MyPractice
Long-Term Care

A tailored report for quality care

PRIVATE AND CONFIDENTIAL
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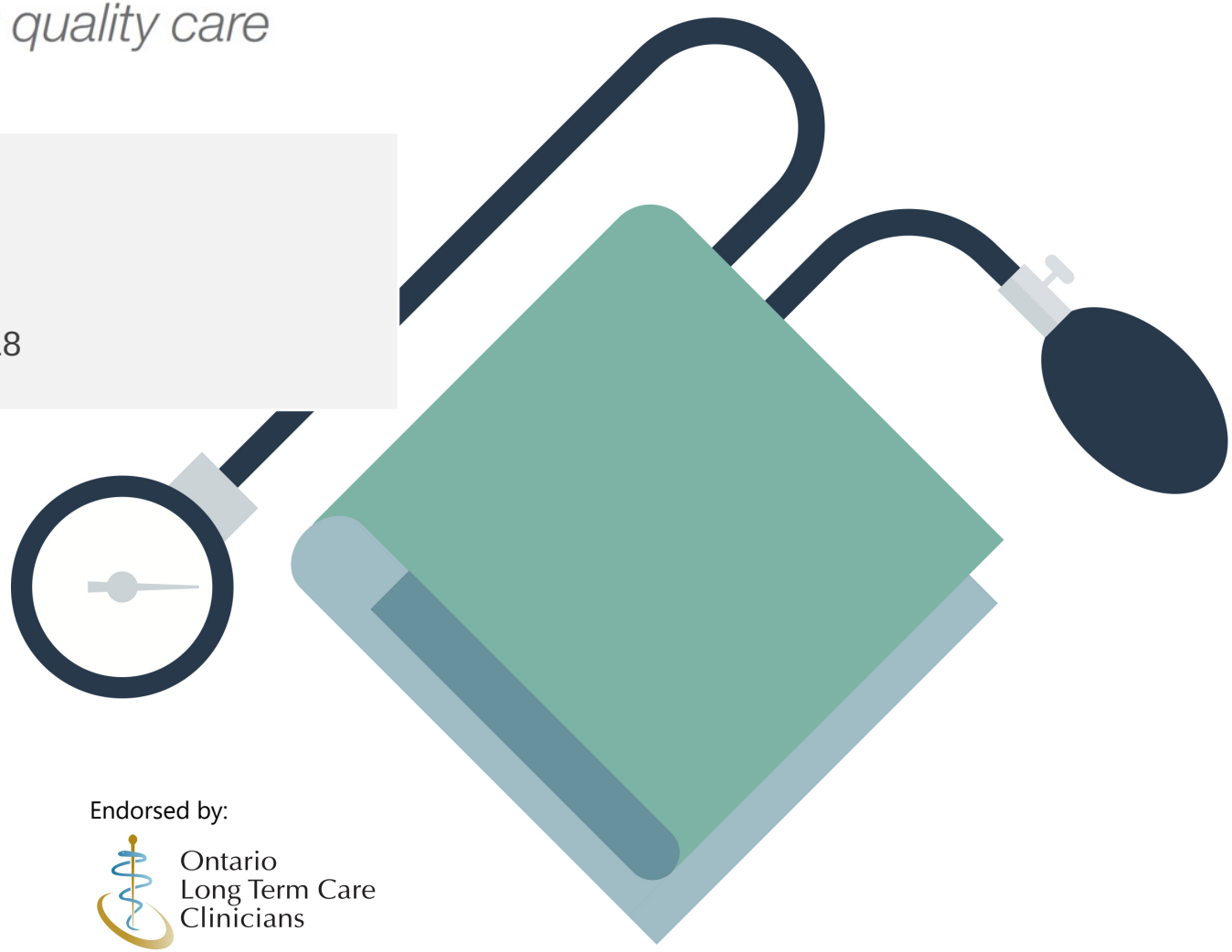
Dr. Sample Physician

LHIN: Sample Lhin

Reporting Period: Mar 31, 2018



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 Association of Residents' Councils, Ontario Medical Association, Ontario Long Term Care Clinicians, Ontario Long Term Care Association, Ontario Pharmacists Association, and Public Health Ontario.

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: Jan 01, 2018 - Mar 31, 2018

What are my overall prescribing rates?

	My Rate (unadjusted)	How does my prescribing compare to my peers?
NEW **Antibiotic Prescribing**	**26.7%**	My prescribing rate is similar to many of my peers (between the 25th & 60th percentile)
NEW **Antibiotic Prolonged Treatment** (more than 7 days)	**9.6%**	My prescribing rate is lower than at least 75 percent of my peers
Antipsychotic Prescribing for dementia without psychosis	**15.4%**	My prescribing rate is similar to many of my peers (between the 25th & 60th percentile)
Benzodiazepine Prescribing	**24.4%**	My prescribing rate is higher than 60 percent of my peers

For indicator-specific inclusion and exclusion criteria, please see detailed indicator pages.

Who are my residents?

Total residents	Mean age (years)	Female	New residents
200	**82**	**70%**	**16%**

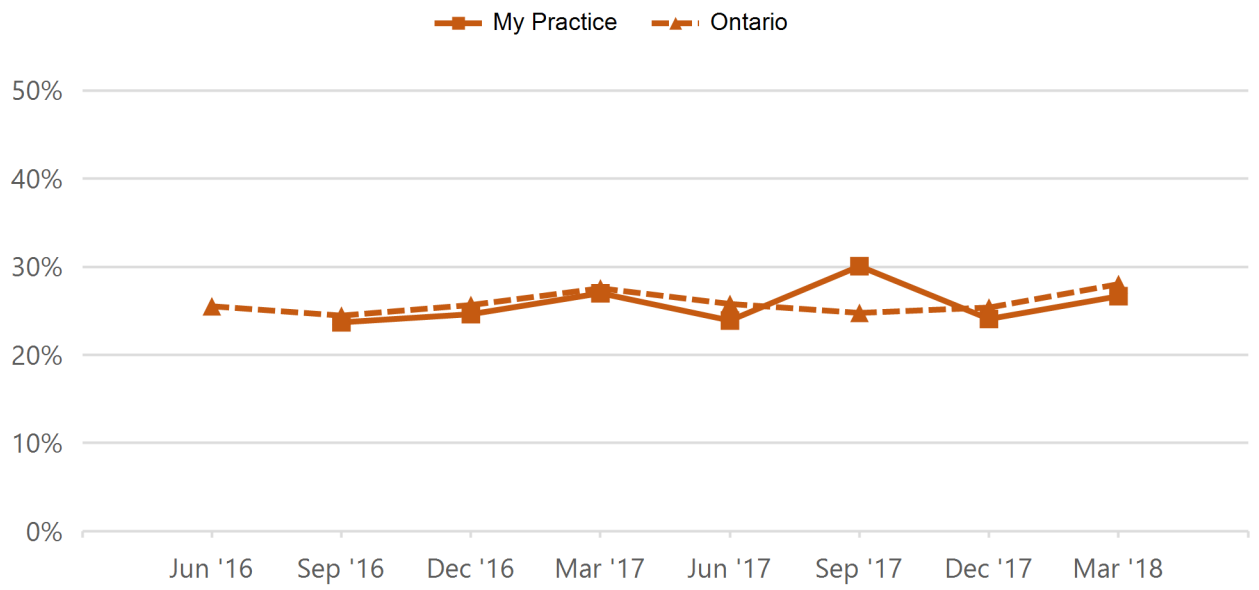
Antibiotic prescribing

Reporting Period: Jan 2018 - Mar 2018

What percentage of my residents were prescribed an antibiotic?

Between Jan 01, 2018 and Mar 31, 2018:

- **26.7%** of my residents were prescribed an antibiotic.[1-2]
- My overall prescribing rate is **lower than** the provincial rate of **28%**. The rate in my LHIN is **40%**.[1-2]



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

Exclusions: Antibiotic creams or ointments, otic or ophthalmic antibiotics.
Inclusions: Residents who are palliative, aged 19 and older, or new to the home.

Number of my residents prescribed an antibiotic
36

Key Change:
Don't do a urine dip or urine culture unless there are clear signs and symptoms of a urinary tract infection (UTI).[3-4]

For more suggestions for improvement, see **Change Ideas: Antibiotic prescribing**.

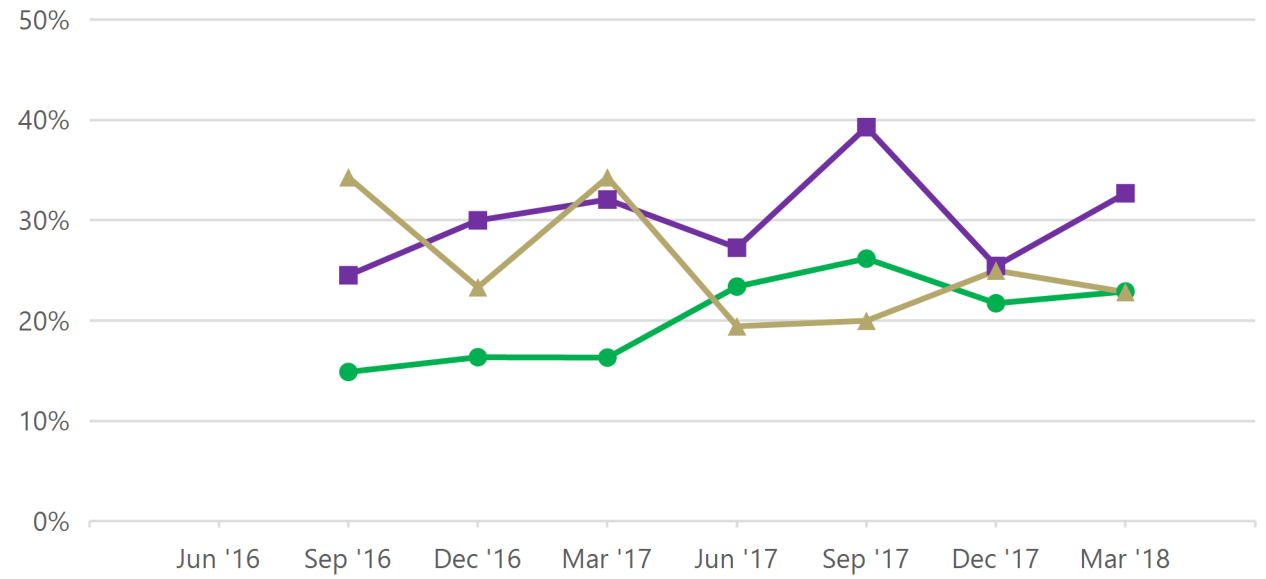
Antibiotic prescribing in my LTC homes

Reporting Period: Jan 2018 - Mar 2018

In my LTC homes, what percentage of my residents were prescribed an antibiotic?

- **3** homes were identified from my OHIP claims in which I provide care for at least six residents.
- Between Jan 01, 2018 and Mar 31, 2018, my antibiotic prescribing rates were:

1. Sample Home A: **32.7% (17/52)**
2. Sample Home B: **22.9% (11/48)**
3. Sample Home C: **22.9% (8/35)**



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Exclusions: Antibiotic creams, otic or ophthalmic antibiotics.
Inclusions: Residents who are palliative, aged 19 and older, or new to the home.

I can help the most residents by focusing my efforts on

Sample Home A

Key Change:
Don't do a urine dip or urine culture unless there are clear signs and symptoms of a urinary tract infection (UTI).[3-4]

For more suggestions for improvement, see **Change Ideas: Antibiotic prescribing**.

Steps I can take to change my antibiotic prescribing

Avoid Treatment of Asymptomatic Bacteriuria	1) *Don't do a urine dip or urine culture unless there are clear signs and symptoms of a urinary tract infection (UTI).* *Common situations where systemic antibiotics are generally **not** indicated:* • Positive urine culture in an asymptomatic resident. • Urine culture ordered solely because of change in urine appearance (e.g., cloudy) or odor • Nonspecific symptoms or signs not referable to the urinary tract, such as falls or mental status change(with or without a positive urine culture). • For additional guidance, use the Public Health Ontario's UTI Program assessment algorithm 2) *Prescribe antibiotics only when resident has clear signs and symptoms of UTI and reassess once urine culture and susceptibility results have been received.*
Review/Establish Criteria or Guidelines for Treatment of Infections	3) *Review other common indications where antibiotics are **not** required in LTC residents.* • Upper respiratory infection (common cold). • Bronchitis or asthma in a resident who does not have COPD. • "Infiltrate" on chest x-ray in the absence of clinically significant symptoms. • Suspected or proven influenza in the absence of a secondary infection (but DO treat influenza with antivirals). • Respiratory symptoms in a resident on palliative care or at the end of life. • Skin wound without cellulitis, sepsis, or osteomyelitis (regardless of culture result).
Educate residents, families, clinicians and other staff	4) *Use the SymptomFreeLetItBe handout when talking with residents, families and staff.*
Suggested Tools and Resources	• Choosing Wisely Canada. Using Antibiotics Wisely Campaign • AHRQ. 12 Common Nursing Home Situations In Which Systemic Antibiotics are Generally Not Indicated • AMMI Asymptomatic Bacteriuria Toolkit. Fillable resident/family letter • Public Health Ontario. UTI Program: Assessment algorithm for urinary tract infections (UTIs) in medically stable non-catheterized residents

Steps I can take with the long term care home to optimize antibiotic prescribing

Avoid Treatment of Asymptomatic Bacteriuria	Implement a program to reduce unnecessary urine culturing. Standardize guidelines of how and when to test cultures and interpretation of urine culture results. *Discontinue routine annual urine screening and screening at admission if residents do not have indicated clinical signs and symptoms of a UTI.* Refer to Public Health Ontario's UTI Program.
Review/Establish Criteria or Guidelines for Treatment of Infections	Work with home's infection control personnel to implement minimum criteria guidelines for antibiotic initiation in your LTC home. Refer to AHRQ. Minimum Criteria for Common Infections Toolkit (UTI, LRTI, SSTI). Implement structured nursing communication tools (e.g. SBAR tools) to aid in clear communication between nurses and prescribers and standardize assessments of residents suspected with infection.
Educate residents, families, clinicians and other staff	Provide education and resources for prescribers, nurses, front-line clinicians and on-call staff about common infections, and the importance of appropriate antibiotic use. Include a consistent message regarding antimicrobial resistance and role of antibiotics. Refer to AMMI Asymptomatic Bacteriuria Toolkit. Myths and Truths about Urinary Tract Infections in Long Term Care Residents. Provide education and resources for residents and families about common infections, antibiotic resistance, and improving antibiotic use. Refer to AMMI Asymptomatic Bacteriuria Toolkit. Fillable resident/family letter or DBND FAQ for Families. Guardians and Health Care Aides-UTI in LTCF.
Evaluate opportunities for Antimicrobial Stewardship	• Public Health Ontario has developed a primer and checklist to identify gaps and provide helpful tools for implementation.

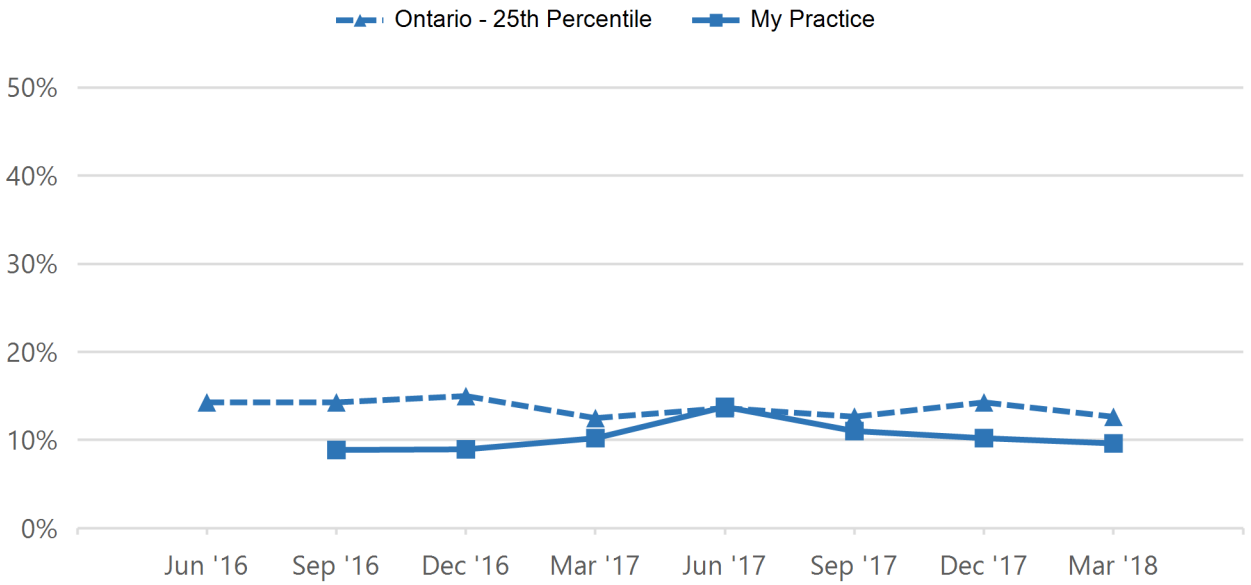
Antibiotic prolonged treatment (>7 days)

Reporting Period: Jan 2018 - Mar 2018

What percentage of my antibiotic treatments were longer than seven days?

Between Jan 01, 2018 and Mar 31, 2018:

- **9.6%** of my antibiotic treatments were longer than seven days.
- My rate is **lower than** the provincial rate at the 25th percentile (**12.7%**). The rate in my LHIN is **30%**.



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Exclusions: Antibiotic creams or ointments, otic or ophthalmic antibiotics.
Inclusions: Residents who are palliative, aged 19 and older, or new to the home.

Number of my antibiotic treatments longer than seven days
13 out of 135 total treatments

Key Change:
Optimize duration of therapy to 7 days or less for uncomplicated cystitis, pneumonia and cellulitis.[5]

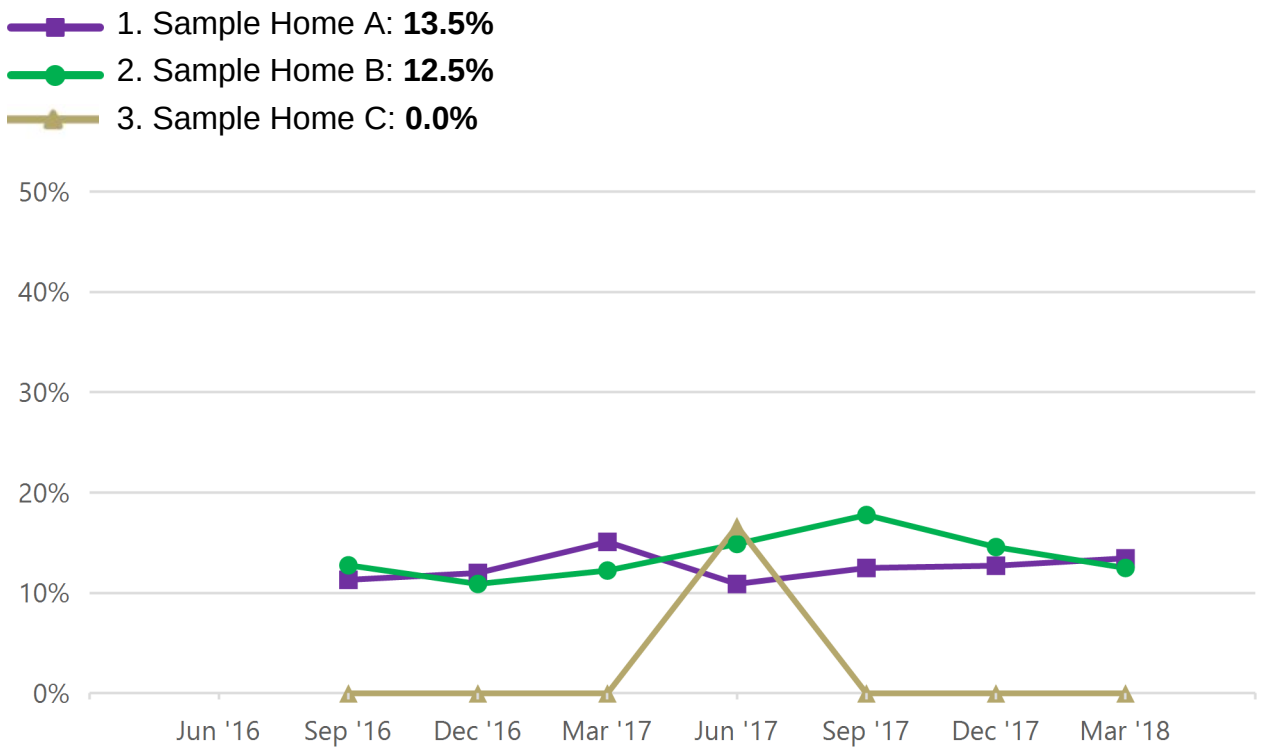
For more suggestions for improvement, see **Change Ideas: Antibiotic prescribing**.

Antibiotic prolonged treatment (>7 days) in my LTC homes

Reporting Period: Jan 2018 - Mar 2018

In my LTC homes, what percentage of my antibiotic treatments were longer than seven days?

- **3** homes were identified from my OHIP claims in which I provide care for at least six residents.
- Between Jan 01, 2018 and Mar 31, 2018, my rates of antibiotic prolonged treatment (>7 days) were:



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Exclusions: Antibiotic creams or ointments, otic or ophthalmic antibiotics.
Inclusions: Residents who are palliative, aged 19 and older, or new to the home.

Key Change:
Optimize duration of therapy to 7 days or less for uncomplicated cystitis, pneumonia and cellulitis.[5]

For more suggestions for improvement, see **Change Ideas: Antibiotic prescribing**.

Change Ideas for Quality Improvement: Antibiotic prolonged treatment

Steps I can take to change my antibiotic treatment durations

Prescribe shorter courses when appropriate.	Optimize duration of therapy to 7 days or less for uncomplicated cystitis, pneumonia and cellulitis. In most cases of uncomplicated infections seen in LTC, short courses of antibiotics are equally effective and result in lower risk of harm.[2] Uncomplicated cystitis ≤ 7 days Uncomplicated pneumonia 5-7 days Uncomplicated cellulitis 5-7 days
Suggested Tools and Resources	Infographic on **Shorter is Smarter:** Reducing duration of antibiotic therapy in long-term care.

Change Ideas for Quality Improvement: Antibiotic prolonged treatment

Steps I can take working with the long term care home to optimize antibiotic duration

Prescribe shorter courses when appropriate.	Implement guidelines or resources to reduce antibiotic exposure for specific infections to the shortest effective duration. Refer to Fact Sheet and Evidence Briefs on **Shorter is Smarter:** Reducing Duration of Antibiotic Treatment for Common Infections in Long-term Care. Uncomplicated cystitis ≤ 7 days Uncomplicated pneumonia 5-7 days Uncomplicated cellulitis 5-7 days Collaborate with pharmacists to ensure appropriate duration is selected for each infection.
Systematically re-evaluate duration of antibiotic therapy	Implement an “antibiotic time-out” and review antibiotic therapy after 48-72 hours or as early as possible. Refer to Public Health Ontario’s Antibiotic Time Out Strategy. Reassess resident status, laboratory cultures, and duration of therapy. Discontinue antibiotic where appropriate. Narrow spectrum of antibiotic therapy where appropriate: de-escalate or streamline.

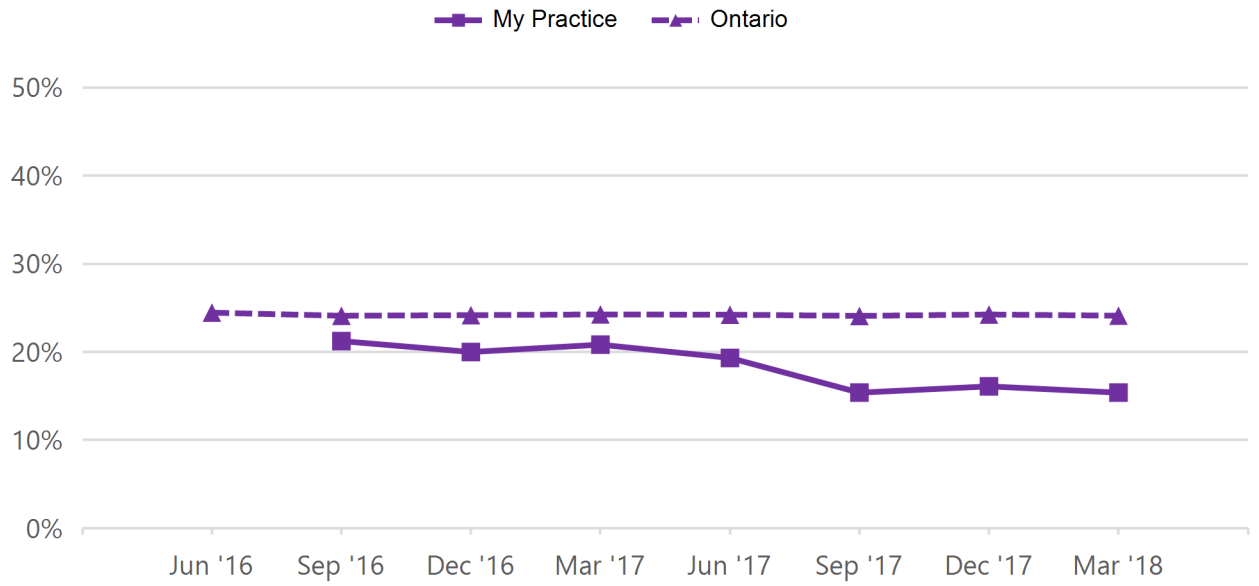
Antipsychotic prescribing

Reporting Period: Jan 2018 - Mar 2018

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

Between Jan 01, 2018 and Mar 31, 2018:

- **15.4%** of my residents with dementia, without psychosis, were prescribed an antipsychotic.
- My overall rate is **lower than** the provincial rate of **24.1%**. The rate in my LHIN is **25%**.
- **7.8%** of my residents were prescribed antipsychotics for at least 90 continuous days.[6–8]
- **0%** of my residents were newly prescribed an antipsychotic (i.e. no prescription in previous 12 months).[9]



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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

Key Change:
Consider a trial of weaning residents off antipsychotic prescriptions where appropriate.

In some cases, antipsychotics are indicated for management of responsive behaviours and BPSD.[10] The data cannot weigh the benefits against the possible harms for a particular resident, but they can point to practice patterns worthy of reflection.

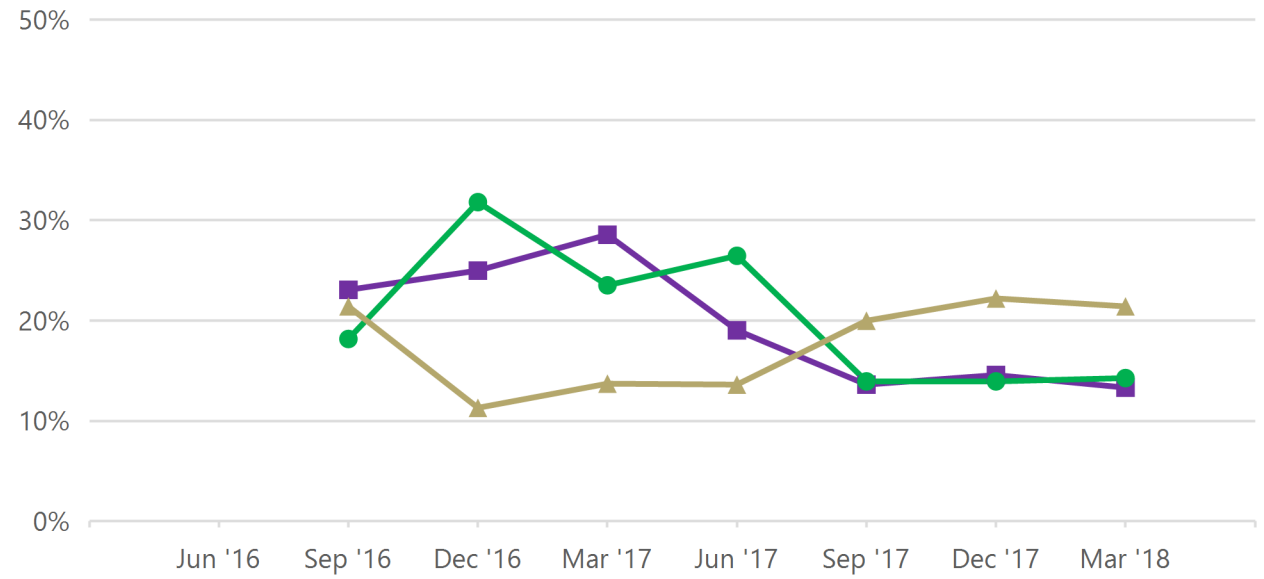
The **Change Ideas: BPSD** suggest ways you can optimize your antipsychotic prescribing.

Antipsychotic prescribing in my LTC homes

Reporting Period: Jan 2018 - Mar 2018

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 Jan 01, 2018 and Mar 31, 2018, among my residents diagnosed with dementia without psychosis, my prescribing rates for at least one antipsychotic were:
  1. Sample Home A: **13.3% (6/45)**
  2. Sample Home B: **14.3% (6/42)**
  3. Sample Home C: **21.4% (6/28)**



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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

Sample Home 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.

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[9]
- Use a standardized and simplified medication review process. See sample worksheet from Alberta Health Services[11]
- 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).[12] Use P.I.E.C.E.S. assessment tool
- Trial non-pharmacological strategies before antipsychotic medications, where appropriate[12–13]

Choose optimal pharmacological interventions

- Trial lowest effective dose for shortest duration.[14] Monitor effectiveness and tolerability using BSMT Tool[15]
- 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[16]
- Behavioural Supports Ontario (BSO)
- Choosing Wisely Canada Toolkit for Reducing Inappropriate Use of Antipsychotics in LTC[17]

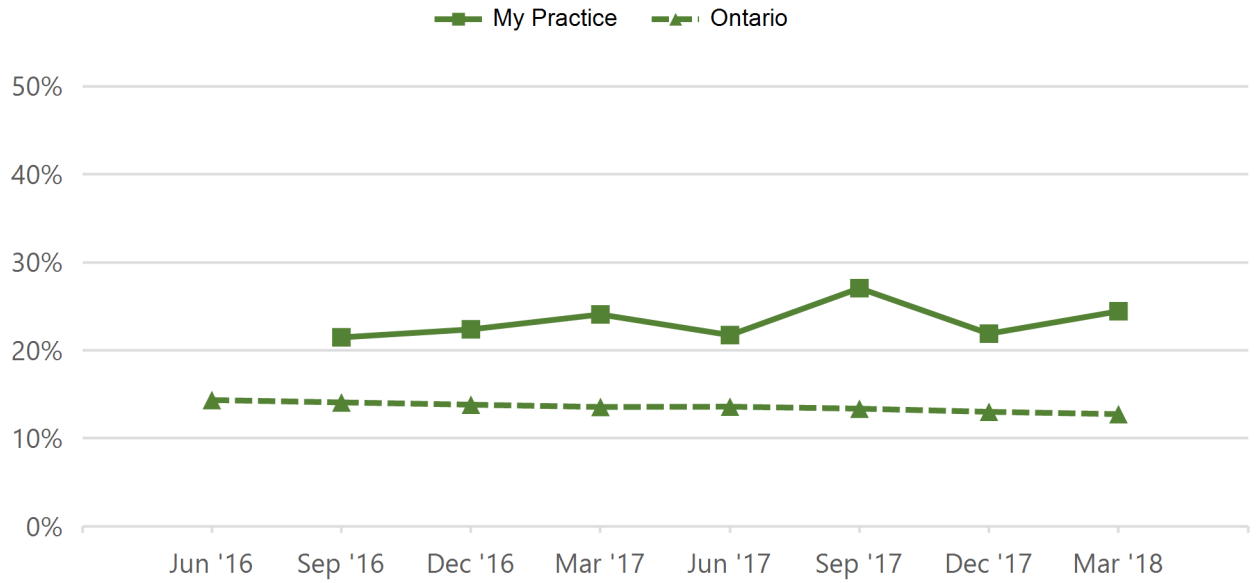
Benzodiazepine prescribing

Reporting Period: Jan 2018 - Mar 2018

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

Between Jan 01, 2018 and Mar 31, 2018:

- **24.4%** of my residents were prescribed at least one benzodiazepine.
- My overall rate is **higher than** the provincial rate of **12.8%**. The rate in my LHIN is **10%**.
- **13.3%** of my residents were prescribed benzodiazepines for at least 90 continuous days.



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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).

Number of my residents prescribed a benzodiazepine
33

Key Change:
After reflecting on your rates and indications for benzodiazepine use in individual residents, consider a trial of weaning where appropriate.

Sometimes benzodiazepines are appropriate, but benzodiazepines do contribute to the risk of falls which can lead to injury.

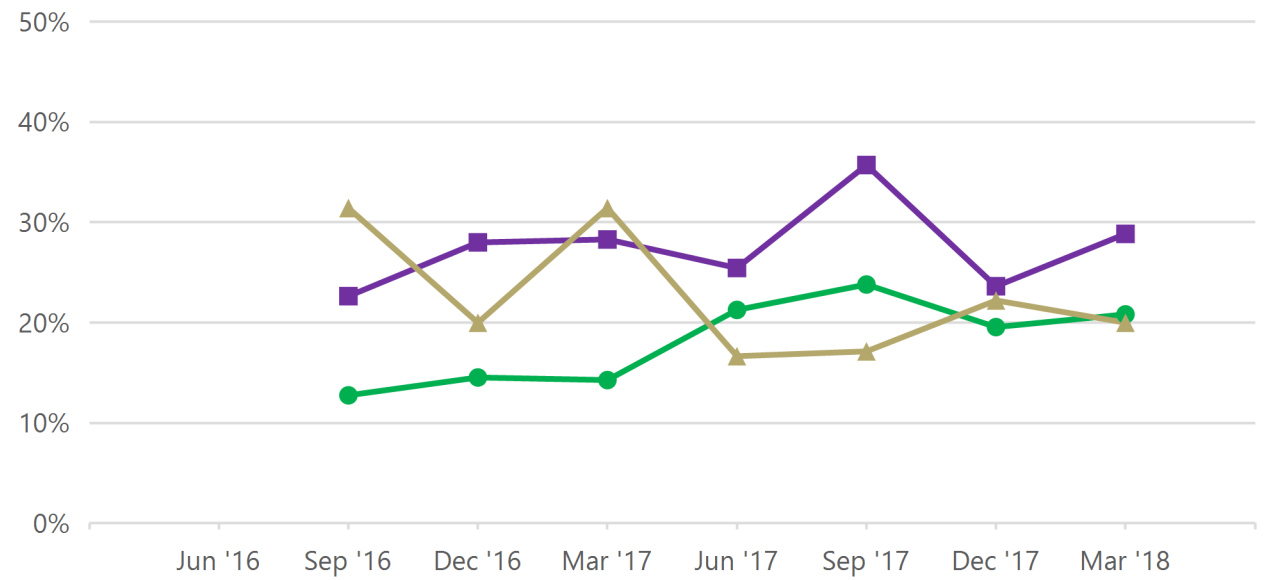
The **Change Ideas: Falls and Mobility** suggest ways you can optimize your benzodiazepine prescribing.

Benzodiazepine prescribing in my LTC homes

Reporting Period: Jan 2018 - Mar 2018

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 Jan 01, 2018 and Mar 31, 2018, my prescribing rates for at least one benzodiazepine were:
  1. Sample Home A: **28.8% (15/52)**
  2. Sample Home B: **20.8% (10/48)**
  3. Sample Home C: **20.0% (7/35)**



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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

Sample Home 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.

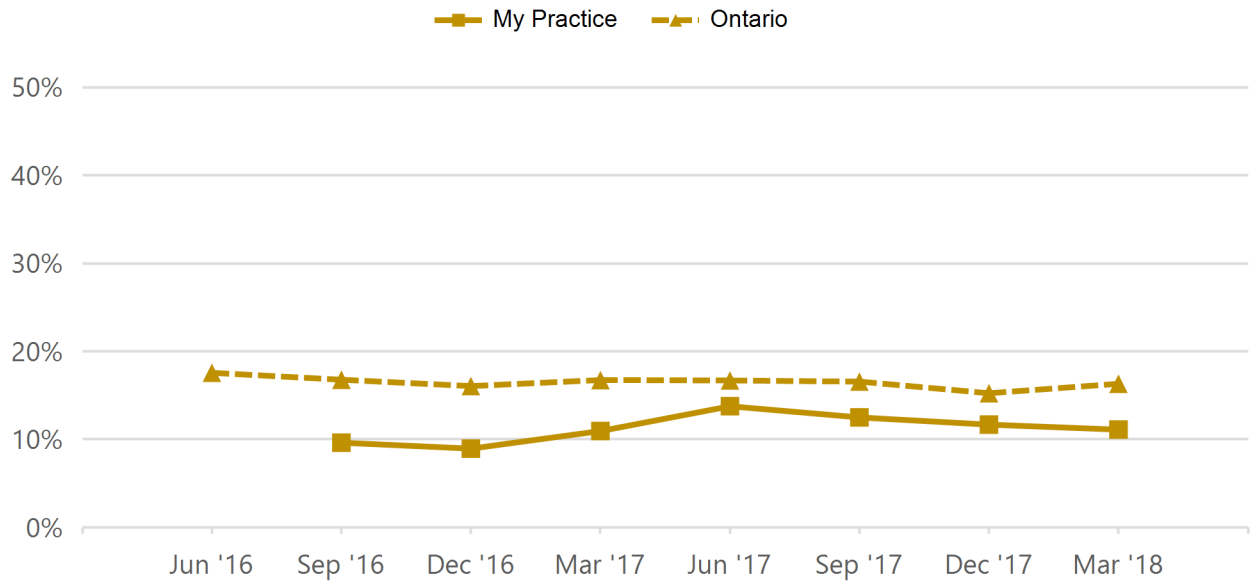
Three or more specified CNS-active medications

Reporting Period: Jan 2018 - Mar 2018

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

Between Jan 01, 2018 and Mar 31, 2018:

- **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 **16.3%**. The rate in my LHIN is **20%**.



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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)

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.

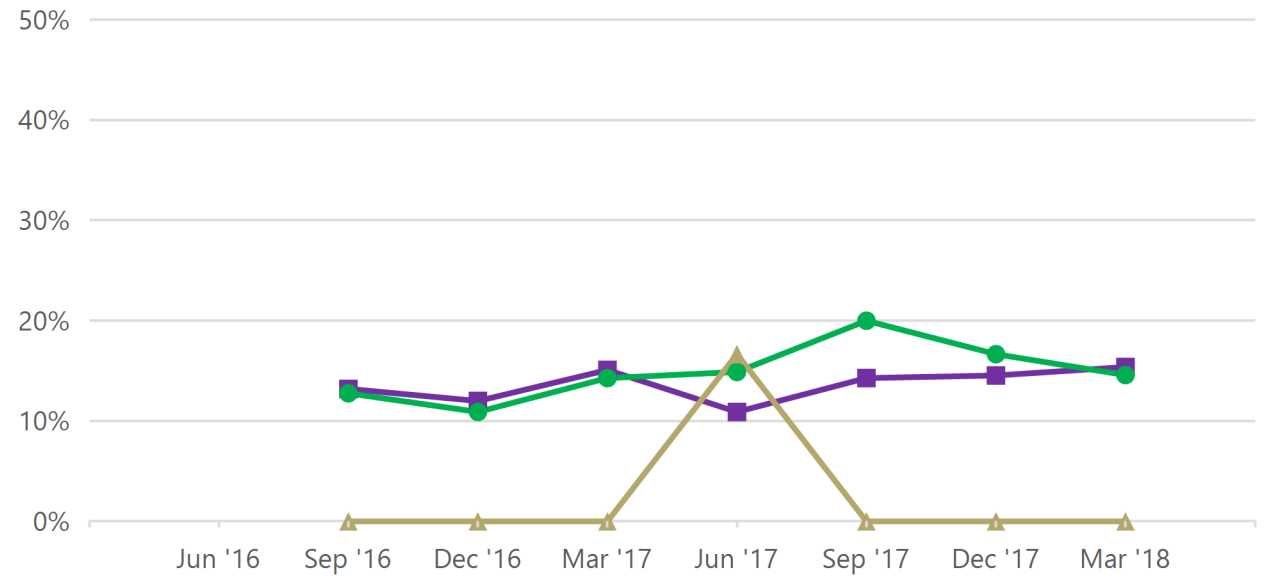
The **Change Ideas: Falls and Mobility** suggest ways you can optimize your prescribing of these CNS-active medications.

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

Reporting Period: Jan 2018 - Mar 2018

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 Jan 01, 2018 and Mar 31, 2018, my home level prescribing rates of three or more CNS-active medications (antipsychotics, opioids, benzodiazepines [oral], and antidepressants, including TCA and trazodone) were:
  1. Sample Home A: **15.4% (8/52)**
  2. Sample Home B: **14.6% (7/48)**
  3. Sample Home 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

Sample Home 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[9]
- 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[18]
- 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[19] and ISMP Canada BEERs List[20]
- Check Ontario Pharmacy Evidence Network / Bruyère Research Institute Deprescribing 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: Additional information

Data Source: OHIP/ODB cohort Period: Jan 01, 2018 – Mar 31, 2018	My Residents	Ontario
Total number of residents	200	76582
Mean age (years)	82	84
85 years and older	49%	56%
Female	70%	69%
Male	30%	31%
Residents new to the LTC home (<100 days)	16%	12%

†Data suppressed as per ICES' privacy policy, additional suppression may be applied to prevent back-calculation of suppressed data; N/A: Data not available

Data Source: ICES-Derived Cohorts Period: Jan 01, 2018 – Mar 31, 2018	My Residents	Ontario
Residents with asthma	15%	14%
Residents with chronic obstructive pulmonary disease	35%	15%
Residents with congestive heart failure	25%	21%
Residents with dementia	55%	70%
Residents with diabetes	45%	37%

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My resident profile: Continuing Care Reporting System (RAI-MDS)

Period: Apr 01, 2016 – Mar 31, 2017	My Residents	Ontario
Residents without psychosis on antipsychotics in the last 7 days	22.0%	20.5%
Residents who fell in the last 30 days	26.0%	14.6%
Residents in daily physical restraints over the last seven days	18.0%	5.3%
Activites of Daily Living (ADL):		
Independent (0)	10%	3%
Limited Impairment (1-2)	20%	12%
Extensive Assistance (3-4)	30%	50%
Dependent (5-6)	40%	34%
Aggressive Behaviour Scale (ABS):		
No Aggressive Behaviour (0)	10%	54%
Some Aggressive Behaviour (1-2)	20%	24%
Severe Aggressive Behaviour (3-5)	30%	16%
Very Severe Aggressive Behaviour (≥ 6)	40%	6%
Cognitive Performance Scale (CPS):		
Relatively Intact (0-1)	20%	19%
Mild / Moderate (2-3)	30%	49%
Severe (4-6)	50%	32%
Pain Scale:		
No Pain (0)	10%	68%
Less than Daily Pain (1)	20%	23%
Daily Pain, but Not Severe (2)	30%	7%
Severe Daily Pain (3)	40%	1%

CIHI indicators are calculated as rolling four-quarter averages

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Methods

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).[21–23] 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.[24–25]

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.[26]
- 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 than 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.

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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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MyPractice
Long-Term Care

A tailored report for quality care

Screenshots of the online *MyPractice*: LTC sample report

Email PracticeReport@ontariohealth.ca for more information

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Overview

Reporting period: Jan 1, 2020 – Mar 31, 2020

ANTIBIOTIC PRESCRIBING

27 %

of my residents were prescribed an antibiotic

Higher than most of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

ANTIBIOTIC PROLONGED TREATMENT

10 %

of my antibiotic prescriptions were longer than seven days

Lower than most of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

ANTIPSYCHOTIC PRESCRIBING

15 %

of my residents with dementia without psychosis were prescribed an antipsychotic

Lower than most of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

BENZODIAZEPINE PRESCRIBING

24 %

of my residents were prescribed a benzodiazepine

Higher than most of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

CNS-ACTIVE MEDICATIONS

11 %

of my residents were prescribed three or more specified CNS-active medications

Similar to many of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

Who are my residents?

See a detailed view of your resident profile

About this report

Learn more about the *MyPractice: Long-Term Care* reports

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Antibiotics

Reporting period: Apr 1, 2018 – Mar 31, 2020

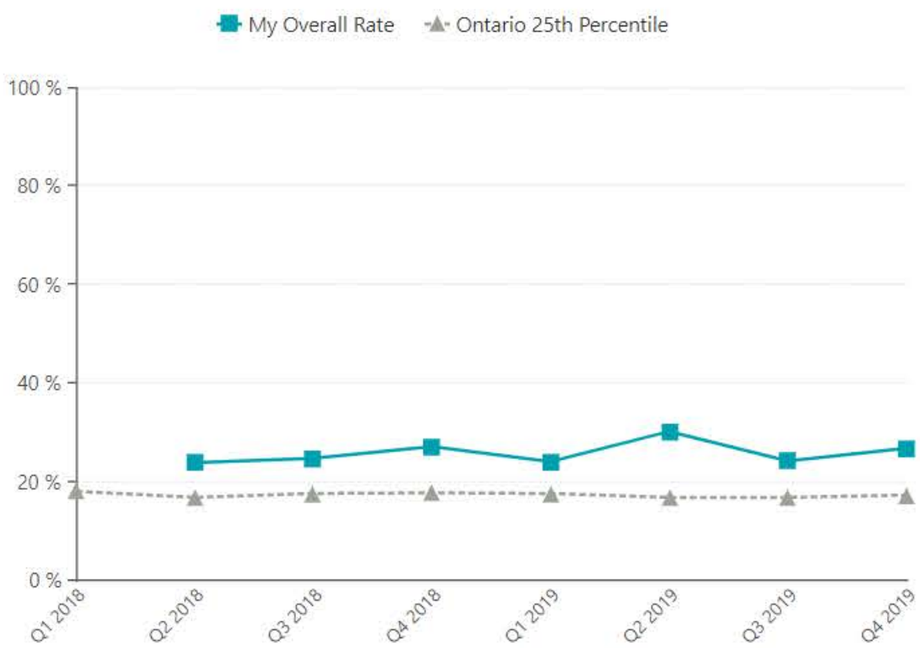
My LHIN: Sample LHIN

Select Your:

Comparator: Ontario 25th Percentile

Home: My Overall Rate

What percent of my residents were prescribed an antibiotic?



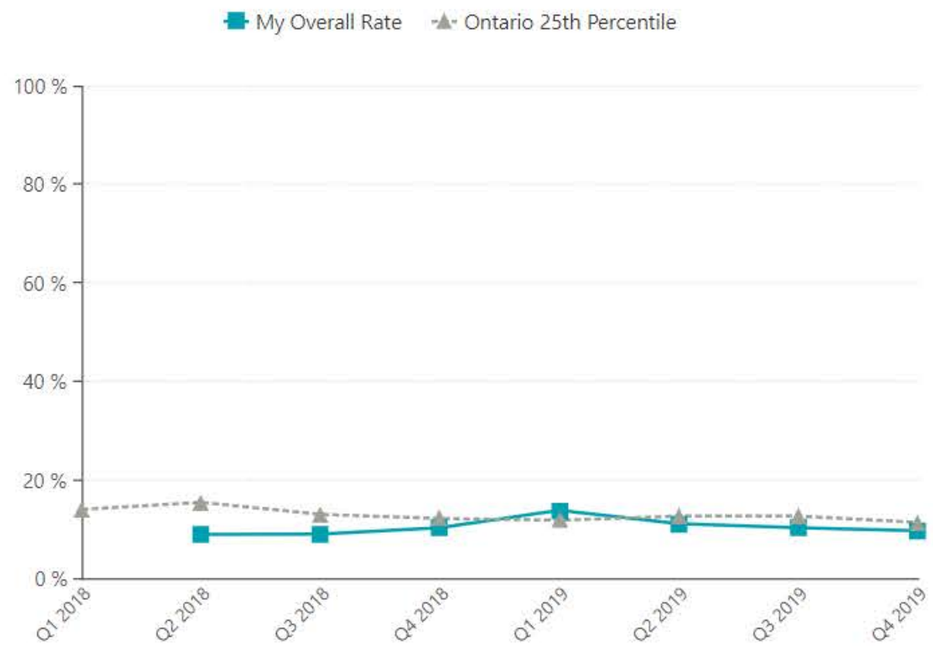
Gaps in the graph are due to suppression as per ICES' privacy policy and data availability. Q4 2019 represents Jan 1, 2020 to Mar 31, 2020

In the most recent quarter, **36** of my residents were prescribed an antibiotic.

Key change: Don't do a urine dip or a urine culture unless there are clear signs and symptoms of a urinary tract infection (UTI).

Change Ideas: Antibiotic Prescribing

What percent of my antibiotic treatments were longer than seven days?



Gaps in the graph are due to suppression as per ICES' privacy policy and data availability. Q4 2019 represents Jan 1, 2020 to Mar 31, 2020

In the most recent quarter, **13** of my **135** antibiotic treatments were longer than seven days.

Key change: Optimize duration of therapy to 7 days or less for uncomplicated cystitis, pneumonia and cellulitis.

Change Ideas: Antibiotic Prolonged Treatment

IMPORTANT QUESTIONS

Are my residents sicker or more complex than others? Collapse

Table: Select resident characteristics

Reporting period: Jan 1, 2020 – Mar 31, 2020

	My Practice	Ontario
Residents with asthma	15 %	15 %
Residents with chronic obstructive pulmonary disorder	35 %	15 %
Residents with congestive heart failure	25 %	21 %
Residents with dementia	55 %	70 %
Residents with diabetes	45 %	37 %

N/R: Data suppressed as per ICES' privacy policy, additional suppression may be applied to prevent calculation of suppressed data. N/A: Data not available.

Data sources: ICES-Derived Cohorts

How do I know these data are accurate? Expand

How is my antibiotic prescribing rate calculated? Expand

How is my antibiotic prolonged treatment rate calculated? Expand

What are some limitations of these data? Expand

Is low antibiotic prescribing reasonable and safe? Expand

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Antipsychotics

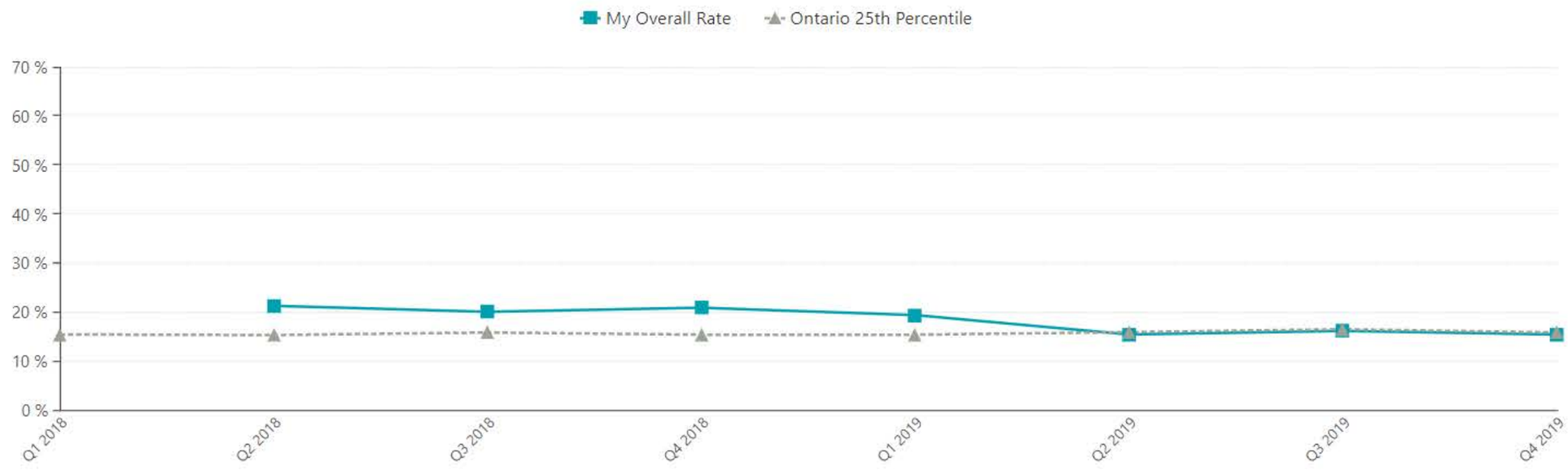
Reporting period: Apr 1, 2018 – Mar 31, 2020

My LHIN: Sample LHIN

Select Your:

Comparator: Ontario 25th Percentile Home: My Overall Rate

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



Gaps in the graph are due to suppression as per ICES' privacy policy and data availability. Q4 2019 represents Jan 1, 2020 to Mar 31, 2020

In the most recent quarter, among my residents who have dementia without psychosis:

18 were prescribed an antipsychotic.

9 were prescribed an antipsychotic for over 90 days.

0 were newly prescribed an antipsychotic.

Key change: Consider a trial of weaning residents off antipsychotic prescriptions where appropriate.

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

Change Ideas: Antipsychotics

IMPORTANT QUESTIONS

Are my residents sicker or more complex than others?	Expand
How do I know these data are accurate?	Expand
How is my antipsychotic prescribing rate calculated?	Expand
What are some limitations of these data?	Expand

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Benzodiazepines

Reporting period: Apr 1, 2018 – Mar 31, 2020

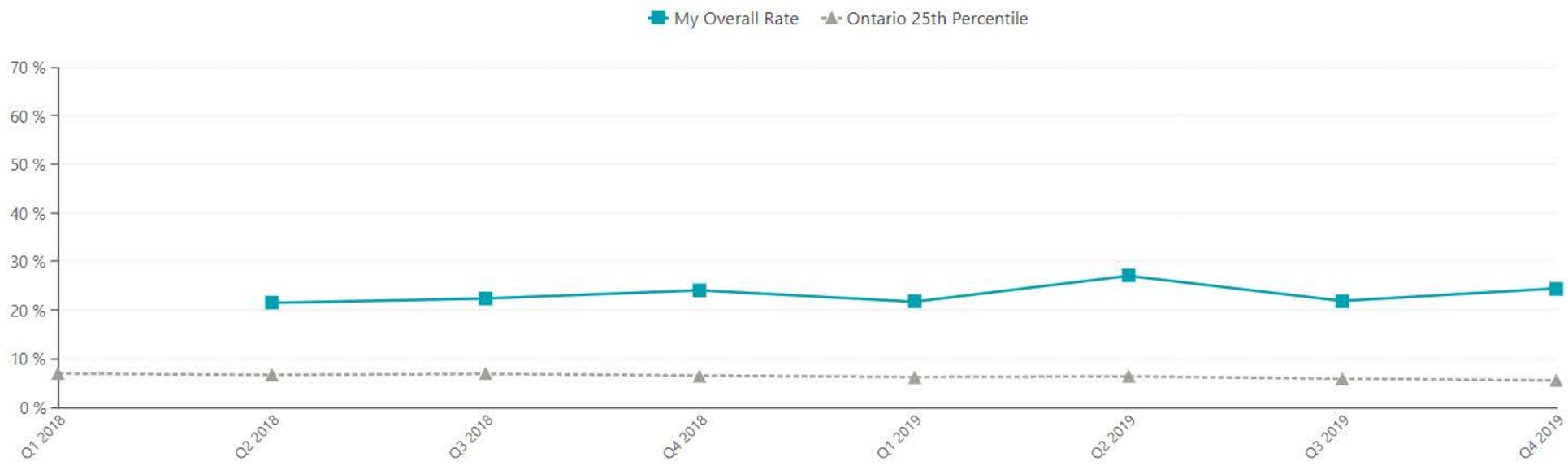
My LHIN: Sample LHIN

Select Your:

Comparator: Ontario 25th Percentile

Home: My Overall Rate

What percent of my residents aged 66 and older were prescribed a benzodiazepine?



Gaps in the graph are due to suppression as per ICES' privacy policy and data availability. Q4 2019 represents Jan 1, 2020 to Mar 31, 2020

In the most recent quarter, among my residents:

33 were prescribed a benzodiazepine.

16 were prescribed a benzodiazepine for at least 90 days.

Key change: After reflecting on your rates and indications for benzodiazepine use in individual residents, you may consider a trial of weaning where appropriate.

Sometimes benzodazepines are appropriate, but benzodiazepine do contribute to the risk of falls which can lead to injury.

Change Ideas: Falls and Mobility

IMPORTANT QUESTIONS

Are my residents sicker or more complex than others?	Expand
How do I know these data are accurate?	Expand
How is my benzodiazepine rate calculated?	Expand
What are some key limitations of these data?	Expand

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CNS-Active Medications

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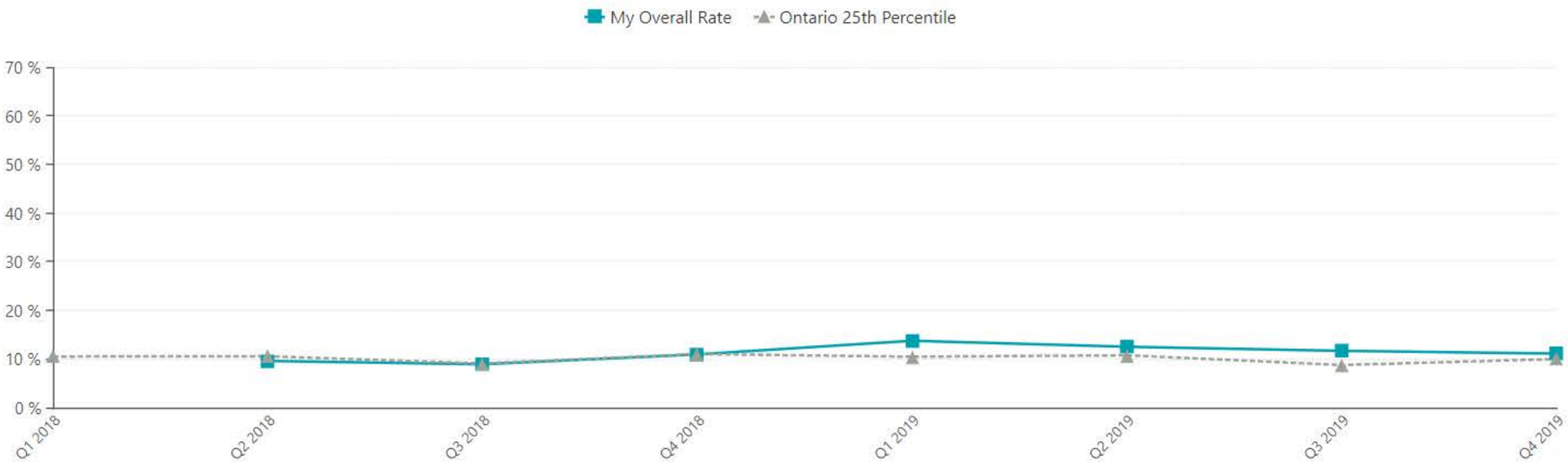
My LHIN: Sample LHIN

Select Your:

Comparator: Ontario 25th Percentile Home: My Overall Rate

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



Gaps in the graph are due to suppression as per ICES' privacy policy and data availability. Q4 2019 represents Jan 1, 2020 to Mar 31, 2020

In the most recent quarter, among my residents:

15 were prescribed three or more CNS-active medications (including antipsychotics, opioids, benzodiazepines [oral], and antidepressants, including TCA and trazodone).

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.

Change Ideas: Falls and Mobility

IMPORTANT QUESTIONS

Are my residents sicker or more complex than others?	Expand
How do I know these data are accurate?	Expand
How is my three or more CNS-active medications rate calculated?	Expand
What are some limitations of these data?	Expand

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Change Ideas: Antibiotic Prescribing

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Avoid Treatment of Asymptomatic Bacteriuria

1) Don't do a urine dip or urine culture unless there are clear signs and symptoms of a urinary tract infection (UTI).

*Common situations where systemic antibiotics are generally **not** indicated:*

- Positive urine culture in an asymptomatic resident.
- Urine culture ordered solely because of change in urine appearance (e.g. cloudy) or odor.
- Nonspecific symptoms or signs not referable to the urinary tract, such as falls or mental status change (with or without a positive urine culture).
- For additional guidance, use the Public Health Ontario's UTI Program: Assessment algorithm

2) Prescribe antibiotics only when resident has clear signs and symptoms of UTI and reassess once urine culture and susceptibility results have been received.

Review/Establish Criteria or Guidelines for Treatment of Infections

*3) Review other common indications where antibiotics are **not** required in LTC residents.*

- Upper respiratory infection (common cold).
- Bronchitis or asthma in a resident who does not have COPD.
- "Infiltrate" on chest x-ray in the absence of clinically significant symptoms.
- Suspected or proven influenza in the absence of a secondary infection (but DO treat influenza with antivirals).
- Respiratory symptoms in a resident on palliative care or at the end of life.
- Skin wound without cellulitis, sepsis or osteomyelitis (regardless of culture result).

Educate residents, families, clinicians and other staff

Use the SymptomFreeLetItBe handout when talking with residents, families and staff.

Suggested Tools and Resources

- Choosing Wisely Canada. Using Antibiotics Wisely Campaign
- AHRQ. 12 Common Nursing Home Situations in Which Systemic Antibiotics are Generally Not Indicated
- AMMI Asymptomatic Bacteriura Toolkit. Fillable resident/family letter.
- Public Health Ontario. UTI Program: Assessment algorithm for urinary track infections (UTIs) in medically stable non-catheterized residents

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Avoid Treatment of Asymptomatic Bacteriuria

- Implement a program to reduce unnecessary urine culturing.
- Standardize guidelines of how and when to test cultures and interpretation of urine culture results.
- *Discontinue routine annual urine screening and screening at admission if residents do not have indicated clinical signs and symptoms of a UTI.*
- Refer to Public Health Ontario's UTI Program

Review/Establish Criteria or Guidelines for Treatment of Infections

Work with home's infection control personnel to implement minimum criteria guidelines for antibiotic initiation in your LTC home.
Refer to AHRQ. Minimum Criteria for Common Infections Toolkit (UTI, LRTI, SSTI).

Implement structured nursing communication tools (e.g. SBAR tools) to aid in clear communication between nurses and prescribers and standardize assessments of residents suspected with infection.

Educate residents, families, clinicians and other staff

Provide education and resources for prescribers, nurses, front-line clinicians and on-call staff about common infections, and the importance of appropriate antibiotic use. Include a consistent message regarding antimicrobial resistance and role of antibiotics.

Refer to AMMI Asymptomatic Bacteriuria Toolkit. Myths and Truths about Urinary Tract Infections in Long Term Care Residents.

Provide education and resources for residents and families about common infections, antibiotic resistance and improving antibiotic use.

Refer to AMMI Asymptomatic Bacteriuria Toolkit. Fillable resident/family letter or DBND FAQ for Families, Guardians and Health Care Aides-UTI in LTCF.

Suggested Tools and Resources

Public Health Ontario has developed a primer and checklist to identify gaps and provide helpful tools for implementation.

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Change Ideas: Antibiotic Prolonged Treatment

Things I Can Do | Things I Can Do With My Team

Back to Overview

Prescribe shorter courses when appropriate

Optimize duration of therapy to 7 days or less for uncomplicated cystitis, pneumonia and cellulitis.

In most cases of uncomplicated infections seen in LTC, short courses of antibiotics are equally effective and result in lower risk of harm.

- Uncomplicated cystitis ≤ 7 days
- Uncomplicated pneumonia 5-7 days
- Uncomplicated cellulitis 5-7 days

Suggested Tools and Resources

Infographic on **Shorter is Smarter:** Reducing duration of antibiotic therapy in long-term care.

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Things I Can Do | **Things I Can Do With My Team**

Back to Overview

Prescribe shorter courses when appropriate

Implement guidelines or resources to reduce antibiotic exposure for specific infections to the shortest effective duration. Refer to Fact Sheet and Evidence Briefs on **Shorter is Smarter:** Reducing Duration of Antibiotic Treatment for Common Infections in Long-term Care.

- Uncomplicated cystitis ≤ 7 days
- Uncomplicated pneumonia 5-7 days
- Uncomplicated cellulitis 5-7 days

Collaborate with pharmacists to ensure appropriate duration is selected for each infection.

Systematically re-evaluate duration of antibiotic therapy

Implement an "antibiotic time-out" and review antibiotic therapy after 48-72 hours or as early as possible.
Refer to Public Health Ontario's Antibiotic Time Out Strategy.

Reassess resident status, laboratory cultures, and duration of therapy.

Discontinue antibiotic where appropriate.

Narrow spectrum of antibiotic therapy where appropriate: de-escalate or streamline.

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Change Ideas: Antipsychotics

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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
- Use a standardized and simplified medication review process. See sample worksheet from Alberta Health Services
- 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). Use P.I.E.C.E.S. assessment tool
- Trial non-pharmacological strategies before antipsychotic medications, where appropriate

Choose optimal pharmacological interventions

- Trial lowest effective dose for shortest duration. Monitor effectiveness and tolerability using BSMT Tool
- 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
- Behavioural Supports Ontario (BSO)
- Choosing Wisely Canada Toolkit for Reducing Inappropriate Use of Antipsychotics in LTC

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Change Ideas: Falls and Mobility

Back to Overview

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
- 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
- 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 and ISMP Canada BEERs List
- Check Ontario Pharmacy Evidence Network / Bruyère Research Institute Deprescribing 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	Central Nervous System Drugs	Blood Pressure Medications	Osteoporosis Prevention	Resident Goal

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Resident Profile

Demographics

Reporting Period: Jan 1, 2020 – Mar 31, 2020

	My Practice	Ontario
Total number of residents	200	76,023
Mean age (years)	82	84
85 years and older	49 %	55 %
Female	70 %	68 %
Male	30 %	32 %
Residents new to the LTC home (<100 days)	16 %	12 %

N/R: Data suppressed as per ICES' privacy policy, additional suppression may be applied to prevent calculation of suppressed data. N/A: Data not available.

Data sources: OHIP/ODB cohort

Chronic Disease Prevalence

Reporting Period: Jan 1, 2020 – Mar 31, 2020

	My Practice	Ontario
Residents with asthma	15 %	15 %
Residents with chronic obstructive pulmonary disorder	35 %	15 %
Residents with congestive heart failure	25 %	21 %
Residents with dementia	55 %	70 %
Residents with diabetes	45 %	37 %

N/R: Data suppressed as per ICES' privacy policy, additional suppression may be applied to prevent calculation of suppressed data. N/A: Data not available.

Data sources: ICES-Derived Cohorts

RAI-MDS Outcome Measures

Reporting Period: Apr 1, 2019 – Mar 31, 2020

	My Practice	Ontario
Residents without psychosis on antipsychotics in the last 7 days	22.0 %	18.4 %
Residents who fell in the last 30 days	26.0 %	15.4 %
Residents in daily physical restraints over the last seven days	18.0 %	3.5 %
Activities of Daily Living (ADL):		
• Independent (0)	10 %	2 %
• Limited Impairment (1-2)	20 %	11 %
• Extensive Assistance (3-4)	30 %	51 %
• Dependent (5-6)	40 %	36 %
Aggressive Behaviour Scale (ABS):		
• No Aggressive Behaviour (0)	10 %	57 %
• Some Aggressive Behaviour (1-2)	20 %	24 %
• Severe Aggressive Behaviour (3-5)	30 %	14 %
• Very Severe Aggressive Behaviour (≥6)	40 %	5 %
Cognitive Performance Scale (CPS):		
• Relatively Intact (0-1)	20 %	17 %
• Mild / Moderate (2-3)	30 %	50 %
• Severe (4-6)	50 %	34 %
Pain Scale:		
• No Pain (0)	10 %	70 %
• Less than Daily Pain (1)	20 %	23 %
• Daily Pain, but Not Severe (2)	30 %	6 %
• Severe Daily Pain (3)	40 %	1 %

N/R: Data suppressed as per ICES' privacy policy, additional suppression may be applied to prevent calculation of suppressed data. N/A: Data not available.

Data sources: CIHI Continuing Care Reporting System (RAI-MDS)
Note: CIHI indicators are calculated as rolling four-quarter averages