Programs and Services

Managed by:

Kate Dymock,

Primary Health Services Director

RN for 40 years

WECHC Director for 14 years

Kate's Programs and Services Overview

- Primary Care
- Diabetes Education Program (DEP)
- Chronic Disease Management
- Chiropody
- Physiotherapy
- Harm Reduction
- COVID Infection Control and PPE

Primary Care Team

- Physicians - 3 FTEs:
  - Dr. Kevin Mardell: .8 FTE
  - Dr. Kasia Rycerz: .9 FTE (on maternity leave)
  - Dr. Rebecca Bond: .8 FTE
  - Dr. Karl Astaphan:.5FTE
- Nurse Practitioners – 3 FTEs:
  - Lindsay Damen: 1 FTE
  - Krista Bodkin: 1 FTE
  - Janelle Johnston: 1 FTE
  - Judy Tigert: casual NP (very few hours)

Primary Care Team

- The Nursing staff – 3 FTEs:
  - Julie Nesbitt RN: 1 FTE
  - Katrina RPN: 1 FTE
  - Heather Vanrabaeys RPN: 1 FTE

Primary Care Clients

- See any applicant who lives anywhere
- Primary Care clients can access onsite Dynacare lab services
- Primary Care clients can access our MDs/NPs for telephone on call after hours support

Primary Care Targets:

LHIN and Health Quality Ontario targets such as:

- Panel size (# of clients rostered) (3447/4347) over annual target
- # unique Individuals seen in a year (target 2280)
- # Service Provider Interactions (target 14,139)
- Colorectal cancer (63% - target 90%)
- Breast cancer (65% - target 74%)
- Cervical cancer screen (72% - target 79%)
- Inter-professional Diabetes Care Rate (87/95%)
- Influenza Vaccination Rate (63%- target 70%)

Areas for Change & Improvement

- Team has dealt with many changes over past several years:
  - instability (vacancies with many maternity/personal leaves etc.)
- Continue to increase panel size
  - All providers accepting clients and working on creative ways to get applicants in sooner
  - Freeze on intakes with COVID- now taking some on again
  - Multiple intakes due to 2 physicians in Chatham Kent who closed their practices and no one taking on new clients
- we needed ability to see clients in 1-2 days of their call. Created a blended model where people can call for same day appointment or book up to 5 days in advance. COVID resulted in majority of appointments by phone
- Increase scope of nurses to increase number of available appointments (increased training/medical directives/skills (pap tests))
- Partnerships with Four Counties and STEGH to help have more successful discharges and see clients within 7 days of discharge for chronic conditions

Successes To Be Proud Of!

- Significant improvement in team dynamics
- Able to get client in for an appointment faster
- Identified & implemented systems better meet MSAA targets (met all targets last fiscal year – will not this year)
- On last Practice Profile, our team reflected good stats in SWLHIN related to our clinical clients:
  - Increasingly more complex clients
  - care for 67% of client needs (vs using walk-ins/specialists)
- Began COVID testing for our clients and senior apartment in Dutton – now running clinics weekly to help community. Turn away many. Working on possibility of permanent testing centre.

Diabetes Education Program

- Program funding received in 2007 for 2 “dyads” and administration support
- West Dyad – (West Lorne, Dutton & Port Stanley):
  - Margaret Intven RN 1FTE
  - Jenna Wissink RD 1 FTE
- East Dyad – (Aylmer):
  - Gwen Hammons RN, .6FTE
  - Melissa Dawson RN, .4FTE
  - Marie Morley RD, 1 FTE
- Katherine McLeod, Secretary, 1 FTE (Aylmer & West Lorne)

Diabetes Targets/Reports

- Services are FREE – no OHIP card required
- Can see anyone who lives anywhere – no restrictions – do not need to be a WECHC Clinical client
  - People can be referred or self refer
  - If client needs diabetes meds and has no provider, our Chronic Disease NP will help until they get a provider
- Targets include:
  - # of unique clients seen annually (950)
  - # Service Provider Interactions (3075)
  - # of groups held (20)
  - # of group attendees (175)

Areas for Change & Improvement

- Increase in # of clients
  - We have the capacity to see more people and welcome referrals – no one is turned away!
  - Our hope is that everyone with diabetes seeks us out – self referrals welcome!
  - Group targets have been tough historically
    - This year we start cardiac rehab program with chronic disease NP in West Lorne
    - Aylmer working with East Elgin FHT to conduct cardiac groups

Successes To Be Proud Of!

- Experienced Based Design stats reflect that clients are happy with the care & services
- Continue to get new referrals annually
  - Very positive primary care provider feedback on services
- Continue to strive for quality care and targets despite 4 maternity leaves in 4 years (no-one ever turned away)
- Implemented Medical Directives to increase scope of practice of providers
- Established great partnerships (EEFHT) and have gained clients as a result – provide MD/NP education on new meds and treatments for diabetes

Chronic Disease Management

- New program as of April 1, 2015
- See anyone no matter where client lives or who their primary provider is
- Nurse Practitioner sees clients in group format and one-on-one to focus on their chronic illness, develop a plan and send back to primary care provider
- Stephanie Aldom NP, 1FTE

Chronic Disease Management Focus

- Funded to see clients needing support with chronic illnesses
  - Goal is to help keep people out of hospital AND decrease utilization of narcotics
  - Focus on:
    - Pain (from any cause)
    - COPD (chronic obstructive pulmonary disease) and Asthma Care /pulmonary rehab
    - Insomnia
    - Heart Failure/Cardiac rehab
    - Any other chronic illness

Chronic Disease Management Targets

- Targets for:
  - Number of clients seen annually (225)
  - Number of client interactions annually (1000)
  - # groups (60)
  - # people seen in group format (300)
- Offers:
  - Education on increasing awareness of what makes things better/worse
  - Acupuncture (trial only)
  - Lending of TENs units (trial only)
  - Laser treatments (trial only)
  - inversion chair
  - Essential oils/meditation
- Services are FREE but intended for short term referrals then return client to their primary care provider with a care plan

Chronic Disease Management Successes

- Program was successful in helping clients have dedicated time to work through options to manage their chronic illness
- Clients report improved confidence, and quality of life with this service
- Established (re-established) partnerships with ECHO, St Joeseph's pain clinic
- Many programs have been successful (pain management, insomnia, C.O.P.D., cardiac rehab)
- No hospital/emergency department admissions for anyone seen by this service

Chronic Disease Management Areas for Improvement

- Position vacant for several months and new NP developing program/services/skills
- Re-evaluating services under new NP style and setting new targets as appropriate

Chiropody Services

- Rick Van der Heide 1 FTE
- Said Chams .2 FTE (contract)to backfill Rick for offloading services
- Services are FREE – pay for orthotics
- A Chiropodist (Doctor of Chiropody)
  - Colleges working to allow increased ability to prescribe
  - Skills allow him to see people with complex needs
    - Does not provide just nail cutting
    - Clients with minimal complications will be seen periodically to ensure that issues do not arise or discharged
    - Sensitive topic as people want free toenail cutting services
- Also has his Masters in wound care so see clients with very complex foot/lower leg ulcers (offloading program)

Chiropody Services Targets

- Number of unique clients seen each year (target 480)
- Client encounters each year 1(target 800)
  - # of encounter targets decreased slightly from the past as he is seeing more complex clients who have longer aptmts
  - Adjusted schedule to allow for urgent same day and intake appointments to be more planful in how appointments slots are used
  - .2FTE seeing many intakes and orthotic appointments
- Offloading services are unique – help heal diabetic foot ulcers using casts or boots to remove pressure from wound. Diabetic foot ulcers result in 85% of lower leg amputations (approx. 2000 per year)

Areas for Change & Improvement

- Monitoring no show rates – appointments are set typically a month or more in advance
  - Implemented automated reminder call system
- Saw only emergent needs during COVID. Seeing more now but not as full as pre-COVID (cleaning between appointments)

Successes To Be Proud Of!

- Over 2000 face to face client appointments annually
- Adds new technology regularly to increase scope of what he offers (wounds care, dopplar, offloading casts)
- Implemented reminder call system to help minimize no show rates to make best use of every appointment slot
- In January 2018, Rick became one of 5 providers in our SWLHIN to offer offloading devices. This is a pilot project with the SWLHIN.
  - Clients with diabetes and foot ulcers can have offloading casts to increase wound healing at no cost to them
  - 1 person in Ontario living with Diabetes loses a limb to amputation due to ulcers that will not heal

Physiotherapy Services

- New funding in 2015
- Purchase services from Talbot Trail Physio (West Lorne Site)
- Who can access services:
  - Anyone
  - Can self refer or have a referral from their provider
  - Anyone without benefit coverage (or benefits have run out)
  - Do not need to see an MD/NP at WECHC

Physiotherapy Services

What services can you access?

- Clients can see physiotherapy team for physiotherapy, acupuncture, pool therapy, shock wave treatments and a few other specialized treatments
- Pool therapy and pelvic floor physio done in St Thomas
- Currently clients can access individual services followed by group services depending on their needs at no cost to them.
- No guarantee on number of visits – fixed budget, depends on demand and client needs.

Physiotherapy Targets

- Individuals served (funded for episodes of care) (350)
- Group sessions (60)
- Group participants (150)
- Service provider interactions (1800)

Physiotherapy Services Areas for Improvement

- Continue to advertise and market program to help spread the word
- Increased group services to help reach more people at cheaper cost to help meet targets
  - Seeking groups wanting support
  - MS group, Seniors exercises etc

Physiotherapy Services Successes

- Working poor with no benefits now are able to have improved quality of life as a result of accessible physiotherapy services
- Addition of group services allows individuals who continue to need services following one on one physio to have professional support at no cost to them, but at a lower impact to our budget
- Positive clinical outcomes reflected on monthly data
- Assisted with the exercise component of our Cardiac Rehab program

Harm Reduction Program

- Harm reduction program since 2015
- Program offers free supplies (needles, saline, cookers, inhalation kits, sharps containers etc.) to individuals to reduce the burden and transmission of HIV, Hepatitis B and Hepatitis C while improving safety in our community.
- As of December 2017, we also provide Naloxone Nasal Spray kits and training to those who have a friend or family member who may be at risk of an opiod overdose
- Program supplies provided to us at no cost from Southwest Public Health Unit
- Staff trained are available:
  - Monday – Wednesday and Friday from 0830-4pm
  - Tuesday and Thursdays from 0830 to 7pm
- Confidential – no OHIP, or ID required
- Increased utilization since COVID

COVID Infection Control and PPE

- Since COVID started, I have worked with Stephanie Aldom (NP and Masters in Public Health) and Rick vanderHeide (Chiropodist and Masters in Wound Care) to:
  - Identify best practices for Infection Control routines
  - Identify best cleaning protocols
  - Develop a risk plan for the centre and off-site work environments
- We have also developed a system to continue to source and secure PPE and submit inventory to Ontario Health twice weekly
- We vet all directives and recommendations and new research to ensure WECHC is working under most current screening tools, decision trees, and guidance documents

Kate's other Committees & Supports

Internal:

- Quality Committee
- Occupational Health & Safety
- Nursing support to clinical questions for Assisted Living

External:

- Palliative Care steering committee (Elgin County)
- Residential Hospice Committee – (Elgin County)
- Elgin Drug Strategy sub committees:
  - Harm Reduction Pillar
  - Treatment Pillar
- Elgin Health Links Steering Committee
  - Elgin Health Links Data sub Committee
  - Health Links Innovation sub Committee