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Title	**Time trends in opioid prescribing among Ontario long-term care residents: a repeated cross-sectional study**
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Reviewer 1	Lana Castellucci
Institution	Department of Medicine, University of Ottawa, Ottawa, Ont.
General comments (author response in bold)	1. The RAI-MDS is used upon entry to LTC, annually and after significant health status change. What qualifies as 'significant health status change' that would prompt a physician to complete these comprehensive yet cumbersome assessments? If it is only after hospitalization, for example, is it possible that narcotics could be prescribed without completion of the RAI-MDS leading to incomplete data? **As noted in our response to Senior Editor item #8, we have provided a brief definition of 'significant health status change' to the text of our Methods.** **It should be noted that within Ontario, routine assessment with the RAI-MDS 2.0 tool by trained facility staff is mandated, this includes the administration of a full assessment within 14 days of admission (or a significant health status change) and on an annual basis thereafter. Consequently, for all long-stay residents (i.e., excluding those discharged or who pass away within 14 days of admission) there would be no concerns with incomplete data.** 2. While the populations of those with dementia and frailty are addressed in this study, I wonder if the investigators can provide justification for not also evaluating those with liver and renal disease. These co-morbidities mark patients requiring particular and unique assessment for opioid prescriptions due to the high potential for adverse events. **Thank you for this comment – it has been addressed (please see our response to Senior Editor comment #18 above).**
Reviewer 2	Ta-Liang Chen
Institution	Health Policy Research Center, Taipei Medical University, Taiwan
General comments (author response in bold)	1. The public guidelines and policies may affect the opioid prescribing. Please add the discussion about how the "Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain" and the "2011 Ontario Narcotics Safety Awareness Act" affect the opioid use. **As noted in our Introduction, existing Canadian guidelines do not address the much older and more clinically vulnerable population cared for in LTC facilities. However, throughout our Interpretation section we have discussed our findings within the context of these existing guidelines - while being cautious not to comment beyond the reach of our data or analyses. As such, we do not feel any further text is required.** 2. Please define the abbreviation "ICES". **Recently, ICES (formerly known as the Institute for Clinical Evaluative Sciences) has undergone a re-branding of its name – it is now to be referred to as ICES. That is, ICES is no longer an abbreviation for the Institute.** 3. The results of this study showed that the proportion of Ontario LTC residents receiving opioids increased significantly for those had no pain. Please explain the reason why they received opioid prescriptions. Furthermore, can you analyze the most common diagnoses of these prescriptions?

	Unfortunately, the linked administrative databases available for analyses do not allow us to comment on the indication or reason for the opioid prescription. As noted in our response to the Senior Editor (item #24 above), we have added this limitation to our Discussion section. Also in response to the Senior Editor (item #21), we have clarified in our Results that this statement refers to those with no recorded pain in the past 7 days (and thus, it is plausible that this reflects an appropriate level of pain management with medications or other non-pharmacological treatments). 4. The results of this study found an increase trend of opioid use in the study population. Can you analyze and explain the most common reasons of opioid use for these vulnerable older adults? **Please see our response to item #3 above.**