Comparative Effectiveness Research Review Disposition of Comments Report

Research Review Title: *Comparison of Characteristics of Nursing Homes and Other Residential Long-Term Care Settings for People with Dementia*

Draft review available for public comment from March 15, 2012 to April 12, 2012. No public comments were received for this report.

Research Review Citation: Zimmerman S, Anderson W, Brode S, Jonas D, Lux L, Beeber A, Watson L, Viswanthan M, Lohr K, Middleton JC, Jackson L, Sloane P. Comparison of Characteristics of Nursing Homes and Other Residential Long-Term Care Settings for People with Dementia. Comparative Effectiveness Review No. 79. (Prepared by the RTI International-University of North Carolina Evidence-based Practice Center. Rockville, MD: Agency for Healthcare Research and Quality. October 2012. Available at: www.effectivehealthcare.ahrq.gov/reports/final.cfm.

Comments to Research Review

The Effective Health Care (EHC) Program encourages the public to participate in the development of its research projects. Each comparative effectiveness research review is posted to the EHC Program Web site in draft form for public comment for a 4-week period. Comments can be submitted via the EHC Program Web site, mail or email. At the conclusion of the public comment period, authors use the commentators' submissions and comments to revise the draft comparative effectiveness research review.

Comments on draft reviews and the authors' responses to the comments are posted for public viewing on the EHC Program Web site approximately 3 months after the final research review is published. Comments are not edited for spelling, grammar, or other content errors. Each comment is listed with the name and affiliation of the commentator, if this information is provided. Commentators are not required to provide their names or affiliations in order to submit suggestions or comments.

The tables below include the responses by the authors of the review to each comment that was submitted for this draft review. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

Source: http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1293&pageaction=displayproduct
Published Online: October 23, 2012

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #1	Executive Summary	ES-1: Prevalence depends on stage and stage affects outcomes	We modified the text here and in the introduction to note that prevalence of dementia differs according to stage of the disease, such that by 2050 approximately 7 million people will have mild dementia, and 6 million will have moderate/severe dementia. We also noted that the impact of dementia relates to the stage of the disease, which leads into the next section.
TEP Reviewer #1	Executive Summary	ES-2, line 21: what subgroups?	We modified the text here and in the introduction to clarify that we were especially referring to different stages of disease.
TEP Reviewer #1	Executive Summary	line 40: Processes or structures would also include special programs like SCUs. SCUs compared later	We added “Alzheimer’s/dementia special care units” to our list of examples in here and in the introduction.
TEP Reviewer #1	Executive Summary	(ES-8) Key Questions always stated as people with dementia, not by subgroup	Data by subgroup are provided only when data were reported by subgroup; the reviewer is correct that subgroup analyses were uncommon.
TEP Reviewer #1	Executive Summary	ES-8: How good is the development of organizational variables? Which ones are most salient?	The results (ES-8) speak for themselves in indicating which organizational characteristics were studied and the related SOE. It is the discussion that addresses this comment, which notes only a few studies examined these characteristics and that further study is needed to know whether the results will hold up over time.
TEP Reviewer #1	Executive Summary	ES-9, line 32: What does 0.9 times worse mean for a measure of QOL?	As noted, a 0.9 difference is not clinically significant.
TEP Reviewer #1	Executive Summary	ES-14, line 10: Can applicability be better discussed? Did stage affect outcomes?	While it was our original intent and desire to further explain applicability in the context of stage, only one study considered the evidence in relation to the level of dementia severity. Given the paucity of information regarding stage, we cannot make broad generalizations regarding how stage moderates the relationship between organizational characteristics, structures, and process and care, and outcomes.

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #1	Executive Summary	ES-15, line 32: Did you look at the excluded studies to see if they might have shed additional light on the questions? The 80% rule may be too stringent. It would certainly affect applicability.	We determined that a case-mix threshold of persons with dementia was important to assure that our findings were relevant to people with dementia. It was decided that the researchers explore the literature to determine whether an 80% cut off point was appropriate. In reference to this exclusion criterion, we state in the discussion of limitations "…two criteria: (1) that the studies did not specify that at least 80 percent of the study population had dementia and (2) that analyses had not been conducted specific to the subgroup of those with dementia. A total of 136 studies were excluded because they did not meet these criteria; some might have been excluded for other reasons as well and in none did at least 70 percent of the population have dementia. Despite the fact that a large proportion of residents in NHs and RC/AL settings have dementia,{Zimmerman, 2005 #3624} we still had to ensure that the populations analyzed in the included studies were specific to this review.""
TEP Reviewer #1	Executive Summary	ES-16: You could drive a truck through the reserach gaps. A table that collects all your earlier criticisms of the literature and uses it as a framework for future research would be helpful.	We agree that there are numerous research gaps. As suggested, we now summarize these in a bulleted summary for future research in both the executive summary and the discussion sections.
TEP Reviewer #2	Executive Summary	ES -11 (2nd to last para) Pleasant sensory stim needs a "for example". This is too broad an area and not easy to guess.	We added "such as calm music and hand massage" here and an the discussion.
TEP Reviewer #2	Executive Summary	ES14 - There is no KQ5 and it is not mentioned under the other 4KQs in this section. It states it is only examined in context of the other KQs but appears forgotten in the ES	We have added information about KQ 3 – 5 in the executive summary.
TEP Reviewer #2	Executive Summary	ES 14 Applicability and numerous other times (pg 52 also). The sentence "In some cases, the strengths . . . " is unintelligible to me. I think what is meant is "a given intervention may have both desired and undesired outcomes". Otherwise this sentence is the obvious: the intervention of a stoplight has a real strength at preventing accidents but also has a real weakness at causing world peace.	As suggested, we modified the wording in here and in the discussion to read "a given intervention may have both desired and undesired outcomes."
TEP Reviewer #4	Executive Summary	My comments relate to the Executive Summary (vs Introduction). This section provides sufficient information to grasp the methods, results, limitations, and conclusions. My only comment is that more information could be included about the exclusion of the move than 5,000 articles to get to a only 13 for further evaluation. This is a salient point – I much information, but little ability to study in aggregate.	We added the PRISMA figure to address this comment about how many studies were ineligible.

Commentator & Affiliation[a]	Section	Comment	Response
Peer Reviewer #4	Executive Summary	The Definition of Dementia sections (ES 1 and 1) define dementia in a way that is not accurate and does not reflect the DSM defintiion in Table 1. Dementia is a syndrome of cognitive deficits that is not, by definition, either progressive or irreversible. This definitional issue is not particularly important for the review, but it may as well be stated correctly, since many consumers do not understand what dementia is	In response to this comment, and recognizing that the definition of dementia is currently undergoing re-examination, we have deleted the words “progressive” and “irreversible” from the text and reworded the text to be more in line with contemporary definitions of dementia.
TEP Reviewer #1	Introduction	p 3, line 30: if the goal is to help families make decisions. You need a model that addresses that perspective.	Our intent was not to address the processes by which families make decisions, but rather to examine the outcomes of interventions/exposures that could be helpful for decision-making. We omitted wording related to “make the best decision” in the objective of the abstract so as not to imply this intent.
Peer Reviewer #1	Introduction	I am most concerned with the opening statement on page 12 of 177 line 10: “inspired by a consumer request”. This statement comes up again at least one more time (page 34 of 177, line 43). What is so remarkable is that the authors have already taken us through a preliminary report that clearly identifies a paucity of findinds and that further identifies that their review was quite sound and rigorous. And all this work because a consumer requested it!	The nominator for this topic was an individual patient/ consumer and nurse/nurse practitioner/PA. The AHRQ Effective Health Care (EHC) Program provides an opportunity for the public to submit suggestions for research. You can submit suggestions via the AHRQ EHC website: http://www.effectivehealthcare.ahrq.gov/index.cfm/submit-a-suggestion-for-research/
Peer Reviewer #1	Introduction	It the consumer was the President, the Chair of the House Ways and Means Committee or Chair of the Senate Special Committee on Aging, might as well just say so. I had a hard time getting past all this excellent effort and money spent just because “a” consumer wanted this done	See comment above.
Peer Reviewer #2	Introduction	The Introduction is very well written. It provides excellent background, and is well organized into meaningful subsections. These subsections provide a broad and comprehensive overview that frames the entire report.	Thank you.
TEP Reviewer #2	Introduction	Again, the intro has good information that may be relevant for a layperson or someone not steeped in these reports, but the rest is impenetratable for the average reader	In cooperation with the Eisenberg Center, the authors will assist in developing research summaries for consumers, clinicians, and policy makers based on this comparative effectiveness review. They will be made available to the public.

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #3	Introduction	The introduction is very nice. However, improvements in residents with dementia is emphasized. Would help if this was noted to be realistic (?). Is maintenance care appropriate or no further loss of function?	This point is well-taken. In this section and in the executive summary, we added this text after presenting the key questions that used the term "improvement": Wording KQ1 and KQ2 in terms of "improving" outcomes for people with dementia recognizes that improvement may be relative; it includes change to a better state of well-being, maintenance of the current state of well-being rather than decline, and also less as opposed to more decline in the current state of well-being.
TEP Reviewer #3	Introduction	Analytic framework. Hat is analytic? QoL could be noted. Evidence that characteristics of settings influence caregivers? Also, caregiver stress - ? reverse if significant other in LTC	We developed the analytic framework to help guide the review process. Through the topic refinement process we developed and revised the framework based on Key Informant and public comment to clearly identify the populations, interventions/exposures, modifying factors, and their relation to health and psychosocial outcomes for people with dementia and caregivers. We did include quality of life as an outcome within the larger grouping of psychosocial outcomes for KQ2 and KQ4. Through our review process we identified a significant gap in the eligible evidence regarding the influence of organizational characteristics, structures, and processes of care on informal caregivers.
TEP Reviewer #3	Introduction	Also, why is dementia care different. Could an argument be made that facilities that provide good care for all residents would also do so for those with dementia?	We agree that good care for all residents could very well be good for residents with dementia. Our review did not look at "dementia care", but instead at organizational characteristics, structures, and processes overall. The only criterion in place related to dementia was the population under study, not the intervention/exposure. We omitted wording related to "dementia management" in the Scope of This Review which may have been misleading.
TEP Reviewer #3	Introduction	A section addresses choosing care sites. This could be better referenced. Also, I think some tools do exist that are helpful (CMS check list?).	The intent of this review was not to examine the decision-making process when choosing care sites. Consequently, this purpose of this section is to establish a need for evidence, primarily by pointing out that no evidence-based guidance exists (which would refer also to the CMS check list).
TEP Reviewer #3	Introduction	The background is good, but page 2 lists sites that care for folks with dementia. More info (N, %, etc)could include those that only care for dementia (I think some AL specializes in this).	The text indicates the number of specialized dementia beds in nursing homes and the percent of assisted living settings that have dementia units.

Commentator & Affiliation[a]	Section	Comment	Response
Peer Reviewer #3	Introduction	Excellent introduction – clearly framed the importance of the issue and questions. I would suggest one minor change, however. Since the authors acknowledge that "numerous consumer/patient guides are available to help the public choose the type of LTC setting that may be best", based on a variety of considerations (geographic proximith, financial affordability, etc.), it is important to recognize (1) NH quality of care ratings (on the CMS website) are also used and important even if not available for other LTC settings, and (2) this review of the evidence on how quality may be affected by the characteristics of LTC settings may ALSO be informative to consumers and caregivers. In other words, acknowledge that consumers base their decisions on many different factors, and the evidence presented in the report is not necessarily better than these other considerations.	In accordance with this suggestion, we changed the text to reflect the availability of the CMS website, and to recognize that existing sources are also of potential value.
TEP Reviewer #5	Introduction	The Introduction is well written, and does a good job outlining the key domains of interest, the context of dementia and informal caregiving, and the other key issues.	Thank you.
TEP Reviewer #5	Introduction	It appears as though these synthesized results were ideally to be used as some kind of decision-making support protocol for families or others seeking optimal residential care settings for persons with dementia. Providing some brief background on existing decision-making supports for persons with dementia (if there are any) may be of interest.	As noted earlier, the intent of this review was not to develop a decision-making support protocol. That said, in cooperation with The Eisenberg Center, the authors will assist in developing research summaries for consumers, clinicians, and policy makers based on this comparative effectiveness review. They will be made available to the public.
Peer Reviewer #4	Introduction	The Definition of Dementia sections (ES 1 and 1) define dementia in a way that is not accurate and does not reflect the DSM defintiion in Table 1. Dementia is a syndrome of cognitive deficits that is not, by definition, either progressive or irreversible. This definitional issue is not particularly important for the review, but it may as well be stated correctly, since many consumers do not understand what dementia is	In response to this comment, and recognizing that the definition of dementia is currently undergoing re-examination, we have deleted the words "progressive" and "irreversible" from the text and reworded the text to be more in line with contemporary definitions of dementia.
Peer Reviewer #4	Introduction	On p. 2, the text on the impact of dementia repeatedly says "the disease" which further confuses the basic definition and suggests that the authors are using information about Alzheimer's only. On p. 1, the data mix figures for dementia and figures for Alzheimer's without distinguishing them. Again, this is not important for the review, but it may as well be correct.	In response to this comment, we have eliminated every instance where dementia was referred to as a disease..

Commentator & Affiliation[a]	Section	Comment	Response
Peer Reviewer #5	Introduction	On page 1, lines 23-32: I wonder if the most recent NIA/AA diagnostic criteria for pre-clinical, MCI due to AD and "full-blown" AD should be acknowledged under the Definition of Dementia?	Since this review is about people with dementia / Alzheimer's disease of sufficient severity to result in placement in a long-term care setting, we feel that introducing issues (and controversies) surrounding MCI is not appropriate. This consideration was discussed with our Technical Expert Panel, as well.
Peer Reviewer #5	Introduction	Table 2 clearly describes the characteristics and definitions related to the organizing model for the report. Likewise Figure 1 (mentioned in general comments above) provides a clear visual representation of the analytic framework for the report. The objective of the review is important, as families are often desperate and confused about what is best to do when challenged with a placement decision.	Thank you.
TEP Reviewer #1	Introduction	p 6: KQ 5 is the money shot. What are the key characteristics?	We have added the following sentence to the paragraph in the Introduction regarding our outcomes of interest, "KQ 5 assessed whether the effect of organizational characteristics, structures, or processes of care on health and psychosocial outcomes varied by the characteristics of the person with dementia (e.g., severity of dementia, functional status) or of the informal care giver (e.g., age relationship, health status)."
TEP Reviewer #1	Methods	p 7, line 44: Were studies limited to only RCTs? Why? What are the implications?	Our review sought to include RCTs, NonRCTs, systematic reviews, meta analyses, subgroup and or post-hoc analyses, case-control studies, and prospective cohorts. In Table 3 admissible evidence is listed outlining the study designs eligible for inclusion as well as those designs that were excluded. The studies included in our analysis included RCTs, Non-RCTs, and prospective cohort studies.

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #1	Methods	p 8, line 31: Why 80% dementia? What if a special unit? Rest of facility <80%?	We determined that a case-mix threshold of persons with dementia would be important. It was decided that the researchers explore the literature to determine whether an 80% cut off point was appropriate. In reference to this exclusion criterion, we state in the discussion of limitations "…two criteria: (1) that the studies did not specify that at least 80 percent of the study population had dementia and (2) that analyses had not been conducted specific to the subgroup of those with dementia. A total of 136 studies were excluded because they did not meet these criteria; some might have been excluded for other reasons as well and in none did at least 70 percent of the population have dementia. Despite the fact that a large proportion of residents in NHs and RC/AL settings have dementia,{Zimmerman, 2005 #3624} we still had to ensure that the populations analyzed in the included studies were specific to this review." Of note, it was taken as a given that all residents in special care units had dementia, so studies of such units were included regardless the proportion of dementia in the rest of the facility.
Peer Reviewer #1	Methods	The authors did not act alone. Throughout the process they consulted the TEP and the rationale for what was included was quite clear. This further focuses on how poor the research effort has been in long term care environments.	Thank you
Peer Reviewer #1	Methods	It was unclear to me at the very beginning if special care units were review, but the authors did as good a job with this data set as they could. There appeared to be absolutely no variance.	Thank you.
Peer Reviewer #2	Methods	The methods are clear. The inclusion and exclusion criteria are explicit and are well justified. The search strategies and described thoroughly.	Thank you.
TEP Reviewer #2	Methods	this is not my expertise but it seems reasonable	Thank you.

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #3	Methods	Methods are wonderful, and clear. However, the analytic framework does not seem "analytic." This just seems to list the questions addressed. Did not seem to guide the analyses. Again, use of informal caregivers seems to stand out as different/odd. A conceptual framework may be more useful?	The analytic framework conveys that the relationship of organizational characteristics, structures, and processes (left hand side) to four areas of outcomes (right hand side) are potentially moderated by characteristics of people with dementia and informal caregivers (middle triangle). We developed the analytic framework or causal pathways to help guide the review process. Through the topic refinement process we developed and revised the framework based on Key Informant and public comment to clearly identify the populations, interventions, modifying factors, and their relation to health and psychosocial outcomes for people with dementia and informal caregivers. The nominator of this topic requested that the review also examine the patient and caregiver bond. We expanded this to include additional outcomes for informal caregivers.
TEP Reviewer #3	Methods	Also, in this section QoL could be noted, since this appears important at future points.	We include quality of life as an outcome of interest within the larger grouping of psychosocial outcomes of people with dementia and informal caregivers. We list our outcomes in Table 3."Study eligibility criteria" in the Methods chapter.
TEP Reviewer #3	Methods	The use of Donabedian's model is good. However, this may be the reviewers limitation, but I thought this most often was presented as SPO. The authors use different terms. Also, does not really address why/how these facors influence care.	Donabedian did most often combine organizational characteristics as a type of structure. We clarified this point in our introduction and executive summary, as well as their relationship to outcomes.
TEP Reviewer #4	Methods	Detail about inclusion and exclusion is adequate in the full report.	Thank you.
Peer Reviewer #3	Methods	I understand why PACE programs were excluded as one of the settings, since most participants live in the community, but federal rules require PACE organizations to continue serving enrollees who are institutionalized, so one could justify including them. If there were any relevant PACE studies that met the other inclusion criteria, I suggest reconsidering this decision, since it would be very useful to see how PACE programs compare to other settings on the outcomes of interest. Since most consumers prefer to remain in the community, it is important to consider care models that allow or promote this option, even if they are relatively uncommon. After all, "person-centered care" should not be limited to deciding when to get up in the morning, or whether to take a bath or shower. It also means being able to decide where one wants to live.	Our review was of people with dementia residing in nursing homes and other residential long-term care settings; PACE enrollee residing in these settings would have been included in the review. What was not included was studies of PACE programs themselves, a decision with which the reviewer agrees In remaining true to the nomination of this topic, the investigative team decided to limit the review to residential care settings. To include studies beyond the residential care settings would introduce additional heterogeneity.

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #5	Methods	Overall, the Methods are strong; the inclusion and exclusion criteria appear justifiable, although I was somewhat surprised that the "processes of care" domain did not yield any more studies, given the large number of clinical interventions that have been evaluated in NH populations for example (although the 80% of the sample as having dementia may have screened many of these studies out).	We determined that a case-mix threshold of persons with dementia would be important. It was decided that the researchers explore the literature to determine whether an 80% cut off point was appropriate. We took this into account through the review process. We state in the discussion, "…two criteria: (1) that the studies did not specify that at least 80 percent of the study population had dementia and (2) that analyses had not been conducted specific to the subgroup of those with dementia. A total of 136 studies were excluded because they did not meet these criteria; some might have been excluded for other reasons as well and in none did at least 70 percent of the population have dementia. Despite the fact that a large proportion of residents in NHs and RC/AL settings have dementia,{Zimmerman, 2005 #3624} we still had to ensure that the populations analyzed in the included studies were specific to this review."
TEP Reviewer #5	Methods	The search approach was nicely laid out, and the definitions of "dementia" (rightfully broadened beyond diagnosis) were appropriate. Given the heterogeneity of the results, no meta-analytic approaches were used, which makes sense.	Thank you.
Peer Reviewer #4	Methods	The inclusion and exclusion criteria are good; the search strategies are stated and logical; and the definitions of the outcome measures are clear and appropriate.	Thank you.
Peer Reviewer #5	Methods	Inclusion/exclusion criteria are clear. May wish to include the term "universal workers "on pg. 8 line 16 for ALs.	We chose not to add the term "universal worker" because the section in question referred to level of training (e.g., certified nursing assistant, registered nurse) and not the manner in which staff were assigned to duties.
Peer Reviewer #5	Methods	And while I can understand the assumption that staff training interventions are a proxy for /presumed indicator of care, I do hope a future systematic review will examine staff training interventions. My own research in RC/AL settings was confounded by the poor quality of record keeping in many of these facilities.	We understand the concern and had various discussions regarding this very topic. It was determined that not only are staff training interventions a proxy for/presumed indicator of care but that the variability of the interventions, staff receiving the training, and site of the training could also affect outcomes. We agree that additional reviews could consider the effectiveness of staff training interventions.

Commentator & Affiliation[a]	Section	Comment	Response
Peer Reviewer #5	Methods	I can also accept the inclusion of symptoms of depression under health outcomes for PwD and caregivers, and not under psychosocial outcomes, but I think it is tricky to decouple depressive sx from anxiety (classified as a psychosocial outcome in this report) because the two are so frequently co-morbid (co-occur) in PwD and their caregivers.	We state in the report that the categorization of outcomes were determined with input from the technical expert panel. While we recognize that depressive symptoms could be considered as either a psychosocial outcome or a health outcome, we have categorized it within the health outcomes. We found in our research that depressive symptoms and anxiety were indeed reported as separate outcomes.
Peer Reviewer #5	Methods	On page 11 under Quality Assessment of Studies, line 32, elimination of studies with overall attrition rate >20% is understandable, but also attrition due to death/disability is very common in this frail, institutionalized population, especially in longitudinal studies. One of my own studies of a dementia SCU had a 15 mo attrition rate of 22%.	We recognize that within this population death is common. When assessing the quality of the study, if substantial attrition due to death was reported, this was taken into consideration.
Peer Reviewer #5	Methods	Fig 2 on pg 16 is useful to understanding the review process.	Thank you.
Peer Reviewer #5	Methods	Just an overall comment about clearly differentiating between "depressive symptoms" and depression (or the disorder). See for example page 27, line 45 where the effect of trials on "depression" is noted, but the tables clearly state the health outcome of interest is depressive symptoms, and again on pg 28 line 22 where the terminology is "depression outcomes", and in Table 13 pg 30 where Outcome is listed as "Depression" and not depressive symptoms, as well as in the accompanying narrative on pg 30 line 23---says "depression" which implies clinical or major, and not just symptoms.	We have changed depression to depressive symptoms throughout the report as our outcome of interest was the increase or decrease of depressive symptoms, not a change in diagnosis.
TEP Reviewer #1	Results	p 15, line 37: 6 studies had a range of dementia. Did you use it?	While these studies included residents with a range of dementia, except for one study the results were not presented separately by degree of dementia, so the range was not as useful as it might otherwise have been.
TEP Reviewer #1	Results	Figure 2: wrong PICOTS?	Wrong PICOTS indicates that a study did not meet inclusion criteria either because it considered the wrong population, intervention/exposure, comparators, outcomes, timing, and/or setting.
TEP Reviewer #1	Results	Poor quality is not typically a reason for exclusion.	There is evidence to suggest that including poor quality studies will result in a higher risk of confounding affecting the strength of evidence of the body of literature. For this reason, we do not include poor quality studies in our analysis. We've added this rationale to the Executive Summary and Methods.

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #1	Results	KQ 5 seems to be buried in KQ 1 and 2.	This review considered KQ 5 in the context of KQs 1-4. Characteristics of the person with dementia and/or the informal caregiver were considered as modifying factors in relation to the interventions and outcomes of interest.
Peer Reviewer #1	Results	The section is quite brief. We already know how much was done in the effort to obtain and analyse data and how little was actually discovered in the process just by reading the abstract.	It is not clear to us to which section the reviewer is referring, and perhaps he/she is primarily making an observation in the context of other evidence-based reviews. Absent additional information, and in light of the fact that reviewers 5,6,7,9,10, and 11 stated the section was thorough, we have not modified it in accordance with the comment.
Peer Reviewer #2	Results	The results are extremely thorough with extensive evidence tables that clearly describe the studies reviewed. The tables are well done and clear. The key messages are explicitly stated, well organized by question with bullet points, and applicable. I do not know of any studies that have been omitted.	Thank you.
TEP Reviewer #2	Results	pg 29 and several other places – The functional skills training intervention was 2.5 hrs per day for 5 d/w. This is incredibly intrusive (would you want to participate) and very costly. However, this is the only time that it is mentioned in both documents. By leaving out that fact in the discussion and other results section, you leave the mistaken impression that this could be an easy thing to implement that could be clinically significant.	The reviewer is correct that the discussion does not adequately address the feasibility for wide-scale adoption. The following sentence has been added to the discussion where further study is suggested: "This point is especially important because the functional skill training studied was conducted 5 days per week for 2.5 hours per day over 20 weeks, which limits its feasibility for wide-spread adoption."
TEP Reviewer #2	Results	pg 44 and a couple of places. It is stated that the individualized assessment and mngt of discomfort found no change in behaviors but significant difference in return of behavior to baseline levels. I am totally confused. First off, the latter sounds like a change in behavior and secondly what is baseline level – it could be that baseline is "bad" and return is undesirable. This needs to be reworded.	The text makes clear that there was no difference using a standardized measure, but there was a difference in return of behavior to baseline levels. As the reviewer notes, the latter measure was not specified, although return to baseline was a good outcome. The next now reads, in part "…found a significant difference in return of behavior to baseline levels (a good outcome) for residents in the intervention group (70% versus 40% in the control group; p=0.002) (low SOE; Table 27).{Kovach, #1689} This apparent contradiction may relate to a difference in measurement."
TEP Reviewer #3	Results	Results are well presented. Tables are clear.	Thank you.
TEP Reviewer #4	Results	Detail is more than adequate in the full report and Appendices to fully explain the study and results.	Thank you.

Commentator & Affiliation[a]	Section	Comment	Response
Peer Reviewer #3	Results	Very thorough and comprehensive presentation of findings. See comment above re: reconsideration of using any studies of PACE organizations that were excluded.	In attempting to remain true to the nomination of this topic, the investigative team decided to limit the review to residential care settings. To include studies beyond the residential care setting would introduce additional heterogeneity.
TEP Reviewer #5	Results	The detail provided in the Results is appropriate, and the study information is illustrated accurately. The key message (namely, that there exists little to no high quality evidence to answer the questions) is made quite clear in various areas of the report. The tables, figures, and Appendices are helpful.	Thank you.
TEP Reviewer #5	Results	As noted in my earlier comment, it is possible some of the clinical studies conducted in nursing homes may have been screened out because of the dementia sample threshold, but given the questions there may have been little choice. Overall, the results emphasize that there is little quality research in this area.	Thank you. We agree. We decided to explore the literature to determine whether an 80% cut off point was appropriate. We took this into account through the review process. We state in the discussion, "…two criteria: (1) that the studies did not specify that at least 80 percent of the study population had dementia and (2) that analyses had not been conducted specific to the subgroup of those with dementia. A total of 136 studies were excluded because they did not meet these criteria; some might have been excluded for other reasons as well and in none did at least 70 percent of the population have dementia. Despite the fact that a large proportion of residents in NHs and RC/AL settings have dementia,{Zimmerman, 2005 #3624} we still had to ensure that the populations analyzed in the included studies were specific to this review."
Peer Reviewer #4	Results	This reviewer sees no problems with the descriptions of the studies or the figures, tables and appendices. This reviewer is not aware of studies that were incorrectly included or excluded.	Thank you.
Peer Reviewer #5	Results	See above comments about depression vs depressive symptoms (sorry this should have been under results and not methods), and also my prior remarks under general comments.: Just an overall comment about clearly differentiating between "depressive symptoms" and depression (or the disorder). See for example page 27, line 45 where the effect of trials on "depression" is noted, but the tables clearly state the health outcome of interest is depressive symptoms, and again on pg 28 line 22 where the terminology is "depression outcomes", and in Table 13 pg 30 where Outcome is listed as "Depression" and not depressive symptoms, as well as in the accompanying narrative on pg 30 line 23---says "depression" which implies clinical or major, and not just symptoms.	We have changed depression to depressive symptoms throughout the report as our outcome of interest was the increase or decrease of depressive symptoms, not a change in diagnosis.

Commentator & Affiliation[a]	Section	Comment	Response
Peer Reviewer #5	Results	There is a lot to digest, but overall, I found the organization of content using key points for organizational characteristics, structures of care, and processes of care very useful in terms of understanding the "takeaway" information in a complex report. I could not find any missing studies that met inclusion criteria. Extensive citations support my conclusion.	Thank you.
Peer Reviewer #1	Discussion	There are findings, and they are discussed very nicely. The authors tell us about special care units and imply that these patient may be sicker. We learn that ALF patients make more transitions to hospitals. We review the data that staff and caregivers believe their interventions help rarely see a result that proves effectiveness. That we are left with soothing touch as our only proven intervention begs the question; is that all we get from interventional research in long term care since the beginning of time?	As is the main point of the discussion, the literature that is of fair or better quality related to organizational characteristics, structures, and process and care, studied in relation to outcomes for a majority (80%) if people with dementia, is sparse indeed.
Peer Reviewer #1	Discussion	This was a review of the entire finding and even the best of the best studies came up with almost nothing. Not a single study has measured the impact on falls. How can we let this happen? The authors appropriately would suggest that we need to rethink the entire process of evaluating our approach to patients in long term care environments.	Thank you.
Peer Reviewer #2	Discussion	The discussion is thoughtful, despite major limitations in the data available. The limitations are clearly stated.	Thank you.
Peer Reviewer #2	Discussion	The section on Research Gaps is well done. I tend to like tables, and would have rather seen a brief two column table with one column stating the research gap, and the second examples of research projects that could fill the gap.	As suggested, we have created a bulleted list that provides guidance for future research.
TEP Reviewer #2	Discussion	ES 14 Applicability and numerous other times (pg 52 also). The sentence “In some cases, the strengths . . . “is unintelligible to me. I think what is meant is “a given intervention may have both desired and undesired outcomes”. Otherwise this sentence is the obvious: the intervention of a stoplight has a real strength at preventing accidents but also has a real weakness at causing world peace.	We have reworded this section as suggested.
TEP Reviewer #2	Discussion	pg 54 – see comments about functional skill training. This needs to be clear this is a very intense intervention tested.	As noted earlier, the discussion now includes this sentence in addressing the need for additional research: “This point is especially important because the functional skill training studied was conducted 5 days per week for 2.5 hours per day over 20 weeks, which limits its feasibility for wide-spread adoption.”

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #3	Discussion	Many elders have multiple diagnoses; therefore more information would be useful in translating how the recommendations apply to these residents. Maybe a scenario or case study “box” or “example” may help a reader?	In cooperation with The Eisenberg Center we will assist in developing research summaries for consumers, clinicians, and policy makers based on this comparative effectiveness review. A scenario or case study “box” or “example” may be appropriate for that effort, and we will thoughtfully consider it.
TEP Reviewer #3	Discussion	I did expect more from SCU studies. The literature has a lot on what is special about special care. So maybe more on the unexpected nature of the findings could help a reader.	The “unexpected” nature of the findings (in terms of not meeting criteria for an evidence-based review) is not limited to SCUs; instead, it extends to all studies that have been conducted in this field. We choose to not single out SCU studies in this discourse, as other organizational characteristics, structures, and processes are of importance as well; that said, we do make specific mention of them, and added a point related to their potential benefit.
TEP Reviewer #4	Discussion	It may be appropriate to include in discussion/conclusion additional specifics about what would be an ideal “standard” for future research to provide a stronger strength of evidence score. For example, do they feel research protocols for NHs and RC/AL facilities should always include % of dementia population by stage, staffing levels, education of staff, etc. This insight could provide a basis for grant-funded research that in the future could facilitate a future comparative effectiveness report allowing for inclusion of more studies.	In accordance with this comment, we have expanded the “Research Gaps” section of the executive summary and discussion to suggest that studies explicitly mention the dementia case-mix of the subjects included in the study.
Peer Reviewer #3	Discussion	Table 30 sums up the findings. I suppose it's reassuring to see that even the studies carried out by the authors of the review failed to provide strong evidence -- an indication that the analysis was carried out objectively. On the other hand, Table 30 exemplifies the dissatisfying results of many CER syntheses -- few if any studies meet the highest evidence standards, so the conclusion after all this fine research is "we don't know enough and more research is needed". Could one of the conclusions also be that it is very hard to perform studies that meet the highest evidence standards on the key questions of this review? There is some discussion of this issue in the "Research Gaps" section, but more discussion of how to overcome the challenges in doing these types of studies would be a valuable contribution to guide future research.	The inclusion of a new bulleted list which summarizes guidance for future research, makes the suggestions more pointed.
TEP Reviewer #5	Discussion	The implications of the findings are stated; simply put, more research is needed in this area. The limitations of current research is clear, and more work is required in this area.	Thank you.

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #5	Discussion	As noted above, some discussion of how decision-making tools could proceed from here would be helpful.	As noted earlier, the focus of the review is not on the development of decision-making tools, but on providing information to help inform decisions. The reviewer's suggestion will be taken into consideration as we assist in developing research summaries for consumers, clinicians, and policy makers based on this comparative effectiveness review.
Peer Reviewer #4	Discussion	The limitations of the available research are well described.	Thank you.
Peer Reviewer #4	Discussion	As noted above, this reviewer thinks that an explicit logic train is needed at the beginning of the review. Such a logic train would make it easier for the reader to understand the text about implications. It would also make it easier to identify important research needs, and more specifically, to differentiate research needs related to the effectiveness of interventions that can be implemented in many settings versus the characteristics of nursing homes and other RCFs that are important for consumers who are trying to select a care setting for their relative with dementia.	The point regarding a logic train is relevant to decision-making, and will be taken into consideration as we assist in developing research summaries for consumers, clinicians, and policy makers based on this comparative effectiveness review.
Peer Reviewer #5	Discussion	I found the intro to the Discussion section readable and informative.	Thank you.
Peer Reviewer #5	Discussion	Also on pg 47 (just to belabor my prior point) line 49 it notes that the health outcomes assess were BOTH depression and depressive symptoms.	We have changed depression to depressive symptoms throughout the report as our outcome of interest was the increase or decrease of depressive symptoms, not a change in diagnosis.
Peer Reviewer #5	Discussion	The implications for clinical and policy decisionmaking, addressed beginning on pg 53 are clear, but again, unfortunate for the dearth of quality studies (especially lack of effective interventions on informal caregivers) to meaningfully guide placement decisions for PwD who can no longer be managed at home.	Thank you
Peer Reviewer #5	Discussion	The discussion of Research Gaps beginning on page 55 is thoughtful and flows logically from review results, and provides guidance for critical areas of future research.	Thank you.

Commentator & Affiliation[a]	Section	Comment	Response
Peer Reviewer #5	Discussion	Although I understand the criteria for study inclusion, I would like to briefly comment on the discussion of detection bias (lack of blinding) and small sample sizes related to research of this nature (pg 56). Sometimes an adequate sample size is difficult to achieve because an outcome under study (such as aggressive behavior in PwD) manifests itself with such large inter-person or intra person variability that a really large sample is called for, or because the viability of conducting interventions in multiple settings (for example research involving a change in a physical setting of a facility is naturally limited in sample size to only residents of that particular facility). Sample size is of course also limited by attrition due to death/decline in this population. Cost is also a big issue/barrier to obtaining sufficient sample sizes, especially for non-pharmacological studies.	We agree with all of the reviewer's points, as these well explain why there is so little definitive evidence in this field. We discussed blinding and sample size as research challenges to point out that to determine the effectiveness of the interventions/exposures of interest, more studies need to be conducted with larger sample sizes to gain more precision in the size of the effect. We recognize that within this population that this may be difficult to achieve and we have added this point to the discussion and in the executive summary.
Peer Reviewer #5	Discussion	Re: blindness: Often, by their nature, non-pharmacological interventions are observable to all (although the participant with advanced dementia may be unaware). For studies looking at the PwD's well being (e.g. agitation, affect, anxiety) the observor will likely see or hear the intervention despite being blinded to it. Furthermore, an impact that is considered by non-blinded caregivers to be significant is perhaps a desirable outcome in this field of research. Thus, while I most certainly support the report calling for more rigorous research in the area, perhaps future reviews can be more inclusive of studies with smaller samples and alternative designs.	We did not consider the lack of blinding as a fatal flaw in the quality assessment of those studies that met eligibility criteria, but instead considered factors such as whether the non-blinded observer was aware of the study aims and had a potential interest in the study outcomes.. Sample size and design remain important considerations in terms of validity, but we agree that the quality of a given study is an interplay of these and other considerations.
	Conclusion		No comments received
	Figures		No comments received
	References		No comments received
	Appendix		No comments received
TEP Reviewer #1	General	Objective seems confusing. Basic question seems to be effect of institutional charaxcteristics on outcomes but latter not clear. Model requires interaction of residents (e.g., severity) and setting. Stated that way in ES-2, line 56 but not in abstract There is a two-way model of structure: AL/NH, SCU/not; this should be the structure of the analysis.	We revised the objective as written in the abstract to include the focus on outcomes. It now reads: "To compare characteristics and related outcomes …" We did not refer to the interaction of resident characteristics in the abstract due to space limitations and also that the review found only two instances when those characteristics were considered. As to the analyses, the report does (for example) differentiate the effect of NH SCUs compared to AL SCUs.
TEP Reviewer #1	General	ES never gets past KQ2	We have resolved this by entering information for KQs 3-5.
TEP Reviewer #1	General	What is the overall problem? Lack of finidngs or lack of good studies?	The lack of good studies relates to the lack of findings; at the end of the day, it is the findings that matter.

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #1	General	If the major finding is a weak literature, why not lay out a better road map for future work?	As suggested, we added a bulleted list in the Executive Summary and Discussion of the full report" that provide a road map for future work.
Peer Reviewer #1	General	I am struck by how little we know about interventions in the nursing home. The report is superior even though the substrate is generally of poor quality. The greatest value is to a wide audience to show that there is very little we know of the effectiveness or our interventions. There is also a belief that we are making things better, but we have no evidence to prove this.	Thank you.
Peer Reviewer #1	General	I particularly enjoyed the references and the thoroughness of the review. I believe reference 20 was used a number of times to implicate the percentage of residents in long term care with dementia. That IOM report is now a decade old and US government figures and other more recent data resources should say the same thing.	Thank you. The Institute of Medicine report{Institute of Medicine, 2001 #7088} is cited once because the report highlights the variance and complexity of residential care settings. Indeed, we cite and reference more recent reports and statistics (e.g. Alzheimer's Association, 2010){Alzheimer's Association, 2010 #7063} when referring to percentage of people with dementia in long-term care.
Peer Reviewer #2	General	The report is highly ncongruou meaninfufl because of the prevalence and societal impacts of dementia. The target population is well defined, and the key questions are explicitly stated.	Thank you.
TEP Reviewer #2	General	I am confused about the audience. This was nominated by a layperson, but is dense and difficult to read for me. It is incomprehensible for a lay person. I hope someone translates this for the audience who requested it.	In cooperation with The Eisenberg Center the authors will assist in developing patient research summaries for consumers, clinicians, and policy makers based on this comparative effectiveness review. They will be made available to the public.
TEP Reviewer #2	General	The KQ are clearly defined. However, there is an emphasis on what is the better setting: NF or AL/RC. To me that is an unanswerable question because of the variability between each NF and AL/RC. Not only does quality stds vary from state to state (especially AL/RC), but also within the state, from site to site (and it varies over time). I would maintain that a good AL/RC is always better over a bad NF and just the opposite.	We recognize the variability among both NHs and RC/AL settings. That said, the first placement decision that is made is at that level. The reason our review went beyond this type of organizational characteristic, to examine specific structures and processes, speaks directly to the reviewer's point.

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #3	General	This report is complete. It is comprehensive and detailed. The target audience is clear. The key questions are stated; but, it would help if more information on the inclusion of caregivers would be given. These seem somewhat out of place. It is not clear to the reviewer that informal caregivers should be influenced by long-term care facilities.	Caregiver well-being could be influenced by long-term care facilities because better settings that result in better outcomes for residents are likely to bring peace of mind to the caregiver, as opposed to situations in which poor outcomes occur for the resident.. To clarify this point, we added this sentence into the Scope of This Review in the Executive Summary and Introduction: "Settings that are better for the person with dementia may also be better for the family caregiver, such as by bringing the family peace of mind."
TEP Reviewer #4	General	Thank you for the opportunity to review the manuscript, Comparison of characteristics of nursing homes and other residential long-term care settings for people with dementia. This report was well written with complete transparency as to its strengths and weaknesses. This report is of value in learning "what we do not have evidence for" and could be used to guide future research, especially in determining what variables should be studied and the importance of understanding the severity of dementia among the study populations.	Thank you.
Peer Reviewer #3	General	Key Questions 3 & 4 (effect on caregivers' health and psychosocial outcomes of organizational characteristics, structures, or processes of care in NHs and other Res. LTC settings) seem somewhat off-target or not well chosen, since these organizations generally do not provide direct services to informal caregivers. There may be indirect effects, i.e. caregiver satisfaction with the care their family member receives, or peace-of-mind that their family member is well cared for. But these concepts are generally not measured in studies, nor are care processes explicitly designed or intended to benefit caregivers. Consequently, it was unsurprising that no studies were found that met the inclusion criteria. Were there any studies found, even if they did not meet the inclusion criteria, e.g. no comparison group? If so, it might be useful to at least mention them.	We agree that the relationship between the interventions/exposures would be indirect. Studies that measure family satisfaction are not uncommon, and there is some literature that examines the relationship of caregiver well-being to characteristics of long-term care settings (see for example Williams et al., 2008).{Williams, 2008 #7718} Three potential studies were identified, each addressing encouraging family involvement in care as a means to promote improved family/staff relationships and support resident care. While these studies were excluded for methodological shortcomings (e.g. selection bias, high attrition, inadequate randomization), this literature is evolving and represents an increasingly important aspect of long-term care. This information has been added to the discussion.
TEP Reviewer #5	General	The report is clinically meaningful, to the extent that it provides an overview of outcomes for persons with dementia across a range of residential settings.	Thank you.

Commentator & Affiliation[a]	Section	Comment	Response
TEP Reviewer #5	General	A common issue in any cross-residential analysis is the degree to which they are comparable. In adjusting for study quality, some effort could have been made to demonstrate to readers how well studies adjusted for the myriad case mix and other differences between NH, RC/AL, or other residents. Otherwise, the conclusion that there were few differences in outcomes across settings for persons with dementia is less than robust (and may lead readers or consumers to think that any person with dementia will be just as well in an assisted living setting as a nursing home, whereas clearly dementia severity, care requirements, and other factors come into play).	The fact that so few studies met eligibility criteria and were of sufficient quality to make it into the review speaks for itself as to how well studies adjusted for case-mix and other differences. The conclusions were based on studies that adequately adjusted for characteristics of the person with dementia. The final important point that the reviewer raises is addressed in this section of the Applicability section: "The evidence is therefore insufficient regarding whether the effects of some of the interventions/exposures under study would have been different for different subgroups of the populations. Other than for the small number of findings noted above, we cannot say whether they are the same or different for people at different stages of disease severity or by other characteristics." This point is also made, more succinctly, in the Applicability section of the Executive Summary. We will also recommend that it be reflected in the research summaries for consumers, clinicians, and policy makers that will be developed based on this comparative effectiveness review.
TEP Reviewer #5	General	The target population and audience is defined clearly at the outset of the review, as are the questions to be addressed by the review.	Thank you
Peer Reviewer #4	General	This review includes many valuable ideas and reflects a comprehensive literature search, an extensive knowledge about dementia care and indepth understanding of the field. It lacks an explicit logic train to connect the stated objective(s) and the key questions. The authors and TEP undoubtedly discussed such a logic train in detail. It should be made explicit in the review. Three related issues are as follows:	See comments below in response to individual comments

Commentator & Affiliation[a]	Section	Comment	Response
Peer Reviewer #4	General	The first stated objective is to compare the characteristics of nursing homes and other RCFs to help families select the best residential care option for their relative with dementia. The authors start to explain the logic going from that objective to the key questions with a sentence on p. ES 2, but the next sentence says that long term care settings are complex, and the text then goes on to set what seems to be a somewhat different objective, to determine whether certain characteristics are critical in providing quality care. Both objectives are fine, but the review weaves between them in a way that is confusing and obscures the excellent content that compares the different settings and finds few differences between them (last sentence of the conclusion) which is a very valuable finding for families and an important finding for identifying future research needs.	What seems to be two objectives are actually one, which may have made the logic difficult to understand. As we now state in the Abstract, the objective of this study is: "To compare characteristics and related outcomes of nursing homes (NHs) and other residential long-term care settings for people with dementia so as to reduce uncertainty when choosing a setting of care for someone with dementia." We also reworded the Scope of This Review, which is the section to which the reviewer is referring, to make the logic of the review more clear.
Peer Reviewer #4	General	The first, second and fifth key questions seem to this reviewer to fit with either of the objectives noted above, but the third and fourth questions are problematic. A logic train that connected the objective(s) to these questions and the specified outcome (caregiver health and psychosocial well-being) would help. This reviewer suspects that such a logic train would be very long and convoluted and require the introduction of many factors related to the caregiver's own personality characteristics, life experience and current life situation that would be very difficult to accommodate in a research design. Ceregivers are obviously very important in any work on dementia care, but it is not clear that adding these questions is helpful in this review. The review says repeatedly that no studies were found to address the two questions, implying a research gap that should be filled. This reviewer wonders whether it would be better to drop these key questions, add text about how the authors think caregiver characteristics are connected to decisions about residential care placement and how they see the specific caregiver health and psychosocial outcomes as possibly connected to these decisions.	We have now clarified the logic for the inclusion of key questions related to informal caregivers, namely, that "settings that are better for the person with dementia may also be better for the family caregiver, such as by bringing the family peace of mind." Question 5 intended to incorporate the types of factors to which the reviewer is referring by examining how the relationship between care and outcomes is moderated by characteristics of the caregiver). We have expanded the discussion related to the literature on informal caregivers as noted below: Three potential studies were identified, each addressing encouraging family involvement in care as a means to promote improved family/staff relationships and support resident care. While these studies were excluded for methodological shortcomings (e.g. selection bias, high attrition, inadequate randomization), this literature is evolving and represents an increasingly important aspect of long-term care."
Peer Reviewer #4	General	Some of the processes of care could be delivered in any setting. Pleasant sensory stimulation is an example; it could be provided in the home, an adult day center or any RCF. Other processes of care are more specific to a congregate care setting or RCF specifically, but it seems unlikely that families would be able to search effectively for settings that provide these kinds of processes of care. The logic train to connect these processes of care to the review objectives should be stated explicitly.	We agree that the processes are not setting-specific, and that consumers may not know to search for them. We will recommend that these points be reflected in the research summaries for consumers, clinicians, and policy makers that will be developed based on this comparative effectiveness review.

Commentator & Affiliation[a]	Section	Comment	Response
Peer Reviewer #5	General	Overall this is a well written, unbiased, evidence-based document, reported in a user-friendly format. The purpose and scope of the review are clear; the 5 key questions are relevant to factors in long term care (LTC) settings that impact on quality of care for persons with dementia and their family caregivers, and are consistently applied throughout the review; the population of interest in addressing the key questions is clearly identified; and the organizational framework for the report summarizing LTC setting characteristics, structures and processes is logical. A good case is made for the need for evidence-based consumer guidance, despite the fact that relatively little guidance can be offered given the overall quality of the research studies reviewed. The conclusions about interventions/protocols that can improve function are important for those who care for PwD, and the finding of "little difference" in outcomes between NHs and RC/AL settings (except for those in need of medical care), is likewise meaningful from both a clinical and cost standpoint. Indeed it is a sad commentary on the state of the science in this area that only 4/13 studies could be rated as "good", 9/13 as "fair" and the majority of poor quality, as well as the fact that no good evidence even exists related to outcomes for caregivers of persons with dementia (PwD). Nonetheless, I thought it was important to include all those studies in Appendix D, so readers can "see for themselves" the breadth of the articles examined versus the "yield" of qualified articles for the review. The analytic framework that guided the systematic review process is clearly described and illustrated (Fig 1) by key questions. Methods are appropriate and the process throrough and detailed enough so as to be replicable. Overall, the tables and figures are useful and highlight important aspects of the review. For example, Table 5 provides a concise description of the included studies. The executive summary captures the essence of the report. Note on cover sheet under Complete List of Authors there is a "D" missing on Division of Health Services and Social Policy Research.	Thank you.
TEP Reviewer #1	Clarity and Usability	KQ5 is the big issue. It gets lost The big message is a weak literature. This should motivate a detailed research gaps section burt it is scant	In the Applicability section of the Executive Summary and Discussion, we now state that “this is a serious omission in the literature and our knowledge base” and expand on it. We also have added this point in the summative table related to Research Gaps.

Commentator & Affiliation[a]	Section	Comment	Response
Peer Reviewer #1	Clarity and Usability	This is an excellent call for appropriate funding and investigation regarding life after I living. There is nothing we can use at present to pick a good nursing home or choose an environment of care that does better than the rest.	Thank you.
Peer Reviewer #1	Clarity and Usability	The manuscript calls into question what we really mean by person centered care and whether it even exists. The authors also ask "what is the best care setting for an older adult with dementia who can no longer be managed at home" (page 78 of 177, lines 7-8). To this end I am struck by the word "managed". Is that what we are really trying to do and can the word managed actually be incorporated into person centered care? The paradigm seems to be incongruous and whether by design or accident, this report may have a profound impact on the way we should look at persons with dementia who live somewhere other than in their own home.	The use of the term "managed" was a poor choice of words. We rephrased it on the Scope of This Review to "cared for" and made the same change where the term was used in the discussion. We strongly agree with the reviewer that people with dementia are not "managed".
Peer Reviewer #2	Clarity and Usability	Overall, the report is extremely well structured and organized with the key points highlighted clearly. The report should be helpful to inform policy and future research – because as pointed out there is hardly any research data available that adequately addresses the question. Thus, messages for evidence-based clinical practice are limited.	Thank you
TEP Reviewer #2	Clarity and Usability	I think the report is well structured and organized. Unfortunately, it demonstrates the lack of good evidence.	Thank you.
TEP Reviewer #3	Clarity and Usability	Yes. But this is probably the weakness of the text. What the results mean for someone with an elder with dementia could be expanded.	We have expanded this point and will be sure it is reflected in the research summaries for consumers, clinicians, and policy makers based on this comparative effectiveness review.
TEP Reviewer #4	Clarity and Usability	The report does seem to repeat same points - this reviewer is not clear if this is needed per AHRQ standards (eg, Abstract, Executive Summary which is 21 pages long followed by a 64 page full report.)	The AHRQ EHC program provides a template for the EPC programs to follow when developing a review. Three components are required including the structured abstract, the executive summary, and the full report. The executive summary will be published as a stand-alone document.
Peer Reviewer #3	Clarity and Usability	At 17 pages, the Executive Summary covered all the major points but is too long for consumers -- one of whom was said to raise the questions that inspired this review. Will the authors or AHRQ produce a consumer-friendly, 2-4 page synthesis?	In cooperation with The Eisenberg Center the authors will assist in developing research summaries for consumers, clinicians, and policy makers based on this comparative effectiveness review. They will be made available to the public.
TEP Reviewer #5	Clarity and Usability	The report is well-structured and organized, and while it likely will not assist consumers in their decision-making process, it lays out some directions for future research.	Thank you.

Commentator & Affiliation[a]	Section	Comment	Response
Peer Reviewer #4	Clarity and Usability	The review is well structured and organized.	Thank you.
Peer Reviewer #4	Clarity and Usability	This reviewer thinks that the most interesting and important findings from the review are about the differences between nursing homes and other RCFs (not many) and the impact of SCUs in either type of facility. These findings are clearly valuable for policy and practice and would help many families as they try to select a care setting for their relative with dementia. The other content of the review is also informative, but this reviewer suggests that more emphasis should be placed on discussion about differences between the kinds of settings, with and without SCUs, both in the conclusion and in the discussion of research gaps.	We agree that these findings are useful, despite the fact that the strength of evidence is low. We singled out the results related to NHs and other settings in the abstract, but did not single out the results related to SCUs because they differed by setting type and also it is possible the risk adjustment was insufficient (a point made in the report). As suggested, In the new table related to Guidance for future research, the first point we make is for more research in these two areas. We will be sure to include these points in the research summaries that are developed for consumers, clinicians, and policy makers based on this comparative effectiveness review.
Peer Reviewer #5	Clarity and Usability	Yes, report is well structured and organized as described in earlier comments. And, as also noted, the usability of the findings for policy and practice decisions is limited only by the small number of rigorous studies meeting inclusion criteria.	Thank you

[a]No public comments were received for this report.