary approach for early diagnosis, treatment and support of problems associated with memory loss. The FHT tem members work collanboratively with phycisians to provide comprehensive care for conditions involving memory loss.*

Program Goal: Optimize access, diagnosis, and care for patients with memory difficulties. Early diagnoses and treatment of memory loss can help to maintain and support cognitive health and quality of life. This can decrease crises and avoidable ER visits and hospitalizations, and delay institutionalization. It will also create capacity at the primary care level to free up specialist resources to focus on the most complex cases.

Access: 23 patients were seen in Q2 resulting in 56 provider contacts.

Stats:

- 100% of patients are satisfied with the service!!
- ***93.3% of patients reported an increased understanding about their condition!***

Highlights: Our Clinical Coordinator, Lindsay Kinger, and Jillian Faulds have joined the Memory Clinic team. Please continue to inform patients at the time of referral that driving concerns will be addressed during their assessment.

OCCUPATIONAL THERAPRY

Program Goals:

- Provide support to improve and maintain daily functioning for patients.
- Decrease unnecessary visits to physicians and LWDH and decrease costs to health care system.

Access: 53 patients were seen in Q2 resulting in 96 patient visits.

Home Visits: 12 home assessments completed.

Falls Assessments: 66.7% of patients over 65 had falls assessments (14/21).

Highlight: Brittan will be attending "Chronic Pain Assessment and Management Best Practice for Occupational Therapists" training in November. She is also now an ADP Authorizer for mobile devices and can assist patients in applying for funding to cover 75% of mobility equipment costs if they are eligible.

Upcoming Events

BARIATRIC SUPPORT GROUP

Cindy Van Belleghem & Kati Heinrich
First Wednesday of Each Month
at 5:00pm
Held in the Conference Room

For anyone who is interested in joining, whether wishing to hear others experiences and learn more about bariatric surgery, those who have had the surgery and wishing to share, and anyone in between.

Did you Know?
Your patients have access to Evening Clinic on Wednesdays until 7pm.

"Your opinion matters"

Help us further develop our programs by sending comments or ideas to:

Colleen Neil
Executive Director
cneil@scfht.ca
468-6321

Sunset Country
Family Health Team

The Team

Executive Director – Colleen Neil
Finance – Stephanie Evenden
QIDSS – Melonie Young
Administrative Assistant – Elizabeth Page
***NEW* Reception** – Jenna Nowak
***NEW* Reception** – Lindsay Whitaker
Clinical Coordinator– Lindsay Kinger
Chiropodist – Andrea Clemmens
Diabetes Dietitian – Cindy Van Belleghem
Diabetes RN – Carolyn Hamlyn
Foot Care Nurse – Sue McLeod *(part time)*
***NEW* Foot Care Nurse** – Chris Anderson *(part time)*
Nurse Practitioner – Barb Pernsky
Nurse Practitioner – Carol Wilson
Nurse Practitioner – Kristen Patrick
Nurse Practitioner – Holly Rose
Nurse Practitioner – Kate McEachern
Nurse Practitioner – Leanne Bratland
Nurse Practitioner – Michael Reid
Occupational Therapist – Brittan Van Belleghem
Pharmacist – June Dearborn
Registered Dietitian – Kate Ronnebeck *(maternity leave)*
Registered Dietitian – Therese Niznowski *(part time)*
***NEW* Registered Dietitian –** Janet Gilfix *(part time)*
Registered Nurse – Jillian Faulds
Registered Nurse – Colleen Snyder
Registered Nurse – Alanna Mutch *(part time)*
Registered Practical Nurse – Breanne Becker *(casual)*
Registered Practical Nurse – Kendall Gray *(maternity leave)*
Registered Practical Nurse – Kendra Madussi *(maternity leave)*
Registered Practical Nurse – Robyn Hall *(casual)*
Registered Practical Nurse – Vanessa Trent *(part time)*
Registered Practical Nurse – Carleigh Edie
***NEW* Registered Practical Nurse** – Kim Loranger
***NEW* Registered Practical Nurse** – Carley Smith *(casual)*
Registered Practical Nurse – Rika Schadek-Parson *(Keewatin Medical Centre)*
Social Worker – Kati Heinrich