This crosswalk is an accompaniment to the Improving Dementia Care & Reducing Unnecessary Antipsychotics Self Assessment created by Health Quality Innovators (HQI). The crosswalk outlines each of the key areas that need to be addressed in order to successfully reduce the use of unnecessary antipsychotics for people with dementia while overall improving quality of life and care. For each area there are more detailed practice ideas and tools to help with the suggested practice.
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**Assessing Resident and Individualized Care Planning:**
Practices to understand who the resident with dementia is and their needs. It is through understanding the individual needs of the resident with dementia that you can understand the meaning of behavior and how to address it.

<table>
<thead>
<tr>
<th>Practice Ideas</th>
<th>Tools</th>
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| Prior to or at admission, facility obtains information on resident preference, routines, social patterns, responses to stress, recent changes in behavior or cognition, and effective responses. | • About Me:  [http://bit.ly/HQI_about_me_worksheet](http://bit.ly/HQI_about_me_worksheet)  
• Long-Term Care Improvement Guide:  [http://www.residentcenteredcare.org/Pages/Tool%20A-Brewster%20Village%27s%20All%20About%20Me%20Form.pdf](http://www.residentcenteredcare.org/Pages/Tool%20A-Brewster%20Village%27s%20All%20About%20Me%20Form.pdf)  
• All About Me (Page 157)  
• Life History Template (Page 159)  
• Preferences for Everyday Living Inventory (PELI):  [http://www.polisherresearchinstitute.org/#!assessment-instruments/c16rg](http://www.polisherresearchinstitute.org/#!assessment-instruments/c16rg)  
• MDS Section F: Preferences for Customary Routines and Activities |
| • Arrange pre-admission meetings with residents and families to get to know them and guide them on what to expect when they move in.  
• Review admission process and evaluate whether information needed about the resident is obtained - e.g., who they are and what they need – and if this information is getting to staff.  
• Practice "conversational assessing" – gathering necessary information in a conversational, natural, relaxed manner in order to build trust and relationships.  
• Talk with both family members and residents, separately if needed. Residents and family members might provide different information.  
• Ask residents and family members to create a preferences collage - a visual representation of the things important to a resident, their likes, preferences, etc.  
• Ask residents and families to create "My Life Story" – a document, album, or book that tells us about a person, including their past history, accomplishments, preferences, etc. (Staff can also help create this with residents and families.)  
• Utilize questionnaires such as "About Me," "20 Questions," and "All About Me" to get to know residents.  
• Utilize the Preferences for Everyday Living Inventory (PELI) to determine things that are important to residents. |  
| • Develop a process for sharing what you have learned about a resident with staff. If the information goes directly into a resident’s chart, ask whether staff is seeing the information and their ideas for sharing it with others.  
• Conduct huddles, which are quick team meetings often led by CNAs, are a way to share important resident information.  
• Communication Log/Notebook for shift-to-shift communication  
• Resident Cardex |
| The information obtained prior to or during the admission process is made accessible to direct caregivers and support staff. | • Review your process for connecting various sources of information about a resident into the care plan (e.g., MDS, life history, PELI, etc.). Is the information you collected about a resident’s preferences, life history, etc. reflected in their care plan?  
• Evaluate how the information you learn about a resident is shared across departments (e.g., dietary, housekeeping).  
• Involve CNAs in the care plan process. The CNA is vital to having a two-way flow of information (CNAs getting information from the care plan and giving information about the resident to create and change the care plan as needed).  
• The admission information is integrated into the care plan and revised as the resident’s condition and/or needs change. |
The facility has a system in place to identify changes in resident preference, response to stress, changes in behavior or cognition, and effective response.

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<thead>
<tr>
<th>Facility practice</th>
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<tr>
<td>Review how different members of the team report changes in residents. Do all members of the team know to whom they should report changes? Do they know what types of changes they should be aware of?</td>
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<td>Involve CNAs in the care plan to ensure that the changes they see in residents are reflected in the care plan.</td>
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<td>Implement Quality Improvement (QI) Huddles. QI huddles are a way to bring staff together to discuss a specific resident and do a root cause analysis of a behavioral expression. QI huddles can happen at any moment, or they can be planned for specific times.</td>
<td>• Implement Quality Improvement (QI) Huddles. QI huddles are a way to bring staff together to discuss a specific resident and do a root cause analysis of a behavioral expression. QI huddles can happen at any moment, or they can be planned for specific times.</td>
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The facility has a system in place to assist staff members in identifying etiology or predictive factors related to individual behavioral expressions and appropriate responses.

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<td>Train staff to assess or ask questions (as appropriate) to help determine etiology of behavioral expression (i.e., assess pain or ask, are you hungry or thirsty?)</td>
<td>• Train staff to assess or ask questions (as appropriate) to help determine etiology of behavioral expression (i.e., assess pain or ask, are you hungry or thirsty?).</td>
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<tr>
<td>Utilize Stop and Watch. This simple communication system will alert licensed staff to changes in resident condition.</td>
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<td>Implement huddles to provide opportunities “on the floor” for staff to share changes and how the resident is responding. This information can then flow through established communication channels (e.g., 24-hour report) so that it is incorporated into the care plan and other types of documentation as needed.</td>
<td>• Implement huddles to provide opportunities “on the floor” for staff to share changes and how the resident is responding. This information can then flow through established communication channels (e.g., 24-hour report) so that it is incorporated into the care plan and other types of documentation as needed.</td>
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<tr>
<td>Utilize the Hand in Hand Brainstorming Worksheet to help staff think through the possible reasons for a behavior and how to respond. Understanding the reasons behind behaviors can help predict or prevent them. For example, if staff learns that the reason Mrs. Jones is going into people’s rooms at night is because she was a nurse and is doing rounds, they can anticipate this and redirect her to other activities where she can feel useful.</td>
<td>• Utilize the Hand in Hand Brainstorming Worksheet to help staff think through the possible reasons for a behavior and how to respond. Understanding the reasons behind behaviors can help predict or prevent them. For example, if staff learns that the reason Mrs. Jones is going into people’s rooms at night is because she was a nurse and is doing rounds, they can anticipate this and redirect her to other activities where she can feel useful.</td>
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Facility practices consistent assignment (same certified nursing assistant to same resident)

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<tr>
<td>Gain leadership support and involvement of licensed and certified staff from beginning to ensure successful implementation.</td>
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<td>Consider trying consistent staffing one neighborhood at a time.</td>
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<td>Consider expanding consistent staffing to other staff such as nurses, housekeepers, etc.</td>
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<td>CNA involvement in care plan:</td>
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<td>QI Huddles:</td>
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<td>INTERACT Stop and Watch:</td>
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<td>Hand in Hand Brainstorming Worksheet:</td>
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<td>Consistent Staffing Tip Sheet:</td>
<td>• Consistent Staffing Tip Sheet:</td>
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<td>NNHQIC resources on consistent staffing goals:</td>
<td>• NNHQIC resources on consistent staffing goals:</td>
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<td>Practice Ideas</td>
<td>Tools</td>
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<td>The nursing home administrator, director of nurses, and other team members as appropriate (i.e., pharmacists, medical director, mental health professional, interdisciplinary team members) review the quality measures and pharmacy reports monthly.</td>
<td>• Casper Reports</td>
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<td>• Compare antipsychotic usage with other quality measures such as pain, pressure ulcers, falls, incontinence, restraints, changes in assistance with ADLs, weight loss, and depressive symptoms.</td>
<td>• Pharmacy Reports</td>
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<td>• Review use of other psychotropic medications (and comparing this with trends in antipsychotic usage to see if there is a relationship).</td>
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<tr>
<td>Quarterly, at a minimum, the facility reviews the quality measures and pharmacy reports with the pharmacy consultant and medical director for the purpose of evaluating and acting on data.</td>
<td>• Casper Reports</td>
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<td>• Review data quarterly at a minimum during QA&amp;A Committee meeting.</td>
<td>• Pharmacy Reports</td>
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<td>• Review and discuss identified trends and patterns.</td>
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<td>• Discuss underlying causes for decrease or increase in antipsychotic medications.</td>
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<td>The facility has a “real-time” system in place to monitor, track, trend, and evaluate the use of antipsychotic medication (including PRN medication) to identify residents that may be appropriate for reduction or elimination of antipsychotic medications.</td>
<td>• AHCA/NCAL Quality Initiative-Antipsychotic Management Toolkit: <a href="http://eo2.commpartners.com/users/AHCA/downloads/Antipsychotic_Management_Toolkit.pdf">http://eo2.commpartners.com/users/AHCA/downloads/Antipsychotic_Management_Toolkit.pdf</a></td>
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<tr>
<td>• Flag residents receiving antipsychotics for ongoing review.</td>
<td>• Nursing Process Approach for Gradual Dose Reduction (Page 7):</td>
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<td>• Evaluate policies and procedures for how they are being monitored, i.e. who is capturing this information, where is it being captured, what information is captured, how often is it captured, with whom is it shared, how often is it being shared, etc.</td>
<td>• Antipsychotic Prescription Log (Page 10):</td>
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<tr>
<td>• Review residents receiving and/or with recommendations for antipsychotic medications weekly during the at-risk meeting.</td>
<td>• Example of forms for identifying residents using antipsychotics: <a href="http://www.nhqualitycampaign.org/files/PsychopharmacologicInterdisciplinary-MedicationReview.pdf">http://www.nhqualitycampaign.org/files/PsychopharmacologicInterdisciplinary-MedicationReview.pdf</a></td>
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</table>
| The facility has an established system for monitoring each identified resident’s reduction efforts for effectiveness of medication changes and approaches (i.e., weekly behavior meetings, weekly at risk meetings, etc.). | • Conduct a comprehensive review of each resident to evaluate potential causes of behaviors, responses, whether they are effective, additional ideas for responses, and whether medication use is appropriate.  
• Establish two way communication channels to share with direct caregivers prescribed and/or recommend medications and approaches. Seek feedback on effectiveness of approaches. | • Questions to Consider in Team Review of Individual Residents with Dementia:  
• AHCA/NCAL Quality Initiative-Antipsychotic Management Toolkit:  
• Antipsychotic Medication Tapering Checklist (page 15)  
• SBAR for Nurse Consideration of Antipsychotic Reduction (Page 16)  
• Examples of forms for documenting ongoing review:  
| --- | --- | --- |
| If a resident is admitted with an order for antipsychotic medication the facility has a system to notify the Interdisciplinary Team and Consulting Pharmacist for review of care plan and physician orders within three days of admission. | • Evaluate policies and procedures for how new residents with orders for antipsychotics are “referred” for review. | • 24-hour report  
• Pharmacy alert systems |
| The facility has a communication system in place to alert the Interdisciplinary team to new orders for antipsychotic medication from external providers (i.e., hospice or consulting medical providers). | • Evaluate policies and procedures for sharing information about new orders for antipsychotics from external providers, i.e. who is the lead responsible for sharing information with others, which team members receive information, how do they receive it, etc.  
• Review new orders during daily start-up meetings | • 24-hour report  
• Electronic Health Record Alert |
| The facility has an established protocol for the prescribing of antipsychotic medications that is communicated to attending physicians, consulting medical providers, and consulting medical service providers (i.e., hospice). | • Provide background information to medical providers on the CMS Partnership to Improve Dementia Care and reducing unnecessary antipsychotics.  
• Develop or review existing policies for prescribing of antipsychotic medications and share with prescribers as well as the whole team.  
• Actively ask for feedback regarding policies and the overall antipsychotic reduction initiative. Share how you are alternatively responding to behaviors of persons with dementia. | • AMDA letter to Medical Directors explaining antipsychotic reduction initiative:  
• Additional background information for physicians on the National Partnership to Improve Dementia Care:  
• Sample Psychotropic Medication Policies:  
https://www.nhqualitycampaign.org/files/SamplePsychotropicMedicationPolicy_6-4-12.pdf  
• AHCA/NCAL Quality Initiative-Antipsychotic Management Toolkit:  
• Algorithm for Treating Behavioral and Psychological Symptoms of Dementia:  
• Antipsychotics in Dementia: Best Practice Guide:  
• Examples of forms for documenting antipsychotic usage and review:  
| --- | --- | --- |
| If a new prescription for an antipsychotic medication is received the facility has a system to notify the interdisciplinary team and consulting pharmacist for review of care plan and physician orders within three days of receiving the physician orders. | • Evaluate policies, procedures, and tracking mechanisms for new antipsychotic prescriptions, i.e., who notifies others, who should be notified and how.  
• Review physician orders during daily start-up meeting  
• 24 hour report  
• Electronic Health Record Alert | • Utilize a tracking form that documents start date of medication, medication, dosage, reason for medication, and reassessment date.  
• Notify nursing leadership ASAP when a new antipsychotic medication order is initiated.  
• Algorithm for Treating Behavioral and Psychological Symptoms of Dementia:  
• Antipsychotics in Dementia: Best Practice Guide:  
• Examples of forms for documenting antipsychotic usage and review:  
<p>| A documented process is in place and utilized when initiating or increasing a dosage of an antipsychotic medication (i.e., decision support algorithm, physician order process, reassessment timeline, etc.). | |  |</p>
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<tr>
<td>Interview staff prior to training sessions, for their greatest challenges with behaviors. Use training time as an opportunity to brainstorm these challenges.</td>
<td>Hand in Hand: <a href="http://bit.ly/HQI_brainstorming_worksheet">http://bit.ly/HQI_brainstorming_worksheet</a></td>
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<tr>
<td>Use individual video clips from Hand in Hand to facilitate discussion about particular challenges, such as a resident &quot;wanting to go home&quot;.</td>
<td>Pioneer Network Individualizing Care Video Clip: <a href="http://www.youtube.com/watch?v=hqKv9v5z2Kg">http://www.youtube.com/watch?v=hqKv9v5z2Kg</a></td>
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<td>Reinforce key content from training through brief “stand-up” in-services, mini-in-services, written materials, etc. For example, Pioneer Network’s Individualizing Care Video Clip and Staff Exercise.</td>
<td>Pioneer Network Engaging Staff in Individualizing Care: <a href="http://bit.ly/reducingtheuseofantibioticstipsheet">http://bit.ly/reducingtheuseofantibioticstipsheet</a></td>
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<tr>
<td>The nursing home administrator, director of nurses, and medical provider periodically attend care plan meetings for residents with behavioral or psychological symptoms.</td>
<td>Advancing Excellence Campaign: Person Centered Care: <a href="https://www.nhqualitycampaign.org/goalDetail.aspx?g=pc">https://www.nhqualitycampaign.org/goalDetail.aspx?g=pc</a></td>
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<tr>
<td>Involve clinical and operational leaders in care plan meetings. It is vital to hear the perspectives of staff on what they have tried and what has or hasn’t been successful.</td>
<td>Applying Person-Directed Care Principles to the Care Planning Process for People with Dementia: <a href="https://www.dhs.wisconsin.gov/sites/default/files/legacy/aging/dementia/Pubs/Applying_PersonDirected_Care-Principles.pdf">https://www.dhs.wisconsin.gov/sites/default/files/legacy/aging/dementia/Pubs/Applying_PersonDirected_Care-Principles.pdf</a></td>
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<tr>
<td>Practice &quot;rounding with reason&quot; during and outside of care plan meetings by asking staff &quot;Do you have everything you need to meet the needs of your residents?&quot;</td>
<td>Person-Directed Dementia Care Planning: <a href="http://dhsmedia.wi.gov/main/Play/61ed21ce620e44acb6d52c75424ae9221d">http://dhsmedia.wi.gov/main/Play/61ed21ce620e44acb6d52c75424ae9221d</a></td>
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<tr>
<td>Use the care plan meetings to evaluate whether there are trends in “behavior problems” that might be related to organizational policies. For example, if behavioral challenges are related to personal care assistance such as bathing, are staff operating under a real or perceived policy about bathing, i.e. needing to bathe residents even when they don’t want to be bathed.</td>
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</table>
| The family or responsible party is encouraged to participate in care plan meetings (facility offers flex scheduling or uses conference calls when in-person attendance is not possible). | • Offer family members or responsible parties alternate care plan meeting dates/times.  
• Talk to family members or responsible parties before the meeting if they are unable to attend. Highlight key changes, successes, and concerns to ask for their input. Follow up with family after the care plan meeting occurs.  
• Offer a teleconference meeting to review plan of care.  

| The facility has resources available and accessible to all staff members to assist in meeting the resident’s need as behavior expressions occur (i.e., person-centered activities and interests). | • Utilize the strategy “prepare, prevent, present” found in the CMS Hand in Hand Training Toolkit. For each resident, staff should ask:  
  How can I prepare for this resident’s actions/behaviors?  
  How can I prevent this resident’s actions/behaviors?  
  How can I be with this resident in the present when behaviors/actions occur?  
• Discuss as a team each resident’s activities and interests that the resident has based on their life history and preferences; identify resources needed to meet the resident’s needs through those activities. For example, Mrs. Riley laughs every time she sees babies. Staff will have pictures of babies that they share with her when they see her starting to get upset. Or, Mr. Jacobs seems to find comfort in sanding wood. Outside of scheduled woodworking activities, staff have sandpaper and wood on hand for him. Most importantly, share this information widely amongst staff.  
• Involve leadership in supporting staff in preparing, preventing, being present. Leaders can ask staff how they can support them in preparing, preventing, being present. For example, if Mr. Anderson starts talking about wanting to go home at 4 pm, and Angie, his nurse aide has learned that going for a walk with Mr. Anderson at 3:45 pm keeps him from getting upset, how can leadership support staff in making this happen?  

| The facility has an established system for identifying and reporting changes in resident condition/behaviors (i.e., huddles, Stop & Watch, etc.). | • Review how different members of the team report changes in residents. Do all members of the team know to whom they should report changes? Do they know what types of changes they should be aware of?  
• Implement Stop and Watch. Stop and Watch is a simple communication system to alert licensed staff to changes in resident condition.  
• Encourage CNAs involvement in care plan meetings to ensure that the changes they see in residents are reflected in the care plan.  
• Implement staff huddles. Huddles provide opportunities “on the floor” for staff to share changes and how residents are responding. This information can then flow through established communication channels (e.g., 24-hour report) so that it is incorporated into the care plan and other types of documentation as needed.  

| Care plan schedule  
• Life History Questionnaire: [http://www.crisisprevention.com/Resources/Knowledge-Base/Use-This-Life-Story-Questionnaire-for-More-Person](http://www.crisisprevention.com/Resources/Knowledge-Base/Use-This-Life-Story-Questionnaire-for-More-Person)  


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**About Me:**

- [Life History Questionnaire:](http://www.crisisprevention.com/Resources/Knowledge-Base/Use-This-Life-Story-Questionnaire-for-More-Person)

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**INTERACT Stop and Watch:**

| The facility has an established system for documenting and monitoring resident behaviors and effectiveness of interventions. | • Assess possible reasons for behavior, including what was happening prior to the behavior and unmet needs.  
• Provide staff training on how to develop responses to behavior - when staff try to understand what the behavior is telling them about what the resident needs.  
• EDGE Worksheet for Describing Behavior:  
• Strategies for Success with People Who Have Dementia Worksheet:  
  [https://www.dhs.wisconsin.gov/forms/f0/f01344.pdf](https://www.dhs.wisconsin.gov/forms/f0/f01344.pdf)  
• Approved organization behavior tracking and documentation form | 
| --- | --- | 
| The interdisciplinary team, to include certified nursing assistants, and other team members (i.e., housekeepers) along with the family or responsible party are involved in the process of developing and implementing effective, person-specific approaches to address behavioral expressions. | • Facilitate staff being able to have team meetings to brainstorm responses to behaviors (i.e., learning circles are a great way to facilitate staff discussion).  
• Evaluate systems for how everyone knows the approaches being tried, and how they determine whether they are working, and what they do when they don’t work.  
• Individualize all “non-pharmacological” approaches to persons with dementia in order to meet the unique needs and preferences of the person. For example, one person might love music and the other might find it overstimulating.  
• Learning Circles:  
• Hand in Hand Brainstorming Worksheet:  
• Possible responses to specific behaviors:  
• Tips on communicating with a person with dementia:  
• Examples of non-pharmacological approaches:  
| Family or responsible party education provided regarding behavioral or psychological symptoms and approaches. | • Schedule a time to meet with family member or responsible party 1:1 either in person or via a teleconference.  
• Provide family member or responsible party with written education materials.  
• Consumer brochure on antipsychotics:  
| The facility has a system in place to notify the family or responsible party of change in resident condition/behavior, physician orders, and/or approaches. | • Ensure daily and per shift processes are in place to notify the designated responsible party of any change in resident condition/behavior.  
• Notifying staff need to be prepared to discuss assessment of resident and approaches. |
<table>
<thead>
<tr>
<th>The facility has a system in place to notify and effectively communicate with the attending physician of any change in resident condition/behavior (i.e., SBAR).</th>
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<tr>
<td>• Prior to notifying physicians of resident changes staff should gather information about the behavior, i.e., what, where, when, how, why.</td>
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<td>The facility has an arrangement that allows for timely access to mental healthcare (psychiatrist, psychologist, LCSW, etc.) through on-site services or telehealth.</td>
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<td>• Establish contracts and/or practice agreements with mental health professionals as needed and appropriate.</td>
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<td>• Review and retain job descriptions for staff mental health professionals to include therapeutic services.</td>
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<tr>
<td>The facility has established procedures and staff are trained in procedures to address emergency mental health needs (i.e., temporary detention order (TDO)).</td>
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<td>• Training is conducted during new hire orientation.</td>
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<td>• Training is conducted on an annual basis and as needed for staff on all shifts.</td>
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<td>• Create relationships with local community service boards.</td>
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### Improvement Plan

For the next three months, what action plan would you be willing to develop that would assist in improving processes and/or reducing unnecessary use of antipsychotic medications?

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<tr>
<th>If you would like to do a comprehensive assessment of your dementia care, here is a tool that might help:</th>
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<tbody>
<tr>
<td>Person-Directed Dementia Care Assessment Tool</td>
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<td><a href="https://www.dhs.wisconsin.gov/publications/p2/p20084.pdf">https://www.dhs.wisconsin.gov/publications/p2/p20084.pdf</a></td>
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This material was prepared by Health Quality Innovators (HQI), the Medicare Quality Innovation Network-Quality Improvement Organization for Maryland and Virginia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. HQI|11SOW|20170221-193040