2019-2022

STRATEGIC PLAN REPORT

MARATHON
FAMILY HEALTH TEAM

WHO WE ARE

MISSION & VISION

Mission statement:
We are a Family Health Team committed to sustainable, comprehensive, high quality primary care for our communities.

Vision Statement:
The Marathon Family Health Team, through its work, and collaboration with community partners will work to achieve optimal health and wellness for the people of our communities.

Marathon Family Health Team (MFHT) is an interdisciplinary primary care team who operates under a Family Health Team model. MFHT employs two nurse practitioners, a physician assistant, three nurses, multiple allied healthcare providers (social worker, dietitian, health promoter), an epidemiologist, as well as an Executive Director, a Human Resources Manager and an Electronic Medical Records Coordinator.

MFHT is attached to an affiliated physician group (MPAG) who is committed to our organization's mission, vision and strategic directions. MPAG employs seven administrative staff who support the physician group practice and its associated locums and learners.

The following strategic plan report reflects the accomplishments of MFHT. However, it is acknowledged that MFHT and MPAG work collaboratively to offer high quality primary care, and that MPAG strongly supports MFHT as it works towards achieving its strategic directions and improving the quality of the primary care services offered to the communities we serve.

PRIMARY CARE PROGRAMS & SERVICES

Marathon Family Health Team allied healthcare providers, with the support of the administration team and affiliated physician group, work together to offer the following programs and services:

- Acute/episodic care
- Acute musculoskeletal pain
- Asthma and COPD education
- Birth control counselling
- Blood pressure checks
- Care coordination
- Chronic disease and cancer screening
- Chronic disease management
- Chronic pain self-management
- Ear flushes
- Exercise counselling
- Foot care
- Health behaviour change support
- Injections
- Liquid nitrogen treatments (warts, skin keratosis)
- Mental health support
- Mindfulness
- Nutrition counselling
- Periodic health reviews
- Prenatal appointments
- Postpartum appointments
- Physicals
- Return to work appointments
- Shared-care psychiatry
- Skin rashes/conditions
- Spirometry
- Smoking and vaping cessation
- STI screening
- Suture removal
- Swabs
- System navigation
- TB skin testing
- Well baby appointments
- Well woman appointments
- Wound care
- Urine drug testing
- Vaccinations

NEW PROGRAMS & INITIATIVES

Antibiotic/I.V. infusion treatments → 2021

BETTER Program → April 2022

Emotional Eating & Cravings Program → Sept 2020

Falls Prevention Program → Dec 2022

Home & Community Care Program → Jan 2020

HealtheSteps Program → April 2022

NatureRx Initiative → June 2022

Palliative Care Program → Jan 2021

RAAM Clinic → Jan 2020

Step Outside Program → May 2022

Social Work Program → Jan 2022

Wellness Check-in Program → Sept 2020

We are pleased to report that the Marathon Family Health Team managed to provide continuous comprehensive and quality care to our patients and their loved ones despite pandemic-related challenges. With the addition of virtual (e.g. phone or video) appointment options and the successful operation of the Marathon COVID-19 Assessment Centre, there were few disruptions in services throughout the pandemic.

HIGHLIGHTS

Key priority 1: Enhancing Indigenous Relationships to Respond to Healthcare Goals

OBJECTIVES

1. Cultivate Cultural Competency
2. Expand Partnerships and Culture of Collaboration

- 100% of staff and providers received Indigenous Cultural Safety Training
- Participated in an Introduction to Indigenizing Public Spaces workshop to help identify strategies to create a culturally-friendly clinic environment
- Established the Enhancing Indigenous Relationships Committee in 2021, which includes Indigenous representation from Biigtigong Nishnaabeg and Netmizaaggamig Nishnaabeg First Nation communities
  - Terms of Reference were established
  - Truth and Reconciliation Calls to Action in relation to healthcare were reviewed by committee members
- Obtained Indigenous artwork for the patient waiting room, as well as new signage for exam room suites that include Ojibway language
- Participated in events hosted by neighbouring Indigenous communities (e.g. health fairs)
- Provided outreach clinics and workshops in Biigtigong Nishnaabeg First Nation community (e.g. health promotion, nutrition, mindfulness, and diabetes management)
- Prepared Indigenous palliative/end of life bags that include cultural items (e.g. smudging kits)
- Encouraged committees and project leads to integrate an Indigenous lens into new programs and services

COLLABORATIVE PARTNERSHIPS
Community members and healthcare providers from Biigtigong Nishnaabeg and Netmizaaggamig Nishnaabeg.

HIGHLIGHTS

Key priority 2: Develop a Collaborative Community Health Plan

The plan for this strategic direction was to begin in 2020. Due to pandemic related challenges, this strategic direction was replaced by a new focus, which was the COVID-19 pandemic response.

Of note: In 2019, the Marathon Home and Community Care program was established to address barriers in relation to home care.

Accomplished the following in relation to the COVID-19 pandemic response:

- Provided health human resources to support the COVID-19 Assessment Centre
- Created a vaccine planning framework
- Leveraged existing communication strategies to keep communities well informed about COVID-19
- Offered 14 mass COVID-19 immunization clinics that resulted in successfully vaccinating 81% of the 12+ population with 1st doses and 75% with 2nd doses
- Coordinated vaccination clinics at Peninsula Manor Supportive Housing and in the hospital's Chronic Complex Care and Alternative Level of Care units
- Offered 3 COVID-19 booster dose clinics where over 1000 doses were administered
- Offered COVID-19 vaccination clinics for children and youth (6 months to 11 years)
- Assisted the Thunder Bay District Health Unit and Biigtigong Mno-zhi-yaagamig Health Centre with their COVID-19 vaccination efforts
- Redeployed clinical staff to the hospital 1-2x per week to complete rounds in the Alternative Level of Care unit
- Temporarily held the hospital's IV Infusion Program at our site to divert foot traffic
- Participated in community support and outreach efforts
  - Created virtual resources to support patients during provincial lockdowns
  - Developed a volunteer-based Food Delivery Program for individuals who were in isolation
  - Implemented a Wellness Check-in Program to provide vulnerable older adults with the opportunity to connect with staff from the MFHT
  - Launched initiatives (e.g. "Make some noise" and COVID Champion) to promote kindness and encourage connection

OBJECTIVES

1. Engage local partners to identify community needs
2. Develop a community appropriate local health hub

COLLABORATIVE PARTNERSHIPS

Thunder Bay District Health Unit, North of Superior Healthcare Group, Superior North EMS, Peninsula Supportive Housing, Barrick Hemlo, and Marathon OPP.

HIGHLIGHTS

Key priority 3: Support Quality Aging in our Community

- Collaborated with the Alzheimer's Society to establish a "First Link" Coordinator position
- Supported the ongoing operation of a volunteer run Indoor Walking Program
- Established a Quality Aging Committee
- Developed a Falls Prevention Program
- Implemented a malnutrition screen in the hospital admission process, Home and Community Care intake and clinic process
- Developed an aging well flow sheet
- Attached complex patients 65+ with a physician or nurse practitioner
- Increased pneumococcal vaccine uptake
- Provided education to community groups and healthcare providers (e.g. Advanced Care Planning Workshops and Palliative Care Program Lunch n' Learn)
- Developed a Lifestyle Medicine Program which encourages a holistic approach to health and wellbeing
- Created a framework for running group programs/workshops

OBJECTIVES

1. Provide personalized quality care
2. Enhance community and caregiver supports

- Launched programs that focus on chronic disease prevention and screening and the adoption of healthy behaviours: the BETTER Program and the HealtheSteps Program
- Accomplished the following in relation to palliative and end-of-life care:
  - Established a sub-committee
  - Developed a palliative care algorithm
  - Added a measurement group to patient EMRs to track DNR, Advance Care Plan, Palliative Performance Scale scores, and MAiD statuses
  - Created a palliative care disease registry in EMR to identify high risk patients
  - Developed a process for adding patients to the palliative care disease registry
  - Assembled 25 palliative care comfort bags (including Indigenous comfort bags) for distribution to patients receiving palliative or end-of-life care
  - Created paper and digital palliative care resource binders
  - Developed a Narcotic Drugs Handling and Documentation policy
  - Accessed Palliative Symptom Management Kits to be used by providers caring for patients at end-of-life
  - Committee members participated in professional development opportunities

COLLABORATIVE PARTNERSHIPS
Alzheimer's Society, North of Superior Healthcare Group, and Peninsula Manor Supportive Housing.

HIGHLIGHTS

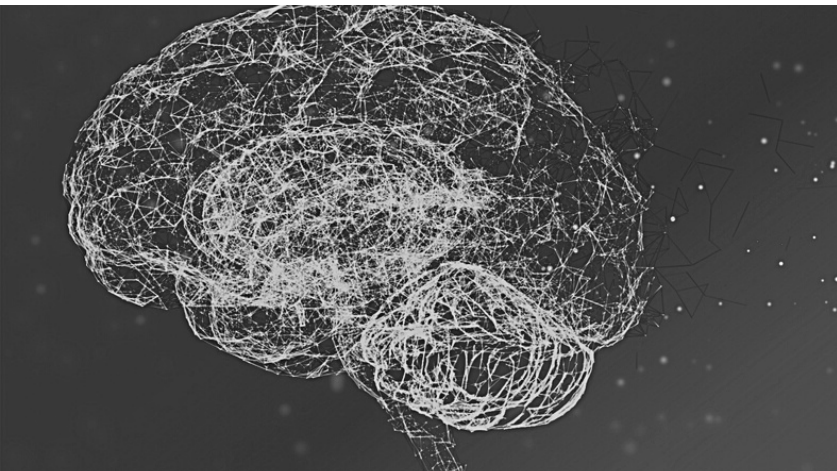
Key priority 4: Optimizing Prevention, Treatment and Care Coordination Strategies to Support Mental Health

- Submitted a funding proposal to the Ministry of Health to establish a RAAM (Rapid Access to Addiction Medicine) clinic
- Launched the Marathon RAAM clinic
- Accomplished the following in relation to the RAAM clinic:
  - Developed a program model
  - Presented about the RAAM clinic to community partners and Indigenous communities in our catchment area
  - Developed promotional material (e.g. advertising on CFNO radio, banner)
  - Increased awareness about RAAM clinic via public education and participation in community events (e.g. health fairs)
  - Attended RAAM Community Partner and District Steering Committee meetings
  - Implemented a Food Support Program
  - Obtained harm reduction supplies for distribution to patients
  - Developed an annual operating work plan
- Submitted a funding proposal for a Chronic Pain Management Program
- Offered community events/initiatives during Mental Health Awareness Weeks (e.g. "Show Green" and community walks)
- Organized Community Health Fairs in which mental health agencies participated
- Offered eating disorder consults

OBJECTIVES

1. Foster a holistic approach to mental well-being
2. Advocate for timely access to quality care

- Delivered Emotional Eating & Cravings group workshops
- Organized Tree Lighting Ceremonies to create opportunities for connection and to raise funds for local health programs
- Created virtual patient resources to support patients during the pandemic (e.g. Health & Wellness While Staying at Home)
- Implemented programs and initiatives to encourage social connection and prevent loneliness (e.g. Wellness Check-in Program)
- Offered community challenges that encouraged positive mental health practices (e.g. Community BETTER and Wellness While Distancing challenges)
- Utilized a portion of an award ($8,000) to support the enhancement of local walking/ hiking trails
- Developed a NatureRx Program to promote spending time in nature
- Provided Mindfulness Workshops to local groups/organizations



COLLABORATIVE PARTNERSHIPS

North of Superior Counselling Programs, PACE, community volunteers, ParticipACTION, Town of Marathon, Group of Seven Lake Superior Trail Association, and St Joseph's Care Group Eating Disorder Program.

QUALITY IMPROVEMENT

Making health care safe, effective, patient-centred, timely, efficient and equitable.

Marathon Family Health Team participates in quality improvement initiatives to improve the quality of care our patients receive. We measure how we are doing through patient experience surveys and tracking patient health outcomes so we can learn where we can improve our services.

The data below was taken from our most recent patient survey (2019). There was a total of 145 respondents.

75% (up from 70% in 2018) of respondents reported receiving an appointment with their healthcare provider within 0-5 days last time they were sick or had a health problem.

97% (new measure) of respondents reported their healthcare provider always or often listened to the reasons for their visit.

75% (new measure) of respondents reported trusting their healthcare provider with their care.

91% (up from 84.5% in 2018) of respondents reported their healthcare provider or someone at the clinic always or often involved them as much as they wanted to be in decisions about care/treatment.

IMPROVEMENT TARGETS

- Improve access to appointments with family physician / nurse practitioner by:
  - Promoting the use of other healthcare providers to improve access to physicians/NPs
  - Implement initiatives to reduce no show rate
- Provide safer and more effective care by:
  - Recording smoking status in patient charts
  - Offering smoking cessation counselling to patients with diabetes who are current smokers at least once per year
  - Assigning a random urine drug screening appointment to each patient in the MFHT opioid prescribing program who has not completed one in the past 12 months
- Improve quality aging by:
  - Offering a palliative approach to care to eligible patients
  - Supporting palliative patients who want to die at home
  - Assigning patients 65+ to a family physician/NP

ACCOMPLISHMENTS BY THE NUMBERS

The numbers below reflect the accomplishments of Marathon Family Health Team allied healthcare providers (physicians are not included unless otherwise specified) who serve approximately 4,200 patients.

20,364
primary care visits
(50,000+ when physician visits are included)

2,133
urgent care visits

3,747
COVID-19 Assessment Centre visits
(includes visits offered by physicians)

2,488
home & community care visits

3,421
virtual appointments

2,385
RAAM Clinic visits

1,735
published health promotion communication materials

8
rural generalists retained

14
community outreach efforts
(e.g. group programs, challenges and workshops)

$20,000
awarded by ParticipACTION to increase access to local physical activity opportunities

87
locums

6,100+
COVID-19 vaccines administered

15
strengthened partnerships

12
new programs and services

28
learners

1,715
social media followers

STRATEGIC PLAN
2023-2026
COMING SOON