Dementia-Capable WISCONSIN

Department of Health Services:
Comprehensive Listing of the Stakeholder Comments Made Through the January 2013 Dementia Care Stakeholder Survey

The following table includes comments made by respondents to a Dementia Care Stakeholder Survey that was distributed by the Department of Health Services in January 2014. The Survey accompanied the release of a draft document entitled “Wisconsin Dementia Care System Redesign: A Plan for a Dementia-Capable Wisconsin” (Plan). This table includes a comprehensive list of the open-ended comments received from survey respondents. Each respondent to the survey was assigned a number. Those numbers are listed alongside the survey comments to preserve confidentiality, while also allowing for the tracking of an individual’s responses across five strategic categories included in the draft Plan. A summary of the responses to the Survey, including questions on how stakeholders prioritized the strategies included in the draft Plan and how closely stakeholders felt the Plan addressed priorities laid out at a Stakeholder Summit in October, 2013 can be found in the Plan as appendix C at this link: http://www.dhs.wisconsin.gov/publications/P0/P00586.pdf (P-00586).

Stakeholder comments are shown below as they were written in stakeholders’ responses, with the exception that minor spelling errors were corrected and names were redacted unless they were describing items such as services or education being provided by an organization, partnerships engaged in, or suggestions regarding organizations to involve.

Respondent	2. Please assess the importance of each group of strategies outlined in Section 5.1 of the Plan (Community Awareness and Services) and indicate what level of priority you believe each merits.
1	Promote dementia friendly communities. Several communities have successfully organized community-wide responses to dementia, including law enforcement, medical providers, businesses and the general public. Participants have been trained to recognize the signs of dementia, to communicate effectively with people with dementia, and to locate resources for assistance. The Department will promote the concept of dementia friendly communities and the ADRCs Dementia Care Specialists will help to organize these efforts.
2	Expand Dementia Care Specialist Program to all ADRCs
3	Expanding the Dementia Care Specialist Program in the ADRC's. That position is KEY in getting out information to the public and providing much needed information and resources.
4	Increase the Capability and Capacity of Managed Care Organizations (MCOs) to provide dementia-capable services.
5	Needs to include outreach training to physicians especially ER and acute care hospitals. Do clinic and hospital staff have any basic knowledge of dementia...They lack understanding of care provided at assisted living facilities. A quick solution is to prescribe psychotropic medications...and sadly restraints if hospitalized.
6	Dementia Expertise for the ADRC counselors
7	Facilitate early identification and intervention, focusing on non-pharmacological interventions

8	Provide Support for Family Caregivers! They are the back bone when it comes to care of someone with dementia. More funding, more training, and more support. This area needs expanded. NFCSP program was not mentioned. This also can assist families with loved ones with dementia. Also need to promote and strengthen programs such as Share the Care! This program will reduce the need for early facility placement and therefore save funding. Expand the Dementia Care Specialist Program in Aging and Disability Resource Centers (ADRCs). Don't forget about the County Aging Units. They want the DCS program too!
10	Understanding and awareness- too many facilities that state they have a dementia unit do not use basic methods when working with residents such as re-approaching.
12	Health care provider education to guide individuals to resources.
13	Caregiver support and options available.
14	Dementia specialists at ADRCs.
15	Increase the role/time for ADRC Dementia Specialists. Promote a train the trainer program, stemming from the ADRC.
16	5.1.3 Provide Support for Family Caregivers: Dementia has an exponential impact on family caregivers. Expand access to support programs increase caregiver education, expand and update AFCSP.
18	I feel good strides are being made as far as understanding and awareness of dementia. Providing supports for family caregivers is an area that needs continued emphasis. Even the process of becoming enrolled in Family Care is stressful to family. Numerous contacts asking for the same information even though the first contact was responded to in a timely manner makes family member anxious. A phone call from Medicare on New Year's Day asking for same information already given caused anxiety (family worries that numerous calls means funding will be denied and loved one will have to move from assisted living facility; and where will they go). Being informed that a rate could not be negotiated between Family Care and facility caused much anxiety. Loved one had already lived in Memory Care for 1 1/2 years and now told to find a new place!
19	Strengthen Dept. and ADRC information and referral resources to facilitate access to dementia care resources in the community.
20	When you provide support to family and caregivers you have a better outcome, we are seeing less early placement when families have support from community. It starts with awareness and reaching out. This is a must for families.
22	An important part of the understanding and awareness priority should be information about how diet and lifestyle affect dementia risk.
23	Services for families, and person diagnosed that lives alone, allow funding for greater support for respite care for relief for caregivers
24	Expand Dementia Care Specialist to all ADRC's and fully fund position.
26	It is imperative that education is provided routinely both for caregivers in the community (family caregivers) and those in LTC settings. The other key is going to be safe harbors for those with challenging behaviors.
27	Personally, the biggest struggle I perceive within the community is with providers. Too many doctors are labeling individuals with Alzheimer’s or Dementia as having cognitive impairment, memory decline or other related and equally redundant diagnoses. It's like pulling teeth to get an accurate diagnosis if they truly have Alzheimer’s or Dementia. I think that alone should be a high priority. My experience is that Dane County struggles more than surrounding counties with acknowledging this diagnosis.
28	I believe the family support portion to be of the most significant. I think it must be coupled with numbers and percentages for each community in order to help everyone understand the magnitude of the problem.
29	Early and accurate diagnosis is key to timely treatment and optimal caregiver support.
30	Increase the Capability and Capacity of Managed Care Organizations (MCOs) to provide dementia-capable services.

31	Expand the Dementia Care Specialist Program in Aging and Disability Resource Centers (ADRCs)
32	Standardization of training for facilities who state they provide dementia care or have specialty units to care for residents with dementia
33	Expand AFCSP. This program will cover so many varying types of support, including education, direct client service, help that helps
34	Expanding the Dementia Care Specialist program in ADRCs throughout the state.
35	Promote dementia friendly communities
36	Providing support to family caregivers is most important. It will help individual families and the economy at large as people's incomes won't see such reductions. It will also keep people out of higher cost facilities.
38	We must support family caregivers with training/information, support groups, respite
39	Promote dementia friendly communities
40	Expand Dementia Care Specialist Program: Throughout the redesign especially under this Section, the DCS is an important position for developing dementia friendly communities and helping promote and support programs and many more tasks.
41	Expand dementia care specialist program
42	Promote dementia friendly communities. A community that is accepting of people with dementia and understand the signs and symptoms will make it easier for intervention and early identification.
43	Clinic provider awareness
44	Increasing understanding and awareness of dementia. I would strongly emphasize the importance of education on all dementias, not just AD, as well as the prevalence and intensity of challenging behaviors. I also think the AA has done the entire future of dementia care, and mental illness for that matter, a huge disservice in encouraging dementia to be removed from the DSM. Dementias affect similar parts of the brain and often times have symptoms very similar to mental illnesses - hallucinations, delusions, depression, anxiety, etc. Practitioners and care providers need to be aware of these possible symptoms and be able to implement both environmental and medical treatments.
45	Provide support for family caregivers
46	Based on the WI Dementia Care Redesign (draft) document (pg.17) providing support for family caregivers speaks directly to the overall concerns that our CMU, psychotherapy services and Housing programs are particularly attuned to as families make transitions with their aging loved ones from home-based services to a more restrictive environment of care (e.g. assisted living). Families provide valuable nature supports in their aging family member's life and these supports are utilized by our CMU Care Managers, JFS psychotherapists as well as our programming services and medical supports in our assisted living building. With an increase in support for family members through JFS's services in Family Care, psychotherapy and housing programs we could work closely with families as the need for more intensive medical care and programming becomes evident. To that end, the other two goals in 5.1; increasing understanding/awareness as well as early identification/intervention would be a natural bi-product of the provision of support for family caregivers.
47	Increasing awareness and understanding is vital for the entire community. Not only to family members and care givers require additional education and support, so do the facility staff and regulating bodies. Some facility regulations are contrary to client-centered care.
48	Provide support for family caregivers. Most families need resources both educationally and financially to maintain their loved ones safely at home.
49	Expanding the Dementia Care Specialist program to all ADRC's.
50	Expanding dementia care specialists within ADRC--resources to community
51	Early identification and intervention, underlying causes of behavior to be examined, before giving an individual a dementia diagnosis.

52	Increase the capability and capacity of MCO's to provide (and adequately fund) dementia-capable services. Included in this should be a way to drastically improve ACCESS. Currently, it is taking up to 60 days to even get enrolled in MCO's resulting in an unreasonable and risky delay for the individual with dementia to get the services and safety that they need and deserve.
53	Engage public health departments in the dementia initiative. Expand and update the Alzheimer's Family Caregiver Support Program.
54	Expand capacity for dementia screening and diagnosis. Page 16
55	Expand the Dementia Care Specialist Program. A needed enhancement to current staffing... I think it may need to be expanded... assuming the new cases for the disease will be an additional 82,000 by 2035. We may need to develop a public/private partnership to meet the needs of the new cases that our efforts will uncover as well as the projected cases.
56	Develop support system for emergent and respite needs for family caregivers.
57	Development of more dementia specific criteria in the Long Term Care Functional Screen. Emphasis on creation of Dementia Friendly Communities.
58	Promoting dementia friendly communities. Support for caregivers.
59	Working with Wisconsin communities on developing dementia-friendly communities and engaging existing resources.
60	Expand the Dementia Care Specialist Program.
61	Dementia Care Specialist in ADRCs; webpage development.
62	Increase capability of MCOs.
63	I particularly endorse the strategies to support Family Caregivers by enhancing access to education, support groups and AFCSP.
64	Expand capacity for dementia screening and diagnosis.
66	Facilitating early identification - working with a memory diagnostic clinic for 12 years we have seen an improvement in the community's knowledge of various dementias but it is still not where it needs to be; if people don't get a high quality evaluation they may not get diagnosed accurately which often increases the caregiver's stress level and often the patient's as well
67	Voluntary support. The only way I see this working from a fiscal and resource management process.
68	Identification and intervention
69	Expand the Dementia Care Specialist Program
70	3-4 people with dementia live at home and of these 22% live alone. Support from a service like an in home memory care program which is a new initiative which our team is developing with the UW Oshkosh Business Office under the name Memories 4Ever.LLC
71	Promote dementia friendly communities. If all stakeholders and those involved are on the same page, we can provide better overall options and a safer environment for our community members with dementia. There are so many people who do not understand the disease and how to effectively communicate with this population, so this strategy is essential to creating a successful integrated dementia care system.
72	Expanding the dementia specialist in the ADRC.
73	Expand the Dementia Care Specialist Program in Aging and Disability Resource Centers - education and awareness are key -particularly of interest to me is what can we do pre-dementia, as far as memory exercises, etc. to prevent problems if possible?
74	Strengthen dept. and ADRC information
75	I think it is imperative there is more outreach and awareness about Alzheimer's disease. The general public believes this is a disease for just old people, when in fact we are seeing much younger individuals being diagnosed and coming to our office.

76	Providing support for family caregivers is extremely important as it allows the caregiver to learn strategies to prevent caregiver burnout and develop formal and informal supports for themselves and their family member with dementia. This in turn will allow people with dementia to stay home for longer periods of time. It also will provide education to the caregivers as to the changes that may occur with their family member as far as personality, behavior, abilities etc. Learning how to effectively deal with a family member who may no longer seem like their previous self is important in order to maintain an ongoing relationship between a caregiver and loved one.
77	Expand the Dementia Care Specialist Program in ADRC's
78	There is greater need to connect with patients with dementia and family caregivers earlier in their lives. The ADRC's original charge was to be that clearing house for information - financial resources as well as community resources, it is important to strengthen this role.
79	An overriding need is to realign the lead AFCSP (Alzheimer's Family Caregiver Support Program) agency in each county with the lead NFCSP (National Family Caregiver Support Program) agency, therefore having both programs administered by the same department. NFCSP is a federal program to help family caregivers and was modeled after Wisconsin's AFCSP program in 2000. Currently one-third of the county aging units/ADRCs administer AFCSP. The rest of the county AFCSP programs are administered by Human Services (i.e. Behavioral Health) and are sometimes lacking coordination with the NFCSP program, which is administered by aging units. Historically counties which have both programs administered by the Aging Unit/ADRC are better at utilizing their AFCSP funding.
80	Expand Dementia Care Specialist Program at ADRCs to consistently assist community and facilities.
81	Early detection is essential not only for the person with dementia but for the family caregiver. Early detection provides an opportunity for the family caregiver to process the trajectory of the disease and to become educated and equipped with essential tools to become the best caregiver and advocate possible for their loved one. However, neither of these will be successful without addressing the issue of stigma that surrounds a dementia diagnosis. The issue of stigma continues to be a major barrier for family caregivers and the person living with dementia. Within the context of this plan there needs to be a specific focus on developing a statewide campaign that is (inclusive of all families and communities) that changes the view of dementia by removing the death sentence diagnosis perspective. The campaign should send the message that a diagnosis does not mean instant death and offer caregivers hope as they care for their loved ones.
82	The Dementia Care Specialist is great to have in each county. My concern is what is the basic education/knowledge required for this position. I know 4 persons with this job and they all vary in their abilities with a couple I feel lack some of the basic knowledge needed to assist families when they begin their role. I know many skills can be learned so I feel there needs to be a consistent training program that even the DCSs must complete to meet competency requirements.
84	Underserved populations - Black, Hispanic, LGBT, Different abilities, prison and homeless populations.

85	The Dementia Specialist program is very promising and supported by the Alzheimer's Association, however we have several concerns that we hope can be addressed in the implementation phase. First, the DS's need to be given a clearer mandate to collaborate with our organization - we provide many of the same services and we have seen mixed results in collaborations with the ones employed to date. Consideration should be given to having at least some of the new DS's be employees of the Alzheimer's Association, the successful model which is being used in Ashland County. Second, we think the evidence based programs utilized by the DS program should be expanded beyond LEEPS and Mittlemann. Our Early Stage and Savvy Caregiver Programs are both evidence-informed and evidence based. Given the broad scope of work expected from the DS's, we think the training component could be contracted out, at least in part, to organizations such as ours. On AFCSP, we clearly support increased funding, but also call for a careful review of the structure of the program and an analysis on how the money is currently being used. On using volunteers, again we strongly support and have a 30 year track record of doing just that for things like caregiver support groups and peer run early stage programs. The Alzheimer's Association should be included as a possible candidate for grant funding to expand or initiate volunteer programs. In terms of outreach to increase referrals to ADRC's, we agree this is a worthy goal, but just as important it outreach to increase referrals from ADRC's to Alzheimer's Association programs. We have worked with many caregivers who told us the ADRC never informed them of our education and support offerings. We strongly support increasing the capacity of MCO's to provide dementia capable services. This is especially important if outreach and education efforts turn out to be successful, and isolated older adults begin to turn more to Family Care for support. We strongly support engaging public health departments and stand ready to assist as we have over the past years on state surveys and local public health department work. However, we have to point out that true awareness will not be raised until there is a systematic, well-funded public awareness program aimed at the general public to help them recognize the warning signs of dementia and where to turn for help. In supporting Early Identification and intervention, early stage programs should be provided by the organizations that already have well established approaches and track records in providing them, rather than having organizations such as public health departments establish that expertise. In Family Caregiver support, we respectfully submit that expecting 15 Dementia Specialists to do Memory Care Connections statewide is unrealistic and may not be the best use of resources. We among other organizations already provide evidence based programs and would be happy to provide more through direct funding from the State.
86	Increase funding for the AFCSP. $4000 is barely enough to help support the individuals.
87	Strengthen Department and ADRC Resources to facilitate access to dementia resources in the community
88	Dementia-capable MCO provider Networks: invest in training(s) that would include community based direct care workers
91	Expand and update the AFCSP; costs to the State are reduced the longer an individual can be supported by natural supports. Increase respite funding and create a pool of trained respite providers. What is key is that there needs to be a substantial increase to home health care agencies in their MA reimbursement rates. These rates have not increased for 5 years. It is impossible to recruit and retain high quality, committed caregivers at the low wages home health care agencies are forced to pay due to low reimbursement. You can provide all the training you want but if the work is undervalued, no one will show up to take the jobs. What happens is that only the unemployable end up in these positions.
93	Outreach
94	Expansion of dementia care within ADRC
95	Early identification and intervention
96	Critical to engage public health in the planning and implementation of this initiative as Alzheimer's is a Public Health crisis. This really has not been done up to this point, so it's wonderful to see its inclusion in the plan.

97	Promote dementia friendly communities...especially as it relates to understanding by law enforcement
98	Strengthen Dept. and ADRC Information & Referral resources to facilitate access to dementia care resources in the community.
99	Provide support for family caregivers.
100	Increase capability and capacity of MCOs to provide dementia capable services.
101	Making whole communities more dementia friendly is very important, as many caregivers feel isolated and their loved ones misunderstood. In turn that will increase the education of the disease so that it is being blamed and not the person.
102	Expand capacity for dementia screening and diagnosis
103	Pg. 13 - Expand the dementia care specialist program in ADRC's. I believe this would be beneficial but need full funding for position.
104	Outreach to physicians and other primary care providers through education and support is key to the early identification, quality management, and increased positive health outcomes for those living with AD and other dementias and their families.
105	Increase capacity and capability of the Managed Care Organizations to identify and respond to this
106	With the existence of the Alzheimer's Alliance and Association, perhaps it's redundant to also hire a dementia specialist at the ADRC.
107	Increase county HHS workers on dementia and how to better serve those with dementia.
108	Promote Dementia friendly communities
110	Our feedback has been provided via our January 13, 2014 letter to Secretary Kitty Rhoades. Please refer to this letter for our comments requested by this survey.
111	Expand capacity for dementia screening and diagnosis.
112	Expand dementia care specialist program - Outreach to increase referrals to ADRC

Respondent	**3. Keeping in mind that the draft plan is a high-level outline and does not include detailed discussion, is there language in Section 5.1 (Community Awareness and Services) that you feel needs clarification? If yes, please explain.**
1	Yes. Many people don't know where to start or to go to. If you could code agencies or levels of dementia to levels of care I think it would help people go to the right place more quickly or not feel like they have no clue what to do for someone.
3	Establishing strict guidelines as to how a business or community becomes dementia friendly. If all 72 counties are doing different training programs, it becomes jumbled and confused and the consumer suffers.
5	Expand on concept of dementia friendly communities.
8	Outreach to increase referrals to the ADRC. Outreach and partner with Public Health Departments. Also don't forget about the public libraries.
9	There is not enough community staff with expertise to adequately plan for an individual with dementia
15	Specifically address RURAL WI. We are in Ashland, which often is relegated to LESS than Rural and often does not get addressed in the Southern part of the State.
16	Under 5.1.2, Outreach to Physicians: need to more fully detail how this will engage Wisconsin physicians into participating in dementia care redesign. Still appears to be a wide gap in physician engagement in community awareness and support.
28	I think going into the ins and out of being a family care giver is important, to help everyone understand the challenge and why there is a need for support.
36	It was pretty clear.
40	If an ADRC does not get the DCS position, who is going to carry on the responsibilities set forth in the redesign?

42	I think all 3 of the above warrant top priority. I can't say that language needs clarification - it probably comes down to what is going to give the greatest return on the funding that is available.
46	While the language in the section is very clear, it may be helpful to have a clearer understanding of how a diagnosis of serious mental illness and a concomitant diagnosis of dementia may pose even more significant challenges for the family, care management teams, and other involved professionals. This may require additional ADRC support specialist who are experts in both mental health and medical domains.
49	Can APS workers be included in the Cognitive Screen Training?
50	What is the anticipated impact to enhancements to the LTC Functional Screen? Puzzled that 6% of IRIS participants have Dementia--how can a person with a diagnosis of Dementia direct all their own care?
52	I am not finding any language in Section 5.1 that I feel needs clarification.
53	At this juncture we would not support prioritizing increasing the capacity and capability of Family Care MCO's to provide Dementia Care Services. The Family Care MCO's have access to individuals that are already in the system and possess access to providers who uniformly possess understanding and expertise (albeit of varied degrees) in dementia care. Also, the reach of the MCO's is limited and extends only to Medicaid recipients. We believe this is too short sighted and it would be more productive to target efforts on reaching, educating, screening and diagnosing the broader population of individuals affected or afflicted by the disease. Once that has been achieved we facilitate screening and diagnosis of greater numbers of individuals to establish their needs and then direct them to Family Care, other appropriate programs or providers that are available and equipped to address those needs. Indeed, we perceive the most urgent and largest need for awareness and education to be within the general public that currently is outside the reach of the current system and possesses little understanding of dementia or appreciation of how to access to the system to secure care for those in need of services. We submit that stimulating that awareness can be best achieved by focusing resources on local health departments, organizations and development of dementia savvy and friendly communities. Similarly, the cooperation and participation of acute and primary care providers should be proactively solicited in this initiative as they typically will be the first line of health care providers to identify symptoms in individuals that call for screening and referral for diagnosis. To that end, we would recommend that representatives of the Wisconsin Hospital Association and State Medical Society participate in the development of the new system.
54	On the bottom of page 17 and the top of page 18 it refers to the Memory Care Connections programs that if utilized by caregivers effectively can delay the need for institutionalization by 18 months. Question about the proof of this statement. Further clarification would be needed to show that this is proven to be a fact and there is enough research to state this will definitely occur with the Memory Care Connections program.
55	Case Management is critical to the overall success of building and executing an effective care plan for a client and the caregiver. It will be important for the Dementia Care Specialist to have the bandwidth to handle the work load. Will the Care Specialist have training or certification as a case manager as the position is currently defined?
56	How are funds for AFCSP accessed?
58	Any dementia friendly community needs to examine training, standards and policies to ensure their transportation systems are dementia friendly. Specific mention of transportation systems is important as many outside of the field do not consider the implications of the lack of appropriate transportation options. Part of early detection and programming will be to address the issue of driving. While many can still drive throughout the early stages of dementia, they will need to plan for when they will need to stop driving. Adult day programs should be included as an important option for caregivers. This is a low cost way to provide care, socialization as well as respite. Day services allow caregivers to continue working. At an average of $67 per day, this is cost effective option.
64	Further clarification regarding coordinated efforts to provide evidence based practices is needed. Local Health Departments have a broad array of responsibilities; how will this fit in and be funded.

68	Cognitive screening and what the screeners are taught and using
75	Is there a plan from the state to help counties with outreach activities such as ads, TV commercials, radio, etc.?
77	I would like to know how you are sure that these positions are effective. Is there any hard evidence or data or just positive evaluations? What qualifications does a Dementia Care Specialist have? Provider input should be sought for the development of best practice guidelines and revision of the functional screen. Can you provide an example of dementia friendly communities?
78	Reference is made to Best Practices - there are many already out there being used by the long-term care industry so clarifying that those are looked at information is gathered. Reference is made to positive evaluations for Dementia Care Specialists - is this a statement made from data that was collected? Are there specific requirements for the Dementia Care Specialists? It is important the revision of the Functional Screen be part of the plan.
79	While we agree that evidence based programs are important and successful, we should not discredit other non-evidence based programs, such as Caregiving Relationships for People Who Care for Adults or Share the Care. When listing the evidence based programs within this plan, it seems that Powerful Tools for Caregivers (PTC) is the only program that is not dementia specific. We suggest removing PTC from section 5.1.2 and keeping it in section 5.1.3. We also suggest researching other dementia specific programs. Furthermore, we support Wisconsin caregivers having access to dementia specific programming; however we question the feasibility of the goal listed on page 44: 'at least one PTC class location in each county by 2015.' There is not one program that is ideal for all caregivers.
85	In several sections we believe that the terms culturally competent needs to be included, and outreach and awareness efforts have to geared toward the specific needs of certain communities such as Latino and Hmong, to name just two. We also need many more bilingual dementia resources such as United Community Center's successful model to meet the needs of the fast-growing Hispanic/Latino population.
91	It is unlikely that there will be a strong volunteer component in communities. Most supports will need to be paid supports with people who are trained and scheduled to provide specific care. Continue to invest in MA and focus on rebalancing away from institutional settings.
94	With an increase in Dementia Care Specialists in ADRCs will these people be available to organizations and communities? What will their role be?
96	With regard to increasing public awareness, early detection and support to caregivers which is covered in this section, I would suggest adding more strategies that leverage public/private partnerships. Partnership between ADRCs and the Alzheimer's Association and WAI Memory Diagnostic Clinics across the state would be positioned well to address these three areas collaboratively within communities in an efficient and sustainable way. Two great examples of current partnerships include: The ADRC-N/Alzheimer's Association - Greater Wisconsin Chapter joint DCS position. The DCS leverages current ADRC programs such as LEEPS and Memory Care Connection while working with and for the Alzheimer's Association on physician outreach and other programming and works collaboratively with the WAI Clinics. Another broader community collaboration is the Fox Valley Memory Project which involves the Outagamie ADRC, Alzheimer's Association, Lutheran Social Services, UW Health, Goodwill Industries and others to create a dementia-friendly community across the Fox Cities offering Memory Cafe's, a Caregiver Resource Center, WAI Memory Diagnostic Clinic, Vocational training and Research/data collection. This project is mainly supported by the Fox Valley Community Foundation and other private and grant funding.
99	Under this strategy, we believe the following additions should be made:-Promote advanced care planning in the early stage of a dementia diagnosis-Maximize use of palliative care and hospice in late/end stage dementia-Leverage community-based services to support dementia patients who are residing at home.
100	From my perspective, it may make more sense for the related strategy of Increase capability and capacity of MCOs to provide dementia capable services to be a strategy for 5.1.2. rather than 5.1.1.

103	Pg. 18 - AFCSP - yes, funding has been reduced but because of the guidelines of the program some people don't quality. If they truly want to engage in this initiative they need to revisit the AFSCP and NFCSP programs. Pg. 14 - Outreach to Increase Referrals to the ADRCs and page 15 Engage public health departments in the dementia initiative - it appears the State wants to market and campaign this through a variety of programs/services. This appears to be to be a duplicative effort.
104	In the Community Awareness and Service section it is not mentioned that any of these strategies will be customized to the needs of underserved and under-represented populations in both rural and urban areas. One size does not fit all communities. For a strategy to be successful it must take into account that flexibility to unique needs will be expected. I applaud the Dementia Care Specialist Program, however, there is not mention of the competency standard or curriculum that will be developed for these professionals to be successful in these communities. Also, the MCO dementia Care leads will need a core competency education to affect the change needed in these organizations.
107	Improve the section that addresses how nursing homes are not cited for behaviors by residents with dementia. Many nursing homes will not take residents because they are fearful of getting cited by the state.
110	Our feedback has been provided via our January 13, 2014 letter to Secretary Kitty Rhoades. Please refer to this letter for our comments requested by this survey.
112	The standards of care & education provided to MCOs should be consistent with training and standards of care provided to all other providers - i.e. single training plan developed - that can be implemented based on needs of the care unit

Respondent	**5. Please note one "Related Strategy" detailed under Section 5.2 (Facility Based Long Term Care) that you feel is particularly important.**
1	There are also a number of examples of best practices employed by care facilities in Wisconsin. One example is the Music and Memory program, which helps nursing home residents with Alzheimer's disease and related dementias find enjoyment and connection through personalized music. Another example is Serial Trial Intervention, an evidence-based model for23identifying and treating the underlying causes of agitated and disruptive behaviors in people in the advanced stages of dementia.
2	Disseminate information on promising dementia care practices
3	Training, training, and more ongoing training is the key to providing quality dementia care. Staff turnover is regular in the nursing home setting. Therefore, training must be provided to all new staff and ongoing training for those who stay.
4	Seek federal flexibility for facilities that adhere to best practice guidelines- the biggest barrier I see professionally is that we're afraid to admit someone displaying behavioral symptoms for fear of an incident that will put us at risk of a citation. Explore incentives for facilities that adopt best or promising practices and show positive outcomes.
5	Promote dementia friendly facility design. Are plans for new facilities reviewed with dementia care in mind? Do architects understand dementia and what that means for building design?
6	Seek federal flexibility for facilities that adhere to best practice guidelines.
7	Improve quality of dementia care in facility settings utilizing evidence based, person centered care. If that is successful more families would be willing to accept support.
8	Let's put a stronger focus on keeping the person in the home and not in a LTC facility.
10	Quality care facilities
13	All of it
14	Training of caregivers -screening for appropriate placement
15	Develop specific facilities designated for Dementia care (under current CBRF guidelines, but revamp to fit the particular needs). Nursing homes are not willing to take people and until reimbursement is there for them to, they will not. I believe in specific facilities geared towards the specific needs of Dementia, including crisis units specifically for Acute cases

16	Explore incentives for facilities that adopt best or promising practices and show positive outcomes. Quality care costs money, financial incentives for quality care.
18	Improving the quality of care in facility settings. Falls and receiving medical care are concerns. Facility does not provide medical care from outside providers so no labs for diabetes done in 1 1/2 years; family called when medical emergency (fall) for their decision if ER care is needed (facility needs to make that decision with quality nursing care or at least make recommendation to family) Staffing of 1:10 with many high cares and a few challenging behaviors is insufficient. Although it appears that family is not satisfied with this facility, in reality they are pleased but quality of care needs to improve.
19	Seek Federal flexibility for facilities that adhere to best practices guidelines.
20	It is important that we improve the quality of dementia care in LTC settings; too many facilities cannot deal with behaviors of these types of clients. And they end up moving from facility to facility and this can cause more delay in their care needs. And they can decline faster
22	An important part of dementia care priority should be using information about how diet affects dementia when planning meals and supplements.
23	Mandate higher caregiver care in memory units (PPD). Promote and reimburse facilities that have safe units for residents with higher behaviors.
24	Federal laws prohibit facilities to serve folks with challenging behaviors. More flexibility from feds in regulations for facilities needed.
26	Challenging behaviors are changing the landscape of care that needs to be provided in our state. Facility design is important, however, just having a safe placement is of utmost importance, if no one is willing to keep our residents safe because they are difficult or have challenging behavior; we are doing a huge disservice to this population. Each community needs to have a place that specializes in high level needs of those who demonstrate challenging behaviors.
27	There is increasing feedback from families that CBRF's aren't willing to take on an individual with behaviors. That being said, when the care for someone becomes too much and their needs are that of a skilled nursing facility, there is a lack of facilities to accommodate these needs. This should be of the utmost priority. Have you toured Badger Prairie? The fact that the design was cognizant of needs for individuals who have Alzheimer’s and dementia speaks highly and should be replicated elsewhere in the community.
28	It is impossible to separate one of these from the other. Dementia-friendly facility without access or quality of care does little to address the issue. It must be a balance approach to truly address the concerns.
29	Additional funding/reimbursement is warranted for skilled facilities that embrace the challenge of providing innovative, compassionate dementia care. Facility design is only as effective as the staff who provide direct care.
30	Address barriers that deter some nursing homes from admitting and providing ongoing care for residents with challenging behaviors.
31	Provide Staff training opportunities
32	Environmental design of facilities providing dementia care
34	Seek federal flexibility for facilities that adhere to best practice guidelines
35	Seek federal flexibility for facilities that adhere to best practice guidelines.
36	Improving quality of care at facilities is of most importance (w/ facility design playing a supportive role in this).
37	The state agencies must have an understanding that these residents will exhibit behaviors, the facility must respond appropriately, but to expect no behaviors is a deterrent to LTC facilities.
38	Ensure chemical restraints are reduced/eliminated to manage behaviors as a cheaper and easier behavior management strategy than increased staffing, staff training, etc.
39	Continue to Improve the Quality of Dementia Care in Facility Settings
40	Develop guide lines to address causes of regulatory violations related to challenging behaviors.

41	Improve quality of dementia care. We need more dementia focused facilities and wings. The dementia simulation programs are excellent and could be eye opening for nursing homes and staff. Addressing barriers that prevent admissions is almost equally as important
42	Provide staff training opportunities. This training could include training on those challenging behaviors that are holding back facilities from wanting to admit people.
44	As a LTC provider who specializes in caring for individuals with dementias and related challenging behaviors, promoting dementia-friendly facility design is most important. This however, needs to also focus on properly hiring and educating state surveyors and MCO teams to ensure they have the intellect and educational background necessary to comment on best practices. A degree in social work requires no curriculum on psychology, zoology, etc. so offers a very limited understanding of the organic processes underlying dementia. Providers are not the only component to require a huge revamping.
45	Provide staff training opportunities
46	From the perspective of our RCAC services the related strategy cited: Developing guidelines to address the causes of regulatory violations related to challenging behaviors would be salient as it incorporates several domains of challenges when serving seniors with dementia. The suggestion of a decision tree is a highly useful tool when multidisciplinary care team members are present with families and responsible for making objective decisions based on subjective and sensitive observations of a loved-ones needs.
47	Staff in care settings requires additional training and understanding to be able to manage individuals with challenges issues. Staff are poorly-paid and programs are under-staffed so when residents struggle with dementia-related problems, staff have limited resources or ability to safely address them.
48	Improvement needed in both the caregiver education within facilities and better designed dementia-friendly facilities.
49	Developing best practice guidelines for how to effectively care for residents with behaviors that may threaten other residents.
50	Development of best practice guidelines for Facility management of challenging behaviors. Assure consistency.
51	Nursing home spend much time and energy in caring for the dementia resident, extra dollars for staff are needed. This committee needs to be aware the State is citing facilities in using psychotropic medications which most often given the dementia a stable psychosocial well-being and content within themselves.
52	Seek federal flexibility for facilities that adhere to best practice guidelines. Indeed, some behaviors are not predictable and/or preventable!
53	'Address Barriers that deter some nursing homes from admitting and providing on-going care for Residents with Challenging Behaviors.' We submit that, without question, this must be the top priority in this category. But, the focus should not be limited to nursing homes. It is essential to identify and address barriers that are present in all long term care facilities and care settings. Indeed, unless those barriers are identified and overcome in all settings, the vision of an expanded scope and quality for the state's current dementia care system cannot and will not be realized.
54	Explore incentives for facilities that adopt best or promising practices and show positive outcomes. Page 24
55	Incentives for facilities that adopt best or promising practices.
56	Use of a provided decision tree for addressing challenging behaviors
57	Develop and disseminate Best Practice guidelines. Create incentives to adopt best practices and show positive outcomes.
59	Developing best practice guidelines.
60	Develop guidelines to address the causes of regulatory violations.
61	Regulatory issues related to challenging behavior; promote and provide access to best and promising practices; incentives for facilities to adopt best practice and evidence-based standards;

62	Staff training and environment
63	In my opinion, addressing the barriers that prevent facilities from admitting residents with challenging behaviors is most important initiative in the report. Facilities don't have adequately trained staff, often don't have sufficient staff, lose money with each admission, and face harsh penalties if they admit someone that most other facilities reject.
64	Provide staff training opportunities
67	Explore incentives for Best Practice. Financial based incentives as these interventions take staff and facility resources.
68	Barriers to admitting residents with behaviors. More education for surveyors and individual considerations for how facilities handle such behaviors and focused sites and follow-up teaching
69	Address Barriers that Deter some Nursing Homes from Admitting and Providing ongoing care for residents with challenging behavior.
70	Of particular importance is the need to evaluate- and develop a program for assistance to keep individuals at home with a certified dementia care giver.
71	Seek federal flexibility for facilities that adhere to best practice guidelines.-Best practices regarding challenging dementia behaviors need to be set and followed, however, as stated in this section, Some behaviors are not predictable and preventable . There needs to be more understanding from the regulators standpoint that sometimes these incidents are not preventable, despite proper precautions. Many facilities are afraid of the liability as far as admitting particularly challenging residents, so this needs to be addressed, as is noted in this draft.
73	Seek federal flexibility for facilities that adhere to best practice guidelines.
74	What financial support can the facilities rely on to admit directly from the community to ensure payment for services? Enhance connection with ADRCs. Provide financial incentives for quality providing facilities.
75	Provide staff training opportunities - simple, cost-effective, and better care for the residents. All facilities need to have individuals trained in dementia care.
76	Developing best practice guidelines to effectively care for residents with challenging behaviors with ongoing staff training will be an effective tool in working with people with dementia. How to face challenging behaviors and learning to assess potential underlying causes can keep people with dementia residing in a facility versus being detained in a hospital.
77	Improving the functional screen and further improving quality needs to be accomplished through improved reimbursement. Changes to Chapter 55 need to be made to address the barriers and be consistent in all counties.
78	The importance of revision of the Functional Screen is repeated here. The Functional Screen is directly and/or indirectly affecting reimbursement and as indicated further back in the document providing quality care costs money. Barriers have been increased by the changes in Chapter 55. The long-term care industry is and has responded to dementia-friendly facility design already - and continues to use best-practices, some of which have been referenced in the report.
79	Establishing mentorship programs which link high performing facilities with ones needing improvement is a positive and cost effective way to improve quality care in long term care facilities statewide.
81	One of the key components to developing a dementia friendly environment is recruiting and retaining competent personnel. In order for a facility to be consider dementia friendly, it should have a set of key core standards approved by the state that demonstrate the ability to appropriately care for people living with all stages of dementia. In addition, all staff and personnel should be required to have ongoing hours of dementia training that should include all the stages of dementia. Staff should also have to sessions on how to engage family members and learning cultural differences and beliefs about aging, illness, and end of life and other soft skills for working with residents and families.
82	I feel there needs to be set criteria on what is dementia quality care and then some very specific educational requirements for employees. I believe in HS 83 it states a person most have 6 hours of training in the area of specialty that a facility is promoting such as memory care. But I do not recall it stating what specifically the training needs to encompass.

85	We support all of the priorities here and stand ready to assist. This will continue to be a tricky area with fact-finding and data being paramount. We also support the concept of incentivizing best practices and rewarding facilities that demonstrate the ability to take and serve people with the most significant behaviors. Our experience has shown that these facilities are often smaller community-based places that operate under a less regulated and litigious environment.
86	Better staff training opportunities to include classroom training and not strictly web based
87	Address barriers that deter facilities from admitting and providing ongoing care
88	Identify factors leading to citations related to challenging behaviors and educate providers about how to prevent these circumstances
89	The statement that facilities are only cited on care plan errors is likely true, but if the way they approach it so black and white doesn't change, the facilities still will not admit them even if you research actual errors made.
91	There is a systematic bias towards nursing homes. Nursing homes should not be the only providers to receive financial incentives for implementing best practices, redesigning their facilities to be more in line with current designs or training their staff. We do not want people to be forced into nursing homes in order to get the best possible care. The best possible care should be available in the community before an individual declines such that institutional placement is necessary.
94	Addressing barriers that deter nursing homes from providing ongoing care.
96	It's difficult to pull out one related strategy as these all weave together and truly lead to better care for all in particular those with challenging behaviors. Ideally, we start with education and training both to family caregivers and providers to help in reducing negative outcomes.
97	There is a great need to develop a safe harbor for providers that provide care to individuals with challenging behaviors - it isn't just the number of facilities that experience immediate jeopardy citations, it's the perception that they are more at risk of these citations if they admit a resident with known behaviors.....Also, it is essential to provide a higher level of reimbursement to those providers that admit residents with challenging behaviors as frequently additional staff time and training are required to safely care for these individuals.
98	Provide staff training opportunities.
99	Address barriers that prevent families from admitting residents with challenging behaviors. Reimbursement is a huge part of this as often additional personnel are needed.
100	On page 21, the Plan states: Some behaviors are not predictable and preventable. This is an important point that needs more elaboration and focus in the Plan. What percentage of LTC residents have behaviors that are not predictable and preventable? If this is a large percentage, would this change some of the strategies provided in the plan? How does the plan address such behaviors? Are such behaviors correlated with certain dementia-related diseases or co-morbidities? If so, would this change some of the strategies in the plan?
101	You don't take into account that the majority of those with memory loss are living in CBRF Memory Care homes, yet these homes are not required to have additional dementia training or are treated any different than a typical CBRF. In addition, all funding related to additional dementia training has only been offered to SNF's in Wisconsin, which is not fair or appropriate. In my community there are only 40 SNF dementia specific beds and over 100 CBRF Memory Care beds.
102	Identify factors leading to citations related to challenging behaviors and educate providers about how to prevent these circumstances
104	The idea of a safe harbor is an excellent strategy for allowing the facilities that are caring for those with difficult behaviors to have the time to find the intervention that will work best for a specific patient. As with communities, one size does not fit all patients either.
105	Incentivize facility adoption of best or promising dementia care practices

106	The implication that CMPs are such a large driver of SNF reluctance to admit residents with behavior issues is a bit short-sighted. Additionally the ideas that IJs that have been issued stem from lack of training or inadequate staffing is over-simplified. For instance inadequate staffing can stem from an individual resident needing 1:1 care, thus monopolizing caregiver time from others. Facilities review referrals based on their ability to care for that person in the context of how that person will fit into the environment and with consideration for the safety of other residents and staff. To determine environmental fit we look at whether our building might be appropriate, as we don't have a small, specialized area for people for whom the world might have grown too big. We do this to be fair to the patient so that we don't get into an emergency situation where we can't care for them and have to transfer them.
107	The Plan focuses on education as if that will fix everything. That's only part of the issue. Also, it doesn't address Chapter 51/55.
108	Continue to improve the quality of dementia care in facility settings with accessible education
110	Our feedback has been provided via our January 13, 2014 letter to Secretary Kitty Rhoades. Please refer to this letter for our comments requested by this survey.
111	Develop guidelines to address the causes of regulatory violations relating to challenging behaviors.
112	Staffing issues - training, education and staffing models including turnover and consistency of assignments

Respondent	**6. Keeping in mind that the draft plan is a high-level outline and does not include detailed discussion, is there language in Section 5.2 (Facility Based Long Term Care) that you feel needs clarification? If yeas, please explain.**
5	Is there any financial incentive for assisted living facilities, especially those who have a high percentage of dementia residents?
6	I guess the biggest concern is why DHS is not working alongside of facilities during the survey process for ideas and interventions for difficult dementia residents. Instead the facilities get penalties. Facilities already cannot afford increased staff due to low reimbursement from Medicaid yet they get fined on top of it. We need to work together not have the punitive nature.
13	Few skilled nursing facilities are being built currently, maybe some focus on supporting facilities to remodel to dementia friendly environments
15	See #5. I am very interested in developing a specific crisis unit for Acute Behavior r/t Dementia for extreme northern Wisconsin. There is nothing here and families are forced to move their loved ones far down State where they are unable to visit etc., (often) due to their physical problems (in the instance of a spouse).
16	5.2.3 Discusses nursing home modernization program allowing dement-capable design. Will financial incentives be developed for assisted living facilities to incorporate dementia-capable design?
28	Yes, to me the clarification comes in the interaction between the three elements. Having a father who could not get access to an appropriate facility, who was serviced by individuals who did not understand or know how to cope with patient with dementia in surrounds that were more upsetting and confusing for him.
46	The language appears appropriate based on the ongoing need to insure that our aging population is being served by medical environments in a manner which holds both the highest legal and ethical standards as it's a priority for client/patient care.
51	Behavioral management is the key to certain residents to function at their optimal level of functioning. We are talking about the specific classes of dementia, i.e., Lewy body, Alzheimer’s.

53	The initiative to address barriers to admission and retention of individuals with dementia should be given to priority within the Facility Based Long-Term Care Section. However, the focus of the section is far too narrow in characterizing the realm of legitimate considerations that individually and collectively constrict the willingness and ability of facilities to admit individuals with behavioral symptoms. Increased exposure to regulatory enforcement and sanction is a significant, but not the only, consideration. Equally relevant factors include, but are not limited to, concern for preserving the safety and rights of other residents; the magnitude of a facility's existing Medicaid losses; the increased staffing and training costs that will not recognized or reimbursed thru Medicaid fee for service or Family Care reimbursement; increased exposure to civil litigation and liability; the lack of access to external resources to assist in crisis intervention; and the difficulty, if not impossibility of being able to either temporarily or permanently transfer a resident who's behaviors put other residents, staff, or themselves at risk. The scope legitimate concerns that are disincentives for admission go well beyond the enforcement risk. The recommended strategy of employing a 'comprehensive study of all immediate jeopardy citations' is too narrow. The envisioned review should extend to all deficiencies relating to acts or omissions in the provision of dementia care. Just as important, the evaluation should assess the impact of acts, omissions and inherent flaws within the survey and enforcement system. Of particular focus should be an evaluation of the appropriateness and impact of the 'strict liability standard' as a barrier to accessing care for individuals exhibiting challenging behaviors. Indeed, we would submit the exercise of identifying best practice standards contemplated under 5.2.1 will serve no purpose if there is no concomitant acknowledgement that adherence to those standards will preclude citation and sanction where negative outcome occurs despite a facility's best efforts. We also request more clarity with respect to intentions regarding development of incentives for facilities that adopt best or promising practices and show positive outcomes. The incentives that are proposed should include assisted living as well as nursing facilities. Recommendation to encourage Family Care MCO's to 'include dementia care expectations' into contracts should reflect an expectation that requires MCO's to specifically identify how it will reimburse facilities for compliance with those expectations. Also the strategy on page 24 of the encouraging MCOs to insert dementia care expectations for providers into their contracts cannot be reconciled with immediately following recommendation to 'to promote adoption of voluntary standards for dementia care.' Moreover, dementia care expectations and payment responsibilities should be uniform and identical for all MCOs. 'Wisconsin's Dementia Care System Redesign Imitative' will not succeed if each MCO is afforded contractual authority to mandate its own designs, standards and expectations.
54	One area that is not addressed at all is how the acute care provider (hospitals) fit into this. Hospitals are known to have difficulty dealing with patients with dementia and often resort to use of medications to control behaviors. In the skilled nursing centers we have been asked and continue to do well to decrease use of these medications with our residents but often the hospitals are held to a different level of scrutiny and our residents come to us very medicated due to the hospital not using non-pharmacological approaches. Could we add acute care providers in this area? Also, on page 22 the statistics indicate citations involving residents with dementia due to aggressive behaviors but does it take into account citations that are given out due to co-morbidity of the dementia residents. Often, these account for some citations and we are unsure as to if this data included on this page takes that into account.
55	All identified strategies are needed.
57	The strategy to conduct a comprehensive study of all IJs given with a root cause analysis is a good one, but should be conducted with other entities involved than just the department. The process put in place should have greater transparency with a broader set of eyes. If not, it would have the appearance of another IDR process. How would the results of this study effect and be integrated with the survey process?
60	When developing guidelines and seeking federal flexibility how will this be integrated into the survey process?
64	How promising practices be incorporated into staff training and policies.

77	Multiple training opportunities already exist. I don't think that MCO's should be putting additional requirements on the providers without providing reimbursement.
78	The current survey system in long-term care is punitive in nature so possibly movement toward a system that is reflective of quality improvement would make many things possible. We all recognize that more regulation does not ensure quality. Assisted living regulations are controlled by state regulations so there is opportunity at this level to be more creative. Please continue to recognize there are multiple educational opportunities already existing that could be used - i.e. Hand in Hand. Realizing again that providing quality care costs money.
79	There should be clarification on words such as encourage, promote and explore. We also question where the money would come from for 'providing financial incentives.'
82	Could you please define MCO a bit further?
94	Would it just be immediate jeopardy cites or would it include less immediate cites? Please define cost neutrality.
96	Family Care and MCOs are threaded throughout the Plan, but what is missing is the commitment to expand Family Care statewide in the counties that currently do not have it, in particular in the seven northeast Wisconsin counties. I would like to see Family Care expansion addressed and implemented which would be an integral part in creating a Dementia-Capable state.
97	I am unclear as to what encouraging MCO's to include dementia care expectations into contracts with nursing homes means for the provider. Again, if the provider is expected to provide a higher level of care for the same reimbursement, it is less likely the provider will be willing to admit individuals with challenging behaviors. Please clarify what you would expect from the MCO's related to reimbursement for these dementia care expectations
100	Page 25 of the Plan discusses the Nursing Home Modernization Program. I suspect that many do not have an understanding of what the Nursing Home Modernization Program is or what the cost neutrality requirement of that program is. To help support the strategy identified, additional information regarding these that program and the cost neutrality requirement may be helpful.
101	There is very little to no mention of CBRF care.
102	Deficiencies are not cited for dementia care but the resident's that do get cited for related care issues more than likely have dementia component that impact care. It may not be the primary diagnosis but still impacts how care is provided.
104	The plan looks like it will make the needed education for facilities and caregivers available to both prevent and provide better outcomes for residents with difficult behaviors, which is much needed; however, there is no mention of the education that needs to happen at the survey or auditor level regarding root cause analysis and interventions. This education will allow these individuals to be able to see when interventions have been put into place despite the sometimes uncontrollable escalation that leads to a specific resident to resident or resident to staff event.
110	Our feedback has been provided via our January 13, 2014 letter to Secretary Kitty Rhoades. Please refer to this letter for our comments requested by this survey.
112	Staff training - needs to be mandatory for all levels of staff I believe in Florida, RNs must complete dementia training as part of mandatory continuing education and licensure requirements. Should also be mandatory for CNAs

Respondent	**8. Please note one "Related Strategy" detailed under Section 5.3 (Care for Individuals with Significant Challenging Behaviors) that you feel is particularly important.**
1	The requirements under Chapter 55 of the Wisconsin Statutes related to procedures for emergency protective placement of persons with dementia need to be clarified and implemented in a consistent manner across the State. The emergency protective placement law does not explicitly address a number of issues that arise when placements are made and county APS agencies, county corporation counsel, crisis units, law enforcement, and facilities often interpret the law differently. This leads to inconsistencies among counties and less than optimal care for people with dementias who are the subject of emergency protective placement. People with dementia suffer trauma when handcuffed by law enforcement and transported in squad cars.

2	Identify obstacles to designation of emergency protective placement facilities.
3	The mobile crisis team is a wonderful idea, however most staff associated with after hours on call are experts in the chapter 51 area. They are not trained in dealing with Alzheimer's Disease and other dementias. This type of training takes money, both in staff time and resources. Unless money comes with the plan, I do not see it being successful.
4	Explore incentives for facilities that adopt best or promising practices and show positive outcomes.
5	Would a mobile crisis team respond to an assisted living facility versus having to send a resident to an ER for an evaluation?
6	Develop and disseminate dementia assessment tools for use by crisis response and stabilization teams.
7	While implementing evidence based care there still may be a need for emergency treatment. Facilities still need a place to go when all interventions fail and the person is a safety risk to themselves or others.
9	Promoting dementia capable crisis teams. This should be piloted. Main issue is keeping the person safe at their current location and not be subject to another more restrictive placement.
10	Shortage of quality facilities
13	Looking at penalties related to management of difficult behaviors from survey agencies.
15	Clarify Procedures for Emergency Protective Placement. Most emergency responses are NOT geared to handle acute, violent situations and often leave the person in place. CBRFs are required to then meet the needs of the Residents but even an increase in staff does not assure safety for the person in crisis or other Residents. There needs to be a very easy, specific system in place that all stakeholders understand (not just the CBRF/NH).
16	5.3.3: Shortage of declared intake facilities state wide. Only 15 of 72 counties have a formally designated intake facility.
19	Identify areas that need clarification related to emergency protective placement requirements and procedures.
20	Crisis planning and intervention is so critical, it is important for facilities and families to have plans in place in case crisis happens. This is not a normal part of aging and it can be so difficult to manage this disease process. I have found crisis planning has helped my consumers out; they have told me having plans in place has helped in time of need.
23	As a facility that cares for behavioral residents, there is little support for uncontrollable behaviors, even if there is an actual threat to others, and with violent behaviors. Support would be a big plus.
24	Need funding from state to fund facilities that will accept EPP and are willing to be a PP site. In this county the hospital is the site for EPP's and the cost is 1275 per day which comes out of tax levy as the individuals do not meet in patient criteria to be funded by Medicare.
26	The current shortage of facilities that are available to meet the special needs of our Alzheimer patients with challenging behaviors is at a crisis level.
27	It seems as though there is no consistency statewide with how crisis units respond/intervention is handled/dealing with those exhibiting behaviors. Maybe consistency state wide for all counties should be considered.
28	Crisis response is the most important in my thinking. If crisis are responded to appropriately there will be less need for placement. This response needs to focus not only on the identified person, but, on the caregiver and their state and behaviors.
29	With the expansion of dementia care education and appropriate, effective, research-based intervention - it is anticipated that crisis response/stabilization and emergency protective placements will decrease.
30	Address the Shortage of Facilities Designated to Accept Emergency Protective Placements
31	Promote dementia capability in existing mobile crisis response system
33	Promote dementia-capability in the existing mobile crisis response system.
34	Explore amending DHS 34 to expand mobile crisis response programs to ensure dementia-capable capacity

35	Identify and pursue options to address facility concerns and incentivize facility designation.
36	Clarifying procedures will help to expand the capacity for crisis response/stabilization. It may help to create a new niche that will allow more facilities to arise.
38	Ensure chemical restraints are reduced/eliminated to manage behaviors as a cheaper and easier behavior management strategy than increased staffing, staff training, etc.
39	Create consistent standards and training related to crisis and caring for persons with challenging behaviors.
40	Identify areas that need clarification related to emergency protective placement requirements and procedures.
41	All 3 of these are related and extremely important. Law enforcement doesn't understand Chapter 55, there is no crisis response and there is absolutely no facility that is going to take a demented person at 11:00 at night on a Saturday. As an APS supervisor who gets theses calls on the evenings and weekends - all three of these are a huge problem
42	Identify and pursue options to address facility concerns and incentivize facility designation. Taking on individuals with challenging behaviors does result in increased expenses to the facility. It is unrealistic to think a facility will accept anyone with a challenging behavior if they can't cover the cost of caring for the individual.
43	Promote Home and Community Base services
44	Addressing the shortage of facilities designed to accept emergency protective placements. Despite a provider's best efforts, there may be times when individuals require emergency services in a safe, secure environment where more emergent treatments can be administered. Currently, people are ping-ponged literally around the state, from Waukesha to Madison to Winnebago, as most facilities are either full or claim the person isn't appropriate for their program. This obviously places a huge stress on the resident as well as his/her family.
45	Facilities that are willing to accept emergency protective placements.
46	Emergency protective placements are always challenging for family caregivers and facilities. The procedures for such placements at time appear subjective from the time the decision is made to call for assistance for the patient up and until the actual decision for acceptance is made by a more restrictive facilities (mental health or medical detention). It would be extremely helpful if there was an on-call multidisciplinary team with medical, mental health, legal and paraprofessionals who can assist the facility and/or family when having to make such difficult and highly involved decisions. Often the word of the paraprofessional (RCAC - CNA) or family member are dismissed while these are the parties with the most day-to-day contact with the patient and truly have the most insight into changes in daily functioning and significant negative changes therein.
47	While I believe that expanded crisis response capacity is always a valuable tool for the community, as the manager of a highly-effective 24/7 mobile crisis team, I find that crisis has little impact in this area. When a patient with dementia is struggling or acting out, no amount of mental health intervention is going to make the patient not demented. We find in these situations, the patient is doing his or her job....being a patient with dementia. The staff are typically the ones in crisis as they do not have the skills or back-up staffing patterns to be able to provide the one-to-one intervention required to maintain the safety of the residents and staff at the facility. I worry about efforts to move this issue onto the Ch. 51 system which is also already burdened with shortage of psych beds and treatment programs. Additionally, Ch. 51 facilities are not safe setting for the demented elderly person and there is some agreement that dementia is a permanent condition that limits the subjects ability to benefit from active treatment.
48	Crisis response is very important as behaviors place both caregiver and patient in danger.
49	Providing counties with funding to develop an intake facility for emergency protective placements. If individuals who are diagnosed with dementia cannot be detained in an inpatient psychiatric facility and the county has not developed a facility for these individuals where does the individual go? This places family members, APS workers, the court system and others in an extremely difficult situation.
50	Assessment tools for caregivers

51	When a dementia resident exhibits unsafe practices, such as wandering, changes in mood/behaviors, resistance to ADL tasks, families need immediate support in care giving and alternative placements within a distance for ongoing support, visitation and advocacy
52	Develop and disseminate dementia assessment tools for use by crisis response and stabilization teams.
53	We consider each of the three to be top priorities of equal importance. They are intimately related and intertwined such that if one is not achieved, fulfillment of the others would not be possible.
54	Our team was struggling with identifying only one strategy in this area so we have selected two. We selected: Promoting dementia-capability in the existing mobile crisis response team (page 27) and Identify and pursue options to address facility concerns and incentivize facility designation. (page 30)
55	Promote dementia-capability in the existing mobile crisis response system.
56	How to properly evaluate at time of crisis, how to determine if the behavior is dementia related.
57	Identify and pursue options to address facility concerns and incentivize facility designation.
59	Developing policies and best practice guidelines.
60	Identify areas that need clarification related to EPP
61	Develop & fund crisis stabilization teams and emergency placement facilities
62	Clarify procedure and assessment
63	I think intervening and stabilizing when there is an initial crisis and having facilities appropriately funded and trained to provide emergency placements are equally important.
64	Promote dementia-capability in the existing mobile crisis response system.
67	Identify options to address facility concerns and incentivize the facility.
68	Ease of protective placement. Get rid of obstacles. Require management organizations to do what is proper for individual care and monetary consequences for those who don't follow the rules. Example: management organization who places a resident with complicated needs into a facility incapable of providing proper level care such as skilled nursing. Result is needless ER visits and hospitalizations without negative consequences to the skimping management company.
69	Expand capacity for Crisis Response and stabilization
70	A trained Mobile crisis intervention program is essential to stabilize a person to remain in a safe environment and danger free from themselves and others.
71	Identify and pursue options to address facility concerns and incentivize facility designation.
73	Explore amending DHS 34 to expand mobile crisis response programs to ensure dementia-capable capacity.
74	Get provider input in developing these strategies for crisis response and stabilization
75	Promote dementia-capability in the existing mobile crisis response system.
76	Promoting dementia capability in the existing mobile crisis response system is a high priority to our department. Maintaining the focus on treating people in place rather than uprooting people who are confused and aggressive should be less detrimental to all involved in the situation. This may be accomplished by providing crisis responders the necessary assessment tools in order to appropriately intervene.
77	All of the strategies are important to deal with situations in an emergency. This includes re-visiting legislation recommended by the legislative council special committee. I totally agree that financial incentives need to be developed. Quality care costs money.
78	Taking the opportunity to look at the recommendations of the Legislative Council Special Committee study is a place to start in reference to Section 5.3. Work has already been done on this. Legislation reflective of the needs of this group of people needs to be part of the crisis and stabilization process.
79	Promote dementia-capability in the existing mobile crisis response system.
80	Procedures for protective placement; facilities who accept significant challenging behavior.
81	See comments in final answer.

82	We need to have the designated placement sites and within each county. Some families have to travel very far because there are not enough sites.
85	We strongly support the expansion of mobile crisis programs and would point out two things related to using them for dementia care. First they must be available and robust on a 24 hour basis since so many of the Alzheimer's related difficult behaviors happen at night. Second, they must be available to people with dementia in both community and facility settings. We strongly support the development of treat in place dementia capable models and suggest that these be well-funded and evaluated. Clarifying procedures in Ch. 55 is extremely important and supported, however, we will still need to settle the question of what is an allowable facility under the law for accepting placements and providing care. The position of the Alzheimer's Association is that the current complete ban on the use of psychiatric facilities in this capacity is not good policy. The State's own facility at Mendota is a model provider of care and should be allowed to continue to do so, and there are several private and county-operated facilities that have great expertise as well. We respectfully submit that the State should drop its opposition to further deliberation of the Legislative Council Committee bill now known as AB575 so continued discussion of its merits can take place. We strongly support the language regarding expanded emergency protective placement facilities.
87	Promote dementia capability in the existing mobile crisis response system
88	Explore amending DHS 34to expand mobile crisis response programs to ensure dementia-capable capacity.
89	The staff that responds needs to have better training. In my experience they will no longer even come out to help when there is a crisis because they report they are not allowed to do anything for someone with Dementia due to the court case.
91	Be sure that police and medical authorities are all on the same page and have a protocol to follow. Provide a timely complaint process for individuals and families.
93	Explain and define a 51/50 hold when a person is in danger to themselves or others.
94	Dementia assessment tools by crisis teams
96	Counties and providers are seeking clarity around emergency protective placement which should be the first step in the strategies as outlined.
97	Clarify procedures for emergency detention
98	Identify areas that need clarification related to emergency protective placement requirements and procedures.
99	Expand capacity for crisis response.
100	Identify obstacles to designation of emergency protective placement facilities.
101	In order for homes to help those with more developed expressions the State needs to encourage, pay for this care and assist with issues that arise. Plus more training of specialized care needs to be rewarded.
102	Identify areas that need clarification related to emergency protective placement requirements and procedures
103	Pg. 30 - Incentivize facility designation. I think this is the area I found of most interest and curiosity for facilities admitting people with challenging behaviors for EPP. More information on how and when a receiving facility is needed should be designed. The state should look at the work done in 2013 by the legislative workgroup to understand the issue more clearly.
104	We all know that prevention is foremost; however, clarifying procedures for EPP and addressing the shortage of facilities that are able to accept EPP are crucial to providing quality care in our communities. It is a reality that we will have some people that experience difficulties despite all of our best efforts to prevent problems, this is a degenerative disease after all and change is imminent.
105	Identify and correct any obstacles to designation of emergency protective placement facilities.
106	Creating units/facilities that are appropriate for these people might reduce the number of emergency transfers that need to take place. Or perhaps a crisis unit could come to them so they don't need to be transferred away from where they've (hopefully) grown accustomed.

108	Promote dementia capability in the existing mobile response system as well as training and education
110	Our feedback has been provided via our January 13, 2014 letter to Secretary Kitty Rhoades. Please refer to this letter for our comments requested by this survey.
111	Identify and pursue options to address facility concerns and incentivize facility designation.
112	Develop and disseminate dementia assessment tools

Respondent	**9. Keeping in mind that the draft plan is a high-level outline and does not include detailed discussion, is there language in Section 5.3 (Care for Individuals with Significant Challenging Behaviors) that you feel needs clarification? If yes, please explain.**
5	Options for emergency placement for residents in rural areas...
9	Currently Chapter 34 mobile crisis stabilization teams are not equipped to support the dementia population. This cannot just be an added responsibility to current Human Service mental health mobile crisis teams' responsibilities without adequate training and financial support. This would be a tremendous disservice to both the mental health and dementia populations.
15	Again, I would like to reiterate the need for specialized units, either stand alone, as part of existing CBRFs or BHU, especially in remote, rural areas. There need to be specific regulations, offset from DHS 83 that address this but give the leeway for facilities to provide this service.
27	Some of the language, especially when repeating if someone has Alzheimer's along with mental health issues and/or AODA, could be best stated with co-occurring disorders. Felt a little repetitive.
28	I believe it is clear, but, expansion of the explanations could be beneficial.
46	Once again, the language reflects thoughtful consideration of both the legal and ethical challenges associated with making decisions around detaining a patient in a highly restrictive environment.
49	If dementia-capable mobile crisis response is he preferred approach why is this not mandated for all counties to have?
53	We believe the Section 5.3 strategies for developing facilities for emergency protective placement must be expanded to address the current absence of middle-ground facilities willing, dedicated and able to provide effective dementia care to individuals exhibiting significant challenging behaviors above that appropriate for continued residency within a nursing home/assisted facility setting but below that appropriate for transfer to an emergency protective placement facility. Such 'middle-ground' facilities would be established, not to warehouse dementia patients, but rather to permit access to specialized best practice services in a dedicated environment. As expressed earlier, a formidable barrier to initial admission of an individual with early stage dementia, it is the fact if the individuals behaviors escalate in frequency or intensity despite a facility's best efforts, securing an appropriate alternative placement will be difficult if not impossible. Recognition that more appropriate alternative settings will likely not be accessible if a resident's behaviors escalate is a barrier to initial admission as it understandably elevates facility concern for future risk of regulatory sanction, increased staffing costs, and maintaining the safety and rights of other residents and staff. If we are going to effectively redesign the dementia care system the strategies should focus on establishing a logical continuum of dedicated care settings for different acuity levels, rather than concentrating resources at the extremes.
54	Our team felt as a collective whole that this area needs to be addressed ASAP as it is a big need and incredibly important for skilled nursing facility providers.
55	All identified strategies are needed.
59	More detail on DHS 34.
60	This is an area that needs to be acted upon ASAP even if it is only a temporary fix until the whole plan is in place. People with dementia, their families and facilities have been suffering since the court decision in May of 2012 we cannot wait another 2 years or more to get relief from the current system.

63	County Adult Protective Services are funded with Community Aids (which hasn't been increased in 15 years or more) and county tax levy (for which there are strict levy limits). The report incorrectly assumes county APS services are in a strong position to respond to dementia needs. For the most part, the same could be said for mobile crisis teams.
64	Difficult to provide feedback, minimal knowledge base as a Public Health Practitioner.
68	Explanation of types of behaviors and how they are dementia related and unlikely to be handled at home. So general public understands what such abnormal behaviors ar.
69	From an ER point of view, I think there is a key component missing, and that is the provider specialist who is overseeing the care of these patients. We here in the ER truly have the challenge of placing these patients in a timely fashion because there is not consistent medical staff available to accept and write orders for the facilities that these patients are going to. As a result, these patients wind up waiting in the ER facilities for 6-8 hours.
72	I don't really understand the difference between 'Expand capacity for crisis response and stabilization' and 'Address the shortage of facilities designed to accept emergency protection placement.' All the same problem. Who responds and where to do they go.
77	Not in this discussion is how the hospital input needs to be sought.
78	Is acute care going to be part of the discussion as there doesn't seem to be mention of them in the document? They need to be.
94	5.3.1 where is the funding to expand mobile crisis programs? 5.3.3 if law require counties to designate one intake facility for protective placement, why only 15 of 72?
97	Yes, it is unclear if procedures for emergency detention are adequate under current legislation. On page 29, it indicates a strategy is to review statutes and regulations. This has been completed with legislation introduced so am unclear as to what benefit additional review will do.
99	We recommend adding the following strategy:-Utilize psychiatric and palliative care practitioners in proactively addressing complex behavioral symptoms.
100	Page 26 of the Plan states Although a person may have both dementia and a mental illness or substance use disorder, for an individual with dementia only, the appropriate response to challenging behaviors is likely to be different from the response needed in the case of challenging behaviors among people with mental illness and substance abuse disorders. It appears that this statement is intended to support some of the strategies in section 5.3. If so, this statement itself needs some supporting evidence. Further, the statement paints dementia and mental illness as something very different. The truth is there are similarities between dementia and mental illness as well as differences. Those similarities and differences should be identified and strategies built upon those similarities and differences rather than building strategies only on the differences. Additionally, it is not clear what point the statement is trying to make....One could say that the response to symptoms of depression and schizophrenia are likely to be different as well. Finally, page 26 of the Plan states: 'Currently, there are no generally accepted standards that can be used to appropriately and adequately evaluate the type and level of care needed by people with dementia who exhibit challenging behaviors.' This statement should be reviewed by physicians in geriatric medicine for confirmation. As currently written, the statement could be read to mean that there is no scientific backing behind decisions made by physicians that diagnose and treat individuals with dementia and challenging behaviors.
102	I think that there needs to be some standardization on how protective placement standards are applied. It is different for each different police department
103	Explore amending DHS 34 to expand mobile crisis response programs to ensure dementia-capable capacity. Escalating behaviors in nursing home facilities should be addressed through the nursing home regulations to allow individuals to receive MH care in their facility. Current regulations make this difficult. Making mobile crisis available 24/7 is costly for counties and will not assure that someone is able to go out when needed.
104	I know that the Special Legislative committee, comprised of people from the field, worked on strategies for these cases, where does their work fit into your picture? Is it fiscally responsible to throw away or redo their work?

110	Our feedback has been provided via our January 13, 2014 letter to Secretary Kitty Rhoades. Please refer to this letter for our comments requested by this survey.
112	How to develop consistency across 72 counties - seems this should not be left up to the counties - maybe create larger units

Respondent	**11. Please note one "Related Strategy" detailed under Section 5.4 (Dementia Care Standards and Training) that you feel is particularly important.**
1	Develop voluntary training standards for caregivers and other professionals involved with people with dementia. While a number of training opportunities are available, there is currently no consistent set of standards for determining what knowledge, competencies and training are needed for caregivers and other professionals who work with people with dementia. This strategy develops a foundation for the entire spectrum of training opportunities, taking into account the training resources that are currently available and supplementing those with widely accessible and affordable training resources.
2	Research existing standards and best and promising practices
3	There are currently a large amount of trainings offered to in home, family caregivers. However, families often cannot overcome the barriers to getting to attend these classes, i.e., respite care, on site caregiving during trainings.
4	Develop dementia care standards and a voluntary assurance program for facilities and home care agencies.
5	Develop standards based on type of provider...Identify criteria for level of dementia care. Many assisted living facilities claim to have dementia care but what does that mean?
6	Provide additional training opportunities relating to dementia care
7	Develop and share best practices regarding standards of care. Hand in Hand toolkit should be used.
8	Develop voluntary training standards for caregivers and other professionals involved with people with dementia.
10	Affordable training
15	Developing a specific set of standards, hopefully thru the CCDET, where a certification can be obtained and transferred. The training needs to be specific to not only dementia but CPI (or similar), laws, Residents Rights and all aspects that ALL stakeholders have (families, Residents, Caregivers, Medical personnel)....what are their responsibilities and how do they interact. Too often, there is one expert and a lot of people saying, my hands are tied when they are not aware of the actual rules, interventions etc....i.e. the Care provided needs to be interdisciplinary and the training has to match this...what is YOUR specific role?
16	Identifying and listing available dementia care training offers an all-encompassing variety of dementia care standards for Wisconsin to develop its foundation of best practices and standards from.
19	Research existing standards and best and promising practices.
20	I feel it is particularly important to have training opportunities for caregivers and professionals. The more understanding and education out there for people, the better we can be as a whole in the care of people with dementia/Alzheimer's.
22	An important part of dementia care training should be a review of the research about how diet and lifestyle affects dementia.
23	Training is a big plus. We do so yearly for all staff who in the special care unit.
24	Developing pertinent standards for the type of facility that will be serving this population.
26	Training, training, and more training
27	A well-trained, competent workforce is critical to the provision of quality dementia care.
28	Development of standards of practice seem most important to me. Without standards there is no measure that guides.

29	Generally, skilled facilities are staffed by professionals who are eager to learn effective care and treatment strategies. At the same time, it must be acknowledged that current state and federal funding, minimum staffing requirements and growing regulations greatly limit their ability to engage in worthwhile training.
31	Develop Dementia Care Standards and a Voluntary Assurance Program for Facilities and Home Care Agencies
33	Develop dementia care standards and a voluntary assurance program for facilities and home care agencies.
34	Develop dementia care standards and a voluntary Assurance program for facilities and home care agencies
35	Develop dementia care standards for facilities and providers.
36	Developing standards will help to direct the nature of trainings.
39	Research existing standards and best and promising practices
40	Promote voluntary use of dementia care standards and training programs
41	Develop dementia care standards
42	Develop standards based on the type of provider or facility, the type and level of dementia care provided, and acuity of the people served.
43	Promote Training for Police officers
44	Providing additional training opportunities is essential. These trainings need to be designed to educate providers from administration level down to direct care. Perhaps train the trainer models. Most current trainings offered are quite remedial or theoretical (i.e. presenters have gained their material from institutions rather than in the field). What we know about the diseases needs to be explained at a level appropriate for the audience, and then practical applications suggested.
45	Training and best practices for dealing with dementia.
46	It is very difficult to keep up with all the new research and best practice models as it relates to dementia care for service providers and other stakeholders (e.g. families, psychotherapists, care managers, and RCAC staff). If there were care standards to use as a guideline it would help our program administrators make determinations around which training opportunities would be most beneficial for our professional and paraprofessional staff. Care standards will also offer the opportunity for highly qualified agencies to demonstrate their acumen in the area of dementia care based on care standards. It is fair to say that not all agencies are going to specialize in the dementia care (all cannot be experts at everything) however, when a new dementia diagnosis is giving to a love-one, having standards to assess potential caregivers or care giving environments may be very assistive for families and care managers.
47	Increased training and standards are extremely important for all care-givers. Improved reimbursement for providers so that staff can receive better pay is also important.
48	Detailed Standards of practice and protocols related to care of those with Dementia would be of benefit to all.
50	Develop standards of care for persons with Dementia
51	Trained staff, (certified)should receive re-imbursement, additional monies to employee for higher wages
52	Develop Dementia Care Standards and a Voluntary Assurance Program for Facilities and Home Care Agencies.

53	There is an essential need, not to explore, but to establish financial incentives for providers that comply with staff training and other dementia standards. With good reason, Medicaid providers in all settings are skeptical that that any new or continuing Medicaid program payments will be sufficient to cover the cost of the care they are expected to provide. Moreover, it is inappropriate to characterize the behavior-add on for nursing homes as an incentive; the add-on merely represents a recognition that historical payment methodologies do not adequately recognize costs associated with care of individuals with behavior/cognitive impairment. However, the level of funding devoted to that recognition is woefully below the level of costs that are incurred. The recently amended add-on provision in the nursing home payment formula merely provides a more equitable means for distributing an inadequate level of funding.
54	Identify existing dementia care programs. (page 31)
55	Develop voluntary training standards for caregivers and other professionals.
56	Registry of trained caregivers and professionals
57	Research existing standards and best and promising practices. (Nationally and internationally)
58	Develop standards for care and training and incentives to train
59	Creating a widely accessible training program, possibly web-based through an organization like Care2Learn.
60	Develop a training program for caregivers and other professionals
61	List resources on website; include links; make resources available at minimal to no costs.
62	Education
63	Research best and promising practices.
64	Promote voluntary use of dementia care standards and training programs.
67	Having a Standard of Practice puts the responsibility on the facility, yet allows us to account for the high turnover of staff and the unique challenges to ongoing education. Allows us to be creative with our interventions and education of interventions
68	Training to meet the demands of the onslaught of Dementia cases in the future is imperative. Top priority for society and medicine.
69	Provide additional training opportunities relating to dementia care
70	Develop standardization training programs for caregivers and other professionals involved with people with dementia.
71	Research existing standards and best and promising practices.
73	Develop voluntary training standards for caregivers and other professionals involved with people with dementia.
75	Develop voluntary training standards for caregivers and other professionals involved with people with dementia.
76	Determining standards for facilities and providers to follow regarding care provided to people with dementia should be a priority. This will allow caretakers the ability to determine which facilities follow the determined guidelines set for caring with people with dementia. Also having the competency testing and a registry for potential employers to access prior to hiring someone are also important. This will help caregivers know the person they hire to provide home care services for their family member has been trained to a set of standards.
77	Developing dementia care standards should be done by the providers and professional organizations.
78	It is important to note that the industry (assisted care and long-term care) is already making commitments and providing training on dementia and such programs.
79	We support developing a dementia training program for professional caregivers with competency testing and certification. It would be a great way to partner with the local technical colleges in order to review CNA curriculum and require increased dementia training.
80	Broader availability/access to training
82	Developing the dementia care standards.

85	While we support the need for standards of care, we support using an approach of best practices and incentivizing them financially over an approach solely based on standards. We worry that the momentum that currently exists around the Dementia Capable Plan could be eroded if a series of disagreements about standards takes place. We also support the use of already existing standards that have been developed by providers as a good starting place. The Alzheimer's Association has already developed extensive models for training direct care staff, both in person and online, and those should be utilized to the greatest extent possible. We also have popular modules on training law enforcement and other first responders.
86	Many facilities already have their own dementia training. Bringing together providers who already do the training and comparing their trainings to develop standards would be ideal
87	List training opportunities from the Department's dementia care website.
88	Develop dementia Care standards and a voluntary assurance program for facilities and home/community care providers
93	Training should be done by qualified individuals and should be consistent. Should work with established education, like the WTCS.
94	Financial incentives will be huge
95	Daily Care Providers required Dementia Care training
96	I am pleased to see the development of dementia care standards and training addressed in the plan. I see these areas as the building block for everything within the plan - addressing challenging behaviors, providing quality care, creating public awareness, etc.
97	Provide additional training opportunities for caregivers and other professionals....consider utilization/modification of CMS's Hand In Hand training already developed
98	Develop voluntary training standards for caregivers and other professionals involved with people with dementia.
99	Standards.
101	Training is of utmost important for caregiver and should be required for all homes that do dementia care. The training needs to be in-person and assessed for content and appropriateness.
102	Develop voluntary training standards for caregivers and other professionals involved with people with dementia
104	Dementia-based staff education programs are plentiful, what is needed most is an incentive program that creates a fiscal benefit to help offset the costs therefore encouraging compliance.
105	5.4.2 Identify best and promising standards and practices and develop training standards to reflect these.
106	The [redacted] already has an excellent Dementia Specialist training program. Please leave it to them with suggestions as needed.
110	Our feedback has been provided via our January 13, 2014 letter to Secretary Kitty Rhoades. Please refer to this letter for our comments requested by this survey.
111	Promote voluntary use of dementia care standards and training programs.
112	Develop standards for all levels of care, community through institutional.

Respondent	**12. Keeping in mind that the draft plan is a high-level outline and does not include detailed discussion, is there language in Section 5.4 (Dementia Care Standards and Training) that you feel needs clarification? If yes, please explain.**
1	I think it's very important to have clear, consistent messages, standards and practices across the state.
10	Why is training not to be required for workers and facilities?
15	No, but having an MS-Training Development has shown me: Training needs to be based on the NEEDS assessed by all stakeholders. It is not just outcome based for the individual in crisis but for the staff, the families, the individual etc. They all have a need that needs to be met and training is where that starts.

16	CCDET and DHS are not the experts on dementia care training. So with that being said, it is absolutely necessary to have facility and services providers, clinical professionals, advocates, and other stakeholders overseeing the training standards...the Alzheimer's Association, The National Institute on Aging's Alzheimer's Disease Education Referral Center and other leading academic research and provider trade associations must be the leaders in this.
24	How will training be rolled out for all these different groups of individuals while standards are being developed? A catalog of training opportunities and education need to be available and kept current.
28	Once again I would like to see this expanded. Training means nothing without the means of implementation. Having worked in a nursing home at one time I can tell you that there is nothing more frustrating than learning a new technique then not being able to implement or at least try the new methods.
47	Little mention of paying providers and direct care staff a worthwhile wage that will motivate and attract quality providers.
53	We are concerned the acknowledgement that 'a well-trained competent workforce is critical to development of quality dementia care' does not likewise acknowledge and underscore the critical need to provide improved wage and benefits for members of that workforce. As indicated on page 24 ' 'Providing Quality Care Costs Money'. However, the plan offers no indication of a commitment to provide Medicaid funding that will assure the care givers who provide that quality will receive a level of wages and benefits that is representative of their training, skills, and performance. We would also submit the credibility of the plan's commitment to develop financial incentives would be strengthened if the proposed strategy acknowledged and underscored the need for total transparency in term of demonstrating the cost of DHS and MCO dementia expectations will be properly funded through their respective fee-for-service or contract payments. Currently, few MCOs will afford providers access to their payment methodology or specifics of how they determined resident specific rates. Since most residential care providers have not received Family Care rate increases in the past five years, they will be highly skeptical of the proposition MCO's will provide payment incentives in their future rates. Contracts historically have been utilized by MCO's to define higher performance expectations without a corresponding commitment to reimburse the cost of those expectations. The strategy proposed strategy should be clarified to articulate an express expectation of cooperation and transparency for providers in identifying their costs; for MCO's in their reimbursement of those costs; and for DHS in establishing MCO capitation payments.
54	As a team we appreciated the fact that in this section it denotes voluntary attestation to the compliance and not mandate this section or have special licensure as part of this.
55	All identified strategies are needed.
56	Describe how the listing of attest versus confirmed compliance will be established.
58	Training should also be provided to public and private transportation providers (taxi/bus) as well as volunteer drivers who provide a large number of rides for people who need higher levels of service - taking someone with dementia into an appointment so they do not get lost. This is something many other transportation providers are not designed to do. They can advertise as dementia friendly transportation providers if trained. Transportation providers under contract with MCOs and the NEMT Medicaid transportation broker should also have standards and financial incentives to provide the training and higher level of service to those with dementia just as LTC facilities.
63	Ongoing, hands on, on site, training with real consumers is essential. Relying solely on classroom training is not very effective. Ongoing, hands on training is expensive. Given high turnover rates among direct care staff, expertise within a facility will diminish over time without an ongoing investment in training.
64	Yes. Exploring financial incentives for providers that comply with staff training and other dementia standards. Would there then be disincentives for those who do not comply?
77	Will facilities be surveyed on voluntary standards? Will MCO's mandate the voluntary standards? My concern is the voluntary will become mandated.
78	Will voluntary participation jump to mandatory or in verbiage from the document compliance issues?

79	When using the term caregivers, be specific about whether this refers to professional or family caregivers. There seems to be a lack of training opportunity for family caregivers. Not all caregivers are willing or able to attend a class. Address training for caregivers who find it difficult to leave the house, for example, train home care workers to train the family caregiver and/or support the state-wide family caregiver telephone support group.
91	I would suggest that training for people involved with others with dementia should not be voluntary. Home care workers in particular need strong training. Expand the capacity of technical colleges to provide CNA training.
94	What costs will be expected of facilities to pay for training or will this be part of the program
96	The Alzheimer's Association has for several years provided much needed professional education and training to both family caregivers and professionals. I would suggest leveraging existing training resources and the public/private partnership. We currently have both in-person and online training for all caregivers (family and professional). All of our family programs are free so it's an efficient and sustainable way to provide that education. Our Foundations training is currently one of the programs that CMS recommends and our Dementia Specialist training is unique to Wisconsin. Again, I would suggest to not duplicate efforts, but tap into existing cost-effective resources as mentioned in the plan also considering the Alzheimer's Association's education and training.
100	One issue that is not addressed in these strategies is cost effectiveness. 1) The training should also support cost effective care. 2) The strategies also need to consider whether the strategy itself is cost effective/appropriately balances the likelihood of achieving the strategy's quality goal vs. the cost to implement the goal.
110	Our feedback has been provided via our January 13, 2014 letter to Secretary Kitty Rhoades. Please refer to this letter for our comments requested by this survey.
112	This will need to be done in a logical progression - Identify what exists - best practices -then develop standards & regulations - education programs - then hold people accountable

Respondent	**14. Please note one “Related Strategy” detailed under Section 5.5 (Research and Data Collection) that you feel is particularly important.**
1	Conduct a statewide inventory of dementia care facilities and services based on the level of dementia care they provide. The Department will develop an instrument for collecting relevant information from MCOs, counties, facilities and community dementia care providers, and other stakeholders. Questions to be addressed in the survey could include such things as: Do staff have dementia-related training? Are dementia-specific services are provided? Do facilities have protocols to identify challenging behaviors? Do those protocols vary based on acuity? Can the facility describe their admission and discharge policies related to cognitive status and behavior? Does the facility have an accepted designation as an emergency protective placement facility and its capacity? Can the facility describe the procedures and arrangements they have with counties for emergency protective placements? Data will be compiled into a resource inventory to describe and quantify the resources available to provide dementia care at the different levels of acuity reflected in the proposed classification system.
2	Conduct a statewide inventory of dementia care facilities and services based on the level of dementia care they provide
4	Develop provider classifications relating to the dementia care services provided and acuity of the population served.
5	Inventory/classification system to identify facilities' definition of dementia care.
6	A statewide inventory of dementia care facilities and services based on the level of dementia care they provide.
7	Advancing Excellence has some tools that would be useful.
10	Quality practiced care

15	Conduct a statewide inventory of dementia care facilities and services based on the level of dementia care they provide - and then add to the pool by developing more (based on Metrics that you determine). We know that there is NOTHING north of Highway 8, so developing something is as important as finding out what we DO have.
16	Identifying data elements and sourced for developing baseline measures and costs
19	Conduct a statewide inventory of dementia care facilities and services based on the level of dementia care they provide.
20	I feel very strongly about having a relationship with facilities and knowing what types of care needs they can handle. It is so frustrating when you hear about people being bounced from place to place. It's important for the wellbeing of people with dementia/Alzheimer's to be able to stay in a facility and not be moved due to lack care options.
22	An important part of dementia care data collection should be how facilities are using information about how diet affects dementia when planning meals and supplements.
23	If data needs collection that is fine, but nursing staff have enough documentation that takes away from actual care of residents. If documentation could be fast and easy that would benefit.
24	Data and outcomes very important to have when trying to secure additional funding.
26	Communities need a clear way to identify the best match for each person with Alzheimer's disease, and families need to have more information available to them to assist with this match.
27	Information about the prevalence of dementia, service capacity and utilization, as well as the cost and quality of dementia care, is critical to the implementation of the strategies that have been identified for promoting a more dementia-capable system of care in Wisconsin.
28	I see both as equally important.
29	No more data....please.
30	Conduct a statewide inventory of dementia care facilities and services based on the level of dementia care they provide.
31	Identify data elements and sources for developing baseline measures
33	Develop provider classifications relating to the dementia care services provided and acuity of the population served.
34	Conduct a statewide inventory of dementia care facilities and services based on the level of care they provide
35	Develop provider classifications relating to the dementia care services provided and acuity of the population served.
36	Developing a data collection plan will help gain knowledge of what is available and allow for easier classification.
39	Develop and employ metrics for measuring progress in achieving a dementia-capable system of care.
40	Convene a workgroup to develop facility classification based on acuity
41	Inventory facilities that provide dementia care is huge - many say they provide dementia care but really have no specialization in that area at all
42	Develop provider classifications relating to the dementia care services provided and acuity of the population served.
44	Inventorying providers of dementia care is far more important than developing a data collection plan to facilitate dementia care. I would be very concerned about the latter given the people who would likely be composing such a tool.
45	Identifying what works in caring for those with dementia.

46	The information offered in section 5.5 is cross tiered as it relates to guidelines around the need of serve based on severity of symptoms and guidelines to implement standards of care for dementia patients. 5.5.1, as stated will allow for family caregivers as well as other professionals to make decisions based on Dementia Care Standards (if implemented as stated in 5.4) and baselines for measuring the cadre of all services offered to people living with dementia. These baselines will also have to account for the level of care needed for someone diagnosed with dementia as they travers the disease progression. This can be accomplished by using the LTCFS data at assigned intervals thus the possibility of assigning baselines for care management associated with the functional screen assessment domains utilizes a tool that many multidisciplinary teams are familiar with to guide baselines of service provision.
48	Facility protocols need to be evaluated to determine the quality of care and help establish Standards of Practice to promote positive outcomes for our patients with dementia.
50	Collect data for baseline and then ongoing QI
51	Most nursing home facilities manage some sort of dementia related individual, some facilities have specific memory units, these units should provide specific training to staff, higher re-imbursement level, and increased availability of units across the state.
52	Develop and employ metrics for measuring progress in achieving a dementia-capable system of care.
53	'Analyze data to evaluate the availability of dementia-capable care appropriate for different acuity levels across the state.' Given limited budget and program resources it is imperative that blue-print for development of a new delivery system target investment of those resources in expanding or creating new services in areas where there is an identified unmet need.
54	Develop and employ metrics for measuring progress in achieving a dementia-capable system of care. (page 37)
55	Develop provider classifications....
56	Inventory of providers of dementia care
57	Conduct statewide inventory of dementia care facilities and services based on the level of dementia care they provide.
59	Developing performance indicators.
60	Develop and employ metrics for measuring progress in achieving a dementia-capable system of care
61	Key benchmarks and performance based indicators
62	Inventory and analysis
63	My experience has been that the quality of service provided by a facility can change quickly, especially if key management or direct care staff leave. If an inventory is developed, it needs to be regularly updated. Perhaps ratings can be set as part of licensing or site visits, with enhanced ratings being publicly posted only after 2-3 years of continuous positive audits.
64	Identify data elements and sources for developing baseline measures.
67	Utilizing already existing measurement tools and strategies so that additional forms and paperwork and data reporting are not required in addition to the burden of documentation and reporting already required.
68	Data for best practices. Guide for providers and families
70	Developing a data collection Plan is paramount to supporting any program.
71	Develop and employ metrics for measuring progress in achieving a dementia-capable system of care.
73	Identify data elements and sources for developing baseline measures.
75	Identify data elements and sources for developing baseline measure.

76	Helping families or providers to determine which facility provides the level of services to meet the needs of their family member can be beneficial to a successful placement if or when needed. It is important to provide as much disclosure allowing facilities to be compared in regards to the dementia related services offered and the dementia related training provided to the staff, so that an informed decision can be made by caregivers if the time comes that their loved ones needs to move into a facility. Knowledge is power and this information can help caregivers feel empowered when having to make such a difficult and emotional decision.
77	If the data collection, it should be scientific, realistic and directly tied to payment for quality.
78	It is important that data collection be scientific and realistic in nature and the results directly reflected in reimbursement.
79	Creating a statewide inventory of dementia care facilities and services based on the level of dementia care they provide will be extremely helpful to family caregivers in choosing long term placement for their loved one.
80	Facilities identification
85	The State has done great work so far on data collection related to the Alzheimer's epidemic and should be applauded. In this area, reaching consensus with groups as to which data should be collected and why will be extremely important. In regard to developing an inventory, please know that each of the Alzheimer's chapters have extensive databases of all available local resources and we would be happy to share.
87	Develop and employ metrics for measuring progress in achieving a dementia capable system of care.
88	Develop and employ metrics for measuring progress in achieving a dementia-capable system of care
91	A classification system would be most helpful to consumers. And classification should not only be based on a facilities self-reporting which is subject to exaggeration.
94	Data element sources for developing baseline measures
95	Financial benefits for high quality proven standards. Individual best practice training
96	Of the strategies listed, I would suggest developing provider classification regarding dementia care services because this is an important area for families. There are some providers that offer dementia care services without having properly trained staff. In other words, the term Dementia Unit or Memory Care Unit is not defined within the state, so there is a great deal of variability both in terms of the level and quality of care and services offered.
97	Developing a provider classifications related to dementia care services provided and the acuity of the population served is an important strategy to help assess services available in communities around the State
98	Collect and analyze data to determine baseline and quality improvement.
100	Analyze data to evaluate the availability of dementia-capable care appropriate for different acuity levels across the state. In many ways, this strategy should be the first step of the Plan as that data will help provide a much better picture of the scope and scale of the problems that the Plan seeks to address.
101	We should have a rating system for the quality of care given at each home and then reimburse them according to the high quality of care.
102	Identify data elements and sources for developing baseline measures
105	5.5.2 Create a statewide inventory of facilities caring for persons with dementia
106	Not sure why this would affect MCO contracts. Not all providers need to be dementia capable; there are plenty of other populations to serve.
110	Our feedback has been provided via our January 13, 2014 letter to Secretary Kitty Rhoades. Please refer to this letter for our comments requested by this survey.
112	Identify data elements

Respondent	15. Keeping in mind that the draft plan is a high-level outline and does not include detailed discussion, is there language in Section 5.5 (Research and Data Collection) that you feel needs to clarification> If yes, please explain.
1	I think the data should be available to families and clearly define what types of services are available at which facilities so they may make informed decisions for their loved ones.
5	Will health care providers be surveyed to know the staffs' level of dementia training?
46	Exceptions to the rules will always be a factor in determining the need for contingencies when the care standards and baseline measures for both service providers as well patients do not fall into clear cut criteria.
53	We have reservations about pragmatics of proceeding with 'Development of a Data Collection Plan to Facilitate Quality Measurement.' Soliciting data to project future demand and cost of services make great sense as they can be objectively quantified. However, measuring quality and quality of life in dementia care will be difficult. Indeed, it would be an exceedingly subjective exercise and as there are a conspicuous absence of outcomes that can be measured. Accordingly, we would recommend focusing initial efforts on determining how best to effectively measure quality, and subsequently determining what data exist or could be acquired to facilitate that measurement.
55	All identified strategies are needed.
77	The classification is very confusing and appears to be creating silos. Seems to be a very lofty goal.
78	In classification systems there is the tendency to then create a silo type system which then offers additional challenges and barriers. This is not needed as we look at Dementia Care Redesign.
79	It will be important to carefully research data that is already being collected before developing new data collection strategies.
94	Curious about how the classification system will work. We don't want or need another 5 star system!
96	I would suggest adding a section to research and data collection on monitoring the implementation of the plan and accountability of deliverables - these should be measured as well. It is addressed in the next steps, but perhaps including that piece in this area would make sense as well.
100	I would recommend considering adding an additional strategy that would help providers and families to better identify in real time where there is current availability for long term dementia care for different acuity levels and, if possible, specific challenging behaviors.
102	Please make sure that this data information is not used in a punitive manner against facilities.
105	We need to make sure that there is adequate data collection and metrics, but more importantly, there needs to be an understanding on what data will be collected and why. Also how will it be tracked?
110	Our feedback has been provided via our January 13, 2014 letter to Secretary Kitty Rhoades. Please refer to this letter for our comments requested by this survey.
112	How to develop a classification system?? How to identify and survey caregivers in the community?? Churches, parish nurses, primary care providers, home care agencies, etc.

Respondent	17. Do you have any final comments or concerns regarding the Dementia Care System Redesign Plan?
1	Have the European models been looked at that create a community within a facility? The residents have access to a store and outings within a safe facility.
5	Who will educate the legislators on dementia care if state regulations need to be revised? Do ADRC and human services have adequate staff to meet expanded roles? (County workers are all overworked and have increased case loads.)This is an incredibly amazing project and certainly needed.
6	As a discharge planner, work with facilities that have dementia units, not against them. Many facilities are closing their dementia units. Nursing Homes cannot prevent all falls with residents with dementia. A lot of the expectations from state surveyors are unrealistic and nursing homes are expected to be perfect when this is not realistic especially if there is no harm to the resident.

8	Need to include more assistance to family caregivers. Again, they are the backbone. They need more intense support. This will keep people in their homes, safe, and therefore, less facility placement. More emphasis on programs such as Share the Care.
11	How are you going to fund these programs? Providers are getting less income and more expenses. Less income will equal less services or shortcuts! All plans are great on paper, who is going to do the work? The lowest paying people on the pole! I think you really need to address the cost of these programs and get the money in place. I have not understood how the state or the county will pay for these programs!
15	Again, I am happy that this is being addressed. On behalf of those in extreme rural WI, we need things addressed here too, with our specific logistical problems. I would love to develop something here and look forward to answers to some of the ongoing questions we all face in regards to this area.
16	Very generalized with an aggressive timeline that may cause many priorities to be rushed through, not thoroughly developed.
18	Hospice in dementia facilities needs oversight. Shortly after loved one was admitted family was asked to enroll him in hospice so the facility could get a mechanical lift through hospice. After checking discovered this could be fraud due to loved one in good medical health. 1 1/2 years later loved one is still in stable health. What measures are in place to ensure hospice is not utilized incorrectly? It is a tremendous benefit when used appropriately.
20	As the dementia care specialist with the ADRC I have seen a significant increase in awareness and crisis preparation for the community. However, I feel that there is still great need out in the community. This need is high and keeps getting higher for supportive teams and resources for caregivers and their loved ones.
23	No. I think it is important for facilities that have special care units to have input on what is addressed and the priority. Behaviors are challenging, and education for staff is needed to assure needs are met.
27	Really can't stress enough the need to address medical providers in the Dane County and all communities!
28	I think it is a good beginning. As long as it continues and is monitored as it goes.
29	Excellent work! Looking forward to improved outcomes for our WI families.
35	Any new requirement upon counties or providers needs to be fully funded.
38	We MUST consider people with Down Syndrome and Other IDD when planning a Dementia Care System given the comorbidity that exists in this population. They will require different support and interventions than other people with dementia. Plan is a good start - I hope it comes to life and is implemented fully (and as intended from the Wingspread Summit) and not abandoned or watered down. The elements need to all be in place for success. Without knowing the stance of substitute care facilities on these plans, it's hard to anticipate whether the incentives are sufficient to change their practice.
40	I would just say how proud I am of Wisconsin and all the agencies affiliated with the dementia care system design. My passion for over 23 years has been with only dementia residents and the program addresses issues I have seen and dealt with. The implementation will take time but the final results will give that dementia resident a great quality of life!
42	I think the team did a wonderful job with this report. The success will depend upon the funding that can be created to carry out the strategies.
43	Nothing relating to Tribal ADRS, Tribal Aging, Native American Family Caregiver
44	I would again like to emphasize that the redesign MUST include all facets of caring for individuals with dementia. As it is now, we, as the CBRF, are providing our own training to staff, our own minimum standards of practice, our own counseling/education to family and care teams, etc. because there is nowhere else to go. Dementia care also cannot subscribe to a measurable outcomes method. Most often, it is a progressively degenerative process. The goals for care need to accommodate this inevitable deterioration. There should be a collaboration with this and the philosophy of palliative care.

46	The redesign will be instrumental in bringing a needed integration of the multidisciplinary approaches to care for people living with dementia. It will also provide a tool for family members who incur the extreme emotional and often financial challenges related to wanting to provide loved ones with the best care possible.
47	Yes, Washington County Human Services department operates the Acute Care Services Crisis Intervention Team [redacted]. We provide 24/7 mobile crisis intervention and have become a valued resource within our community. I would be extremely interested in participating in a pilot program.
48	With any such plan there is a need to keep all the stakeholders aware of the opportunity to establish goals and protocols. The protocols for in home care vs. facility care will need to be established and informational support bridges placed for needed collaboration.
49	Counties encounter difficulties in establishing emergency protective facilities and a dementia crisis mobile response team because they are not given and funding. Without additional funding these necessary services will not be established OR other needed programs will need to be cut to establish them.
52	It is very costly to either remodel or build new dementia friendly environments, and our reimbursement keeps declining. I do not see in the plan financial support to create dementia friendly environments, unless I missed it.
53	I am concerned that the enthusiasm for complete redesign that permeated the Summit has not been captured in the implementation plan. I feel that to a great extent the plan has taken the outside the box recommendations from the summit and brought them back into the box.
54	[redacted] as one of the largest skilled nursing providers in the State of Wisconsin would like to applaud the Secretary for being proactive and seeing this plan as vital to our community in the future. This plan is extremely needed and is very comprehensive to meet the needs of all community members in Wisconsin who are experiencing dementia or Alzheimer's or caring for a loved one with the disease regardless of where they reside in the community.
55	Thank you for advancing the plan to improve the quality and level of care for dementia persons and supporting the caregivers.
58	Without the specific mention of the transportation systems that individuals with dementia and their caregivers will eventually need to rely on, this aspect of dementia care can be easily overlooked. Any care setting will have needs for transportation and transportation providers will face some of the same challenging behaviors as direct care workers in LTC facilities, but are often alone and in a moving vehicle. They can also be some of the first people to notice changes in behavior in individuals developing dementia. Thank you.
60	As I stated earlier we need relief ASAP regarding the placement of individuals who are exhibiting aggressive behaviors, even if it is a temporary fix until the new system can be put in place.
61	The focus for out-of-home care primarily emphasized nursing home placement. Small, home-like residential settings should receive equal consideration; and may be preferable for many people with dementia especially in using best practice environmental standards.
62	Needs involvement of geriatricians.
63	I commend WDHS for prioritizing dementia care. I worry that, unless significant investments are made, any improvements will be only temporary.
64	As a Public Health worker, my experience with Dementia care is minimal. I recognize the tremendous need for skilled, effective care in the future. I am not certain how Public Health will be able to be an active participant given the vast array of duties and shrinking resources that LHDS are experiencing.
66	I am very happy to see this redesign plan. Having worked in the nursing home setting and as a director of one of the support services in the state I have seen issues in all of the areas discussed. You have really covered all areas well. Getting the input from the community was essential and obviously comprehensive.
67	It sounds good. Have you looked at what the 'We all hold the keys' team did and can we work together? There is no way CMS is going to change the federal regulations for nursing home care for residents with behaviors. Best of luck on that issue.

68	Keep up the good work. Involve a large network of providers please.
69	It is greatly needed
70	Expanding the use of Dementia Specialists is vital to handling the increasing demand for treating individuals with dementia with in home memory care. The opportunity to treat individuals at home is very important to sustaining a fiscally responsible initiative.
73	I look forward to see the future results.
75	I believe all components are top priority; it is hard to choose what is most important.
76	This is quite a large undertaking which, if successful, will dramatically change the shape of our current dementia care system providing a much greater opportunity to have someone's needs met in whatever place they reside. It will also provide caregivers the necessary tools to make educated and informed decisions when it comes to hiring providers, dealing with challenging behaviors and caregiver burnout. Good luck with this endeavor.
77	I think that this report has focused on facilities, and not enough on the problems in the community and people in crisis in their homes.
78	The plan seems to focus a good portion on the long-term care system when in reality, when the dementia-diagnosed person reaches that level of service, is well into the progressiveness of the condition. It also identifies the need for basic education for the public about the disease and its process but it appears there is little reflection on the middle time of care needs - when families, caregivers and the person themselves need support.
79	Dementia Friendly Communities have already been developed in several communities. There are other agencies that could be helpful in expanding this to more communities. Creating a toolkit for communities to use would be essential. Marketing efforts for increased education/awareness of Alzheimer's/dementia should be done as a statewide campaign to be the most cost-effective. Partnering with medical systems is already being done through the GWAAR Health Promotion Team's Health Care Partnership Project which relates to Care Transitions.
80	Excellent & looking forward to seeing results.

81	In her presentation at the South Eastern Chapter Alzheimer's Association's Annual Dinner in Milwaukee this past November, Secretary Rhoades spoke specifically about a Dementia Capable-Wisconsin Plan that would recognize and address the needs of all families in Wisconsin facing dementia, including underserved and underrepresented communities that present unique needs from the general population. Equally important, she reported that stigma would be recognized as one of the key barriers to addressing AD. The Wisconsin Plan for a Dementia-Capable Wisconsin is a great start to recognizing the needs of those in the general population living with dementia, their families and the problems they face. However, the plan clearly comes short in recognizing the needs of ALL Wisconsin families dealing with Alzheimer's disease, especially those in underserved and underrepresented communities. Nor is the issue of stigma addressed as one of the key barriers. The current Wisconsin Data Census Report indicates that Wisconsin's aging population is expected to double over the next 10 years. Many will be living in rural or urban areas with limited transportation options and poor access to health care providers and supportive care services. In our diverse aging populations, we can expect an increase of elders living alone, with aging partners, or being supported by family caregivers. In addition, with the increase of diverse aging populations we can expect higher rates of co-morbid health conditions and the need for greater use of public health services. I suggest the following to be included in this plan to ensure that ALL communities are involved and will benefit equally from this plan: Develop and implement culturally specific strategies to engage and address the needs of diverse urban and rural communities. This should include education, outreach and issues of stigma around dementia. The training curriculum that is being developed should include a module on cultural inclusion and working with diverse populations. This should include race, ethnic, geographic location, disability, life style choices, etc., and should be required (not optional). The training should also require yearly updates. All ADRCs, health care providers and law enforcement would be expected to complete this training. In order to provide a voice for the community and for family caregivers, a module should be developed within the training curriculum that includes community partners, lay leaders and family caregivers presenting their stories and experiences to professional providers. The development of a statewide community/ lay leader advisory board to help guide the implementation and sustainability of developing a fully inclusive a community friendly dementia plan is essential to the success of a long-term state model.
85	Our belief is that we need to educate and involve the State Legislature on the details of the Plan to secure their support. Our final comment is that we have never been so excited and encouraged by any policy effort before this. The State is taking on incredibly important work, showing great compassion and leadership, and will put Wisconsin on the map for dementia capable services. Please take any critiques of the draft plan as honest and earnest efforts to make this the best plan it can possibly be. Our special thanks to the many State staff who worked behind the scenes under tight timelines to get the Plan to this point - amazing work product and my hat is off to you all!
86	The process of developing a uniform set of training requirements that is applicable to all support settings and inclusive of an adequate variety of stakeholder input is unclear. Currently, the Wisconsin Long-Term Care Workforce Alliance (WLTCWA) has partnered with Wisconsin Personal Services Association (WPSA) and the Survival Coalition toward preparation of a response to the anticipated Department of Workforce Development Office of Skill Development: Fast Forward Grants relevant to the health care industry. These statewide coalitions include a wide breadth of members occupying all aspects of the long-term care service system. The intention of the collaborative grant response to produce outcomes that will be evidenced-based and efficiently produce a sustainable workforce that meets the identified unmet needs for early intervention, capacity of community-based supports, and streamlined cost-effective and quality care. It would appear prudent for DHS to accept an invitation to collaborate with leadership of the WLTCWA and other groups to ensure streamlined efforts toward training opportunities related to supports for individuals with dementia care. [redacted]

88	The process of developing a uniform set of training requirements that is applicable to all support settings and inclusive of an adequate variety of stakeholder input is unclear. Currently, Wisconsin Long-term Workforce Alliance (WLTCWA) has partnered with Wisconsin Personal Services Association (WPSA) and the Survival Coalition toward preparation of a response to the anticipated Department of Workforce Development Office of Skill Development: Fast Forward Grants relevant to the health care industry. These statewide coalitions include a wide breadth of members occupying all aspects of the long term care service system. The intent of the collaborative grant response is to produce outcomes that will be evidenced based and efficiently produce a sustainable workforce that meets the identified unmet needs for early intervention, capacity of community based supports and streamlined cost effective and quality care. It would appear prudent for DHS to accept an invitation to collaborate with leadership of the WLTCWA and other groups to ensure streamlined efforts toward training opportunities related to supports for individuals with Dementia Care. [redacted]
90	Summary: 1) Increased placement options for residents with challenging behaviors; 2) More leniency from DQA regarding incidents involving challenging dementia and relate behaviors
91	You must grapple with reimbursement rates paid to agencies doing the front line work to support people in their homes. Personal and Home Health Aides are have a growth rate of 70.5% and 69.4%. The demand for new workers is projected to outstrip the number entering the workforce by one million until 2020. Increase investments in community based direct care workforce. Support efforts by providers to recruit, retain and access competent long term care workforce-including those self-directing employers.
93	The process of developing a uniform set of training requirements that is applicable to all support settings and inclusive of an adequate variety of stakeholder input is unclear. Currently, the Wisconsin Long-Term Care Workforce Alliance (WLTCWA) has partnered with Wisconsin Personal Services Association (WPSA) and the Survival Coalition toward preparation of a response to the anticipated Department of Workforce Development Office of Skill Development: Fast Forward Grants relevant to the health care industry. These statewide coalitions include a wide breadth of members occupying all aspects of the long-term care service system. The intention of the collaborative grant response to produce outcomes that will be evidenced-based and efficiently produce a sustainable workforce that meets the identified unmet needs for early intervention, capacity of community-based supports, and streamlined cost-effective and quality care. It would appear prudent for DHS to accept an invitation to collaborate with leadership of the WLTCWA and other groups to ensure streamlined efforts toward training opportunities related to supports for individuals with dementia care. [redacted]
94	Some concern at how quickly this is anticipated to be implemented
95	The board will follow up with a phone call to [redacted] requesting a future meeting to discuss the collaborative possibilities related to the Fast Forward grants.
96	I want to thank the department and the stakeholders for putting together a very comprehensive plan with a very aggressive timeline which will truly serve current and future families affected by dementia in Wisconsin very well. It's clear that a great deal of thought and development went into the plan. I am also very excited at the prospect of Wisconsin for the first time having a state plan to develop a dementia-capable state! My broad recommendation is to consider all the stakeholders who currently address aspects of the plan so that we are not duplicating efforts, but working collaboratively to provide services in a sustainable and cost-effective way. Again, leveraging the public/private partnerships that Wisconsin residents would appreciate seeing. I would also suggest that there is shared-ownership of the plan with all of the stakeholders including the Legislature who will need to approve the Family Care expansion for example. Again, I thank you very much for your efforts - this is a truly positive step for Wisconsin and I appreciate the opportunity to make comments!

97	Would like the State to consider modifications of the State regulations for assisted living to allow for care to be provided in these settings....for example, providing a process to allow CBRF's to be locked for individuals with significant wandering to allow for safe care to be provided in a community setting
99	More work needs to be done to address advanced dementia and care at the end of life. It is almost completely absent from this plan.
101	You have to have CBRF Memory Care providers at the table and in the planning mix. In addition, you have to recognize top providers in each community.
103	This plan is very high level and lacks significant measures to address the community issues. I hope that future details are included to assist the State with providing resources where they will be effective for consumers.
105	The Agency is pleased that the State is addressing this for Wisconsin individuals with Dementia. We greatly appreciate the leadership of the Department for taking on this important initiative. We are hoping that everyone in the state continues working together to make this plan successful. This is statewide effort and keeping the lines of communication open is vital. We are hoping there is continued conversation in a more detailed manner regarding the following: Dementia Specialists, Safe Harbors, Standards and Certification Programs and Potential Statutory Changes. One area that is not mentioned in this plan is respite. It has been our observation over many years that this is really an important area that needs to be addressed in our state. Lastly and perhaps more importantly, how is this initiative going to be funded in the future? Thank you for the opportunity to comment.
110	A copy of our January 13, 2014 letter to Secretary Rhoades is posted below: January 13, 2014Secretary Kitty Rhoades Department of Health Services, Room 6501 West Wilson St. Madison, WI 53703 Subject: [redacted] Comments on the Wisconsin Dementia Care System Redesign Dear Secretary Rhoades: [redacted] applauds the work of the Department of Health Services (DHS) to redesign the State's long term services and supports system as it relates to persons with dementia. Our Association also appreciates the opportunities provided to its staff and members to directly contribute to this important redesign effort and we look forward to continuing this dialogue with you and your staff. As requested, the following provides the Association's initial comments on the DHS report, Wisconsin Dementia Care System Redesign: A Plan for a Dementia-Capable Wisconsin. In addition, we have submitted these comments via the DHS electronic survey provided to stakeholders on January 2, 2014. Our comments are centered on the Plan's Section 5.0, found on pages 13-38.5.0 A Dementia Agenda for Wisconsin –[redacted] Comments and Observations. The Association generally supports efforts to strengthen and expand the resources and assistance available from the ADRCs, including creating greater access to the Dementia Care Specialist Program and consumer information via the ADRC web page. We suggest this section be further expanded to include efforts to better connect and educate persons/families about: (1) the public and private financial resources available to address the needs of persons with dementia and; (2) the level of personal responsibility that may be required to access certain care or service options. We do have immediate concerns regarding provisions found in Section 5.1.1 on pages 14-15 calling for an increase in the capability and capacity of the Managed Care Organizations (MCO) to provide dementia-capable services. The Plan states, 'The Department will work with the MCOs to develop dementia care skills, including skills needed to prevent situations involving challenging behaviors from escalating to a crisis level.' Since the MCOs do not provide direct care and services to persons with dementia, the provider community is concerned that the MCOs will be compelled to add additional dementia-related requirements to their MCO-Provider contracts and these additional requirements will come without a concomitant increase in provider payments. We will address this concern below as we offer comments on the Plan's 'voluntary training and certification requirements' discussed under Section 5.4 on pages 31-36.The Association makes special note and support of provisions found on page 15 calling for continued work on developing and testing enhancements to the Long Term Care Functional Screen. Our hope is that these efforts will lead to both recognition of the costs associated with caring for persons with dementia and higher payments to the provider community. [redacted] members wish to take exception with a provision found in Section 5.1.3 on page 17: 'In cases of degenerative diseases such as Alzheimer's, caregiver

	stress increases as the disease progresses. If a caregiver does not understand the disease trajectory, or has not been taught techniques to deal with their loved one's difficult behaviors, then caregiver depression and physical illness can result. It is not uncommon for a spousal caregiver to become seriously ill or die before the person with dementia dies, which leaves the person with dementia no alternative other than to be admitted to a nursing home. Programs to support family caregivers can significantly delay the need for institutional care and reduce costs to the Medicaid program.' While [redacted] fully support efforts to serve people at the right time, right place and right cost, we submit that the above quoted paragraph unfairly depicts facility-based providers as part of the problem, not part of the solution. On behalf of the membership's nursing facilities, we suggest amending the report to state, '..to become seriously ill or die before the person with dementia dies, often resulting in a crisis as family and friends are forced to make sometimes uninformed and costly decisions regarding appropriate ongoing care and service options.' AND DELETE THE FOLLOWING: ‘... which leaves the person with dementia no alternative other than to be admitted to a nursing home. Programs to support family caregivers can significantly delay the need for institutional care and reduce costs to the Medicaid program.' As one might expect, [redacted] has a few comments to offer regarding Section 5.2, Facility-Based Long-Care. Section 5.2.1 on pages 20-21 appears to be an attempt to address one of the top priorities identified during the Dementia Care Stakeholder Summit in early October 2013. The Stakeholder report said the system should, 'Revise state regulations to allow for 'safe harbors' that let facilities care for residents who engage in challenging behaviors in place with less fear of liability or regulatory penalties.' Instead of recognizing this priority as a legitimate concern, the Plan attempts to minimize the gravity of providers' regulatory concerns by suggesting the root of the problem is 'the home did not properly assess the resident and implement the plan of care or did not re-evaluate the care plan after the resident became aggressive.' This conclusion completely misses the mark. The Plan's proposed limited review of nursing home immediate jeopardy (IJ) citations as a way to assess the need for safe harbors fails to account for a significant and growing number of 'Level G -D citations' and, perhaps more significantly, the chilling effect the overall punitive nature of survey system has on providers' decision to admit or retain residents with behavioral challenges. It is well known that the Wisconsin nursing home regulatory environment and DQA's reliance on punitive measures imposes a standard unlike that in place for nearly all other States (This fact is documented by CMS citing statistics found at: www.leadingagewi.org/sites/default/files/reg5top10.pdf). [redacted] submits the DHS offer to seek federal regulatory flexibility regarding the imposition of IJ cites for incidents related to residents with behavioral challenges might be worth the effort although it is likely to be unsuccessful, particularly given CMS' history of unbending adherence to its historical positions (page 21). However, the Association also believes that DQA has significant regulatory flexibility in determining the level of both severity and scope of certain incidents and suggests a review of the DQA citing practices would be more productive than discussions with CMS. We also note the success of the WCCEAL program in promoting an effective assisted living quality improvement system over a punitive regulatory system. {Note: [redacted] strongly endorses the Department's support of the WCRC and WCCEAL and recommends DHS work to sustain these efforts.}In addition to the providers' regulatory concerns in serving persons with significant behavioral challenges, the Plan also needs to be amended to include references to the separate but related obstacles provides face when deciding to admit or retain residents with significant behavioral challenges. They include: Lack of adequate payments from the Medicaid fee-for-service and Family Care programs and the resulting impact on staffing levels [redacted]; The impact such residents may have on the quality of care and life for other residents; Lack of a readily available short and long-term placement options if the resident's behavioral challenges escalates to a level far beyond the facility's capabilities to address; and potential legal actions that may be brought against the provider community. [redacted] supports DHS efforts to promote best practices and resource tools developed by the provider community, consultants, educators and others. In doing so, we suggest DHS become familiar with the Wisconsin Clinical Resource Centers and other collaborative work being accomplished by [redacted], the trade associations, advocates and others (e.g., efforts to reduce the use of antipsychotic medications in nursing homes and Interact training). As additional best practice resources and tools are developed or refined, we recommend that DQA's

nursing home and assisted living surveyors appropriately inform providers of this information. Section 5.2.2 (pages 23-24) includes several strategies related to dementia training and certificate programs. However, it is worth noting that a highly regarded training program and toolkit already exists for nursing homes. Federal law requires CMS to ensure that nurse aides receive regular training on caring for residents with dementia and on preventing abuse. CMS, supported by a team of training developers and subject matters experts, created the Hand in Hand program to address the need for nurse aides' annual in-service training on these important topics. The mission of the Hand in Hand training is to provide nursing homes with a high-quality training program that emphasizes person-centered care in the care of persons with dementia and the prevention of abuse (see: www.cms-handinhandtoolkit.info/). The majority of our comments on training and certificate programs will be included in our remarks on Section 5.4 (pages 31-36). As noted by our comments on Section 5.4, the Association does not support the morphing of best practice guidelines into mandated requirements. The Plan calls for an exploration of 'incentives for facilities that adopt best or promising practices and show positive outcomes.' [redacted] fully supports the Plan's statements that: 'Providing quality care cost money. This strategy looks to develop a closer relationship between the care provided and the reimbursement they receive through the State's Medicaid program.' {Section 5.22, page 24}Our hope is that the above DHS statement will be made applicable not only as it relates to serving persons with challenging behaviors, but to the overall Medicaid and Family Care programs. The current Medicaid nursing home fee-for-service formula severely limits direct care (RNs, LPNs and CNAs) funding. According to a March 2013 report (www.leadingagewi.org/sites/default/files/malossowner.pdf), over 96% of all Wisconsin nursing homes are not fully paid for their direct care staffing costs. Thus it is imperative that the reimbursement system begin to examine staffing costs necessary to serve persons with challenging behaviors. As noted during the deliberations by the Legislative Council Special Committee on Legal Interventions for Persons with Alzheimer's Disease and Related Dementias, residents needing one-on-one staffing attention generate costs 6 to 8 times higher than an average nursing home resident. To be clear, the current add-on for residents with Behavioral and Cognitive Impairment challenges does not begin to constitute an incentive payment; it merely offers an extremely modest add-on payment based on certain resident characteristics and diagnoses. [redacted] supports the recommendation to make this add-on payment an actual incentive payment and examine ways to more effectively recognize the costs associated with caring for persons with complex medical and behavioral needs. The Association also has concerns with the Plan's call to, 'Encourage MCOs to include dementia care expectations into contracts with nursing homes.' (Section 5.22, page 24) It is our immediate fear that this intent would negate an earlier statement that the Plan seeks 'to improve the quality of dementia care by building on current successes and relationships within the context of existing regulations.' At the heart of our concern is the reality that MCOs do not provide direct care and services to Family Care recipients. Rather, the MCOs contract with the provider community for care and services required and desired by the recipient. Should DHS seek to 'include dementia care expectations into contracts with nursing homes' it is reasonable for providers to assume that MCOs would translate these expectations into requirements when contracting with providers. We also are curious why nursing homes are singled out by DHS when imposing MCO contracting expectations. Other [redacted] members have concerns similar to those expressed by our nursing facilities. For example, in a recent in-person survey of fifty [redacted] assisted living providers, 100% reported they have not received a rate increase from their MCO for at least three years (one AL provider last received an increase eight years ago). A number of providers have either capped Family Care participation or are opting out of the program altogether. Thus, new requirements imposed by the MCOs are not likely to be well received by the provider community and could negatively impact recipients' access to necessary care and services options. The Association applauds the Plan's recognition of the development of dementia-friendly facility designs as discussed under Section 5.2.3 (pages 24-25). We wholeheartedly agree that the 'cost neutrality' requirements of the DHS Modernization Program severely limits the Program's effectiveness in offering incentives to organizations wishing to undertake significant renovation or replacement projects. Since the need to modernize the physical plants of aging facilities is not limited to facilities that predominantly serve persons with dementia, [redacted] encourages DHS

	to offer a budget proposal intended to increase the overall number of qualifying projects. [redacted] supports many of the strategies identified under Section 5.3 (pages 28-30), particularly as they related to crisis intervention and mobile response capabilities. However, we believe the Plan lacks a clear focus on the designation and role of facilities intended to serve persons with behavioral challenges. [redacted] urges DHS to reexamine its position on the legislation (2013 Assembly Bill 575) proposed by Legislative Council Special Committee on Legal Interventions for Persons with Alzheimer's Disease and Related Dementias. From our members' perspective, the need for this legislation will not be negated by the recommendations advanced by the DHS Plan, even if parties work to 'clarify Chapter 55 provisions' or 'address inconsistencies among counties.' In short, the Plan must directly address situations that can only be described as an immediate and certain crisis for which no amount of training, certification or education can negate. In addition to addressing the need for each county to designate at least one facility for emergency placements (Section 5.3.3, page 29), the Department should consider how certain facilities might also serve, on an on-going, non-emergency basis, dementia residents who nonetheless present considerable programmatic, staffing and safety concerns. This could be accomplished either by dedicated facilities or by specialty units within a facility. Several of our county home members have expressed interest in serving as placements for both short-term and longer-stay residents. [redacted] concurs with DHS that much work needs be done to establish appropriate payment and programmatic incentives in order for facilities to serve these roles. Section 5.4 of the Plan (pages 32-36) was not well received by [redacted] members. Many of our concerns already have been covered in the above remarks, so please forgive a certain amount of redundancy. Members fully support promotion and recognition of available voluntary training and education programs designed to make our long term services and supports system more dementia capable. Publicizing and making available resources (i.e., best practices, toolkits, educational programs and related information) would likely prove helpful to both consumers and providers. Yet, it is our strong belief that creation of a 'Voluntary Assurance Program for facilities and Home Health Agencies' (page 33), replete with standards, training provisions, staffing ratios and other recommendations, would quickly transform into mandated requirements by either DHS or MCOs, or both. (The Association is reviewing its position on a truly voluntary certificate program and will provide feedback to DHS separate from these remarks. We do have concerns about the use of limited additional funds necessary to create the program and a registry.) A glimpse into why our fear isn't unfounded can be found in the verbiage used in the DHS plan calling for this 'voluntary' program. For example, providers would be required 'to attest to their compliance' (emphasis added), and the standards may include 'staffing ratios...and criteria for admission, transfer and discharge.' (page 33) More directly, Section 5.4 (page 35) notes the Department's intent to 'Create Incentives for Compliance with Staff Training and Other Standards.' (Page 36; emphasis added) This Section goes on to say DHS will 'encourage MCOs to contract with providers that follow the dementia care standard. MCOs will also be encouraged to include provider contact requirements to comply with state-approved dementia care standards, including staff that have completed and obtained certificates of training.' (emphasis added) How could these standards not become mandates? The Plan also says the DHS strategy would involve, 'Encouraging MCOs to build dementia care expectations and incentives into their contracts with the nursing home, assisted living facilities and community-based providers in the MCO's provider networks.' (Page 36) Providers expect the MCOs would impose the DHS-directed expectations/standards, but are predictably skeptical the MCOs would increase provider rates to reflect these new mandates. To be blunt, most providers are simply asking the MCOs to provide cost of living increases so caregivers can receive wage increases and/or maintenance of fringe benefits. Given this state of affairs, expecting the MCOs to suddenly provide higher payments related to newly created dementia standards and training mandates would be spectacularly optimistic on the part of the provider community. Section 5.5 (pages 36-38) includes several recommendations related to research and data collection. The need to learn more about the quality and cost of serving persons with dementia is not isolated to facility-based providers. [redacted] suggests Section 5.5 gives far too great of emphasis on the 25% of the dementia population that is receiving facility-based care, while largely ignoring the majority of persons living at home or in an unregulated setting. The Plan calls for the development of 'provider classifications relating to the dementia care services

	provided and acuity of the population served. A stakeholder workgroup will be convened to assist the Department in developing a classification system that can be related to service standards and caregiver training needs. A classification system could differentiate those providers or facilities delivering a basic level of care from those that are equipped to provide crisis stabilization and response, address co-occurring medical or psychiatric conditions, or manage challenging behaviors on a long-term basis.' [redacted] believes many of the issues embedded in this DHS recommendation could be addressed by identifying facilities serving as emergency protective placement facilities, and by designating facilities as special care facilities as an appropriate option to serve longer-stay residents with serious behavioral challenges. The Association would be concerned that further subdividing facilities beyond what we have suggested could lead to an unnecessary differentiation among the general nursing home provider community. For many facilities, revisions to the current Behavioral and Cognitive Impairment add-on could help better relate resident conditions to payment levels and provide recognition that all nursing facilities are likely to serve a significant number of persons with Alzheimer's Disease or related conditions. Following this approach, and not creating separate classification systems within the provider community, would avoid creating provider 'silos' and reinforce that future long term care populations are most likely to include a dementia-related condition. In closing, [redacted] appreciates the opportunity to participate in the redesign of the Wisconsin dementia care system. The Association and its members are available to further assist the Department and stakeholders in this endeavor and we look forward to continued and ongoing dialogue on this important topic. [redacted]
111	Needs to move forward quickly. The need is great and growing.
112	The basic concepts and needs are addressed but the implementation and funding needs are not adequately addressed. It would be good to take it on the road and get more input from MCO's and people in the community