MyPractice
Long-Term Care

A tailored report for quality care

PRIVATE AND CONFIDENTIAL
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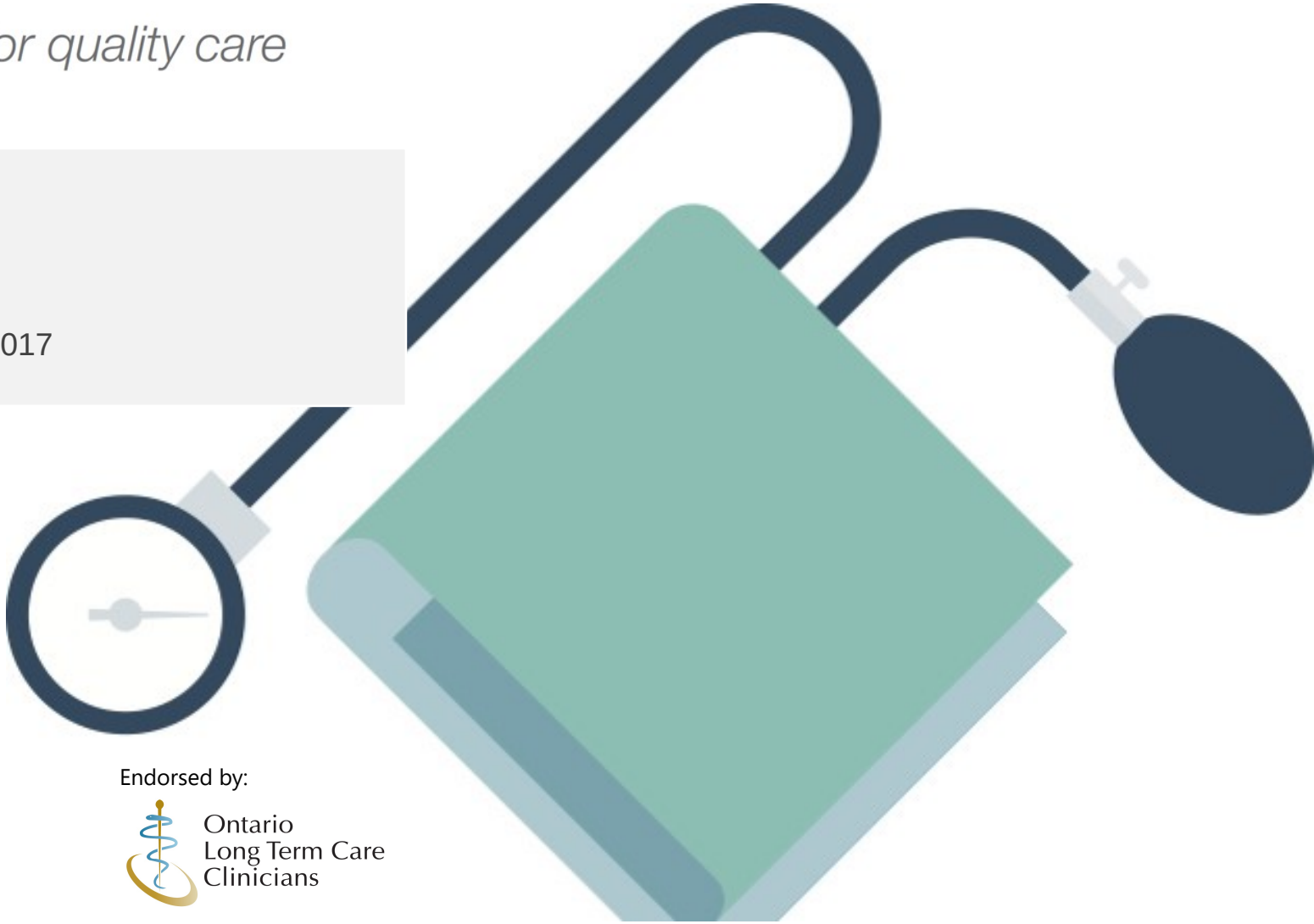
Dr. Sample Report

LHIN: Sample Lhin

Reporting Period: Jun 30, 2017



Health Quality Ontario
Let's make our health system healthier

Endorsed by:
Ontario Long Term Care Clinicians

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Report Overview

Background

The *MyPractice:* Long-Term Care report is intended to help you with your quality improvement efforts.

This report DOES	This report does NOT
• Provide an overview of prescribing patterns • Provide aggregate data on residents' characteristics • Provide comparator data • Provide ideas for quality improvement • Complement other data sources such as pharmacy reports • Report unadjusted rates • Include PRN prescriptions	• Provide details about specific patients • Provide specific instructions for clinical care • Provide direct links to your LTC home's electronic data • Replace clinical judgement • Capture appropriateness of medications related to falls, but presents the data as a risk factor for falls • Tell you what targets are best for your practice

This report was developed by

Health Quality Ontario (HQO) and supported by the Institute for Clinical Evaluative Sciences (ICES). The content was developed in consultation with an Advisory Committee and Clinical Working Group with membership representing the following organizations: AdvantAge Ontario, Nurse Practitioners' Association of Ontario, Ontario Medical Association, Ontario Long Term Care Clinicians, Ontario Long Term Care Association, and Ontario Pharmacists Association.

Additional information

- For more information about *MyPractice:* Long-Term Care reports, please email us at PracticeReport@hqontario.ca.
- For more information on indicator definitions, limitations, or data sources, please refer to the methodology notes.
- For more technical details, please refer to the technical appendix on HQO's *MyPractice* web portal.

Summary: Apr 01, 2017 - Jun 30, 2017

What are my unadjusted overall prescribing rates?

	My Residents	Ontario Rate	How does my prescribing compare to my peers
Antispsychotic Prescribing for dementia without psychosis	**15.3%**	**24.3%**	My prescribing rate is lower than at least 75 percent of my peers
Benzodiazepine Prescribing	**24.4%**	**13.6%**	My prescribing rate is higher than 60 percent of my peers
3 or more Specified* CNS-Active Medications	**11.1%**	**16.7%**	My prescribing rate is similar to many of my peers (between the 25th & 60th percentile)

Exclusions: All indicators exclude residents under 66, in palliative care, or new to the LTC home (in home for less than 100 days).
*Specified CNS-active medications include antipsychotics, opioids, oral benzodiazepines and antidepressants (including trazadone).

Who are my residents?

Total residents	Mean age (years)	Female	New residents
145	**85**	**76.6%**	**17.9%**

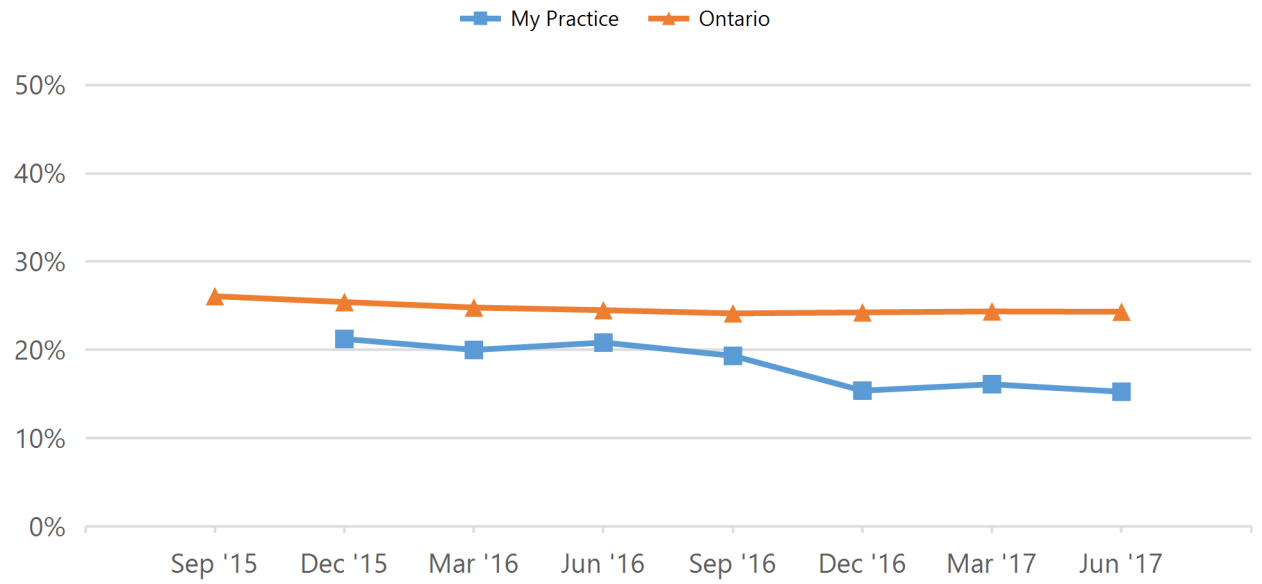
Antipsychotic prescribing

Reporting Period: Apr 2017 - Jun 2017

What percentage of my residents aged 66 and older who have dementia without psychosis were prescribed antipsychotics?

Between Apr 01, 2017 and Jun 30, 2017

- **15.3%** of my residents with dementia, without psychosis, were prescribed an antipsychotic.
- My overall rate is **lower than** the provincial rate of **24.3%**. The rate in my LHIN is **27.6%**.
- **7.8%** of my residents were prescribed antipsychotics for at least 90 continuous days.[2–3]
- **0%** of my residents were newly prescribed an antipsychotic (i.e. no prescription in previous 12 months).[4]



†Data suppressed as per ICES' privacy policy (e.g. number of residents between 1 and 5). Gaps in graph are due to suppression.

Exclusions: Residents who are under 66 years old, diagnosed with psychosis, in palliative care, or new to the LTC home (in the home for less than 100 days). Diagnoses are captured through previous five years of OHIP/DAD/OMHRS data and one year of ODB data.

Number of my residents with dementia (without psychosis) prescribed an antipsychotic
18

In some cases, antipsychotics are indicated for management of responsive behaviours and BPSD.[5] The data cannot weigh the benefits against the possible harms for a particular resident, but they can point to practice patterns worthy of reflection.

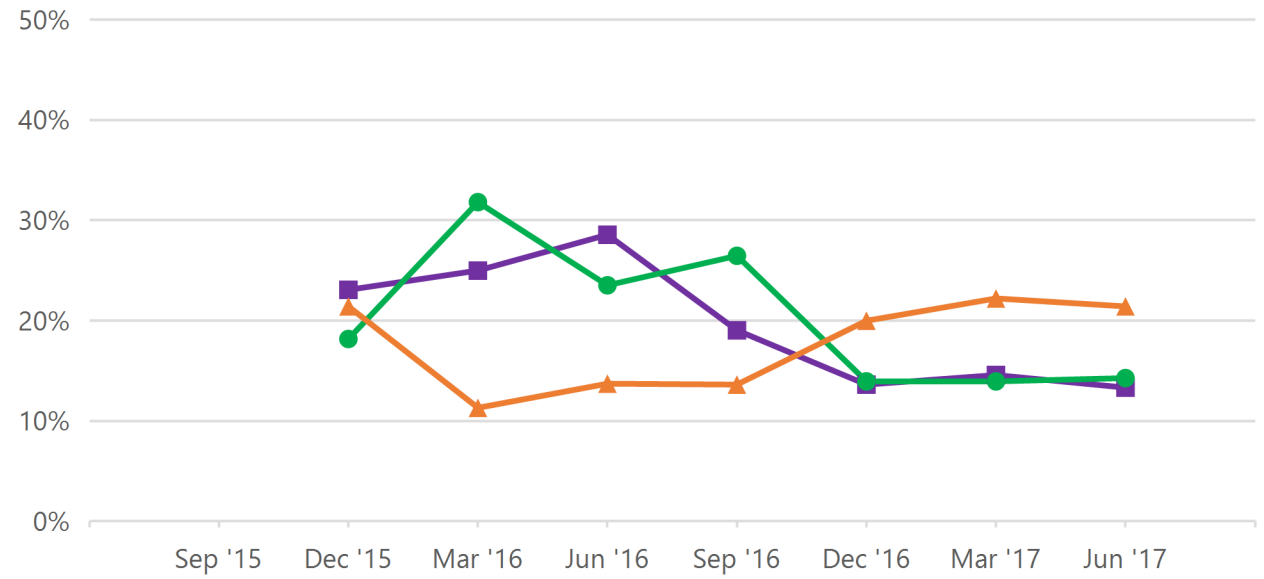
The **Change Ideas: BPSD** suggest ways you can optimize your antipsychotic prescribing.

Antipsychotic prescribing in my LTC homes

Reporting Period: Apr 2017 - Jun 2017

What percentage of my residents aged 66 and older diagnosed with dementia without psychosis were prescribed an antipsychotic in each of my LTC homes?

- **3** homes were identified from my OHIP claims in which I provide care for at least six residents.
- Between Apr 01, 2017 and Jun 30, 2017, among my residents diagnosed with dementia without psychosis, my prescribing rates for at least one antipsychotic were:
  1. LTC Home Sample A: **13.3% (6/45)**
  2. LTC Home Sample B: **14.3% (6/42)**
  3. LTC Home Sample C: **21.4% (6/28)**



†Data suppressed as per ICES' privacy policy (e.g. number of residents between 1 and 5), additional suppression may be applied to prevent calculation of suppressed data.

Exclusions: Residents who are under 66 years old, diagnosed with psychosis, in palliative care, or new to the LTC home (in the home for less than 100 days). Diagnoses are captured through previous five years of OHIP/DAD/OMHRS data and one year of ODB data.

I can help the most residents by focusing my efforts on

LTC Home Sample C

Are my prescribing practices different across my LTC homes?

Ask the home administrator or RAI coordinator in each of your homes for home level aggressive behaviour scale and pain scale data from CIHI to see if there are differences that may influence prescribing practices in each home.

Do the homes you support have different relationships with specialized behavioural support services that may influence prescribing patterns in each home?

The **Change Ideas: BPSD** suggest ways you can optimize your antipsychotic prescribing.

Change Ideas for Quality Improvement: Behavioural and Psychological Symptoms of Dementia

How can I optimize my antipsychotic prescribing?

Identify improvement efforts planned or underway and what resources and supports are available

- Ask the Medical Director or Quality Committee about the home's Quality Improvement Plan and approach to antipsychotic prescribing. Ask the home to review the Behavioural Symptoms of Dementia Quality Standard
- Explore opportunities to work with the home's Behavioural Response Team and Champions
- Consult external outreach teams such as Psychogeriatric Resource Consultant, Behavioural Supports Ontario (BSO), Seniors Mental Health services

Verify current resident data

- Review data from your home and pharmacy provider (indications, new starts, summary of responsive behaviours, interventions)
- Verify the data related to the number of residents prescribed antipsychotics, new starts, PRN orders and administration rates
- Request a medication tracking tool from your pharmacy provider

Improve medication review process

- Consider a team approach to quarterly medication reviews involving physician, pharmacist and nurse[4]
- Use a standardized and simplified medication review process. See sample worksheet from Alberta Health Services[6]
- Review the Continuous Use indicator at quarterly multi-disciplinary medication review and summary of resident recent behaviours and identify residents appropriate for a trial of adjusting antipsychotic use/dose

Update and implement individualized behaviour care plans

- Use standardized assessment tools to inform care plans (DOS, CMAI, KSBA)
- Rule out triggers such as medical problems (pain, constipation, infection).[7] Use P.I.E.C.E.S. assessment tool
- Trial non-pharmacological strategies before antipsychotic medications, where appropriate[7–8]

Choose optimal pharmacological interventions

- Trial lowest effective dose for shortest duration.[9] Monitor effectiveness and tolerability using BSMT Tool[10]
- Check Centre for Effective Practice Use of Antipsychotics in Behavioural and Psychological Symptoms of Dementia (BPSD) Discussion Guide

Learn from your peers

- Dr. Auger's Story: Reducing Antipsychotic Prescribing Rates in My Practice[11]
- Behavioural Supports Ontario (BSO)
- Choosing Wisely Canada Toolkit for Reducing Inappropriate Use of Antipsychotics in LTC[12]

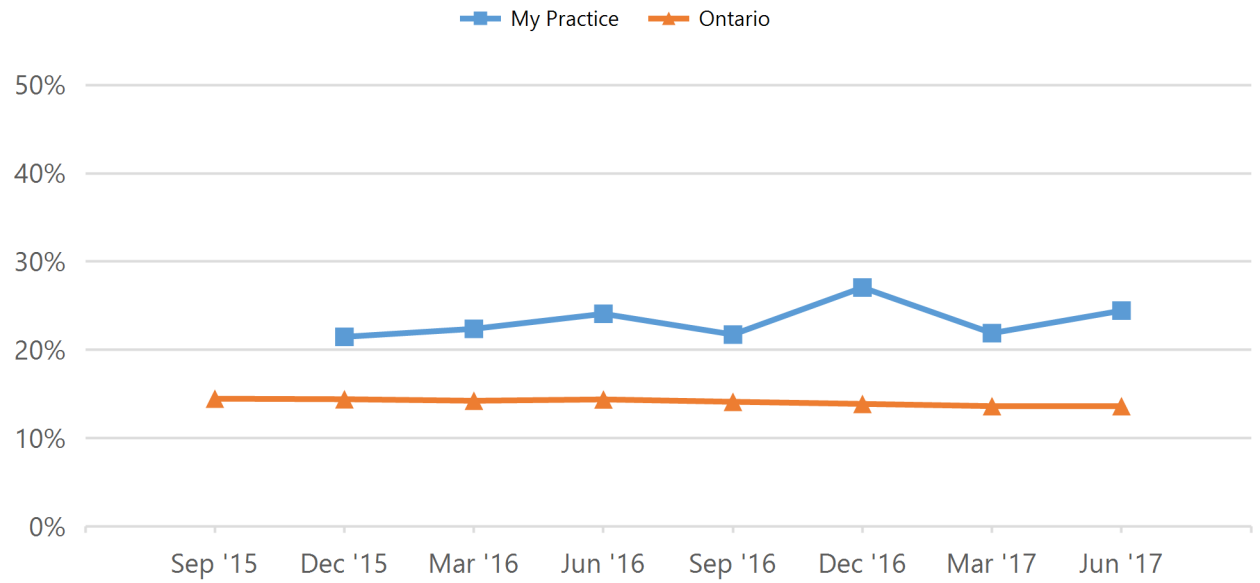
Benzodiazepine prescribing

Reporting Period: Apr 2017 - Jun 2017

What percentage of my residents aged 66 and older were prescribed benzodiazepines?

Between Apr 01, 2017 and Jun 30, 2017

- **24.4%** of my residents were prescribed at least one benzodiazepine.
- My overall rate is **higher than** the provincial rate of **13.6%**. The rate in my LHIN is **13.9%**.
- **13.3%** of my residents were prescribed benzodiazepines for at least 90 continuous days.



†Data suppressed as per ICES' privacy policy (e.g. number of residents between 1 and 5). Gaps in graph are due to suppression.

Exclusions: Residents who are under 66 years old, in palliative care, or new to the LTC home (in the home for less than 100 days).

Number of my residents prescribed a benzodiazepine
33

Sometimes benzodiazepines are appropriate, but benzodiazepines do contribute to the risk of falls which can lead to injury. After reflecting on your rates and indications for benzodiazepine use in individual residents, you may consider a trial of weaning where appropriate.

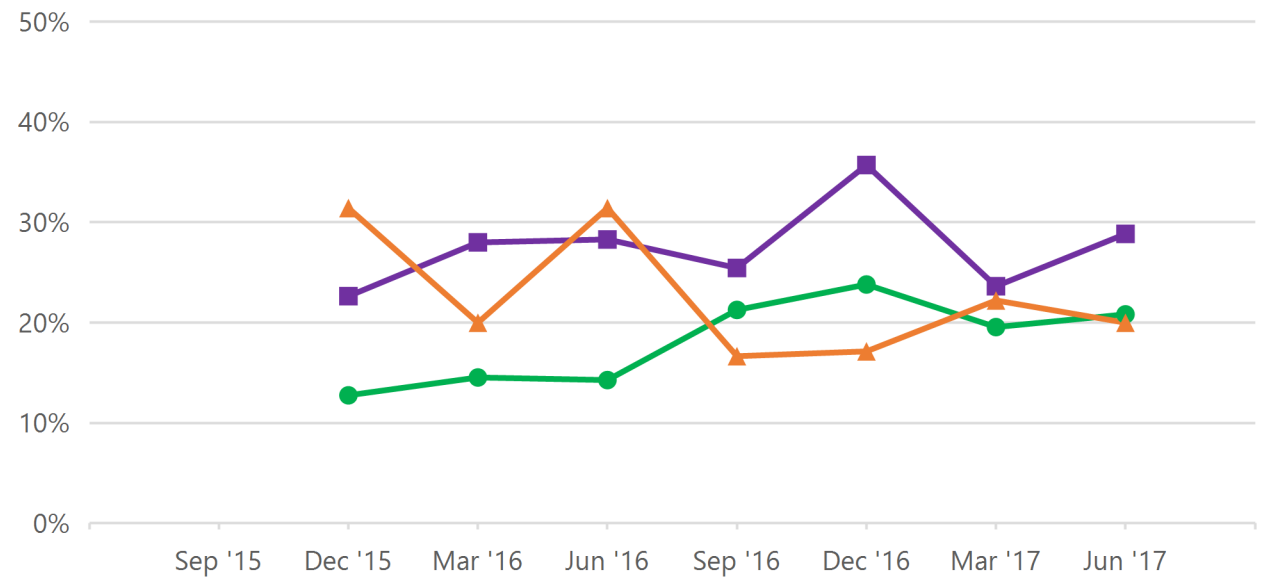
The **Change Ideas: Falls and Mobility** suggest ways you can optimize your benzodiazepine prescribing.

Benzodiazepine prescribing in my LTC homes

Reporting Period: Apr 2017 - Jun 2017

What percentage of my residents aged 66 and older were prescribed a benzodiazepine in each of my LTC homes?

- **3** homes were identified from my OHIP claims in which I provide care for at least six residents.
- Between Apr 01, 2017 and Jun 30, 2017, my prescribing rates for at least one benzodiazepine were:
  1. LTC Home Sample A: **28.8% (15/52)**
  2. LTC Home Sample B: **20.8% (10/48)**
  3. LTC Home Sample C: **20.0% (7/35)**



†Data suppressed as per ICES' privacy policy (e.g. number of residents between 1 and 5), additional suppression may be applied to prevent calculation of suppressed data.

Exclusions: Residents who are under 66 years old, in palliative care, or new to the LTC home (in the home for less than 100 days).

I can help the most residents by focusing my efforts on

LTC Home Sample A

Are my prescribing practices different across my LTC homes?

Consider speaking to the home administrator or RAI coordinator in each of your homes. They can obtain home level CIHI data on the falls in the homes. Consider focusing efforts on residents who fall repeatedly to see if benzodiazepines can be tapered.

The **Change Ideas: Falls and Mobility** suggest ways you can optimize your benzodiazepine prescribing.

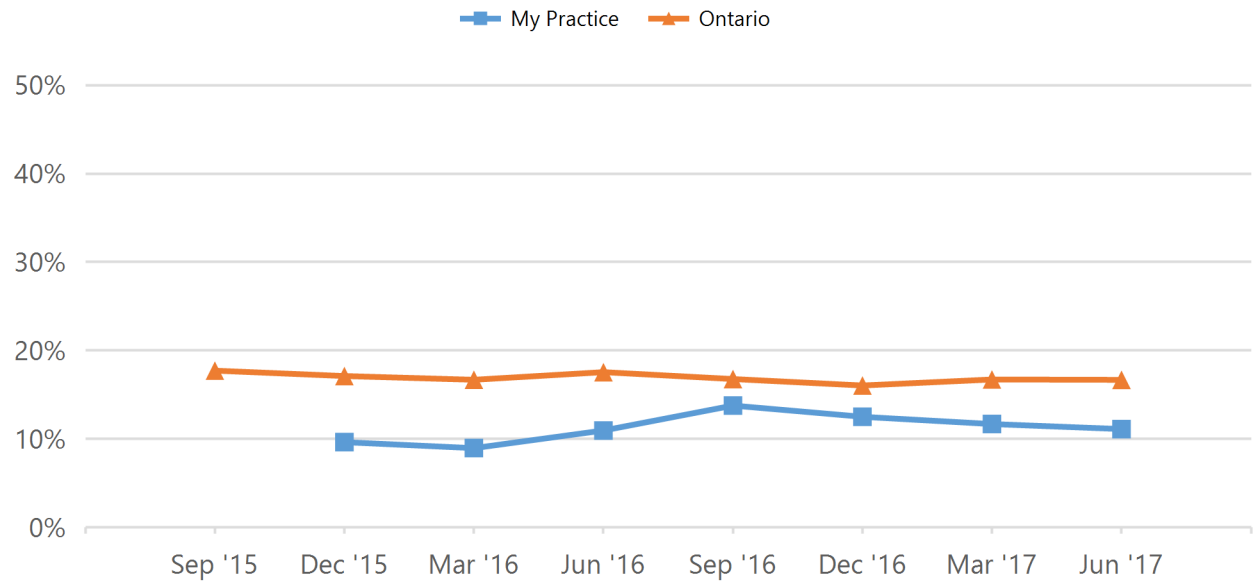
Three or more specified CNS-active medications

Reporting Period: Apr 2017 - Jun 2017

What percentage of my residents aged 66 and older were prescribed three or more specified CNS-active medications?

Between Apr 01, 2017 and Jun 30, 2017

- **11.1%** of my residents were prescribed three or more specified CNS-active medications (antipsychotics, opioids, benzodiazepines [oral], and antidepressants, including TCA and trazodone).
- My overall rate is **lower than** the provincial rate of **16.7%**. The rate in my LHIN is **19.8%**.



†Data suppressed as per ICES' privacy policy (e.g. number of residents between 1 and 5). Gaps in graph are due to suppression.

Exclusions: Residents who are under 66 years old, in palliative care, or new to the LTC home (in the home for less than 100 days)

Number of my residents prescribed three or more CNS-active medications
15

Although there are valid indications for these medications, there is an additive increased risk of falls and confusion that should be monitored. Consider a trial of weaning where appropriate or substituting with a safer medication. The data cannot weigh the benefits against the possible harms for an individual resident, but they can point to practice patterns worthy of reflection.

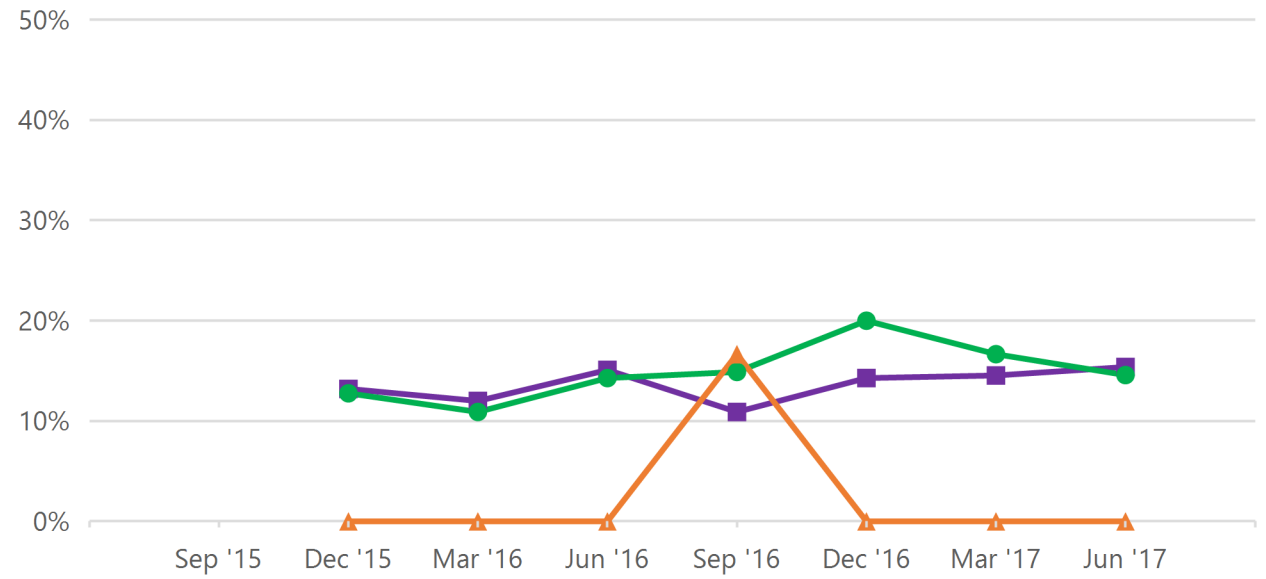
The **Change Ideas: Falls and Mobility** suggest ways you can optimize your prescribing of these CNS-active medications.

Three or more specified CNS-active medications in my LTC homes

Reporting Period: Apr 2017 - Jun 2017

What percentage of my residents aged 66 and older were prescribed three or more specified CNS-active medications in each of my LTC homes?

- **3** homes were identified from my OHIP claims in which I provide care for at least six residents.
- Between Apr 01, 2017 and Jun 30, 2017, my home level prescribing rates of three or more CNS-active medications (antipsychotics, opioids, benzodiazepines [oral], and antidepressants, including TCA and trazodone) were:
  - 1. LTC Home Sample A: **15.4% (8/52)**
  - 2. LTC Home Sample B: **14.6% (7/48)**
  - 3. LTC Home Sample C: **0.0% (0/35)**



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Exclusions: Residents who are under 66 years old, in palliative care, or new to the LTC home (in the home for less than 100 days).

I can help the most residents by focusing my efforts on

LTC Home Sample A

Are my prescribing practices different across my LTC homes?

Consider speaking to the home administrator or RAI coordinator in each of your homes. They can obtain home level CIHI data on the falls in the homes. You may want to focus efforts on those who fall repeatedly. Consider a trial of weaning where appropriate or substituting with a safer medication.

The **Change Ideas: Falls and Mobility** suggest ways you can optimize your prescribing of these CNS-active medications.

How can I optimize my benzodiazepine and specified CNS-active medication prescribing?

Identify improvement efforts planned or underway and what resources and supports are available

- Ask the Medical Director or Quality Committee about the home's Quality Improvement Plan approach to falls prevention
- Consult with your Falls Prevention Team

Verify current resident data

- Review the data from your home and pharmacy provider for the number of residents prescribed benzodiazepines and 3+ CNS active drugs, duration/administration rate
- Consider using the Falls risk assessment Centre for Effective Practice Discussion Guide

Improve medication review process

- Consider a team approach to quarterly medication reviews involving physician, pharmacist and nurse[4]
- Use a Fall Assessment and Medication Review Flow Sheet (sample below)
- Review Fall risk assessment, functional/cognitive status (CPS) and anticholinergic burden/risk scales

Update and implement individualized behaviour care plans

- Develop process to inform physician post fall. Consider BEEEACH Checklist Centre for Effective Practice Discussion Guide[13]
- Re-assess at each transition (new admission, change in condition)

Choose optimal pharmacological interventions

- Mitigate the risk of falls from medication use. Consider using STOPP/START Toolkit[14] and ISMP Canada BEERs List[15]
- Check the Canadian De-prescribing Network Algorithm to help you decide when and how to reduce benzodiazepines safely

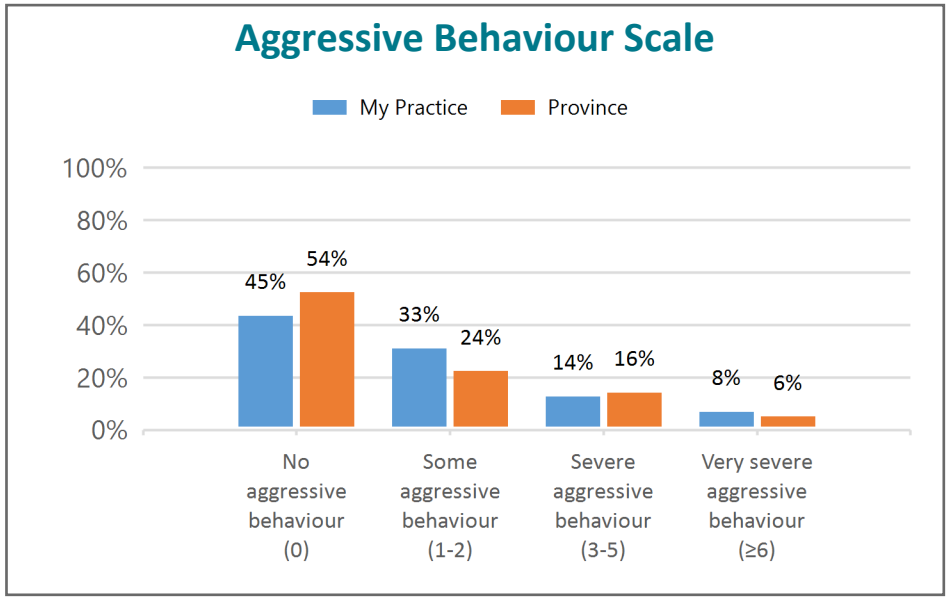
Learn from your peers

- Choosing Wisely Canada Toolkit - Less Sedatives for Your Older Relatives

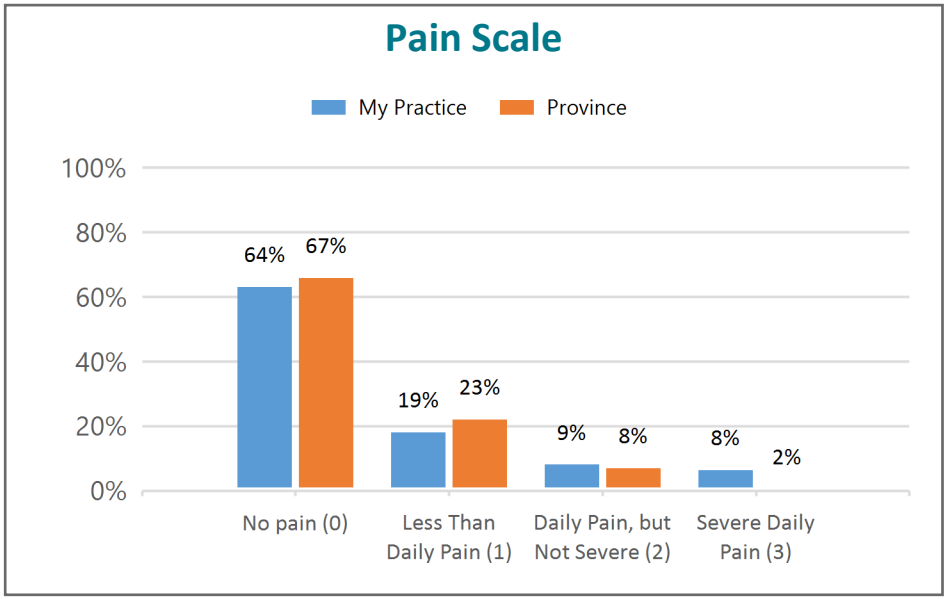
Sample Fall Assessment and Medication Review Flow Sheet

Age	Number of Falls/Quarter	Fractures (Y/N)	Morse Fall Score	Blood Pressure	Central Nervous System Drugs	Blood Pressure Medications	Osteoporosis Prevention	Resident Goal

My resident profile: Key characteristics



Data period: Apr 01, 2015 - Mar 31, 2016
Data source: CIHI, CCRS (rolling 4-quarter average)



Data period: Apr 01, 2015 - Mar 31, 2016
Data source: CIHI, CCRS (rolling 4-quarter average)

The **Aggressive Behaviour Scale (ABS)** is "based on the occurrence of verbal abuse, physical abuse, socially disruptive behaviour, and resistance to care… This scale has been validated against the Cohen Mansfield Agitation Inventory."[15]

This scale was included to provide contextual information to help understand why your rates may differ from the provincial average.

The **Pain Scale** "was originally developed for use with nursing home residents and... has been shown to be highly predictive of pain as measured by the Visual Analogue Scale."[15] Some research suggests that people with cognitive impairment are less likely to be treated for pain.[16]

This scale is included as untreated pain may be an underlying cause of responsive behaviours, and to provide context for understanding your prescribing rates.[5]

My resident profile: Additional information

Data Source: OHIP/ODB cohort Period: Apr 01, 2017 – Jun 30, 2017	My Residents	Ontario
Total number of residents	145	76338
Mean age (years)	85	84
85 years and older	61%	56%
Female	77%	69%
New to the LTC home	18%	12%

Data Source: CIHI, CCRS (RAI-MDS) Period: Apr 01, 2015 – Mar 31, 2016	My Residents	Ontario
Residents without psychosis on antipsychotics in the last 7 days	21.7%	22.9%
Residents who fell in the last 30 days	17.5%	14.2%
Residents in daily physical restraints over the last seven days	8.3%	6.1%
Activitites of Daily Living (ADL):		
Independent (0)	5%	3%
Limited Impairment (1-2)	8%	14%
Extensive Assisstance (3-4)	58%	49%
Dependent (5-6)	30%	34%
Cognitive Performance Scale (CPS):		
Relative Intact (0-1)	20%	20%
Mild / Moderate (3-5)	57%	50%
Severe (4-6)	23%	30%
Depression Rating Scale (DRS):		
No Depressive Symptons (0)	32%	38%
Some Depressive Symptons (1-2)	48%	30%
Possible Depressive Disorder (≥3)	20%	32%

Note: The time periods for the OHIP/ODB data and the CCRS (RAI-MDS) data are different.
CIHI indicators are calculated as rolling four-quarter averages. OHIP/ODB data are presented for the most recent quarter.
Suppressed†: Data suppressed as per ICES' privacy policy (e.g. number of residents between 1 and 5); N/A: Data not available

Methodology

Identifying your residents and your LTC homes: Your CPSO number was linked to administrative databases housed at ICES to identify the residents you cared for. LTC residents were assigned to your practice based on a two-step process using OHIP data: physicians who billed the greatest number of W010 fee codes for a resident were assigned as the attending or most responsible physician (MRP); for residents with zero W010 codes billed, the physician who billed the greatest number of LTC fee codes for a resident was assigned as the MRP. Your resident group includes individuals between 19 and 115 years of age, for whom there was information on date of birth and sex, and a valid LTC institution number. Institution numbers recorded in the OHIP billings for the residents who are assigned to you as the MRP were examined to identify the LTC homes in which you practise. For physicians who practise in more than one LTC home, data were provided for up to three LTC homes in which the physician has the largest number of residents for whom the physician provides care.

Indicator calculation: For details on indicator calculation please consult the Technical Appendix. Please note, psychosis and dementia were identified by examining the preceding five years of OHIP, Discharge Abstract Database (DAD), and Ontario Mental Health Reporting System (OMHRS) data for relevant diagnoses, and one year of Ontario Drug Benefit (ODB) for medications related to the treatment of dementia (cognitive enhancers/cholinesterase inhibitors).[17–19] Psychosis includes schizophrenia, bipolar disorder, tics or Huntington's disease and other forms of psychoses (including dementia-related psychosis). Canadian Institute for Health Information (CIHI) indicators were calculated using CIHI methodology applied to the most recent fiscal year for which data were available.[20–21]

Data Interpretation Considerations

Results of analyses should be interpreted considering the strengths and limitations of the databases including the following:

- The data lag for the prescribing indicators is about six months; whereas it is over a year for the CIHI data.
- The ODB has been validated for the accuracy of prescription claims.[22]
- The ODB data capture dispensing but not administration of a medication, and PRN prescriptions cannot be identified.
- All LTC residents are eligible for ODB coverage regardless of age.
- Since prescriptions for residents in LTC are dispensed and delivered to the home, this report refers to prescribing rather dispensing to emphasize the physician perspective.
- Since current data sources cannot identify medications started in hospital, some prescriptions classified as new starts in LTC could have been initiated in hospital.
- Data suppression is applied to maintain confidentiality as per policies of ICES: values between one and five are suppressed; additional suppression may be applied to prevent the calculation of suppressed data.
- Since non-benzodiazepine benzodiazepine receptor agonists (e.g. zopiclone) cannot be accurately captured in ODB data, they were excluded from the 3+ CNS-active medications indicator.
- The benzodiazepine and 3+ CNS-active medications indicators do not assess appropriateness. These indicators aim to identify residents who may need to be monitored for an increased risk of falls related to these medications, and to identify residents who may be appropriate for a trial of weaning, or substituting with a safer medication that is not as strongly associated with a risk of falls.

Acknowledgements

Participation and confidentiality:

You are receiving this report because you have provided consent to HQO and ICES to participate in this project. 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, the Personal Health Information Protection Act (PHIPA), 2004, which provides the legal authority for ICES to conduct research about the practice patterns of health 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.

About Health Quality Ontario and the Institute for Clinical Evaluative Sciences

Health Quality Ontario 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.

This work was supported by the Institute for Clinical Evaluative Sciences (ICES), which is funded by an annual grant from the Ontario Ministry of Health and Long-Term Care. The opinions, results and conclusions reported in this document are those of the authors and are independent from the funding sources. No endorsement by ICES or the Ontario MOHLTC is intended or should be inferred.

Parts of this material are based on data and information compiled and provided by CIHI. However, the analyses, conclusions, opinions and statements expressed herein are those of the author, and not necessarily those of CIHI.

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