Sunset Country Family Health Team

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Quarterly Report

Issue 15
May 2022

Q4 Highlights: January, February, March 2022

Inspiring a healthier Kenora

Acute & Episodic Care Program

Program Goal

To provide high quality acute care to FHN patients.

Stats

In Q4, **2225 patients** were seen, and **3707 visits** were provided by the team under acute and episodic care.

- 52.2% were in-office visits;
- 47% were phone visits;
- 0.7% other (email, home or virtual visits);
- 1 ER diversions from LWDH.

Health Promotion & 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

131 patients were screened during a Pap screening event held April 5th-April 26th.

1 Mindful Eating Group Session was held in Q4.

All other public group events are currently on hold due to COVID-19 pandemic restrictions. The SCFHT is transitioning events and support groups to a virtual platform where possible.

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 Q4, **75 patients** were seen, resulting in **86 visits**.

Stats

98.31% of Asthma and COPD patients have a spirometry confirmed diagnosis.

57.89% of current smokers seen in the Asthma/COPD program have received a smoking cessation intervention.

42.86% of COPD patients have received a yearly flu shot, and **80.9%** of COPD patients have received a one-time pneumococcal vaccine.

Highlight

The SCFHT is resuming Spirometry testing appointments as community cases fall (COVID-19). We are working through our wait list, and will be prioritizing urgent and moderate urgency referrals.

eAMS program is up and running in the EMR. Daily emails are sent to patients coming in for an asthma appointment. Please continue to look for the toolbar and utilize the program.

The STOP Program available for all patients who smoke.

Cancer Screening Program

Program Goal

Maintain or improve rates of cancer screening of eligible FHN patients according to current evidence-based clinical practice guidelines.

**Please note that SAR values are different from our EMR values; we are continuing to work on reconciling EMR data.*

Stats

48.2% (EMR) / 51% (SAR) of FHN patients are up to date for **cervical cancer screening**.

54.8% (EMR) / 56% (SAR) of FHN patients are up to date for **breast cancer screening**.

52.6% (EMR) / 63% (SAR) of FHN patients are up to date for **colorectal cancer screening**.

Highlight

131 patients were screened during a Pap-a-palooza held April 5th-April 26th.

Reminder for providers to check operative reports and relabel as colonoscopy where needed.

Cancer screening doesn't stop for COVID-19!

It is important for patients to stay up-to-date with their cancer screening!
Our NPs are seeing patients who are overdue for their Pap test. Patients can book their Pap tests through their doctor's office.

Chiropody Program

Program Goal

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.

Stats

0% of patients had a hospitalization due to an unstable wound since their last visit.

90.91% of patients in the program with wounds have controlled or improved their results.

Access

In Q4, **169 patients** were seen, resulting in **263 visits** at the **SCFHT Program**.

87 patients were seen and **115 visits** at the **LWDH Wound Care Clinic**.

Highlight

Please note that foot care services are currently limited due to staffing challenges.

Diabetes Management Program

Program Goal

To 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.

Access

In Q4, **237 patients** were seen, resulting in **533 visits**.

Stats

94.86% of patients with Type 1 or Type 2 diabetes had an A1C in the last year.

82.7% of all patients with Type 1 or Type 2 diabetes had their blood pressure measured in the last six months.

68.69% of patients with Type 1 or Type 2 diabetes had a validated foot screen in the last year.

45.79% of patients had a retinal exam within the last two years.

89.03% of patients set a SMART goal within the last six months.

Highlight

Reminder retinal screenings for T1 or T2 diabetic patients should be done every two years.

Do you have something you'd like to submit for the Quarterly Newsletter?

Contact Carly Freund, Administrative Assistant with your content or suggestions: cfreund@scfht.ca

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Foot Care Services

Program Goal

To screen for and treat diabetic foot conditions in order to prevent or delay complications.

Access

In Q4, **73 patients** were seen, resulting in **87 visits**.

Stats

92.42% of patients with diabetes have had a 60 second foot screen within the last year.

95.89% of patients have an action plan who follow-up with the foot care nurse on an annual basis.

97.06% of patients with chronic problems have their conditions now under control with regular clinic visits.

Highlight

Please note that foot care services are currently limited due to staffing challenges.

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.

Access

In Q4, **166 patients** were seen, resulting in **473 visits**.

Stats

70.10% of patients in the program have improved their blood pressure readings to target after 3 months.

89.69% of patients have set a new lifestyle goal after 3 months.

Highlight

Wait times for an appointment with the Hypertension Management team is low; the SCFHT is able to accommodate HTN referrals and appointment times within 1-2 weeks.

Please highlight urgent referrals and we will ensure these patients are seen quickly.

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.

Access

In Q4, **100 patients** were seen, resulting in **437 visits**.

Stats

69.76% of tests given were within INR target range.

0 INR patients experienced a stroke in Q4, keeping the SCFHT below their 2% target.

1 INR patients experienced a major bleeding event in Q4, which keeps the SCFHT below their 2% target.

Highlight

In Q4, 5 patients transitioned to DOACs (Direct-Acting Oral Anticoagulants). Patients who may be possible candidates for DOACs are patients with non-valvular atrial fibrillation and good renal function.

Lactation Consultation Program

Program Goal

Provide individual patient sessions with expectant parents and mother/baby dyads for support, education, and strategies to establish, maintain, or continue exclusive breastfeeding until 6 months.

Access

In Q4, **34 patients** were seen, resulting in **104 visits**.

Highlight

The SCFHT's Lactation Consultant is seeing moms and infants in office for any infant feeding issues.

Patients may self-refer to see Colleen Snyder for guidance and assistance.

Memory Clinic

Program Goal

Optimize access, diagnosis, and care for patients with memory difficulties. Early diagnosis 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 also creates capacity at the primary care level to free up specialist resources to focus on the most complex cases.

Access

In Q4, **22 patients** were seen, resulting in **34 provider contacts**. 4 clinics were held in Q4.

Stats

100% of patients surveyed in Q4 are satisfied with the service.

100% of patients reported an increased understanding about their condition.

Highlight

Reminder that Memory Clinic is still accepting referrals and wait times are improving.

If you have an urgent referral to the Memory Clinic, or if patients are requiring an urgent follow-up, please send a message to Brittan Amell, OT in PS Suite and mark referral forms as 'urgent'.

Nutritional Counselling

Program Goal

Provide nutrition tools and education to help patients improve their quality of life and decrease the likelihood of developing a chronic disease, or to help patients manage the nutritional component of dealing with a chronic disease to decrease the possibility of adverse events.

Access

In Q4, **109 patients** were seen, resulting in **208 visits**.

Stats

82.46% of follow-up patients have achieved their most recent SMART goal.

90% of dyslipidemia patients had a documented Framingham risk assessment.

Highlight

The SCFHT Dietitian and Occupational Therapist are offering **Mindful Eating: Emotional Eating and Food Craving Management Groups virtually.** By attending this group, patients will learn:

- About the benefits of mindfulness and how to practice mindful eating
- How to become more in tune with their body and learn to respond to natural cues
- Powerful skills to help manage tough food cravings
- Find balance and heal their relationship with food

The Mindful Eating group is a 6-week program, with 2-hour sessions once a week for the 6-week duration. Please refer patients to SCFHT reception to sign up.

The Mindful Eating group sessions is becoming popular! The SCFHT is holding a wait list for interested patients for future sessions.

Occupational Therapy

Program Goal

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

Access

In Q4, **40 patients** were seen, resulting in **79 visits**.

Stats

7 home assessments were completed in Q4.

57.89% of patients over 65 had fall assessments completed.

Highlight

Providers are welcome to contact Brittan for any questions or clarification regarding an OT referral.

Continuing involvement with the Cardiac Rehabilitation Program. Brittan is also co-facilitating the Mindful Eating Group and are planning on offering more sessions in the future.

Pharmacist Services

Program Goal

Assess medications are working effectively and are not negatively impacting the patient's well-being; to identify and help solve possible medication related problems soon after discharge to help minimize risk of re-admittance to hospital; and to provide patient and provider education about medication therapies.

Access

In Q4 there were **146 patients**, resulting in **174 visits**.

Stats

24 patients had a medication review completed in Q4.
110 patients had their medications updated in the EMR.
30 patients had a medication reconciliation.
28 patients had drug information questions answered.
19 patients received assistance with drug navigation (forms, etc.)
87 patients had hospital discharge medication follow-up.
6 patients from the Cardiac Rehab Program.

Highlight

Physicians or NPs who are interested in medication assistance for patients aged 80+ with multiple medications, or patients who are in the Cardiac Rehabilitation Program, are encouraged to reach out to the SCFHT Pharmacist. June is more than willing to help!

Your Opinion Matters!
Help us further develop our programs by sending your ideas or comments to:
Lindsay Kinger, Clinical Coordinator
lkinger@scfht.ca | 468-6321 x327

Primary Care Outreach Program

Program Goal

To provide primary care outreach to the vulnerable sector and to increase access to primary care and mental health services for underserviced populations in Kenora, leading to improved outcomes and quality of life, and reduced emergency room visits and hospitalizations.

Access

In Q4, **255 patients** were seen, resulting in **696 visits**.

Stats

18 patients were seen for trauma/injury.
583 patients were seen for acute illness.
14 patients were seen for chronic illness.
11 patients were seen for mental health.
Patients seen for substances:
5 – alcohol, **19** – drugs
Other: 56

54 connections and referrals to All Nations Health Partners programs and services were made.
2 patients self-reported they would have sought care from the LWDH Emergency Department.
0 referrals to the LWDH Emergency Department were made.

Highlight

The SCFHT Primary Care Outreach team has provided a breakdown of their Hep C Elimination Project. Select this link to view.

Smoking Cessation

Program Goal

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

Access

In Q4 there were **51 patients**, resulting in **85 visits**.

Stats

30% of patients in the program have quit smoking at 12 months.

98.04% of patients in the program have smoking status documented in Risk Factors.

Highlight

Patient success in smoking cessation improves when PCP asks about their status at every visit – providers play a key role.

Social Work

Program Goal

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

Access

In Q4, **0** were seen, resulting in **0 visits**. YTD **138 patients** were seen, resulting in **364 visits**.

Highlight

The SCFHT Social Worker went on extended leave in October 2021 and resigned in January 2022. At this time, the SCFHT is not actively looking to fill this position until we receive the results of the third-party service delivery review, which is scheduled to be completed by the end of March 2022.

During this time, referrals for social work services may be directed to external programs and services:

Adult referrals:

- **LWDH Mental Health and Addictions Program** **(807) 467-3555**: staff are available daily to respond to inquiries for counselling and can deal with more urgent referrals. The youth program there is also available for youth ages 12+.
- **Canadian Mental Health Association-Kenora Branch** **(807) 468-1838**: can provide individual counselling services for 18+.
- **Canadian Mental Health Association-Fort Frances Branch** **(807) 468-4699**: has the Older Adults Program age 60+.
- **WNHAC** **(807) 467-8770**: offers emotional health and wellness programs for their clients.

Child referrals:

- **Firefly** **(807) 467-5437**: is the primary agency for children's mental health. There is a Firefly referral form in PS Suite custom forms.
- **24/7 Crisis Line: 1-866-888-8988**
- **Kenora Mobile Crisis Response Team: 1-888-310-1122** (non-emergent line) or **911**

Please also refer to the '**Kenora Mental Health Interagency Referral Form 2021**' found in PS Suite Custom Forms to refer a patient to an external service.

SCFHT Quality Improvement Committee – Update

The SCFHT Quality Improvement Committee has been working on the Quality Improvement Plan for the 2022/23 year.

In June 2021, the team completed the **Foundations of Quality Improvement** training course through the University of Toronto's IDEAS (Improving & Driving Excellence Across Sectors) Program. This training program introduced the team to key quality improvement concepts and methods which we have begun implementing in our work with the Quality Improvement Plan.

Through guidance and mentorship from the SCFHT QIDSS, Melonie has been working with the team to utilize our training and become more familiar with the quality improvement process and implementation.

The Team

Executive Director – Colleen Neil
Finance Manager – Stephanie Evenden
Clinical Coordinator– Lindsay Kinger
QIDSS – Melonie Young
Administrative Assistant – Programs – Carly Freund
Administrative Assistant – Communications & Executive – Lindsay Whitaker
Administrative Assistant – Jenna Mattson *(casual)*
Reception – Toni Maenpaa
Chiropodist – Andrea Clemmens
Diabetes Dietitian – Cindy Van Belleghem
Diabetes RN – Carolyn Hamlyn
Foot Care Nurse – Sue McLeod *(part time)*
***New* Nurse Practitioner** – Angela Jung *(Kenora Medical Associates)*
Nurse Practitioner – Barb Pernsky *(Keewatin Medical Clinic)*
Nurse Practitioner – Carol Wilson *(Kenora Medical Associates)*
Nurse Practitioner – Holly Rose *(Kenora Medical Associates)*
Nurse Practitioner – Kate McEachern *(Kenora Medical Associates)*
Nurse Practitioner – Michael Reid *(Kenora Medical Associates)*
Occupational Therapist – Brittan Amell
Pharmacist – June Dearborn
Registered Dietitian – Therese Niznowski *(part time)*
Registered Nurse – Diane Debbo *(temporary)*
Registered Nurse – Alanna Mutch *(part time)*
Registered Nurse – Colleen Snyder
Registered Nurse – Jillian Faulds *(maternity leave)*
Registered Nurse – Becky Shorrock (Outreach)
Registered Nurse – Jen Carlson (Outreach)
Registered Practical Nurse – Josh Oliver *(temporary)*
Registered Practical Nurse – Breanne Becker *(casual)*
Registered Practical Nurse – Kendra Madussi
Registered Practical Nurse – Vanessa Trent *(part time)*
Registered Practical Nurse – Kim Loranger *(maternity leave)*
Registered Practical Nurse – Rika Schadek-Parson *(Keewatin Medical Clinic)*