Ontario
Health Quality Ontario

Long-Term Care Practice Report

Dr. Sample Data

Period Ending: December 31, 2015

Endorsed by:

ONTARIO LONG TERM CARE PHYSICIANS

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Report Overview

Background

Physicians who provide care to people living in long-term care (LTC) homes are dedicated to quality improvement, but may not have easy access to regional and provincial data to inform these efforts. The *Long-Term Care Practice Report* addresses this need and supports quality improvement by providing information about your LTC practice. **By signing up to receive this confidential report, you have requested data specific to your LTC practice.** This current report focuses on indicators related to the prescribing of antipsychotics. Future editions may be expanded to include additional topics.

How to use this report

The report is divided into five sections:

- A dashboard for the prescribing indicators
- Detailed data for each antipsychotic prescribing indicator
- Resident demographic characteristics
- Yearly Continuing Care Reporting System (CCRS) data
- Change ideas for quality improvement.

This report is intended to complement other sources of information you may receive (e.g., your pharmacy reports). It provides information to help you better understand your antipsychotic prescribing rates and set quality improvement targets. In addition to your practice rates, this report also provides Local Health Integration Network (LHIN) and provincial rates, as well as rates stratified by relevant diagnosis groups and the LTC homes in which you practise (with up to three LTC homes in which most of your residents live).

Details about the report

Considerations when reading this report include the following:

- Your residents and the LTC homes in which you work were identified using the Ontario Health Insurance Plan (OHIP) Claims History Database and the Ontario Drug Benefit (ODB) Program Database.
- Due to coding practices in OHIP data, you may find that **not every LTC home in which you work is identified in this report.** Please see the section entitled “Identifying the LTC homes you work in” on page 19 for details on how to correct this in future reports.
- The first four prescribing indicators in this report measure the **presence of a dispensed medication**. In LTC, the majority of prescriptions are filled and delivered to the home; thus, this report refers to the prescription rather than the dispensing of medications to focus on the clinician’s perspective.
- It is not possible to identify in the data which prescriptions are for medications taken on an as-needed basis (PRN).
- The report does not include information on medications provided to a resident when in hospital.
- To maintain confidentiality, data is suppressed as per ICES' privacy policies (shown as N/R).
- Diagnoses are identified by examining five years of OHIP, Discharge Abstract Database (DAD), Ontario Mental Health Reporting System (OMHRS) and one year of ODB.

See page 19 for more detailed information about the methodology.

Excel data tables that include the numerator, denominator and rate for each indicator at the practice, LHIN and provincial levels, can be downloaded after you log in at www.hqontario.ca/LTCreport.

Reporting periods: Data for your residents are compiled each quarter. Graphs are labelled using the final month of each quarter and the last two digits of the calendar year (e.g., the label ‘Mar 14’ denotes January 1 to March 31, 2014).

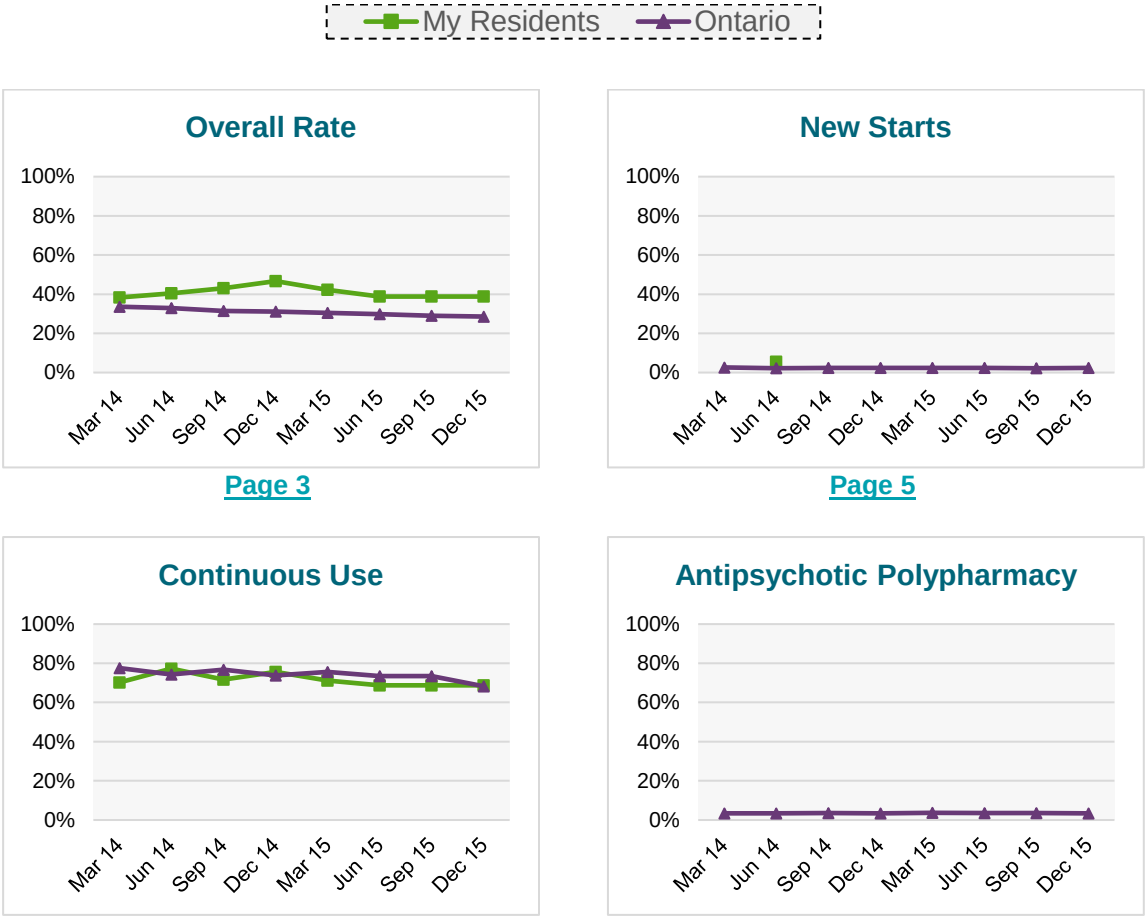
A new report will be provided to you each quarter, and Health Quality Ontario will notify you by email of each release.

My Dashboard

Data sources: **OHIP, ODB, DAD, OMHRS**
My LHIN: **LHIN X**

What are my antipsychotic prescribing patterns?

Data reporting period: **January 1, 2014 – December 31, 2015**



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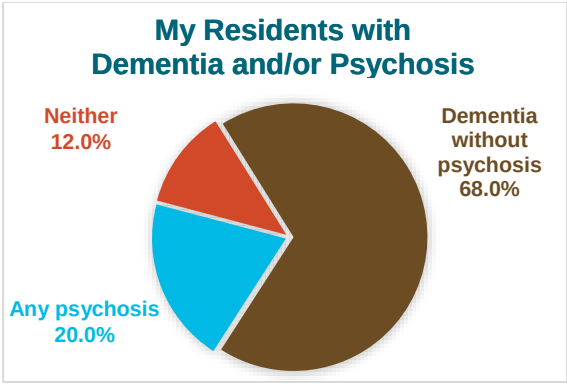
For more information on your results, please click on the page-number link located under each graph.
Data are suppressed to maintain confidentiality (shown as N/R).

Who are all my residents?

Data reporting period:
October 1, 2015 – December 31, 2015

150 # of Residents	**84** Mean Age
29% | **71%** Male | Female	**9%** % New Residents

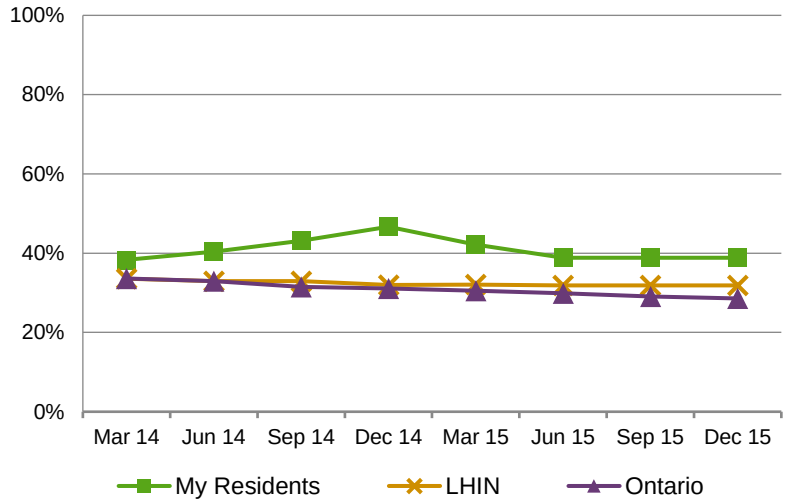


*Diagnoses captured through previous five years of OHIP/DAD/OMHRS data and one year of ODB data.

Overall Rate: Percentage of residents aged 66 and older who have been prescribed an antipsychotic medication

Overall Rate,

by my LTC practice, LHIN and Ontario, January 1, 2014 to December 31, 2015

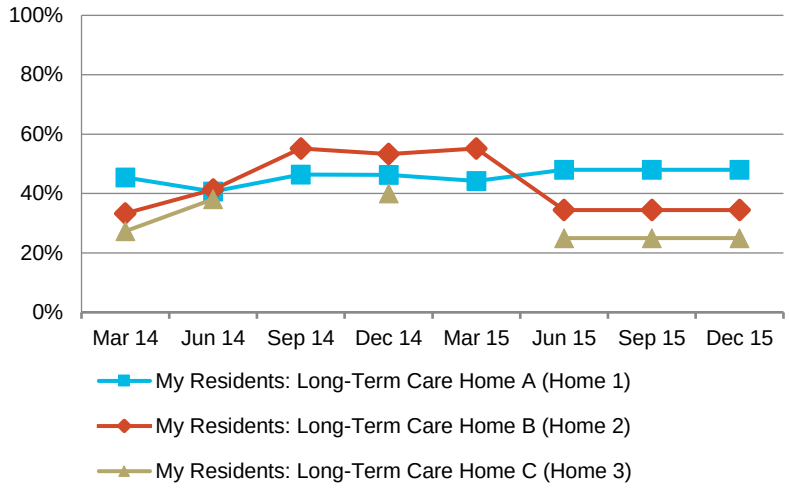


Period	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15
My Residents	38.3	40.4	43.1	46.7	42.2	38.8	38.8	38.8
LHIN	33.6	32.9	32.9	32.0	32.1	31.9	31.9	31.9
Ontario	33.6	32.9	31.5	31.1	30.5	29.9	29.0	28.6

Data Sources: OHIP, ODB, DAD, OMHRS databases
N/R: Not Reported, N/A: Not Available

Overall Rate,

by my LTC Home(s)†, January 1, 2014 to December 31, 2015



Period	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15
My Residents: LTC Home 1	45.5	40.7	46.4	46.3	44.2	48.0	48.0	48.0
My Residents: LTC Home 2	33.3	41.4	55.2	53.3	55.2	34.5	34.5	34.5
My Residents: LTC Home 3	27.3	38.1	N/R	40.0	N/R	25.0	25.0	25.0

Data Sources: OHIP, ODB, DAD, OMHRS databases
†Note: The LTC Home(s) you practise in are identified through the OHIP claims information. Please refer to the detailed Methodology (page 19) or contact practicereport@hqontario.ca if the home(s) listed here do not reflect your LTC practice.

What are the inclusions/exclusions for this indicator?

This denominator includes: *all* residents aged 66 and older who are not in palliative care.

This indicator excludes: 38 residents under the age of 66 and 9 residents in palliative care for the most recent quarter of data. After these exclusions, there were 103 residents in the denominator.

Overall Rate,

by diagnosis for my LTC practice, LHIN and Ontario, October 1, 2015 to December 31, 2015

	Rate among residents with a diagnosis of **Any Psychosis**	Rate among residents with a diagnosis of **Dementia Without Psychosis**	Rate among residents with a diagnosis of **Neither Psychosis nor Dementia**
My Residents	52.4%	31.3%	N/R
LHIN	54.3%	29.6%	13.9%
Ontario	49.0%	25.7%	11.5%

Data Sources: OHIP, ODB, DAD, OMHRS databases
N/R: Not Reported, N/A: Not Available

†*Psychosis* includes a diagnosis of schizophrenia, bipolar disorder, other psychoses (including dementia related psychosis), tics or Huntington's disease. Residents who have a diagnosis of both psychosis and dementia are included in the "any psychosis" group.

What is the indicator measuring?

This indicator provides information on your residents aged 66 and older who have at least one prescription for an antipsychotic medication dispensed, including those with a recorded diagnosis of psychosis or dementia (1) (2) (3). This indicator includes residents with PRN prescriptions.

To better understand your rates, the data are stratified by the LTC home(s) in which you work and by diagnosis groups. The home level data present your rates for up to three homes in which most of your residents live. The data provided by diagnosis are stratified into three mutually exclusive groups based on whether residents have any recorded diagnosis of psychosis or dementia *within the previous five years*.

What are the data showing me?

Between October 1, 2015 and December 31, 2015, 40 of your residents had at least one prescription for an antipsychotic medication filled. The graph "Overall Rate by my LTC practice" shows that your overall rate for this quarter was 38.8%, and the provincial rate was 28.6%.

The rates for up to three homes where you had the most residents can be found in the graph "Overall Rate by my LTC Home(s)".

Finally, the table "Overall Rate by Diagnosis" shows that 32 of your residents had a recorded diagnosis of dementia without psychosis. Among these residents, your antipsychotic prescription rate was 31.3%, and the provincial rate was 25.7%.

Why is the overall rate important to measure?

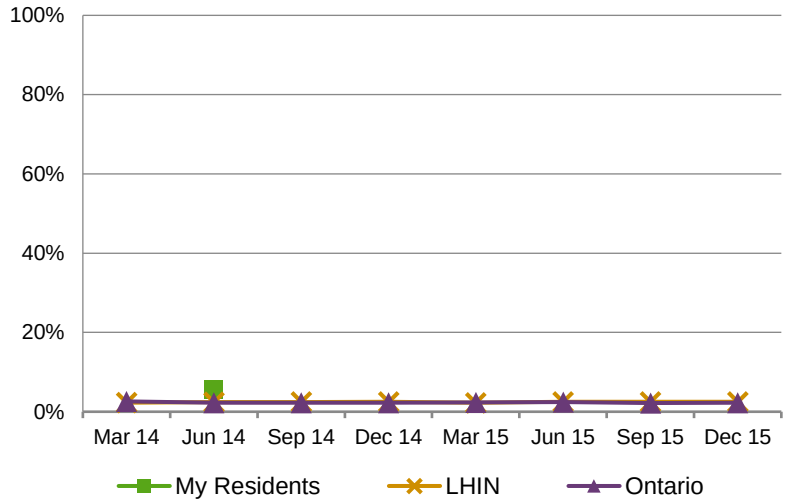
The overall rate is meant to provide an overview of antipsychotic prescribing rates in your practice. The data stratified by LTC homes and by diagnosis groups may help identify the home or diagnosis group driving your overall rates. As well, residents with different diagnoses may have different treatment needs and goals. After reflecting on your rates, you may consider identifying an improvement target for a specific LTC home or group of residents with a specific diagnosis, and test one or more change ideas to move your practice toward your specific target for that group.

To help optimize your antipsychotic prescribing, review the **change ideas** on page 15.

New Starts: Percentage of residents aged 66 and older with a new prescription for an antipsychotic medication

New Starts,

by my LTC practice, LHIN and Ontario, January 1, 2014 to December 31, 2015

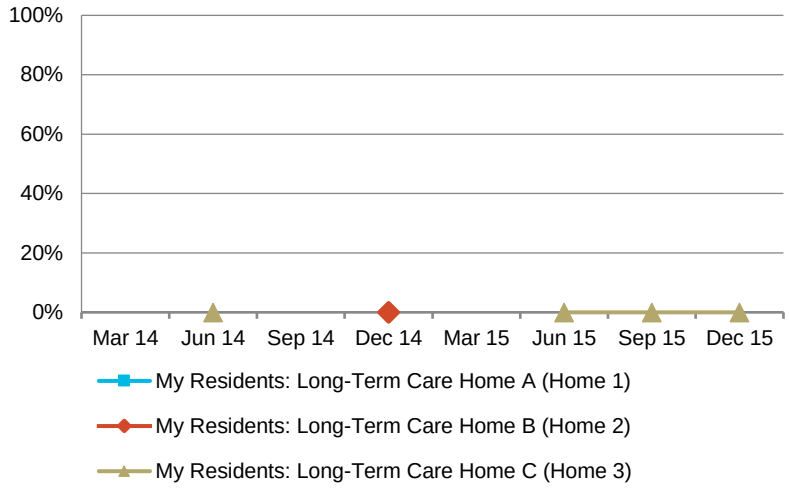


Period	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15
My Residents	N/R	5.5	N/R	N/R	N/R	N/R	N/R	N/R
LHIN	2.3	2.4	2.5	2.5	2.3	2.5	2.5	2.5
Ontario	2.6	2.3	2.3	2.3	2.4	2.4	2.2	2.3

Data Sources: OHIP, ODB, DAD, OMHRS databases
N/R: Not Reported, N/A: Not Available

New Starts,

by my LTC Home(s) †, January 1, 2014 to December 31, 2015



Period	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15
My Residents: LTC Home 1	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
My Residents: LTC Home 2	N/R	N/R	N/R	0.0	N/R	N/R	N/R	N/R
My Residents: LTC Home 3	N/R	0.0	N/R	N/R	N/R	0.0	0.0	0.0

Data Sources: OHIP, ODB, DAD, OMHRS databases
†Note: The LTC Home(s) you practise in are identified through the OHIP claims information. Please refer to the detailed Methodology (page 19) or contact practicereport@hqontario.ca if the home(s) listed here do not reflect your LTC practice.

What are the inclusions/exclusions for this indicator?

This denominator includes: *all* residents aged 66 and older who are not in palliative care. The first antipsychotic prescription in the quarter is "new" if there were no other prescriptions for antipsychotics in the previous 12 months.

This indicator excludes: 38 residents under the age of 66 and 9 residents in palliative care. After these exclusions, there were 103 residents in the denominator for the most recent quarter of data.

New Starts,

by diagnosis for my LTC practice, LHIN and Ontario, October 1, 2015 to December 31, 2015

	Rate among residents with a diagnosis of **Any Psychosis**	Rate among residents with a diagnosis of **Dementia Without Psychosis**	Rate among residents with a diagnosis of **Neither Psychosis nor Dementia**
My Residents	54.0%	N/R	0.0%
LHIN	2.7%	2.6%	1.9%
Ontario	2.3%	2.3%	1.9%

Data Sources: OHIP, ODB, DAD, OMHRS databases
N/R: Not Reported, N/A: Not Available

†*Psychosis* includes a diagnosis of schizophrenia, bipolar disorder, other psychoses (including dementia related psychosis), tics or Huntington's disease. Residents who have a diagnosis of both psychosis and dementia are included in the "any psychosis" group.

What is the indicator measuring?

This indicator provides information on your residents aged 66 and older who have a prescription for an antipsychotic medication, and did not have a prescription for any antipsychotic medication in the previous 12 months (4). This indicator includes residents with a recorded diagnosis of psychosis and PRN prescriptions.

To better understand your rates, the data are stratified by the LTC home(s) in which you work and by diagnosis groups. The home level data present your rates for up to three homes in which most of your residents live. The data provided by diagnosis are stratified into three mutually exclusive groups based on whether residents have any recorded diagnosis of psychosis or dementia *within the previous five years.*

What are the data showing me?

Between October 1, 2015 and December 31, 2015, N/R of your residents had a new prescription for an antipsychotic medication. The graph "New Starts by my LTC practice" shows that your new starts rate for this quarter was N/R, and the provincial rate was 2.3%.

The rates for up to three homes where you had the most residents can be found in the graph "New Starts by my LTC Home(s)".

Finally, the table "New Starts by Diagnosis" shows that 32 of your residents had a recorded diagnosis of dementia without psychosis. Among these residents, your antipsychotic prescription rate was N/R, and the provincial rate was 2.3%.

Why are new starts important to measure?

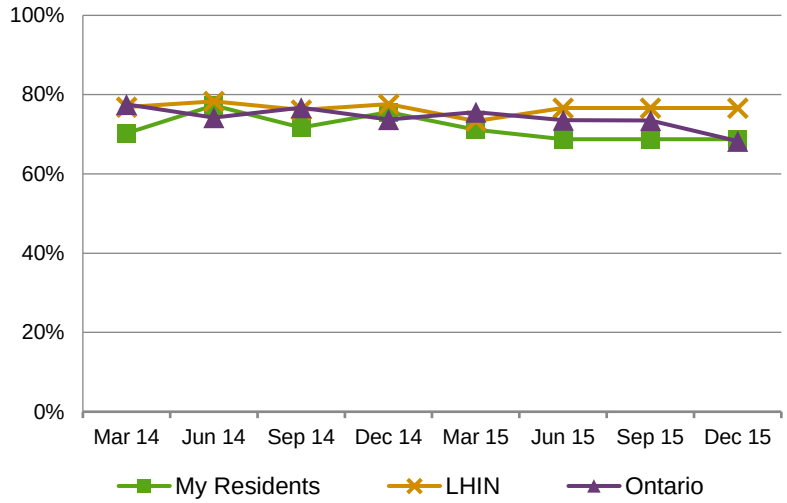
This indicator identifies a subset of your residents from the "Overall Rate", who may have recently been started on an antipsychotic medication. This information will help you to understand whether the number of residents newly started on an antipsychotic is influencing your "Overall Rate". If the number of your residents who have a new prescription is between one and five, then your rate will be suppressed. After reflecting on your rates, you may consider identifying an improvement target and test one or more change ideas to move your practice toward your specific target for the "New Starts" rate.

To help optimize your antipsychotic prescribing, review the **change ideas** on page 15.

Continuous Use: Percentage of residents aged 66 and older with a prescription for an antipsychotic medication for at least 90 continuous days

Continuous Use,

by my LTC practice, LHIN and Ontario, January 1, 2014 to December 31, 2015

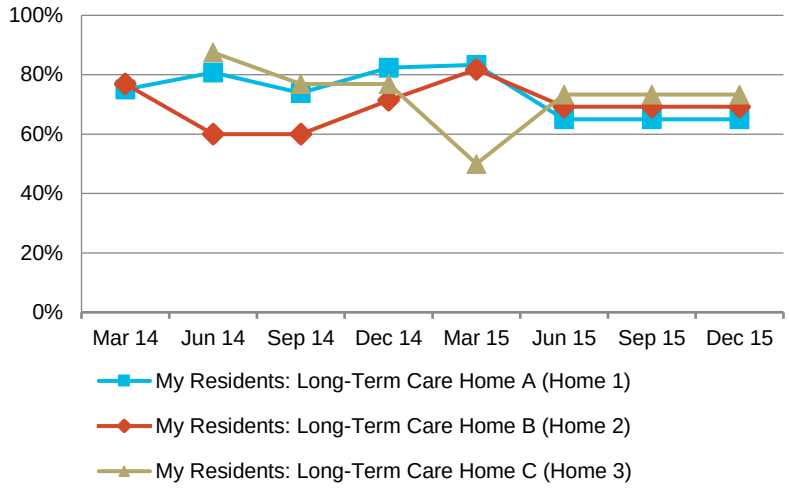


Period	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15
My Residents	70.2	77.3	71.7	75.6	71.1	68.8	68.8	68.8
LHIN	76.9	78.3	76.1	77.6	73.3	76.6	76.6	76.6
Ontario	77.6	74.2	76.7	73.8	75.6	73.5	73.5	68.3

Data Sources: OHIP, ODB, DAD, OMHRS databases
N/R: Not Reported, N/A: Not Available

Continuous Use,

by my LTC Home(s) †, January 1, 2014 to December 31, 2015



Period	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15
My Residents: LTC Home 1	75.0	80.8	73.9	82.4	83.3	65.0	65.0	65.0
My Residents: LTC Home 2	76.9	60.0	60.0	71.4	81.8	69.2	69.2	69.2
My Residents: LTC Home 3	N/R	87.5	76.9	76.9	50.0	73.3	73.3	73.3

Data Sources: OHIP, ODB, DAD, OMHRS databases
†Note: The LTC Home(s) you practise in are identified through the OHIP claims information. Please refer to the detailed Methodology (page 19) or contact practicereport@hqontario.ca if the home(s) listed here do not reflect your LTC practice.

What are the inclusions/exclusions for this indicator?

This denominator includes: residents aged 66 and older, who are not in palliative care, have been in LTC for at least 100 days, and have at least one prescription for an antipsychotic medication.

This indicator excludes: 38 residents under the age of 66, 9 residents in palliative care, residents in LTC for less than 100 days, and residents without any prescriptions for antipsychotic medications for the most recent quarter of data.

Continuous Use,

by diagnosis for my LTC practice, LHIN and Ontario, October 1, 2015 to December 31, 2015

	Rate among residents with a diagnosis of **Any Psychosis**	Rate among residents with a diagnosis of **Dementia Without Psychosis**	Rate among residents with a diagnosis of **Neither Psychosis nor Dementia**
My Residents	84.4%	70.0%	N/R
LHIN	81.1%	75.3%	73.7%
Ontario	73.5%	65.8%	64.8%

Data Sources: OHIP, ODB, DAD, OMHRS databases
N/R: Not Reported, N/A: Not Available

†*Psychosis* includes a diagnosis of schizophrenia, bipolar disorder, other psychoses (including dementia related psychosis), tics or Huntington's disease. Residents who have a diagnosis of both psychosis and dementia are included in the "any psychosis" group.

What is the indicator measuring?

This indicator provides information on your residents aged 66 and older who have a prescription for an antipsychotic medication for a period of 90 continuous days measured from the last date of contact in the reporting quarter (1) (5) (6) (7). Medications must have been prescribed (i.e., dispensed) in LTC to be included in this indicator; thus, residents who have been in LTC for fewer than 100 days are excluded. This indicator allows for a brief gap of one day between the end of one prescription and filling the next prescription. The denominator for this indicator is the number of your residents who have at least one prescription for an antipsychotic medication.

To better understand your rates, the data are stratified by the LTC home(s) in which you work and by diagnosis groups. The home-level data present your rates for up to three homes in which most of your residents live. The data provided by diagnosis are stratified into three mutually exclusive groups based on whether residents have any recorded diagnosis of psychosis or dementia *within the previous five years*.

What are the data showing me?

The graph "Continuous Use by my LTC practice" shows that between October 1, 2015 and December 31, 2015, 68.8% of your residents had a prescription for an antipsychotic medication for 90 continuous days, and the provincial rate was 68.3%.

The rates for up to three homes where you had the most residents can be found in the graph "Continuous Use by my LTC Home(s)".

Finally, the table "Continuous Use by Diagnosis" shows that among your residents with a recorded diagnosis of dementia without psychosis, your antipsychotic prescription rate was 70.0% and the provincial rate was 65.8%.

Why is continuous use important to measure?

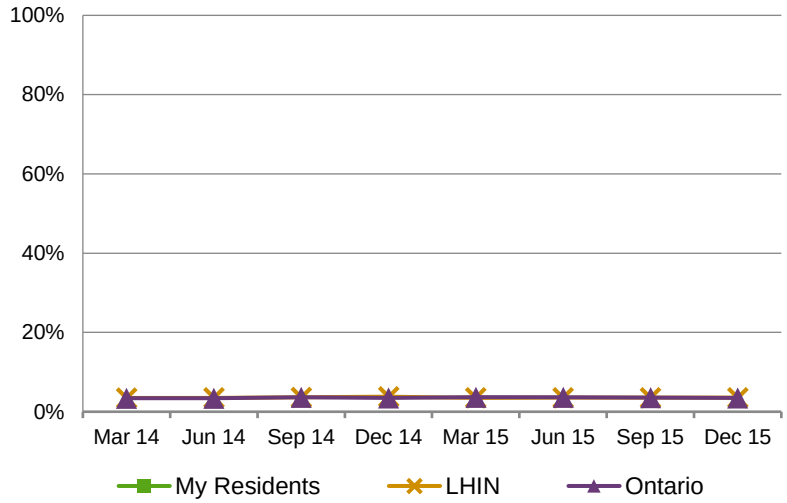
This indicator is intended to support the medication review process by helping to identify the residents who may have been on antipsychotic medications in LTC for at least three months. It also may help identify your residents who only have a diagnosis of dementia (i.e., without psychosis) who could be considered for a gradual trial of weaning if the target behaviours are improved or no longer present. After reflecting on your rates, you may consider identifying an improvement target and test one or more change ideas to move your practice toward your specific target for the "Continuous Use" rate.

To help optimize your antipsychotic prescribing, review the **change ideas** on page 15.

Antipsychotic Polypharmacy: Percentage of residents aged 66 and older with concomitant prescriptions for at least two different antipsychotic medications

Antipsychotic Polypharmacy,

by my LTC practice, LHIN and Ontario, January 1, 2014 to December 31, 2015

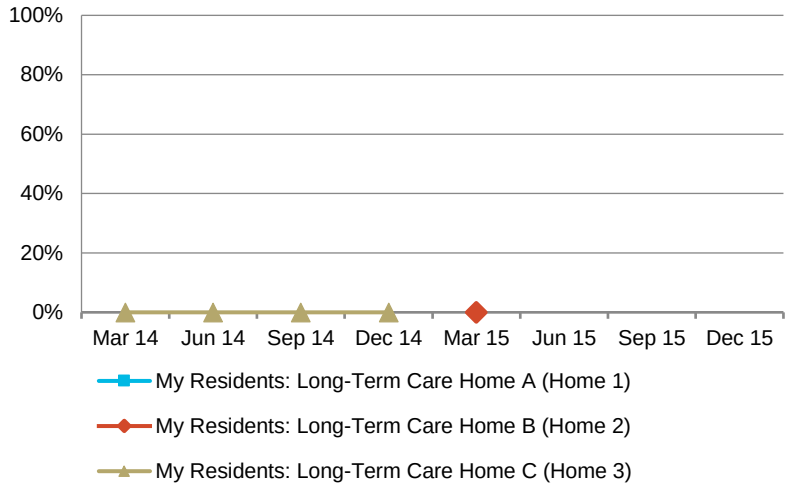


Period	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15
My Residents	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
LHIN	3.5	3.5	3.6	3.8	3.5	3.5	3.5	3.5
Ontario	3.4	3.4	3.6	3.5	3.7	3.6	3.6	3.5

Data Sources: OHIP, ODB, DAD, OMHRS databases
N/R: Not Reported, N/A: Not Available

Antipsychotic Polypharmacy,

by my LTC Home(s) †, January 1, 2014 to December 31, 2015



Period	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15
My Residents: LTC Home 1	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
My Residents: LTC Home 2	N/R	N/R	N/R	N/R	0.0	N/R	N/R	N/R
My Residents: LTC Home 3	0.0	0.0	0.0	0.0	N/R	N/R	N/R	N/R

Data Sources: OHIP, ODB, DAD, OMHRS databases
†Note: The LTC Home(s) you practise in are identified through the OHIP claims information. Please refer to the detailed Methodology (page 19) or contact practicereport@hqontario.ca if the home(s) listed here do not reflect your LTC practice.

What are the inclusions/exclusions for this indicator?

This denominator includes: residents aged 66 and older, who are not in palliative care, have been in LTC for at least 100 days, and have at least one prescription for an antipsychotic medication.

This indicator excludes: 38 residents under the age of 66, 9 residents in palliative care, residents in LTC for less than 100 days, and residents without any prescriptions for antipsychotic medications for the most recent quarter of data.

Antipsychotic Polypharmacy,

by diagnosis for my LTC practice, LHIN and Ontario, October 1, 2015 to December 31, 2015

	Rate among residents with a diagnosis of **Any Psychosis**	Rate among residents with a diagnosis of **Dementia Without Psychosis**	Rate among residents with a diagnosis of **Neither Psychosis nor Dementia**
My Residents	N/R	N/R	0.0%
LHIN	7.6%	1.9%	N/R
Ontario	6.2%	2.1%	2.5%

Data Sources: OHIP, ODB, DAD, OMHRS databases
N/R: Not Reported, N/A: Not Available

†*Psychosis* includes a diagnosis of schizophrenia, bipolar disorder, other psychoses (including dementia related psychosis), tics or Huntington's disease. Residents who have a diagnosis of both psychosis and dementia are included in the "any psychosis" group.

What is the indicator measuring?

This indicator provides information on your residents aged 66 and older who have concomitant prescriptions for at least two different antipsychotic medications, each for 90 continuous days (1) (5). Medications must have been prescribed (i.e., dispensed) in LTC to be included in this indicator; thus, residents who have been in LTC for fewer than 100 days are excluded. Different antipsychotic medications are defined by drug name. The denominator for this indicator is the number of your residents who have at least one prescription for an antipsychotic medication.

To better understand your rates, the data are stratified by the LTC home(s) in which you work and by diagnosis groups. The home-level data present your rates for up to three homes in which most of your residents live. The data provided by diagnosis are stratified into three mutually exclusive groups based on whether residents have any recorded diagnosis of psychosis or dementia *within the previous five years*.

What are the data showing me?

The graph "Antipsychotic Polypharmacy by my LTC practice" shows that between October 1, 2015 and December 31, 2015, N/R of your residents had concomitant prescriptions for at least two different antipsychotic medications, each for 90 continuous days, and the provincial rate was 3.5%.

The rates for up to three homes where you had the most residents can be found in the graph "Antipsychotic Polypharmacy by my LTC Home(s)".

Finally, the table "Antipsychotic Polypharmacy by Diagnosis" shows that among your residents with a recorded diagnosis of dementia without psychosis, your antipsychotic prescription rate was N/R, and the provincial rate was 2.1%.

Why is antipsychotic polypharmacy important to measure?

This indicator is intended to help with medication reviews by identifying the LTC residents who may be receiving two or more different antipsychotic medications at the same time, thereby contributing to possible antipsychotic polypharmacy. These residents could be reviewed to determine: 1) if one of the antipsychotics is a PRN prescription that could be discontinued; or 2) if an optimal dose or use of a single antipsychotic could be substituted for a prescribed combination of antipsychotics. After reflecting on your rates, you may consider identifying an improvement target and test one or more change ideas to move your practice toward your specific target for the "Antipsychotic Polypharmacy" rate.

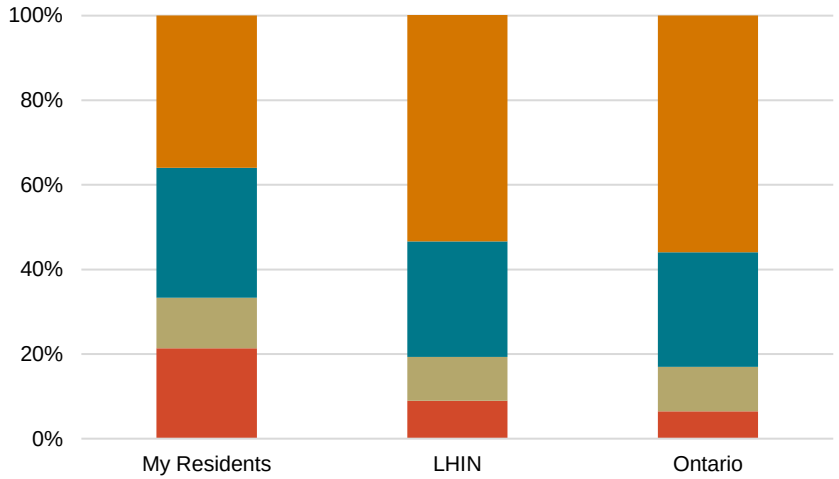
To help optimize your antipsychotic prescribing, review the **change ideas** on page 15.

Characteristics for All of My Residents

Data reporting period: **October 1, 2015 – December 31, 2015**
Data sources: **OHIP, ODB, DAD, OMHRS**

Age Cohorts,

by my LTC practice, LHIN and Ontario, October 1, 2015 to December 31, 2015

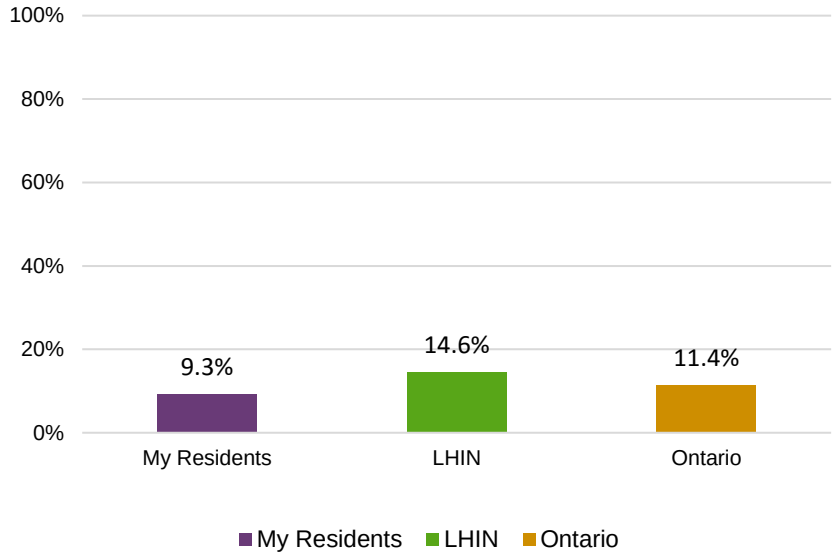


	< 65 years	65 – 74 years	75 – 84 years	85+ years
My Residents	21.3	12.0	30.7	36.0
LHIN	8.9	10.4	27.3	55.9
Ontario	6.5	10.5	27.1	56.0

Data Sources: OHIP, ODB, DAD, OMHRS databases
N/R: Not Reported, N/A: Not Available

New Residents,

by my LTC practice, LHIN and Ontario, October 1, 2015 to December 31, 2015



Data Sources: OHIP, ODB, DAD, OMHRS databases
N/R: Not Reported, N/A: Not Available

Who are the "new" residents?

This indicator shows the overall percentage of residents who have been in LTC for less than 100 days in your practice, your LHIN and Ontario. *Note: Residents may have been in more than one LTC home during this period.

CIHI Antipsychotic indicator: Percentage of residents on antipsychotics without a diagnosis of psychosis

Data reporting period: **April 1, 2014 – March 31, 2015**
Data source: **CCRS**
Please note that data in this section are based on a different time frame and data source than the previous sections.

Data interpretation considerations

This CIHI antipsychotic indicator captures the **use** of antipsychotic medication in LTC among residents who do not have a diagnosis of psychosis. This indicator excludes residents who have a diagnosis of schizophrenia or Huntington's chorea, are end-stage disease, are receiving hospice care, or are experiencing hallucinations or delusions (8). Unlike the other prescribing indicators in this report that include residents aged 66 and older, this CIHI indicator has no lower age limit.

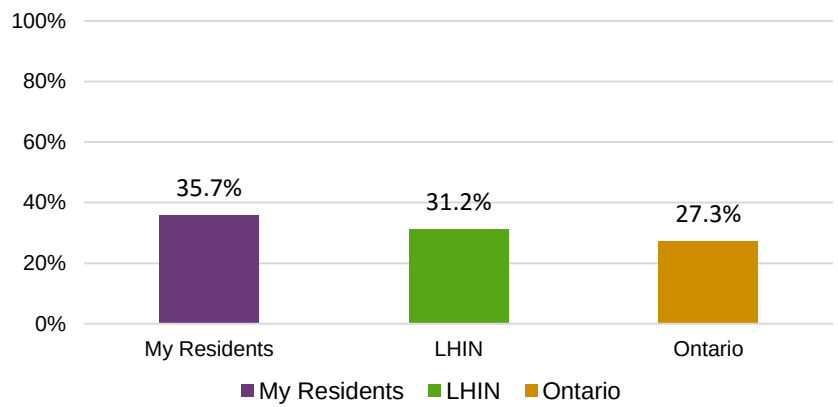
The CIHI indicator only captures diagnoses on the **current** RAI-MDS assessment, unlike the other indicators in this report that capture diagnoses over the previous five years through examining administrative databases. Also, the CIHI indicator excludes residents who have hallucinations or delusions from the indicator; whereas the OHIP/ODB indicators cannot capture these symptoms.

Overall, you may see some differences between your rates among residents with dementia alone and the CIHI indicator due to the differences in capturing diagnoses and symptoms. The CIHI indicator also captures the use of lithium, and this medication is not included in the drug list for the OHIP/ODB indicators in this report.

The CIHI data provide you with a description of your resident population that may help explain why your rates may differ from others. Information about your residents for the Aggressive Behaviour Scale (ABS), Cognitive Performance Scale (CPS), Depression Rating Scale (DRS), and Pain Scale can be found on the following pages (9).

CIHI Antipsychotic indicator,

by my LTC practice, LHIN and Ontario, April 1, 2014 to March 31, 2015



Data Source: CCRS (For this report, CIHI indicators are updated annually.)
N/R: Not Reported, N/A: Not Available

What are the inclusions/exclusions for this indicator?

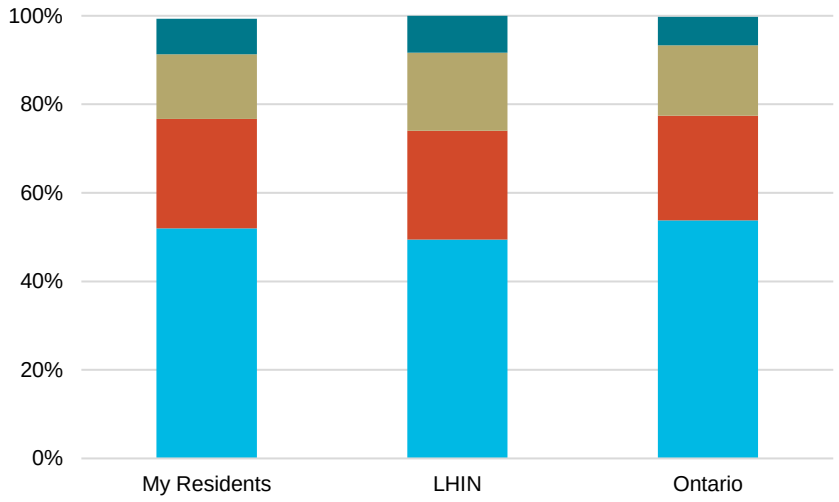
This indicator includes: residents without a diagnosis of psychosis who received an antipsychotic medication on at least one day in the week before the RAI assessment.

This indicator excludes: residents who have a diagnosis of schizophrenia or Huntington's chorea, are end-stage disease, are receiving hospice care, or are experiencing hallucinations or delusions.

More information, including home-level data, is available on the CIHI website (8).

Aggressive Behaviour Scale (ABS),

by my LTC practice, LHIN and Ontario, April 1, 2014 to March 31, 2015



	No Aggressive Behaviour (0)	Some Aggressive Behaviour (1-2)	Severe Aggressive Behaviour (3-5)	Very Severe Aggressive Behaviour (6 or more)
My Residents	52.0	24.7	14.7	8.0
LHIN	49.5	24.5	17.6	8.4
Ontario	53.8	23.7	15.9	6.4

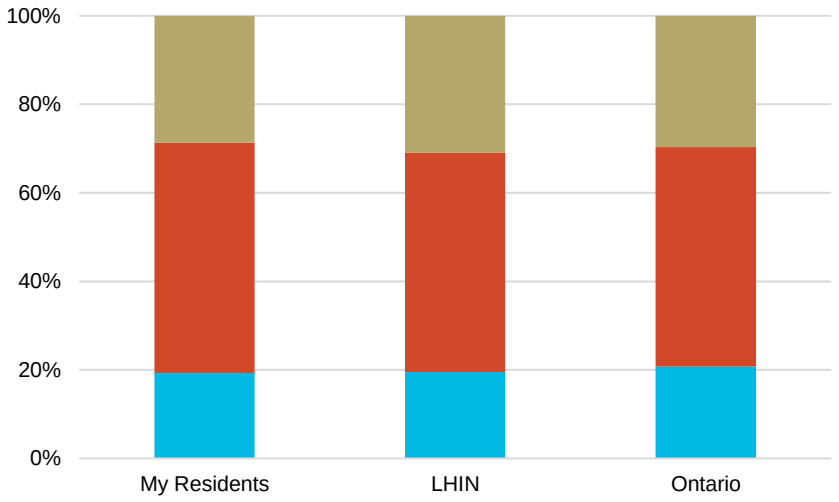
Data Source: CCRS (For this report, CIHI indicators are updated annually.)
N/R: Not Reported, N/A: Not Available

What is this scale measuring?

According to interRAI, the "Aggressive Behaviour Scale (ABS) is a measure of aggressive behaviour based on the occurrence of verbal abuse, physical abuse, socially disruptive behaviour and resistance of care. Scale scores range from 0-12 with higher scores indicative of greater frequency and diversity of aggressive behaviour. A score of 1 to 4 on the ABS indicates mild to moderate aggressive behaviour, whereas scores of 5 or more represent the presence of more severe aggression. This scale has been validated against the Cohen Mansfield Agitation Inventory." (10)

Cognitive Performance Scale (CPS),

by my LTC practice, LHIN and Ontario, April 1, 2014 to March 31, 2015



	Relatively Intact (0-1)	Mild/Moderate (2-3)	Severe (4-6)
My Residents	19.3	52.0	28.7
LHIN	19.5	49.6	30.9
Ontario	20.7	49.6	29.6

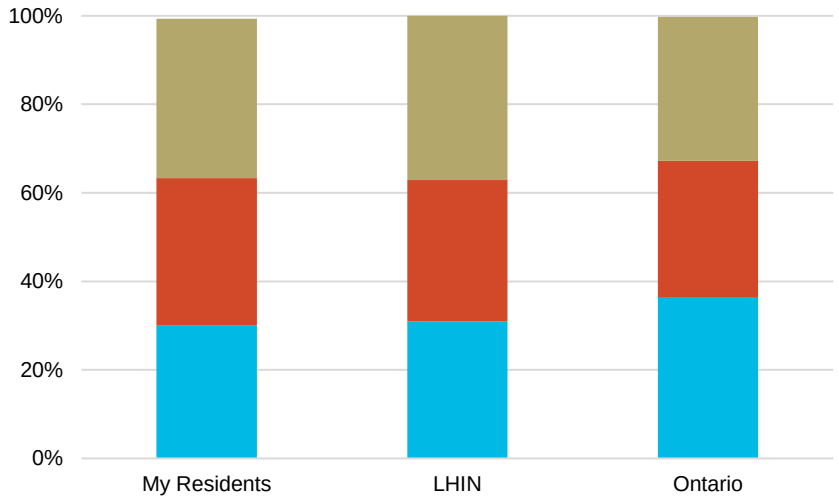
Data Source: CCRS (For this report, CIHI indicators are updated annually.)
N/R: Not Reported, N/A: Not Available

What is this scale measuring?

According to interRAI, the "Cognitive Performance Scale (CPS) combines information on memory impairment, level of consciousness, and executive function, with scores ranging from 0 (intact) to 6 (very severe impairment). The CPS has been shown to be highly correlated with the MMSE in a number of validation studies." (10)

Depression Rating Scale (DRS),

by my LTC practice, LHIN and Ontario, April 1, 2014 to March 31, 2015



	No Depressive Symptoms (0)	Some Depressive Symptoms (1-2)	Possible Depressive Disorder (3+)
My Residents	30.0	33.3	36.0
LHIN	30.9	31.9	37.1
Ontario	36.3	30.9	32.5

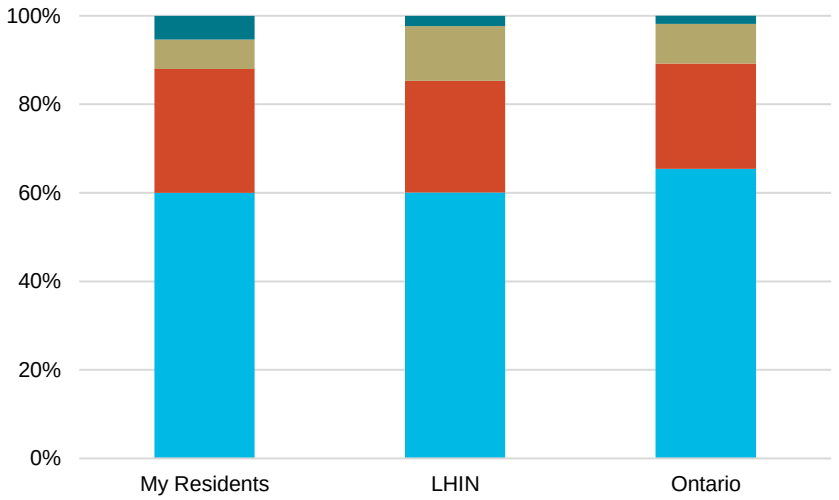
Data Source: CCRS (For this report, CIHI indicators are updated annually.)
N/R: Not Reported, N/A: Not Available

What is this scale measuring?

According to interRAI, the "Depression Rating Scale (DRS) is used as a clinical screen for depression. Validation studies were based on a comparison of the DRS with the Hamilton Depression Rating Scale and the Cornell Scale for Depression. Compared to DSM-IV major or minor depression diagnoses, the DRS was 91% sensitive and 69% specific at a cut-point score of 3 out of 7." (10)

Pain Scale,

by my LTC practice, LHIN and Ontario, April 1, 2014 to March 31, 2015



	No Pain (0)	Less Than Daily Pain (1)	Daily Pain, But Not Severe (2)	Severe Daily Pain (3)
My Residents	60.0	28.0	6.7	5.3
LHIN	60.1	25.2	12.4	2.3
Ontario	65.4	23.8	9.0	1.8

Data Source: CCRS (For this report, CIHI indicators are updated annually.)
N/R: Not Reported, N/A: Not Available

What is this scale measuring?

According to interRAI, the "Pain Scale was originally developed for use with nursing home residents and later translated for use with other interRAI instruments. The scale uses two items to create a score from 0 to 3. It has been shown to be highly predictive of pain as measured by the Visual Analogue Scale." (10)

Change Ideas

What you can do to help manage your residents who are prescribed antipsychotics

For some residents of Ontario's long-term care homes, antipsychotic medications improve quality of life and reduce suffering. But for other residents, these drugs may bring more risks than benefits. To optimize antipsychotic use, the following table will help you identify areas for improvement, based on key antipsychotic prescribing indicators. These indicators provide a snapshot of data that you can use to understand your current prescribing patterns and identify an improvement target, as well as to test one or more of the following change ideas to help you move toward that target.

To learn more about *how* to make changes in your practice, visit HQO's Quality Compass *Quality Improvement: Getting Started* section http://qualitycompass.hqontario.ca/portal/getting-started

Opportunities for improvement	Indicator	Current performance	Set your target
Optimize antipsychotic prescribing	Overall Rate: Percentage of residents aged 66 and older who have been prescribed an antipsychotic medication	38.8%	Decrease/maintain By how much? _____% By when? _____ (date)
	New Starts: Percentage of residents aged 66 and older with a new prescription for an antipsychotic medication	N/R	Decrease/maintain By how much? _____% By when? _____ (date)
	Continuous Use: Percentage of residents aged 66 and older with a prescription for an antipsychotic medication for at least 90 continuous days	68.8%	Decrease/maintain By how much? _____% By when? _____ (date)
	Antipsychotic Polypharmacy: Percentage of residents aged 66 and older with concomitant prescriptions for at least two different antipsychotic medications	N/R	Decrease/maintain By how much? _____% By when? _____ (date)
	CIHI Antipsychotic indicator: Percentage of residents on antipsychotics without a diagnosis of psychosis	35.7%	Decrease/maintain By how much? _____% By when? _____ (date)

Identify areas for improvement and test changes

First, identify areas of focus to improve your antipsychotic prescribing indicators by asking yourself these questions:

1. Does your LTC home have any improvement work underway?
2. Are you able to identify your residents who are prescribed antipsychotics?
3. Have you and your team mapped the medication review process to identify potential gaps and test improvements?
4. Do you and your team have a process to create and update residents' individualized behavioural care plans?
5. What tools and processes are you using to optimize prescibing of antipsychotics to your residents?

Once you identify the areas you would like to improve, review the change ideas that accompany each question:

1 Find out if there are any improvement efforts planned and/or underway

For example, consider asking your nursing administrator:

a) What opportunities exist to work with current behavioural support resources/processes at the home? For example:

- Behavioural Response Team
- Champions
- Quality Improvement (QI) Plans
- QI Team

b) What external resources and supports are available? For example:

- Psychogeriatric Resource Consultant, Behavioural Supports Ontario (BSO), specialized outreach teams

2 Change ideas to identify your residents

a) Consider what data you currently receive from your LTC home and pharmacy provider. Are there additional data you need (e.g., indications, new starts, summary of responsive behaviours and interventions used)?

b) Verify the data. For example:

- Look at your number of residents, total number of residents prescribed antipsychotics and associated indications, number of new starts, and number of PRNs ordered and administration rate

c) Ask your pharmacy provider for a medication tracking tool

3 Change ideas to improve the medication review process

Consider the following strategies to enhance regular quarterly medication reviews:

a) Team approach involving the physician, pharmacist and nurse (11)

b) Standardized and simplified medication review process and documentation. View a sample worksheet from Alberta Health Services (12)

c) Staff identify residents on antipsychotics who may be appropriate to trial reducing/adjusting the antipsychotic dose

d) Staff prepare a summary of residents' recent behaviour prior to medication reviews

4 Change ideas to update and implement individualized behavioural care plans

a) Assess for Behavioural and Psychological Symptoms of Dementia and use findings to inform care plans and medication reviews (13) (14). Some standardized tools include:

- Dementia Observation System (DOS) detects behavioural patterns (15)
- Cohen Mansfield Agitation Inventory (CMAI) tracks the severity and disruptiveness of the behaviours (16)
- Kingston Standardized Behavioural Assessment (KSBA) assesses function, cognition and behaviour (17)

b) All behaviour has meaning: Screen and rule out possible medical problems or environmental triggers (e.g., pain, delirium, constipation) (18):

- Use the P.I.E.C.E.S.™ tool to assess for potential physical, intellectual, emotional, capabilities, environment and social causes of behaviours (19)
- Involve families/caregivers

c) Trial and review non-pharmacological strategies before considering antipsychotic medications, where appropriate (18) (20):

- Consider P.I.E.C.E.S.™, Montessori Methods, Gentle Persuasive Approaches. Click here for additional interventions (21)
- For additional strategies/supports, connect with the home's Responsive Behaviour Program and/or external resources and supports, if available

5 Change ideas for pharmacological interventions

a) Ensure optimal treatment of other conditions that could be contributing to symptoms (18)

b) Consider what behaviours may respond to antipsychotics and which do not (22)

c) Carefully weigh the potential benefits of pharmacological interventions versus the potential of harm (18)

d) If antipsychotics are required, trial the lowest effective dose for the shortest duration (23)

e) Monitor for effectiveness, tolerability and adverse effects. For example, the Behaviour and Symptom Mapping Tool (BSMT) (24)

f) Consult specialists for residents with complex needs/behaviours (13)

g) Involve residents and their families/Substitute Decision Maker in decisions (25)

- Obtain and document consent
- Family education tools and support (26): Choosing Wisely Canada, Alzheimer Society of Ontario

Additional supports to optimize antipsychotic prescribing

a) **Learn from your peers.** Reach out to colleagues through:

- HQO LTC Network activities & resources accessed after you log in to the Practice Reports Web Portal at www.hqontario.ca/LTCreport
- Ontario Long Term Care Physicians
- Long Term Care Medical Directors Association of Canada

b) **Connect with your regional specialized services:**

- Regional Geriatric Programs or local hospital or community-based geriatric consultation services

c) **Connect with provincial tools and supports:**

- Behavioural Supports Ontario
- Centre for Effective Practice's (CEP) Discussion Guide tool is designed to help providers understand, assess and manage residents with responsive behaviours; focusing on antipsychotic medications. The tool was developed as part of CEP's Academic Detailing Service for LTC homes
- Choosing Wisely Canada
- The brainXchange network

Quality Improvement Tools and Resources

Alberta Health Services. Appropriate Use of Antipsychotics (AUA) Toolkit for Care Teams - Medication review requirements of antipsychotics: Antipsychotic medication review sheet. [Online].; 2014. Available from: http://www.albertahealthservices.ca/frm-19676.pdf.

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Methodology

Identifying your LTC residents

To identify your LTC residents, which includes the people living in LTC for whom you have provided care in each reporting period, your College of Physicians and Surgeons of Ontario (CPSO) number was linked to health care administrative databases stored at the Institute for Clinical Evaluative Sciences (ICES). Your report includes LTC residents for whom you were the physician with the greatest number of billings based on a defined set of Ontario Health Insurance Plan (OHIP) History Claims Database LTC fee codes in each quarter. This was a two-step process based on the number of W010 fee code billings for residents with any of these billed, and then based on the remaining LTC fee codes for residents that did not have W010 billings. Since the OHIP data and Ontario Drug Benefit (ODB) Program Database are updated more frequently than other administrative databases at ICES, these were used to identify your residents for each quarter. Your resident group includes individuals between 19 and 115 years of age, who have information on date of birth, sex and a valid LTC institution number. The indicators have additional exclusion criteria; for example, the overall antipsychotic prescription rate will not include palliative care residents or those under the age of 66. Since eligibility for ODB coverage typically begins at age 65, the lower age limit for indicators is set at age 66 to be consistent for the OHIP/ODB indicators and to ensure there is one year of historical data on drug prescriptions for residents.

Identifying the LTC homes in which you work

As part of identifying your residents, the LTC homes in which you work are also identified through the OHIP data. Your billing data include an institution number that uniquely identifies an LTC home; this number is used to identify the LTC homes in which you practise. For an LTC home to be assigned to your practice, there must be at least five residents recorded in the home; this is intended to minimize noise due to random error in the institution codes in the OHIP data. In some instances, these data may not accurately reflect the homes in which a physician practises due to coding practices in OHIP billing. For example, if a physician works in more than one LTC home, but includes the institution number for only one of these homes on all OHIP submissions, then the other homes cannot be identified for the report. If you work in more than one LTC home, but notice that the report does not reflect this, please speak to your billing agent to verify the homes are coded correctly in your OHIP submissions. If you have additional questions please contact HQO at practicereport@hqontario.ca.

Indicator calculation

After identifying your residents and the LTC homes in which you practise, additional administrative datasets were used to calculate both the indicators and the supporting contextual information. For instance, data from OHIP and ODB were used to calculate the indicators of antipsychotic prescribing. For all but the “New Starts” indicator, only medications dispensed in LTC were included in the calculations. For this reason, the “Continuous Use” and the “Antipsychotic Polypharmacy” indicators only include residents who have been in LTC for at least 100 days. The ODB contains information on dispensed medications. In LTC, the majority of prescriptions are filled and delivered to the home; thus, this report refers to the prescription rather than the dispensing of medications to focus on the clinician’s perspective.

Diagnosis Identification

Diagnoses were identified by examining the previous five years of OHIP, Discharge Abstract Database (DAD), and Ontario Mental Health Reporting System (OMHRS) data according to previously published methods and clinical review (3) (27) (28). In addition, ODB records in the previous year were examined for dispensing medications related to dementia (cognitive enhancers/cholinesterase inhibitors) as a surrogate for the diagnosis of dementia. Psychosis includes schizophrenia, bipolar disorder, tics or Huntington’s disease and other psychoses (including

dementia related psychoses). The CIHI Antipsychotic indicator and scales were calculated using the methods of CIHI with the most recent fiscal year available (8) (9). The Technical Appendix provides further details on the methodology used to calculate indicators including the following: a complete list of the Drug Identification Numbers (DINs) for antipsychotic medications, diagnostic codes to identify psychosis and dementia in the different databases, and the method for identifying your residents.

Stratified Data

Stratified data are provided in the report to help understand your rates better. Data are provided for up to three LTC homes in which you practise. These homes are chosen based on the top three homes where the majority of your residents live. All data stratified by LTC home are presented for the same three homes. Data are also stratified by diagnosis groups, based on having a recorded diagnosis of psychosis and/or dementia. Data for three mutually exclusive groups are presented in the report: those with any psychosis, those with dementia and no record of psychosis, and those with no record of either dementia or psychosis.

Data sources

Administrative databases that were used to generate this report include: the OHIP database for physician claims data and cohort definition; the ODB database for prescription information and cohort definition; the Registered Persons Database (RPDB) for patient demographic information; the Discharge Abstract Database (DAD) for acute care data; the Ontario Mental Health Reporting System (OMHRS) for inpatient mental health data; and the Continuing Care Reporting System (CCRS) for the interRAI data (also referred to as RAI-MDS). The latter was only used for the yearly data section found on page 12. The ODB has been validated for the accuracy of prescription claims (29). These datasets were linked using unique encoded identifiers and analyzed at ICES.

Data interpretation considerations

Powerful administrative databases were used to generate this report without asking you to capture additional data. However, these databases do have limitations, including:

- **Data timeliness:** The data lag for these reports is about six months for the OHIP/ODB indicators. Data from the CCRS in this report will not match the time period of the OHIP/ODB cohort, and will be available for update yearly. While HQO and our partners are always looking for ways to provide more timely data, we encourage you to also use local data sources to track and measure your progress.
- **Data comprehensiveness:** Administrative databases cannot capture all the information relevant to these indicators and thus there are missing elements in the report. These include:
    - The indicators calculated using OHIP/ODB data capture the presence of a prescription, but not actual use of the medication.
    - Medications begun in the hospital cannot be identified.
    - PRN prescriptions cannot be identified.
    - ODB coverage usually begins at age 65. Those living in LTC who are younger than age 65 will have ODB coverage.
- **Data suppression**: To maintain confidentiality, data are suppressed as per ICES' privacy policies, in the following manner:
    - N/R (Not Reported): When a value is between one and five, the value and its accompanying rate are suppressed. Additional suppression may be applied to maintain confidentiality even if the value is greater than five. Suppression is denoted by N/R.

  Suppressed values are included in the totals, and every effort is made to suppress the next smallest value.

What does this mean for me?

Although there are data elements missing from this report, where possible, the data have been presented in a way designed to help overcome these limitations. The data stratified by diagnosis and homes in which you practise may help identify areas for improvement. Since ODB coverage usually begins at age 65, the lower age limit for the medication indicators is set at 66. This allows for an equal time period to look for previous prescriptions in the data, consistency for all indicators, and completeness of drug information. As this is an initial release of quality improvement data at the practice level, we welcome your thoughts on future development of this report.

Participation and confidentiality

You received this report because you have provided consent to HQO and ICES to participate in this project. This study was approved by the institutional review board at the University of Toronto, Toronto, Canada. Neither HQO nor ICES will release identified/identifiable data without your additional written consent.

ICES is named as a prescribed entity under Section 45 of Ontario's health privacy legislation, *Personal Health Information Protection Act* (PHIPA), 2004, which provides the legal authority for ICES to conduct research about the practice patterns of health care providers like you. ICES has very strict privacy policies, practices and procedures, as well as data security arrangements that have been reviewed and approved by the Privacy Commissioner of Ontario. A detailed report can be found on the ICES website: www.ices.on.ca.

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About Health Quality Ontario and the Institute for Clinical Evaluative Sciences

Health Quality Ontario (HQO) is the provincial advisor on quality in health care. HQO reports to the public on the quality of the health care system, evaluates the effectiveness of new health care technologies and services, provides evidence-based recommendations, and supports the spread of quality improvement throughout the system.

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