

UPDATE OF QUALITY CONCERNS IN DEMENTIA CARE – WHY DOCTORS SHOULD RARELY PRESCRIBE ANTIPSYCHOTICS IN TEXAS NURSING HOMES

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Definitions

- Dementia – a general term for progressive disorders that damage and destroy brain cells
- Results in memory loss, changes in thinking and behavior that interfere with ability to function independently in everyday life
- Alzheimer's disease is the most common form (50-80% of dementia is due to Alzheimer's disease)



Other Dementias

- Other types of dementia
 - Vascular
 - Lewy body
 - Fronto-temporal lobe dementia (FTD)
 - Mixed dementia
- Differential diagnosis includes
 - Delirium
 - B12 deficiency
 - Thyroid disorders

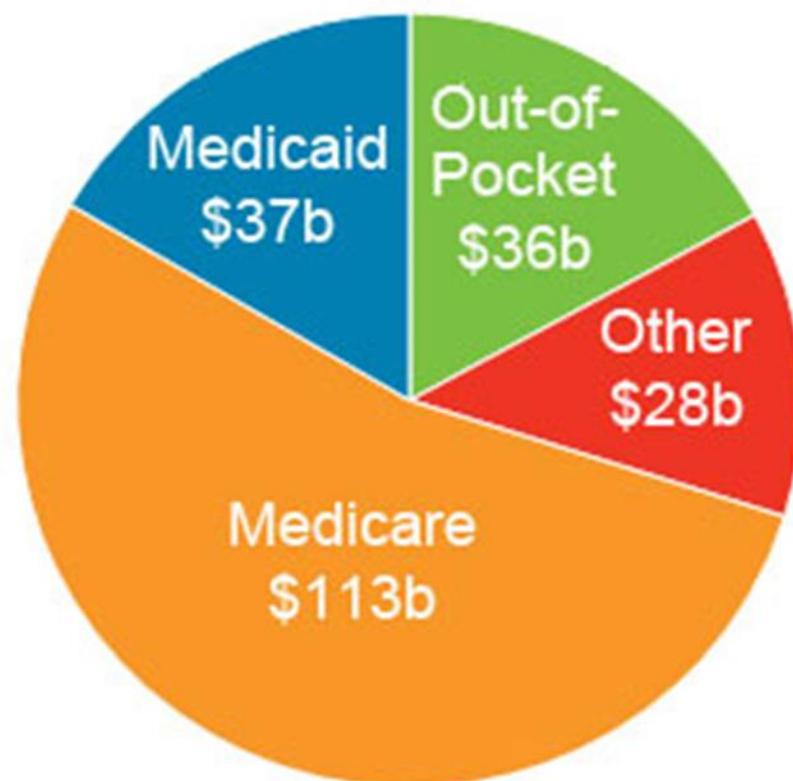
Dementia by the numbers

- Sixth leading cause of death
- Over 5.2 million people currently living with Alzheimer's in the U.S.
 - Includes 200,000 under age 65 with early-onset
- 1/3 of seniors die with dementia
- Almost two-thirds of people with Alzheimer's are women



Dementia by the numbers

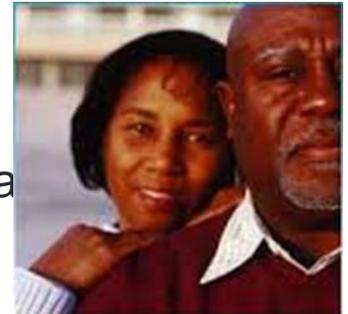
- Cost of over \$214 B annually
 - Predicted to affect over 16 million people by 2050
 - Unsustainable cost of 1.2 trillion



Risk Factors

- Age
 - Risk of developing AD is 50% over age 85
- Family history (parent, sibling, child)
- Heredity

APOE-e4 = risk gene
- Complex interactions
 - Head trauma
 - Heart health, vascular health
 - Latinos and African-Americans in the U.S. have higher rates of heart disease; they may have higher rates of AD as well



Brain Changes with Alzheimer's

- Microscopic clumps of **beta-amyloid protein (plaques)**
- Twisted microscopic strands of **tau protein (tangles)**
- **Loss of connections among brain cells (synapses)**
- **Inflammation** (immune response)
- Eventual **death of neurons** - seen on autopsy as severe shrinkage.

Making the Diagnosis

- AD is a pathological diagnosis
- Core clinical criteria are the cornerstone of dementia diagnoses



Alzheimer's & Dementia 7 (2011) 263–269

Alzheimer's
&
Dementia

The diagnosis of dementia due to Alzheimer's disease: Recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease

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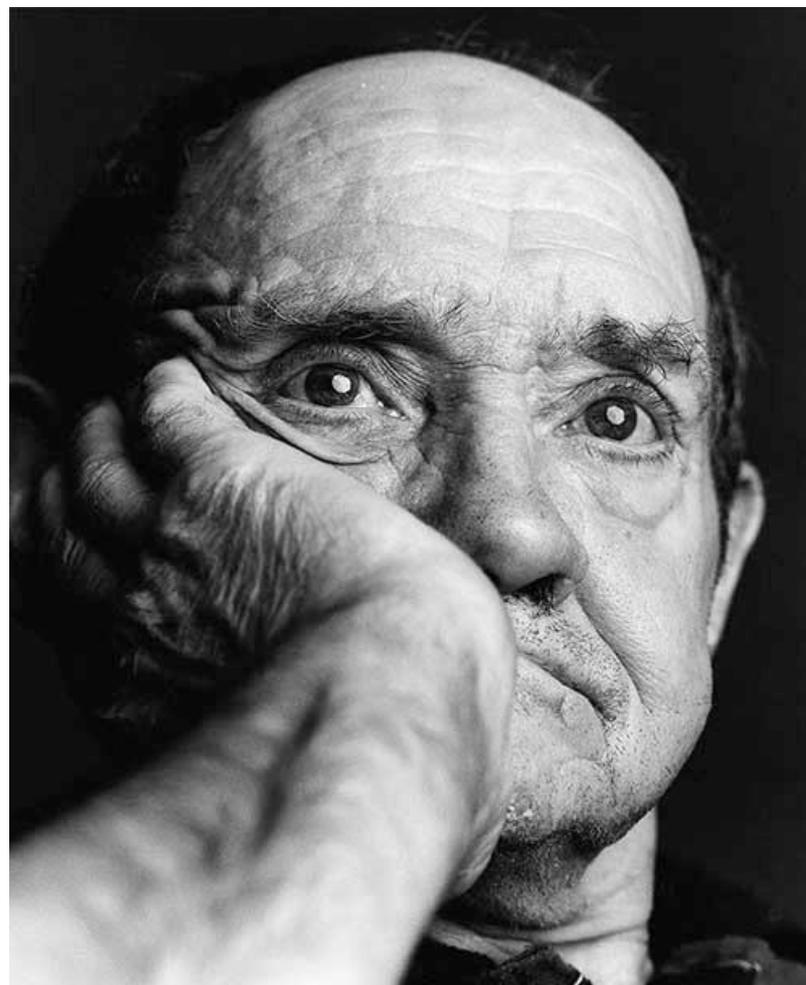
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Related diagnostic categories

- Mild Cognitive Impairment (MCI)
 - Challenging to differentiate from normal aging and from dementia
 - Requires intimate knowledge of the person
 - Intra-personal change over time
- Pre-clinical Alzheimer's disease
 - Pathophysiological evidence before symptoms appear



Making the Diagnosis – all cause dementia

- **Cognitive or behavioral impairment** includes at least **two** of these five domains:
 - Impaired ability to acquire and remember new information
 - Impaired reasoning and handling of complex tasks, poor judgment
 - Impaired visuospatial abilities
 - Impaired language (speaking, reading, writing)
 - Changes in personality or behavior

Making the Diagnosis: all-cause dementia

- Cognitive or behavioral/neuropsychiatric symptoms that:
 - Interfere with ability to function
 - Represent decline from previous level of functioning
 - Are **not explained by delirium or other major psychiatric disorder**

Current Medication Therapy for AD

- **donepezil hydrochloride (Aricept)**—ARICEPT 5mg and 10 mg are indicated for mild to moderate Alzheimer's disease, and ARICEPT 10 mg and 23 mg are indicated for moderate to severe Alzheimer's disease;
- **rivastigmine (Exelon)**, approved in pill and patch form for mild to moderate Alzheimer's disease, and in a higher dosage Exelon Patch for severe Alzheimer's disease;
- **galantamine hydrobromide (Razadyne)**, approved for mild to moderate Alzheimer's disease; and
- **memantine hydrochloride** (twice-daily oral **NAMENDA** and once-daily **NAMENDA XR** capsules) for the treatment of moderate to severe Alzheimer's disease.

Medication use in older adults: renal function

- **Renal function** declines swiftly with aging and even more rapidly with comorbid conditions such as hypertension and diabetes
 - Medications can cause a spectrum of damage to the kidneys, especially through drug excretion
 - **Medications dosages need to be lowered and dosing monitored for older adults**
 - Important to calculate renal function for individuals when prescribing medications
 - Dose according to measured GFR
 - **One-fifth of adults over 60 have chronic kidney disease in addition to age related changes**
- Dharmarajan, T. S., & Davuluri, S. Medications, Renal Function, and Kidney Injury: A Complex Interplay, Wherein Prevention Is Easier Than Cure! *Journal of the American Medical Directors Association*, 15(10), 692-696. doi: 10.1016/j.jamda.2014.07.001

Treatment for Alzheimer's Disease

- There is no cure.
- At this time, there is no treatment to cure, delay or stop the progression of Alzheimer's disease.
- FDA-approved drugs may **temporarily** slow worsening of symptoms for about 6 to 12 months, on average, for about **half** of the individuals who take them.
- For these reasons, **Non-pharmacological approaches** are the cornerstone of managing the disease and
GREATLY IMPROVE QUALITY OF LIFE!

Aliveinside.us – watch the trailer/documentary
about Music and Memory

Nursing Home Residents and Antipsychotics

- In 2010/2011, **one-third to one-quarter of all nursing home residents received an antipsychotic**
 - Dominant treatment for dementia-related behaviors
- 80% are prescribed for off label uses – mostly for dementia-related behaviors
 - **21% receive them without an appropriate clinical indication**
- Tjia, J., Gurwitz, J. H., & Briesacher, B. A. (2012). Challenge of changing nursing home prescribing culture. *Am J Geriatr Pharmacother*, 10(1), 37-46. doi: 10.1016/j.amjopharm.2011.12.005

Antipsychotics, Other Psychotropics, and the Risk of Death in Patients With Dementia Number Needed to Harm (NNH)

- **Conclusions and Relevance** The absolute effect of antipsychotics on mortality in elderly patients with dementia may be higher than previously reported and increases with dose.
- **NNH for Haldol, Risperdal, Seroquel and Zyprexa between 26-50** (for every 26-50 people, one death in 6 months)

Ensuring medication safety: what drugs should we worry about most and why?

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ADVERSE EVENTS IN SKILLED
NURSING FACILITIES:
NATIONAL INCIDENCE AMONG
MEDICARE BENEFICIARIES**



Daniel R. Levinson
Inspector General

February 2014
OEI-06-11-00370

Many Studies on Falls and Medications

REVIEW ARTICLE

Drugs Aging 2012; 29 (3): 359-376
1170-229X/12/0005-0359/\$49.95/0

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Medication-Related Falls in the Elderly Causative Factors and Preventive Strategies

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The Boston Globe

Founded 1872

A rampant prescription, a hidden peril

By Kay Lazar and Matt Carroll
Globe Staff / April 29, 2012

Many Studies on Falls and Medications Finding alternatives to potent sedatives Nursing homes increasingly take new tack in dealing with dementia

By [Kay Lazar | GLOBE STAFF](#)
[APRIL 30, 2012](#)

Mass. fails to rein in sedating of seniors Nursing homes that overuse antipsychotics unpunished

By [Kay Lazar | GLOBE STAFF](#)
[DECEMBER 23, 2012](#)

CMS National Partnership to Improve Dementia Care

Goal - reduce unnecessary antipsychotic medication use in nursing homes.

A unique public-private partnership that began late in 2011 when a group of nursing home advocates visited CMS

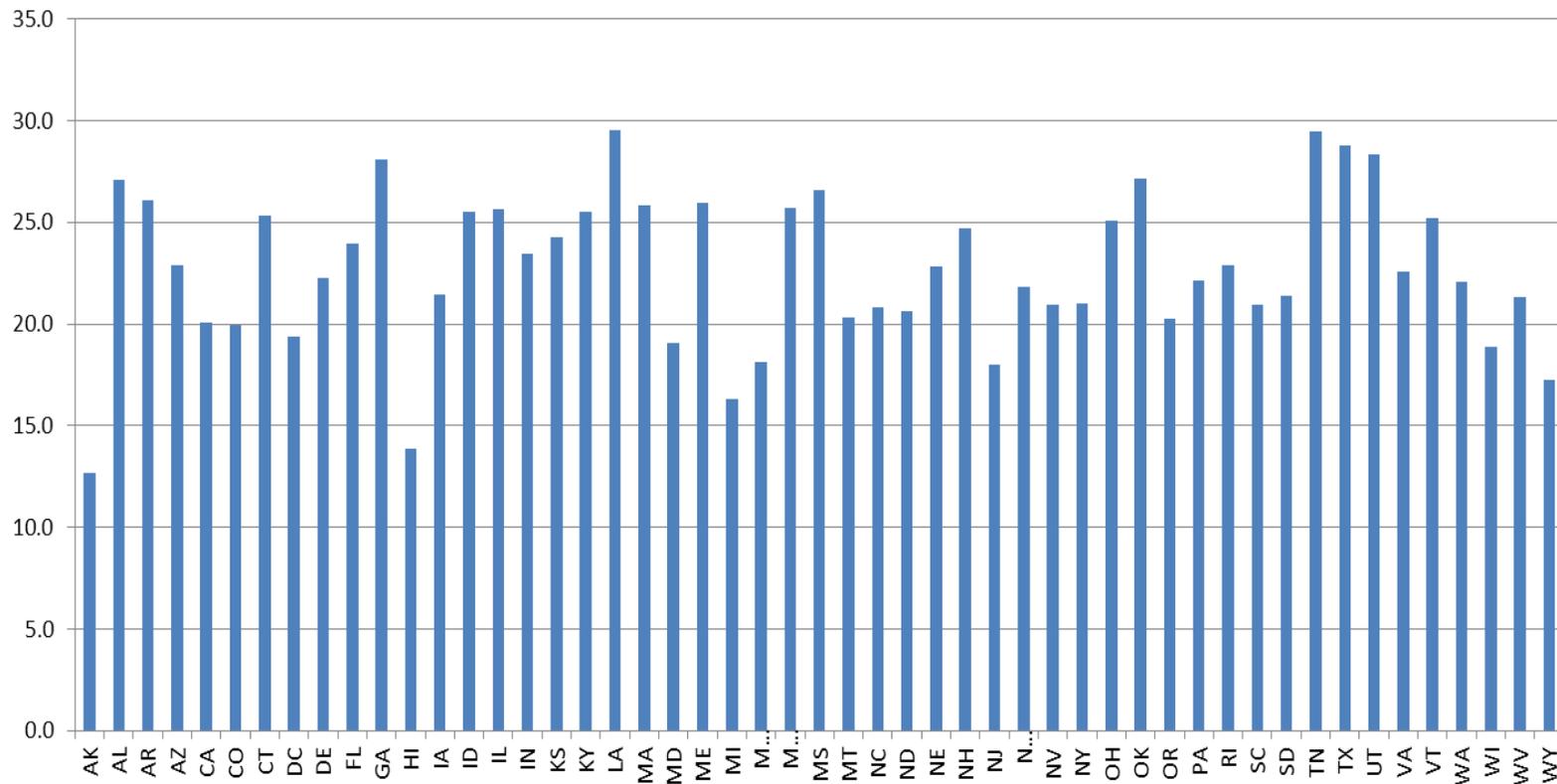


National Partnership First Year Goal

- Reduce national prevalence of antipsychotic medication use in long-stay nursing home residents by 15% by end of 2012
- Baseline: national rate based on MDS data (Nursing Home Compare takes an average of previous three quarters) in December 2011
 - National rate in long-stay residents was 23.9%
 - Denominator includes all residents except those with schizophrenia, Tourette's or Huntington's disease

Antipsychotic Medication Use in Nursing Homes Varies by State

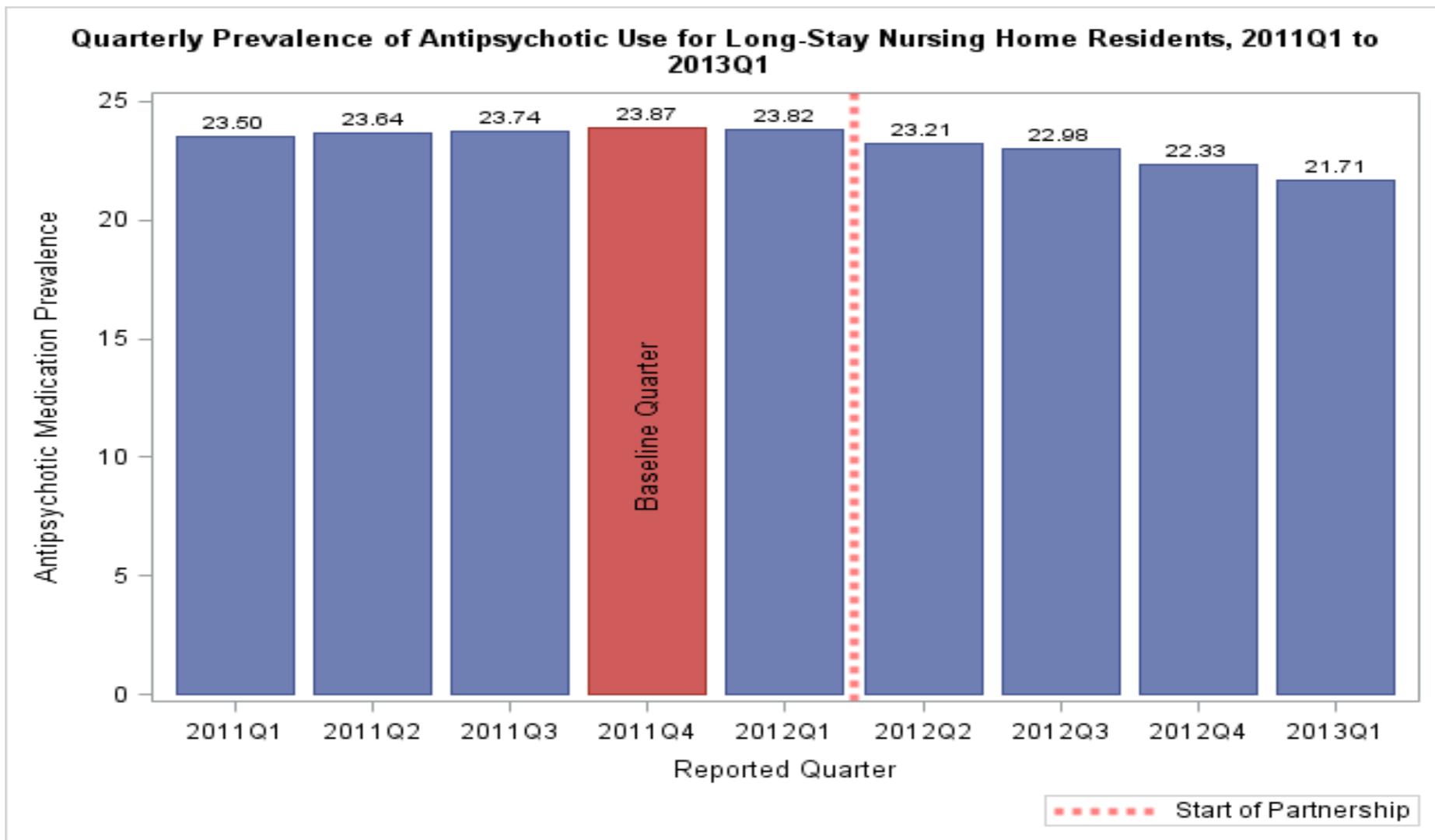
Antipsychotic Medication Use Varies by State (AVG % of long stay residents Q1 - Q3 2012)



Nursing Home Compare Quality Measures

- **Measure:** Percentage of Long-Stay Residents Who are Receiving Antipsychotic Medication
- **Description:** The percentage of long-stay residents (>100 cumulative days in the nursing facility) who are receiving antipsychotic medication
- **Measure:** Percentage of Short-Stay Patients Who Have Antipsychotics Started – Incidence
- **Description:** The percentage of short-stay residents (≤ 100 cumulative days in the nursing facility) who have antipsychotic medications started after admission

Quarterly Prevalence of Antipsychotic Use



Provider, Prescriber & Consumer Training: Advancing Excellence Website

Advancing Excellence
in America's Nursing Homes

Making nursing homes better places to live, work and visit.

HOME	ABOUT THE CAMPAIGN	RESOURCES	PROGRESS	FOR PARTICIPANTS
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UPDATES BY STATE

- Campaign Results
- Recruitment Levels

LIVE UPDATES

The Advancing Excellence in America's Nursing Homes Campaign is a major initiative of the Advancing Excellence in Long Term Care Collaborative. The Collaborative assists all stakeholders of long term care supports and services to achieve the highest practicable level of physical, mental, and psychosocial well-being for all individuals receiving long term care services.

EXPLORE THE NEW GOALS

REGISTER TODAY!

ENROLL NOW!

FIND PARTICIPANTS

SUBMIT DATA

CONTACT US

The Annual CMS Survey: Looking for a Systematic Process

Did the facility:

- Get details about the resident's behavioral expressions of distress (nature, frequency, severity, and duration) and the risks of those behaviors, and **discuss potential underlying causes with the care team and family**
- Exclude potentially remediable causes of behaviors (such as delirium, infection or medications), and determine if symptoms are severe, distressing or risky enough to adversely affect the safety of residents

CMS Survey: Looking for Skilled Nursing Facility Best Practices

- Did the facility:
 - Try environmental and other approaches that attempt to understand and address behavior as a form of communication in persons with dementia, and modify the environment and daily routines to meet the person's needs
 - Assess the effects of any intervention (pharmacological or non-pharmacological); Identify benefits and complications in a timely fashion; Adjust treatment accordingly

Antipsychotic Prescribing Best Practices

- For those residents for whom antipsychotic or other medications are warranted, **use the lowest effective dose for the shortest possible duration**, based on findings in the specific individual
- **Monitor for potential side effects** - therapeutic benefit with respect to specific target symptoms/expressions of distress
 - Inadequate **documentation**: “Behavior improved.” “Less agitated.” “No longer asking to go home.”
 - **Include specifics, why they behaviors were harmful/dangerous/distressing and what the person is now able to do (positive) as a result of the intervention**
- Try **tapering the medication when symptoms have been stable** or adjusting doses to obtain benefits with the lowest possible risk, e.g., Gradual Dose Reduction which is required under Federal regulation.

The Survey Process

- Input from nursing assistants, nurses, social workers, therapists, family and other caregivers working closely with the resident is essential; Input from all three shifts and weekend caregivers is also important in “telling the story”
- Look at communication between shifts, between nurses and practitioners or prescribers
- Look at **whether medications prescribed by a covering practitioner in an urgent situation are re-evaluated by the primary care team and discontinued when possible**
- ***Look at whether or not other psycho-pharmacological medications are prescribed if/when antipsychotic medications are discontinued or reduced***

Interviews

- Surveyors may interview MD/NP/PA/pharmacists and family members via telephone

Record Review

- Clinical record review will include:
 - **admission assessments** (for at least one resident who is a new admission within the past 30 days),
 - **MD/NP/PA progress notes**, nurse's notes, medication administration record and treatment administration record, physician's orders, mental health records, social worker notes, notes from behavioral health/psych services, MDS and care plan.
- Review how **resident responses** are described
- Look for evidence of a process that attempts to identify potential medical as well as non-medical ***underlying causes*** of behaviors, involvement of the family in change in condition when appropriate, pharmacological and non-pharmacological approaches and monitoring for effectiveness of interventions.

Record Review

- Using guidance at F329 (unnecessary medications), evaluate:
 - **why and how prescribers decide whether or not to use an antipsychotic medication**
 - **whether the interdisciplinary team and family are appropriately involved in those decisions**
 - **how the decision is made to use an antipsychotic versus a different class of medication or non-pharmacological approaches**
 - **how risks and benefits are evaluated**
 - **how resident response will be monitored and re-evaluated.**

Antipsychotic Use in Dementia Assessment

MULTIDISCIPLINARY MEDICATION MANAGEMENT COMMITTEE [Read-Only] [Compatibility Mode] - Microsoft Word

MULTIDISCIPLINARY MEDICATION MANAGEMENT COMMITTEE
ANTIPSYCHOTIC USE IN DEMENTIA ASSESSMENT

RESIDENT NAME: _____ ROOM: _____ PHYSICIAN: _____

ASSESSMENT DATE: _____ Initial assessment Continuation assessment
PHQ-9 Score/date: _____ BIMS/CPS Score/date: _____

A. **ANTIPSYCHOTIC (name/dosage/directions):**
• Start Date: _____ Last Dosage Change: _____ (Decrease/Increase)

B. **OTHER CONCURRENT CLINICAL CONCERNS:**

<input type="checkbox"/> Pain	<input type="checkbox"/> Infection	<input type="checkbox"/> Constipation	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Falls	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Other: _____			

C. **REASON FOR ANTIPSYCHOTIC INITIATION:**

Dementing illness with associated behavioral symptoms
 Dementia alone
 Other: _____
 No Indication Identified

D. **TARGETED SYMPTOMS OR BEHAVIORS (why was it started):**

E. **NONPHARMACOLOGICAL INTERVENTIONS:**

F. **BEHAVIORAL TRENDS SINCE LAST ASSESSMENT (In Documentation):**

<input type="checkbox"/> Behavioral symptoms Decreased	<input type="checkbox"/> Behavioral symptoms Increased
<input type="checkbox"/> No Change in Behavioral symptoms	

SUMMARY: _____

G. **ADVERSE EFFECT MONITORING (changes from baseline functioning) [AIMS= _____ date _____]**

<input type="checkbox"/> Drowsiness, sedation or confusion	<input type="checkbox"/> Dizziness or loss of balance	<input type="checkbox"/> Falls	<input type="checkbox"/> Constipation
<input type="checkbox"/> Muscle spasms, tremor, shaking	<input type="checkbox"/> Uncontrolled movements	<input type="checkbox"/> Tardive dyskinesia	<input type="checkbox"/> Vision changes
<input type="checkbox"/> Swallowing difficulty	<input type="checkbox"/> Speech difficulty	<input type="checkbox"/> Headache	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Drooling	<input type="checkbox"/> Increased skin sensitivity	<input type="checkbox"/> Restlessness or anxiety
Other: _____		Other: _____	

MULTIDISCIPLINARY MEDICATION MANAGEMENT COMMITTEE
ANTIPSYCHOTIC USE IN DEMENTIA ASSESSMENT

H. **M3 COMMITTEE RECOMMENDATION (Date: _____):**
[Always consider a dose reduction even if it may have failed in the past]

Gradual Dosage Reduction at this Time:
• Recommended dose reduction (write new orders): _____

Gradual Dosage Reduction NOT indicated due to (BOTH requirements must be met):
• Previous attempt at GDR resulted in reoccurrence of behavioral symptoms (documented date: _____); **AND**
• Clinical rationale why an attempt at GDR would likely impair this resident's function or increase their distressed behavior:

Recent Dosage Change (<60 days): _____

Will Consider GDR when Resident is Clinically Stable:
• Clinical Rationale: _____

Recommend Additional Clinician Assessment of Behavioral Symptoms with Follow-up Report at Next Scheduled Meeting

M3 Committee Members:
Medical Director: _____ Executive Director: _____ D.O.N.: _____
Consultant Pharmacist: _____ Social Services: _____ Nurse Manager: _____

I. **ATTENDING PHYSICIAN ASSESSMENT (Date: _____):**

I Agree with M3 Committee's recommendation (follow recommendation above)

I Agree with M3 Committee's recommendations, but with these orders:

I Disagree with M3 Committee's recommendations because (specific clinical rationale for this resident required): _____

Page: 1 of 2 Words: 397 100% 9:30 AM 11/1/2013

LET'S DISCUSS THE TEXAS PERSPECTIVE

THE TEXAS PERSPECTIVE

LISA B. GLENN, MD

TX. DEPARTMENT OF AGING AND
DISABILITY SERVICES

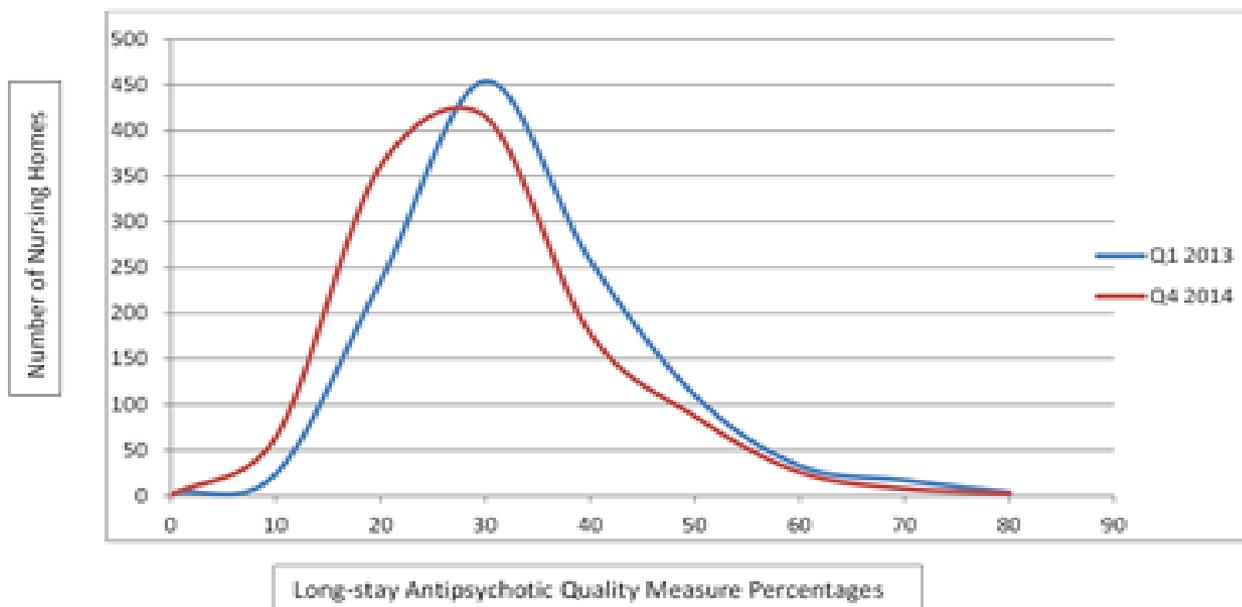
OBJECTIVES

- STATE OF TEXAS NUMBERS
- BARRIERS TO CHANGE IN TEXAS
- RESOURCES AVAILABLE FOR PRESCRIBERS AND STAFF

WHERE ARE WE?

- NURSING HOME COMPARE DATA – BASELINE IN 2011 Q4
 - TEXAS – 28.8%
 - US – 23.9%
- NOW – 2015 Q1
 - TEXAS – 23.2%
 - US – 18.7%
- OVERALL DECREASE
 - TEXAS – 19.7%
 - US – 21.7%

Texas: A Journey of Change



ROOM TO IMPROVE

- OVER 500 FACILITIES OUT OF THE ALMOST 1200 IN TEXAS ABOVE THE STATE AVERAGE
- 36 FACILTIES HAVE OVER 50% USAGE
- TEXAS IS RANKED 50 OUT OF 51 STATES IN USAGE
- ALMOST $\frac{1}{4}$ OF NURSING FACILITY RESIDENTS ARE ON A MEDICATION THAT COULD BE HARMFUL TO THEM.

HEARD ON THE STREET

- REQUEST FOR GRADUAL DOSE REDUCTION
 - JUST SAY NO – NO EXPLANATION
 - RESIDENT IS “STABLE” ON MEDICATION
- DIAGNOSIS TO FIT THE MEDICATION
 - ANECDOTAL REPORTS OF OLDER RESIDENTS WITH NEW ONSET BIPOLAR DISORDER/SCHIZOAFFECTIVE
 - FACILITY WITH “DADS APPROVED” DIAGNOSES

HEARD ON THE STREET

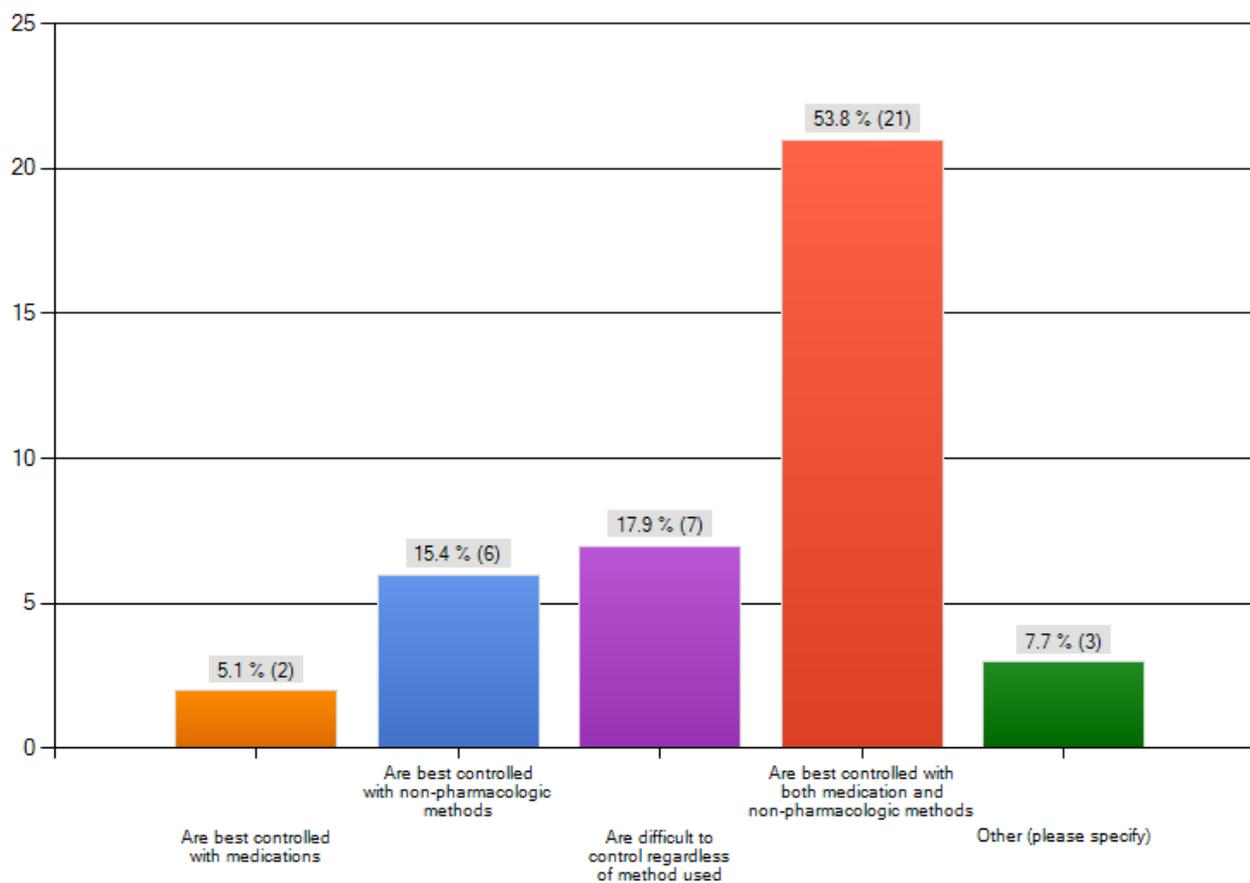
- HOSPITAL TRANSFER ORDERS
 - MEDICATION STARTED IN HOSPITAL – NO ASSESSMENT TO JUSTIFY CONTINUING
- PSYCHIATRIC CONSULTS
 - PSYCHIATRIST ORDERED IT – I HAVE TO CONTINUE IT

HEARD ON THE STREET

- DOCTORS SAY NURSES REQUESTED IT
- NURSES SAY DOCTORS DON'T WANT TO BE CALLED SO THEY ORDER IT

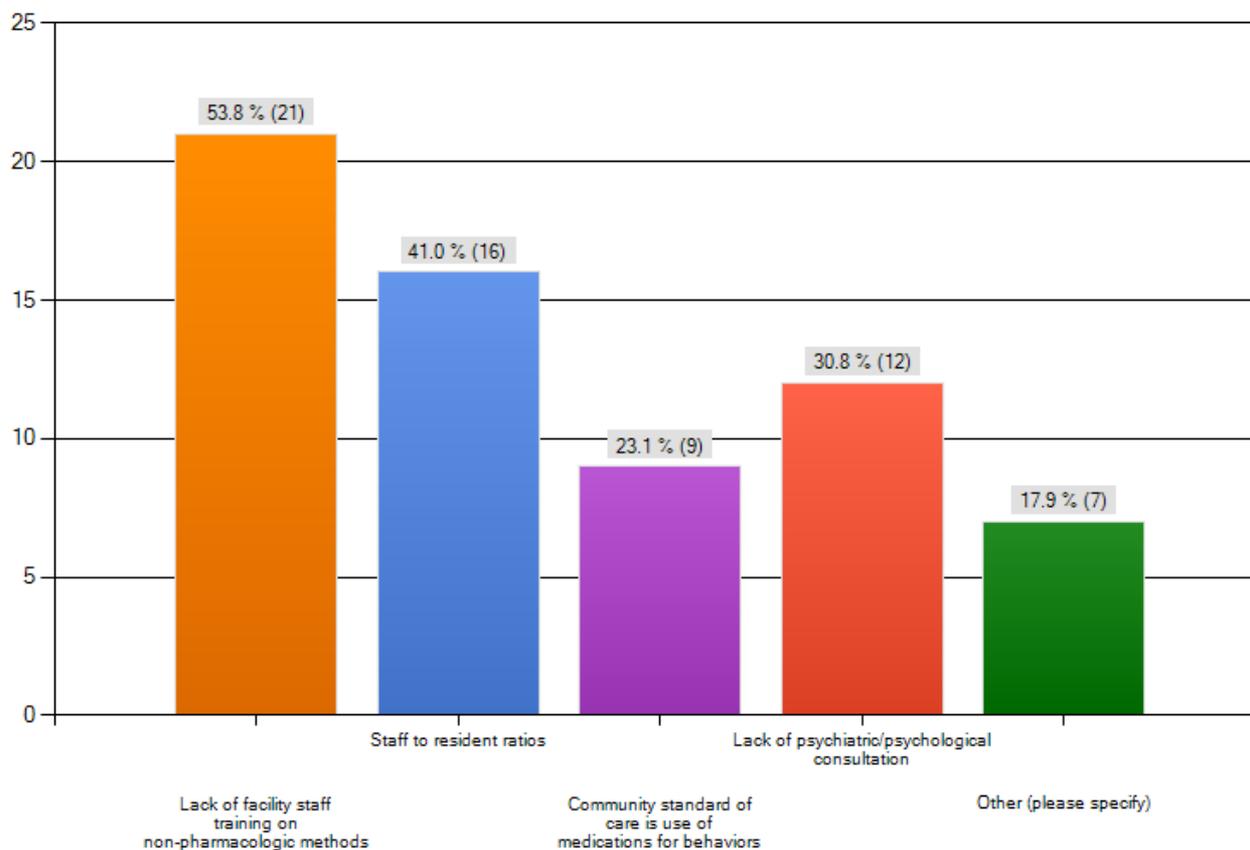
BARRIERS

Challenging behaviors associated with dementia . . .



BARRIERS

Barriers to reducing inappropriate use of anti-psychotic medication include: (select all that apply)



WHAT CAN YOU DO?

- KNOW YOUR NUMBERS – QUALITY MEASURES
 - THE GOAL IS NOT ZERO
- PROMOTE EDUCATION FOR YOUR STAFF AND YOUR PEERS
- COMMUNICATION

KNOW YOUR NUMBERS

- WHAT YOUR RESIDENTS FAMILIES CAN SEE
- NURSING HOME COMPARE
- <https://www.medicare.gov/nursinghomecompare/>
- DATA FROM MDS

ANTI-PSYCHOTIC QUALITY MEASURE

- NUMERATOR: ANYONE WITH AP USE
- EXCLUDED FROM DENOMINATOR IF RESIDENT HAS:
 - SCHIZOPHRENIA
 - TOURETTE'S SYNDROME
 - HUNTINGTON'S DISEASE
- MDS 3.0 QUALITY MEASURES USERS MANUAL, pg 40

INDICATIONS IN SURVEYOR GUIDANCE – APPENDIX PP (PG 432)

- Schizophrenia
- Schizo-affective disorder
- Schizophreniform disorder
- Delusional disorder
- Mood disorders (e.g. bipolar disorder,
severe depression refractory to other
therapies and/or with psychotic features)
- Psychosis in the absence of dementia
- Medical illnesses with psychotic symptoms (e.g., neoplastic disease or delirium) and/or treatment related psychosis or mania (e.g., high-dose steroids)
- Tourette's Disorder
- Huntington disease
- Hiccups (not induced by other medications)
- Nausea and vomiting associated with cancer or chemotherapy

MEDICAL DIRECTOR/PRESCRIBER RESPONSIBILITY IN SURVEYS

- F428
- §483.60(c) Drug Regimen Review
- (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.
- (2) The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

MEDICAL DIRECTOR/PRESCRIBER RESPONSIBILITY IN SURVEYS

- For those issues that require physician intervention, the physician either accepts and acts upon the report and potential recommendations or rejects all or some of the report and provides a brief explanation of why the recommendation is rejected, such as in a dated progress note. It is not acceptable for a physician to document only that he/she disagrees with the report, without providing some basis for disagreeing

MEDICAL DIRECTOR/PRESCRIBER RESPONSIBILITY IN SURVEYS

F329

- §483.25(l) Unnecessary Drugs
- 2. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that:
 - (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
 - (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

EDUCATIONAL RESOURCES- PHYSICIANS/OTHER PRESCRIBERS

- IOWA GERIATRIC EDUCATION CENTER
 - IA-ADAPT
 - IMPROVING ANTI-PSYCHOTIC APPROPRIATENESS IN DEMENTIA PATIENTS
 - MULTIPLE DISCIPLINE MODULES
 - <https://www.healthcare.uiowa.edu/igec/iaadapt/>

EDUCATIONAL RESOURCES- PHYSICIANS/OTHER PRESCRIBERS

- TFM QUALITY IMPROVEMENT NETWORK-
QUALITY IMPROVEMENT ORGANIZATION
(TFM QIN-QIO)
 - NURSING HOME QUALITY IMPROVEMENT
NETWORK – DISCUSSION
FORUMS/RESOURCE MATERIAL
 - <http://www.tmfqin.org/Networks>

EDUCATIONAL RESOURCES- PHYSICIANS/OTHER PRESCRIBERS

- ADVANCING EXCELLENCE IN AMERICA'S NURSING HOMES
 - CMS PARTNERSHIP TO IMPROVE DEMENTIA CARE
 - <https://www.nhqualitycampaign.org/dementiaCare>

EDUCATIONAL RESOURCES

- DADS QUALITY MONITORING PROGRAM
 - <http://www.dads.state.tx.us/providers/qmp>
 - BEST PRACTICES (INCLUDING GRADUAL DOSE REDUCTION)
 - SIGN UP FOR UPDATES (GOVDELIVERY)

QMP INITIATIVES

- TRAIN (Texas Reducing Anti-psychotics In Nursing Homes): FULL STEAM AHEAD
- Five locations around the state in November and early December
- Two-day conference - Day one features
 - Dr. G. Allen Power - A Life Without Drugs: A Proactive, Strengths-Based Approach to Dementia
 - Dr. Madeleine Biondolillo – Ensuring High-Quality Dementia Care in Long-term Care
- Day two – three tracks:
 - Alzheimer’s Disease and Dementia Care Seminar
 - Person Centered Practices Overview: Supporting People to get Better Lives
 - Dr. Susan Wehry - From Patienthood to Personhood: The Oasis Approach to Dementia Care
- For more information
<http://www.dads.state.tx.us/providers/communications/alerts/alerts.cfm?alertid=2014>

QMP INITIATIVES

- ALZHEIMER'S DISEASE AND DEMENTIA CARE SEMINAR
 - 8 hour class
 - Continuing education credit available for some disciplines
 - Most people eligible to become a Certified Dementia Care Practitioner
- VIRTUAL DEMENTIA TOUR®
 - Real-life experience of dementia
 - Powerful sensitivity awareness training

Both classes require a minimum of 10 participants

To request either training send an email to TQM@dads.state.tx.us

QMP INITIATIVES

- Music and Memory Pilot Project
 - For more information:
 - <http://www.dads.state.tx.us/providers/qmp/resources/music-memory.html>
 - <https://musicandmemory.org/>
- Reminiscence Therapy Pilot Project
 - Uses tangible prompts, such as tactile objects, recordings and familiar items, to stimulate discussion of past activities and experiences
 - For more information: TQM@dads.state.tx.us

COMMUNICATION

- STAFF
- NURSES
- PEERS AND OTHER PRESCRIBERS
- FAMILY MEMBERS
- MOST IMPORTANTLY - RESIDENTS

BOTTOM LINE

- AS A PRESCRIBER, YOU WRITE
THE ORDERS

QUESTIONS?

- CONTACT INFORMATION
 - LISA B. GLENN, MD
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