Ontario Long-Term Care Clinicians Community of Practice

May 21st, 2026

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The LTC CoP has not received any financial support from any organization in any form.

Potential for conflict(s) of interest:

- (Presenter) has received (payment/funding, etc.) from organization supporting this program.
- (Supporting organization name) (developed, distributes, etc.) a product that will be discussed in this presentation.

Faculty/Presenter Disclosure

- **Faculty: Ben Robert MD, MBA**

- **Relationships with financial sponsors:**
  - **OLTCC – presenter, facilitator, previous Board member, content developer**
  - **Memberships on advisory boards or speakers' bureau:**
    - **OMA speakers' Board**
    - **Ontario Health – various capacities**
  - **Patents for drugs or devices**: N/A
  - **Other: financial relationships/investments**
    - **Chief Medical Officer, Perley Health**
    - **CLRI, Pallium – facilitator, presenter**

Faculty/Presenter Disclosure

- **Faculty: Rachel Ozer, PhD, MHA**

- **Relationships with financial sponsors:**
  - **Patents for drugs or devices**: N/A
  - **Other: financial relationships/investments**
    - **Senior Knowledge Broker, Ontario Centres for Learning, Research and Innovation in Long-Term Care at Bruyère Health**

Disclosure of Financial Support

- **This program has received financial support from OLTCC and MLTC in the form of unrestricted monies.**
- **This program has received in-kind support from OLTCC in the form of supportive logistics.**

- **<u>Potential for conflict(s) of interest</u>:**
  - May speak to my personal experience involving the other organizations.

Mitigating Potential Bias

- All views are my own.
- I will specify the relationship when needed.

Quality Improvement in LTC: Getting Involved and Making an Impact

Rachel Ozer, PhD, MHA

Session Objectives

- Be able to describe the dimensions of quality, the systemic approach of quality improvement compared to individual clinical care, and the Model for Improvement used widely in healthcare to set overall goals and conduct iterative tests of change for sustainable improvement

- Understand the annual quality improvement process in LTC homes, common current objectives and opportunities to align clinical priorities and concerns with organizational efforts

- Be able to recognize the components of teamwork in LTC practice and opportunities to be an influencer for change through your own contributions as well as collaborative leadership

- Understand the quality improvement practice requirements on physicians and how these could be applied to clinical practice in LTC

Quality is for Everyone

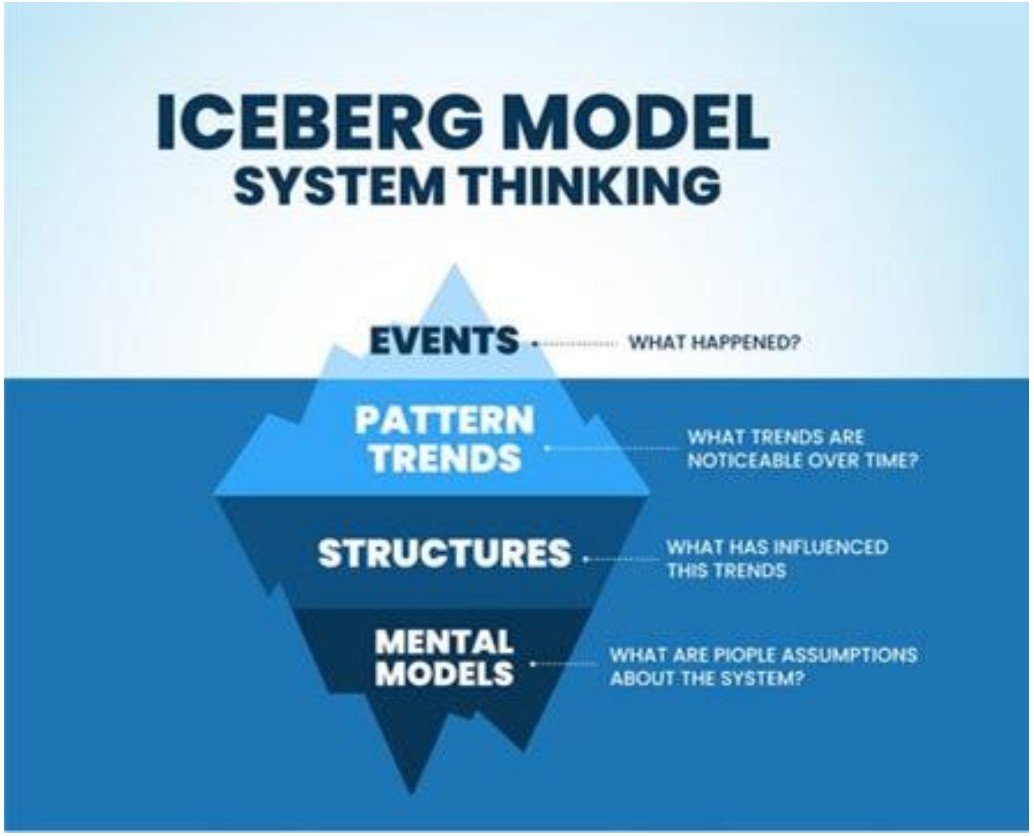
Quality includes multiple goals

- Resident health outcomes aligned to best practice
- Positive resident and family experience
- Health equity
- Positive provider experience and wellness
- Value for Money (Cost Efficiency)

Building a healthcare system that's Fit for Purpose | PwC Canada

QI to Address Systemic Patterns

- Quality improvement recapitulates investigation-diagnosis-treatment cycle at a more systemic level
- Addressing widespread or recurrent factors that impact many individuals
- Identifying and mitigating underlying root causes that otherwise lead to chronic situations



(9) Avoiding Short-Term Solutions: Utilizing the Iceberg Model for Long-Term Success | LinkedIn

LTC Homes All Engage In Improvement

- LTC homes must have a quality lead and a quality committee. The medical director must sit on the quality committee.
- The Excellent Care for All Act created the requirement for annual quality improvement plans. This process is a routine opportunity to address opportunities with organizational support and resources.

What are homes working on?

Long-Term Care

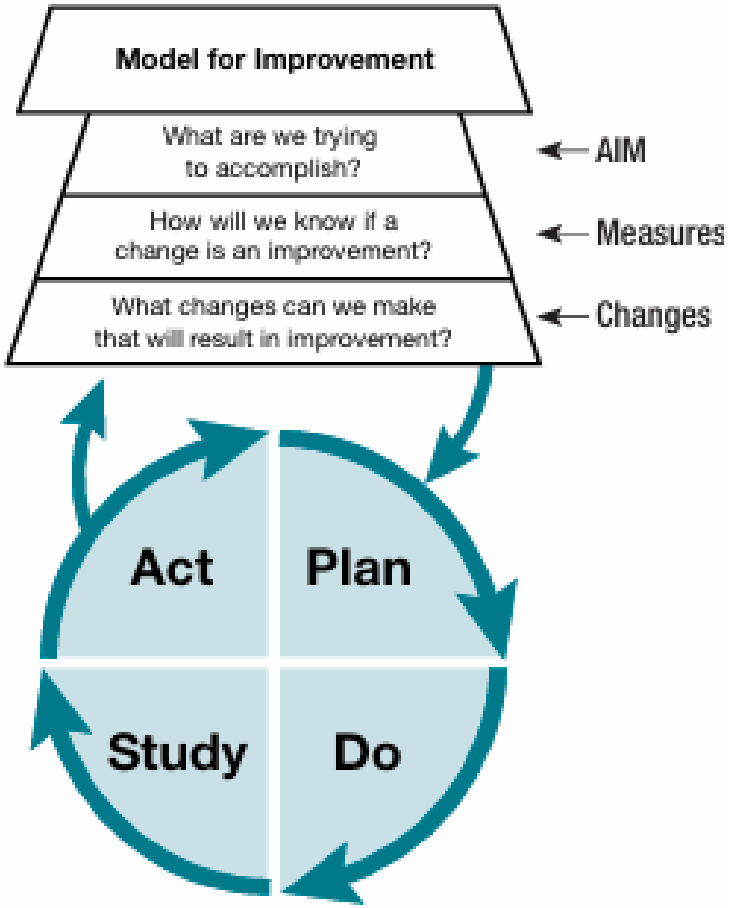
Ontario Health Quality Improvement Plan 2026/27 Program Update

Looking back (progress report)	Looking forward (workplan)	Notable themes and observations
• **86% of change ideas implemented** from 2024/25 submissions • **80% of homes improved** performance in at least one matrix indicator • **Most improved indicator:** Antipsychotic use without psychosis, with over 50% of homes showing year over year improvement • **Indicator showing less improvement:** Avoidable emergency department visits, with less than 50% of homes improving year over year	**Top selected matrix indicators:** • Antipsychotic use without psychosis (70%) • Falls within last 30 days (67%) • Potentially avoidable emergency department visits (60%) **Top common custom indicator themes:** • Pressure ulcers (160 homes) • Resident's dining experience dining (117 homes) • Resident's recreation & activities experience (83 homes)	**Antipsychotic Use** • **Enablers:** Medication reviews, pharmacy and BSO collaboration • **Challenges:** Historical prescriptions and long-standing use **Falls** • **Enablers:** Fall risk screening, environmental assessments and modifications, postfall huddles • **Challenges**: Staff turnover, resident independence, documentation gaps **Avoidable Emergency Department Visits** • **Enablers:** Nurse practitioner availability, in-home diagnostics and treatments, outreach services • **Challenges:** Managing family/resident expectations, after-hours care needs

- Homes want to improve antipsychotic use, falls and avoidable ED visits as well as pressure ulcers, dining, and recreation experiences.
- Enablers and challenges from the provincial experience are known

Getting Involved: the Model for Improvement

- The Model for Improvement is a globally validated approach to healthcare improvement
- Maintain a clear focus on an overall aim and measures of improvement while iteratively testing changes
- Suitable for busy, interprofessional teams, yields value for effort
  - plausible effective interventions
  - begin implementation with small, adaptive, iterative cycles of change
  - cycles converge on sustainable change and new standard procedures



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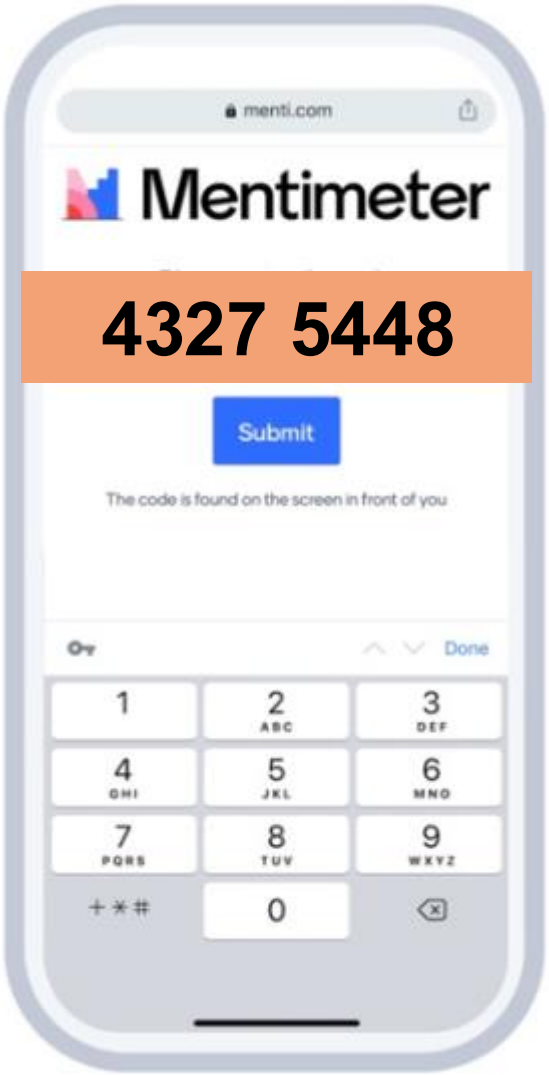
What do you think needs improvement?

What would you like to see improve in the LTC settings where you practice?



ED Optimization Quality Concerns

ED visit may not improve chronic disease and may increase frailty

Visiting ED could involve long waits, days on stretcher, agitating environment

ED is a high-cost care setting for needs that can be met elsewhere

Stressful and emotional urgent decisions between LTC team & care partners

Higher risk of ED transfer based on language & communication

Taking a Supported Approach to ED Utilization

Quality Improvement Road Map to
EMERGENCY DEPARTMENT UTILIZATION

rf-change-package-emergency-dept-util-en.pdf

Your Aim is Your Ultimate Destination

The AIM of _____(LTC home name) Emergency Department Utilization Improvement Team is to decrease the necessity for ED visits experienced by any resident by 25% (from a baseline of ___to ___(per month) by _____ (date).

- Addressing hospital utilization can involve a wide range of care processes in a LTC home so may give ample opportunity to raise clinician concerns/priorities
- Drawing on provincial experience suggests change ideas

Avoidable Emergency Department Visits

- **Enablers:** Nurse practitioner availability, in-home diagnostics and treatments, outreach services
- **Challenges:** Managing family/resident expectations, after-hours care needs

Measures in an ED Utilization Project

Suggested Outcome Measures

1. Number of visits to the ED each month by cause: fall, potentially preventable deterioration in conditions, others
2. Of the residents that went to the ED from the LTC home, percentage of residents who have multiple ED visits within a 30 day period

Suggested Process Measures

1. Percentage of residents at high risk for an ED visit who had a change in condition documented on the Shift to Shift report (or progress notes) in the 24 hours prior to ED visit. *(High risk residents are defined as those admitted to the LTC home within the last 30 days; re-admitted to the LTC home from an ED visit or hospitalization within the last 30 days; those who have experienced a change in medication, change in treatment plan or significant change in condition (as per RAI MDS) within the last 7 days).*
2. Percentage of residents re-admitted from ED/hospital to the LTC home in the previous month with follow-up care documented in the physician's orders and care plan within a 24 hour period.
3. Percentage of all residents in the LTC home who have an up-to-date care plan (10% sample reviewed). *(Up-to-date care plan includes all risk assessments complete and family and resident engagement).*

Change Ideas Across the Care Process

Recognition & Assessment

- Determine baseline ED utilization
- Identify common reasons for ED visits

Engage Residents & Family

- Educate residents about options for services
- Evaluate resident and family satisfaction using surveys

Care Planning for Prevention

- Implement interventions consistent with resident values, needs, preferences, risk factors
- Communicate risk status with family and staff
- Understand resident advance care directives that impact ED utilization
- Follow up on ED transfer record upon return from hospital

Improve Work Flow

- Educate staff about ED utilization, contributing factors and signals of potential change in condition
- Review policy in LTC home related to change in condition and ED transfer
- Establish partnerships with community care, primary care, diagnostic services, paramedic services and acute care

Develop Routine Practices

- Manage chronic conditions. Optimize pain management. Detect early behavior change and altered mental states
- Timely identification and treatment of infections, inadequate food or fluid intake
- Test huddles with interprofessional team to discuss high-risk residents and their care plans

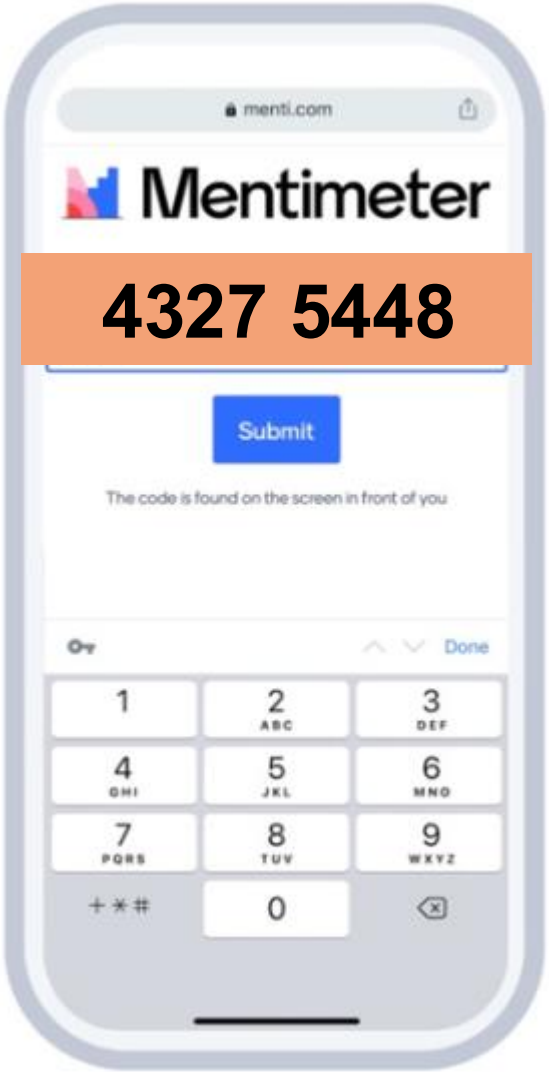
Process of Improvement Work

- **Use a Plan-Do-Study-Act approach to all tests of change**
- Start small – testing a change in a small area for a limited time gives more opportunity to adapt and optimize
- Collect feedback to optimize the change and address barriers, concerns, questions
- Scale the change to involve more participants when it is working well and has support of pilot group

- **Establish a process to review feedback, monitor measures and adjust changes**
- Plan who is the team leading the QI project and how the team communicates
- What is being measured in the tests of change; how often will the measurements be reviewed; who is preparing the data for review
- How will the project communicate “up” – to management for potential resource needs and “down” – to front line teams about how interventions are going and what is needed

Have you participated in LTC improvement projects?

What are barriers or enablers you have experienced around LTC improvements?



Considering Feasible Teamwork

- **LTC Physician Model and Structure of Practice**
- Participation as a consultant does not support time spent on organizational development
- Potential for reactive management that could have benefitted from more proactive care
- Regulatory and social expectations in LTC distinct from community or hospital settings

- **Taking Proactive Approach to Participation and Influence**
- Define available time for improvement discussion – 15-30 minutes before rounds?
- Advocate and help build interprofessional team – family education, health status observation, assessment and communication
- Identify and advocate about structural factors: documentation systems that support updating and communicating about goals of care

Serious Illness Conversation Teamwork

Clinician
Discuss specific clinical situation and prognosis with resident & care partners
Prepare for contingencies & exacerbations

Nursing
Alert resident and care partners to changes in health and supports in the home
Provide information about illness trajectories – education sessions & pamphlets
Organize interprofessional huddles to discuss changing care needs

PSW
Observe and communicate about health changes
Learn and contribute to PAIN-AD assessment

Social Work
Foster support for grief, loss and bereavement in residents, care partners and LTC teams

Dietary Services
Support learning about changes in eating, options in the home and nutrition at end of life

Recreation
Develop and demonstrate meaningful engagement and communication with all LTC residents

Engaging in QI is Physician Practice

Step 1: QI Activities Selection [View]
You will need to independently complete three activities from the list of included QI activities;

Step 2: Practice Improvement Plan (PIP) [View]
You will need to identify an opportunity to improve upon within your practice (i.e. identify a problem that, if solved, will result in better quality of care or services).

Upon completion and submission of your PIP, it will be reviewed by a CPSO Medical Advisor or physician QI Coach using the PIP Evaluation Report. Our CPSO Medical Advisors and QI Coaches are also available to meet with you and support you with feedback and coaching on your QI goals.

All physicians who successfully complete the QI for Individuals program will be considered to have met CPSO Quality requirements for this 5-year cycle.

CPSO's suite of Quality Improvement and Quality Assurance programs are designed to help Ontario physicians engage in self-reflection, improvement, and meet their Quality requirements in five-year cycles.

Participation in these programs also allows physicians to earn Continuing Professional Development (CPD) credits.

CPSO - QI for Individuals & Groups Subset

Small Dot / Big Dot approaches

BIG DOT

- Usually dashboard approaches, or big picture

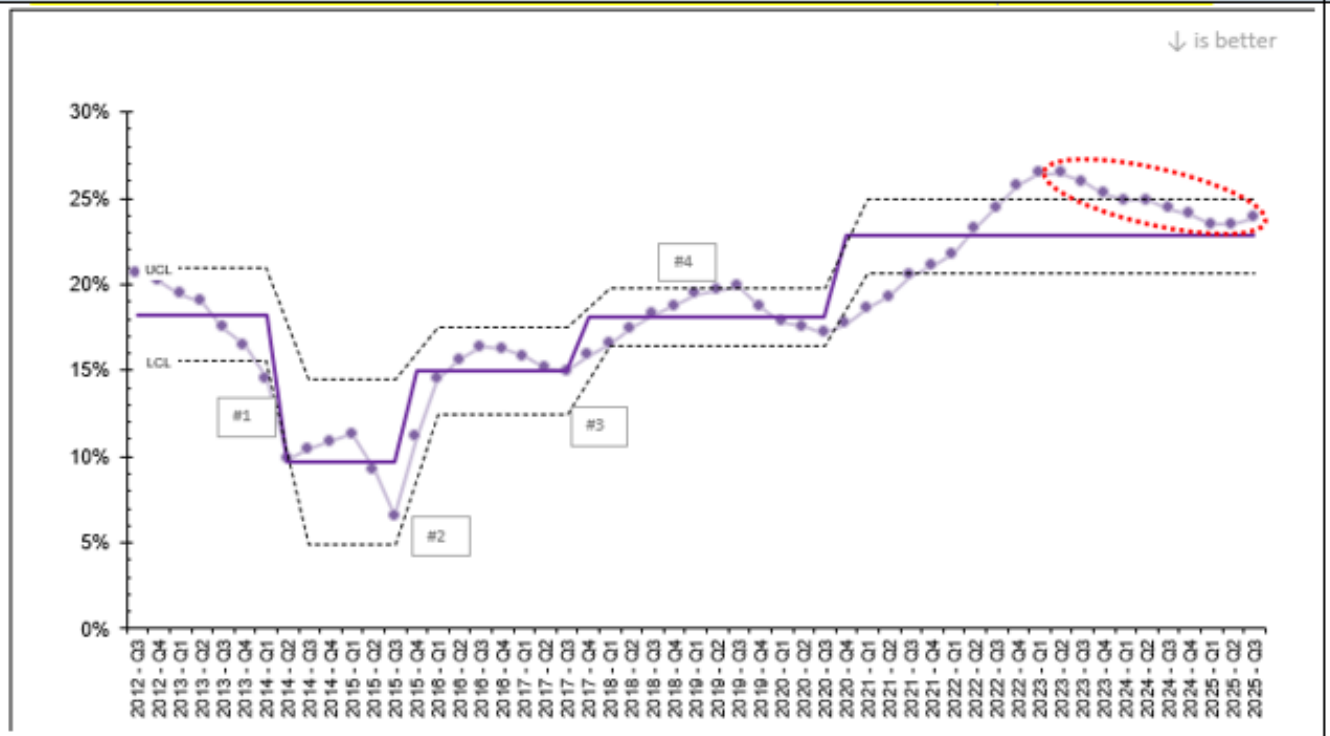
SMALL DOT

- Individual projects
  - Usually considered as the amalgamation of many PDSA cycles.

Small Dot reporting

Green	**No action required**	Performance over time indicates statistical signal of improvement or stable performance that is consistently at or better than identified target*
Yellow	**Some attention required**	Performance over time indicates statistical signal of decline; but performance remains at or better than identified target* Performance over time indicates statistical signal of improvement; but performance still not at or better than identified target*
Red	**Issue of concern**	Performance over time indicates statistical signal of decline or stable performance that is consistently worse than identified target*
Grey	**Further action not recommended at this time**	Performance has deteriorated and/or continues to not meet identified target; however, factors that are driving performance have been thoroughly investigated and are well understood. Significant improvements in performance are unlikely in the absence of substantial investments in QI resources and are not recommended at this time.

Antipsychotic usage

Indicator	Control Chart	Target (if identified)
Medication: Percent of residents on antipsychotics without a diagnosis of psychosis (CCRS eReports) QUARTERLY REPORTING (↓)		23/24 QIP = 22% 24/25 QIP = 25% 25/26 QIP = 24%

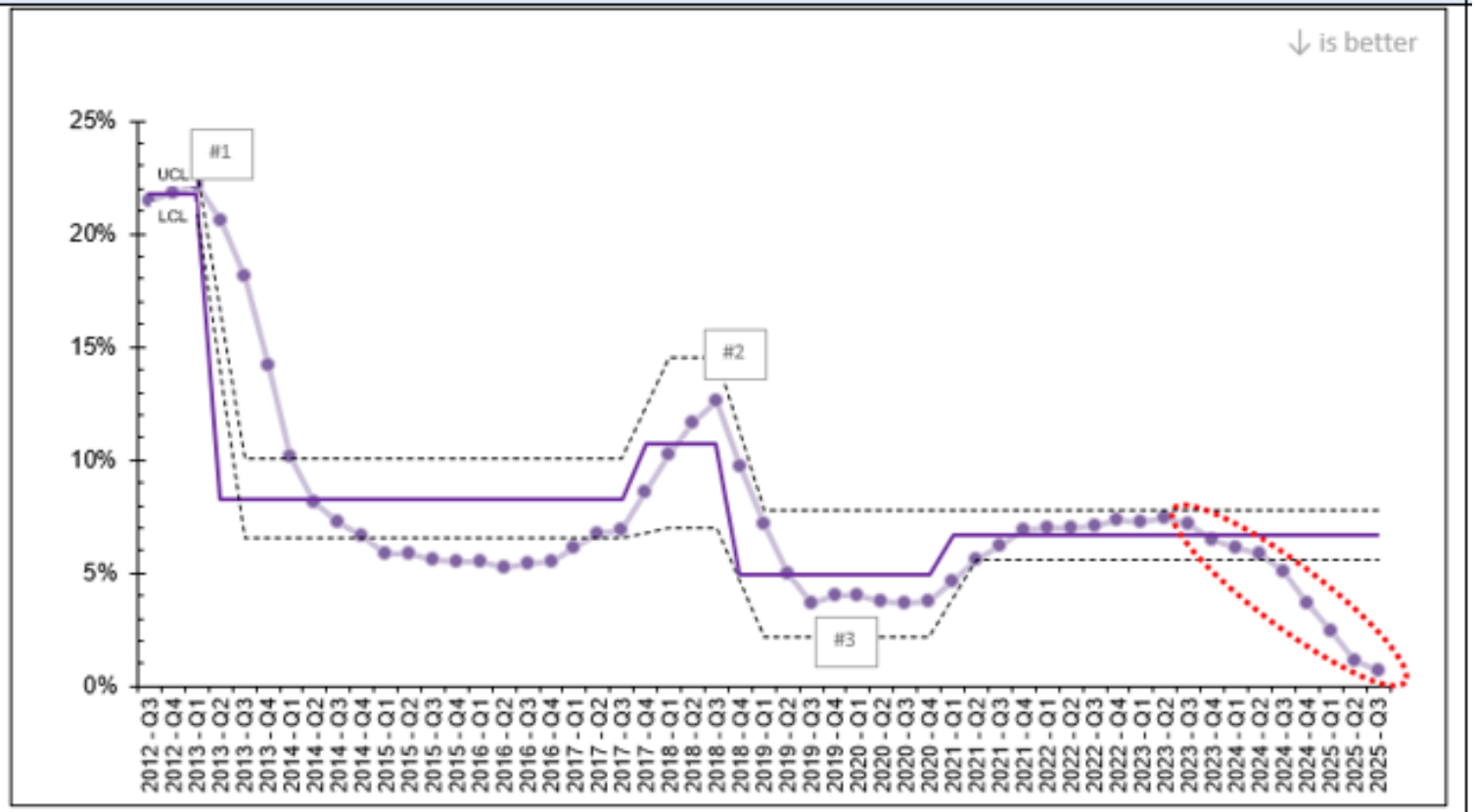
Annotations (if applicable):

#1: Introduced changes in coding practice related to "end-stage disease" (coding of end-stage increased significantly)
#2: Discontinued previous coding practices related to "end-stage disease" (coding of end-stage decreased significantly)
#3: SBSU opened April 2018. Majority of residents on SBSU receive antipsychotics, and do not meet exclusion criteria for the indicator
#4: Introduced Palliative Performance Scale (PPSv2) to enable more consistent coding of end-stage (July 2018). Antipsychotic Deprescribing/Reduction Pilot on G1N started (August 2018)

Restraint usage (possible counterbalance measure)

Restraints: Percentage of residents who were physically restrained (daily) (CCRS eReports)

QUARTERLY REPORTING (↓)

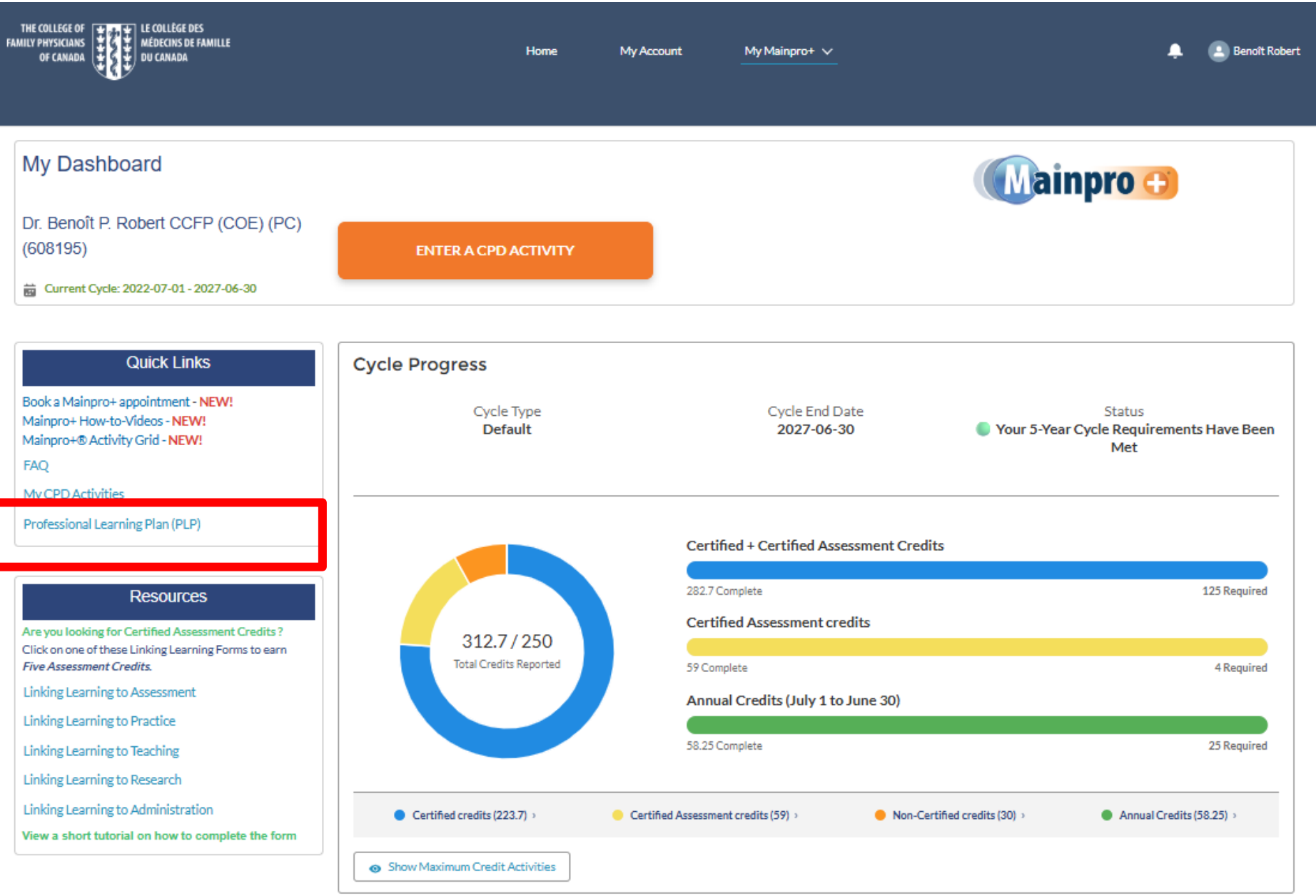


Annotations (if applicable):

#1: Implemented changes from initial LEAN initiative, resulting in significant reduction in restraint usage

#2: Developed new Positioning Device assessment and completed re-assessment of all restraints across the Home with new tool (Sep-Dec 2018).

#3: Positioning Device Assessment implemented across the Home (Jan 2019).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Current Cycle: 2022-07-01 - 2027-06-30
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Cycle Progress
Cycle Type
Default
Cycle End Date
2027-06-30
Status
Your 5-Year Cycle Requirements Have Been Met
312.7 / 250
Total Credits Reported
Certified + Certified Assessment Credits
282.7 Complete
125 Required
Certified Assessment credits
59 Complete
4 Required
Annual Credits (July 1 to June 30)
58.25 Complete
25 Required
Certified credits (223.7) ›
Certified Assessment credits (59) ›
Non-Certified credits (30) ›
Annual Credits (58.25) ›
Show Maximum Credit Activities

My PLP HUB

Dr. Benoît P. Robert CCFP (COE) (PC) (608195)

Current Cycle: Fri, July 1st, 2022 - Wed, June 30th, 2027

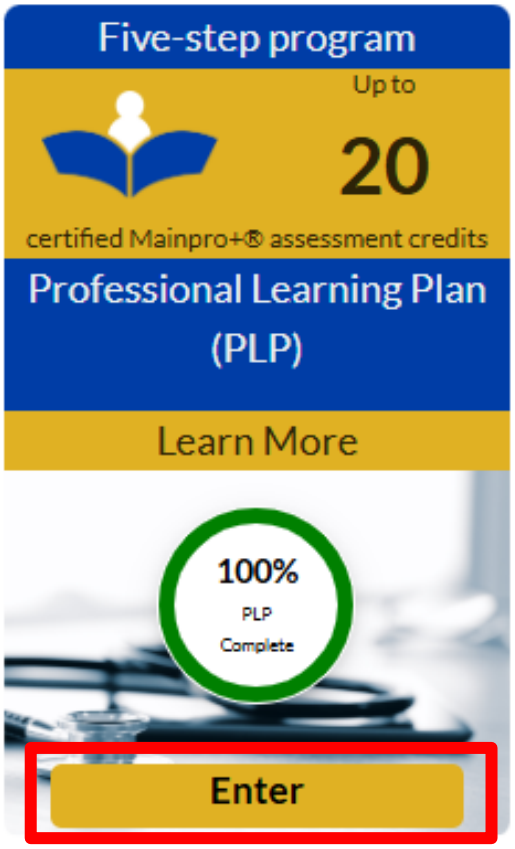
Professional Learning Plan (PLP)

The PAP HUB provides easy access to your current and completed Professional Learning Plans. Click the 'Enter' button on the image to the right to begin a new PAP or resume your in-progress PAP.
Once you have completed your PLP(s), they will be listed below. You can then click the 'Actions' dropdown to:

- Print your Certificate, Completed PLP, or Activity Summary
- View your Completed PLP module

For more information on Professional Learning Plans click HERE.

Need Help?

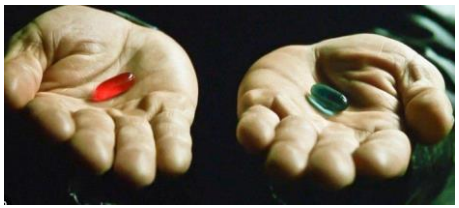



Five-step program
Up to
20
Certified
Mainpro+® assessment credits
Welcome to the CFPC Professional Learning Plan (PLP)
Enter

BLUE Pill or the RED Pill

1. Self guided or peer- supported
2. 5 step program, with post – reflection

3. Suggestions from calendar of events
4. E-mail reminders



PLP

1. Scope of practice
2. Identify Gaps
    - Pick suggestions available from CanMEDS – FM
    - Select the resources you can access
        - Drop down menu
3. SMART goals
    - Set your goal (e.g clinical, personal, etc)
    - Set interim goals (up to 3)
    - Ability to enroll in CFPC programs that may help in your goal
    - Timelines established
4. Commitment to change
    - Identify what can be controlled or not
    - Small tests for what can be controlled
5. Reflection
    - Email reminder is received – based on timeline(s) chosen
    - Share progress, reflections, successes, barriers
    - If goal not reached, can be reflected on
    - E-mail reminder for reflection exercise
        - Reached goal, partial, did not reach

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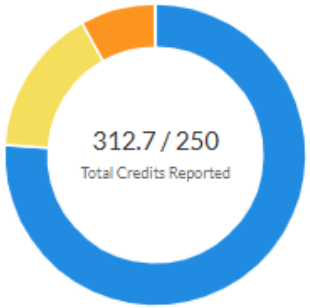
Cycle Progress

Cycle Type	Cycle End Date	Status
Default	2027-06-30	Your 5-Year Cycle Requirements Have Been Met



Certified + Certified Assessment Credits
282.7 Complete — 125 Required

Certified Assessment credits
59 Complete — 4 Required

Annual Credits (July 1 to June 30)
58.25 Complete — 25 Required

Certified credits (223.7) › | Certified Assessment credits (59) › | Non-Certified credits (30) › | Annual Credits (58.25) ›

Show Maximum Credit Activities

Linking Learning to…

1. Activity details
    i. Include the CanMEDS roles that apply
2. Consider the information available
3. Critical appraisal of the information
4. Make a decision (? PDSA) based on the appraisal
5. Reflect (6 – 12 weeks)
6. Evaluate the impact
    1. What are you doing differently
    2. What are the successes, barriers
    3. What further changes would you consider, or do differently

DFCM - Toronto

6 credits

Primary Care Clinician Educational Series

This free self-learning series from the DFCM is designed to provide primary care clinicians with the knowledge and skills to lead quality improvement work in their practice.

There are nine e-modules that cover a range of topics from the **Model for Improvement** to foundational concepts for health system change including **patient engagement, equity, patient safety,** and **leading change.** The final module describes how the series can support family physicians to complete their QI requirements for the College of Physicians and Surgeons of Ontario.

The modules are interactive and include videos, practical resources and examples of real-world application as well as links to journal articles, reports, and websites. The series is designed both as a continuous learning experience and as a resource that users can refer back to as needed. It can be done from start to finish or users can focus on the modules that are most relevant to them.

This 1-credit per hour Self-Learning program has been certified by the College of Family Physicians of Canada for up to **6 Mainpro+ credits.**

If you have any questions about this educational series please email dfcm.quality@utoronto.ca.

Improving quality in primary care: an educational series for primary care clinicians

Primary care clinician series overview | Preview the modules

Register to access the modules

cpd.utoronto.ca/ideas/

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IDEAS
Foundations of
Quality Improvement

Two Spring 2026 Program Sessions