### Algorithm for Treating Behavioral and Psychological Symptoms of Dementia (aka Problem Behaviors)

#### STEP 1: IDENTIFY, ASSESS AND TREAT CONTRIBUTING FACTORS

- Determine and document frequency, duration, intensity and characteristics of each problem behavior.
- Identify, assess, treat or eliminate ANTECEDENTS and TRIGGERS.

<table>
<thead>
<tr>
<th>Unmet physical needs?</th>
<th>Unmet psychological needs?</th>
<th>Environmental causes?</th>
<th>Psychiatric causes?</th>
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</thead>
<tbody>
<tr>
<td>Pain</td>
<td>Loneliness</td>
<td>Level/type of stimulation: noise, confusion, lighting</td>
<td>Depression</td>
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<td>Infection/illness</td>
<td>Boredom</td>
<td>Caregiver approaches</td>
<td>Anxiety</td>
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<td>Dehydration/nutrition</td>
<td>Apprehension, worry, fear</td>
<td>Institutional routines, expectations</td>
<td>Delirium</td>
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<td>Sleep disturbance</td>
<td>Emotional discomfort</td>
<td>Lack of cues, prompts to function &amp; way-find</td>
<td>Psychosis</td>
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<td>Medication side effects</td>
<td>Lack of enjoyable activities</td>
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<td>Other mental illness</td>
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<td>Sensory deficits</td>
<td>Lack of socialization</td>
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<td>Constipation</td>
<td>Loss of intimacy</td>
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</table>

Monitor outcomes to assure full treatment response.
- If problem behavior persists after antecedents are adequately treated. Use NON-DRUG INTERVENTIONS

#### STEP 2: SELECT AND APPLY NON-DRUG INTERVENTIONS

- Select interventions based on the TYPE of problem and ASSESSMENT of retained abilities, preferences and resources
  - Cognitive level
  - Physical function level
  - Long-standing personality, life history, interests/abilities
  - Preferred personal routines and daily schedule
  - Personal/family/facility resources
- Train staff to use selected interventions appropriately: following best practice and evidence-based guidelines
- Tailor intervention to individualized needs, combining approaches and interventions to promote comfort & function
- Monitor outcomes using rating scales to quantify behaviors

Adjust caregiver approaches
- **Personal approach**: cue, prompt, remind, distract (treats, activities); focus on person’s wishes, interests, concerns; use/avoid touch as indicated; avoid trying to reason, teach new routines, or ask to “try harder”
- **Daily routines**: simplify, sequence tasks; offer limited choices; use long-standing history & preferences to guide
- **Communication style**: simple words and phrases; speak clearly; wait for answers; make eye contact; monitor tone of voice/other nonverbal messages
- **Unconditional positive regard**: do not confront, challenge or “explain” misbeliefs (hallucinations, delusions, illusions); accept belief as “real” to the person, reassure, comfort, and distract
- **Involvement/Engagement**: tailor activities to increase involvement/reduce boredom, individualize social and leisure activities

Change the environment
- **Eliminate misleading stimuli**: clutter, TV, radio, noise, people talking; reflections in mirrors/dark windows; misunderstood pictures/décor
- **Reduce environmental stress**: caffeine, extra people, holiday decorations, public TV
- **Adjust stimulation**: reduce noise, activity, confusion if over-stimulated; increase activity/involvement if under-stimulated (bored)
- **Enhance function**: signs, cues, pictures to promote way-finding; increase lighting to reduce misinterpretation
- **Involve in meaningful activities**: personalized program of 1:1 and small group vs. large group
- **Adapt the physical setting**: secure outdoor areas; decorative tactile objects; home-like features; smaller, segmented recreational and dining areas; natural and bright light; spa-like bathing facilities; signage to promote way-finding

Use evidence-based interventions
- **Agitated/Irritable**: Calm, soothe, distract
  - Individualized music
  - Aromatherapy (e.g., lavender oil)
  - Simple Pleasures
  - Pet therapy
  - Physical exercise/outdoor activities
- **Resistant to care**: Identify source of threat; change routines and approaches
  - “Rest stations” in pacing path
  - Adapt environment to reduce exit-seeking
  - Physical exercise/outdoor activities
  - Simple Pleasures
- **Disruptive vocalization**: Distact, engage
  - Individualized music; Nature sounds
  - Presence therapy: tapes of family
- **Apathetic/Withdrawn**: Stimulate, engage
  - Individualized music
  - Simple Pleasures
- **Repetitive questions/mannerisms**: Reassure, address underlying issue, distract
  - Validation therapy/therapeutic lying
  - Simple Pleasures
- **Depression/Anxiety**: Reassure, engage
  - Physical exercise
  - Pleasant activities
  - Cognitive stimulation therapy
  - Wheelchair biking

#### STEP 3: MONITOR OUTCOMES AND ADJUST COURSE AS NEEDED

- Quantify behavioral symptoms using rating scale(s)
- Assess adequate “dose” (intensity, duration, frequency) of interventions
- Provide/reinforce staff training and development activities to assure full understanding and cooperation in daily care
- Adapt/add interventions as needed to promote optimal outcomes
- Consider antipsychotics for persistent and severe cases that meet criteria for use

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**Footnotes:**

a. Diverse symptoms must be assessed and treated individually to assure optimal outcomes.
b. Antecedents or triggers are things that happen before a problem behavior. These may be causal or contributing factors. Causal and contributing factors must be fully assessed and treated before psychotropic medications are used. Ongoing monitoring of these factors is essential to high quality care.
c. Use of evidence-based interventions requires full understanding of the protocols and appropriate application to assure optimal outcomes.
d. For more information about Simple Pleasures, see: [http://health.ny.gov/diseases/conditions/dementia/edge/interventions/simpl/pleas.htm](http://health.ny.gov/diseases/conditions/dementia/edge/interventions/simpl/pleas.htm)

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Antipsychotic Alternatives

The following information suggests ideas for reducing antipsychotic drug use. A carefully monitored use of the alternatives with frequent reassessment is suggested. Always start by assessing the resident for pain*.

General Principles

- Start with a pain assessment.
- Provide for a sense of security.
- Apply the 5 Magic Tools (Knowing what the resident likes to See, Smell, Touch, Taste, Hear).
- Get to know the resident, including their history and family life, and what they previously enjoyed. Learn the resident’s life story. Help the resident create a memory box.
- Play to the resident’s strengths.
- Encourage independence.
- Use pets, children and volunteers.
- Involve the family by giving them a task to support the resident.
- Use a validated pain assessment tool to assure non-verbal pain is addressed.*
- Provide consistent caregivers.
- Screen for depression & possible interventions.
- Reduce noise (paging, alarms, TV’s, etc.).
- Be calm and self-assured.
- Attempt to identify triggering events that stimulate behaviors.
- Employ distraction methods based upon their work and career.
- Offer choices.

What to try when the resident resists care

Therapeutic Intervention

- Evaluate recent medication changes, especially if the behavior is new.
- Determine if the resident is in pain, and if so, why? Treat the pain.*
- Evaluate whether the care can be performed at a different time.
- Determine if the resident is trying to communicate a specific need.
- Evaluate the resident’s sleep patterns.
- Place the resident in bed when he or she is fatigued.
- Evaluate if there has been a change in the resident’s routine.
- Provide a positive distraction, or something the resident enjoys.
- Is the resident hungry? Offer the resident a snack prior to providing care.
- Provide a periodic exercise program throughout the day (e.g. A walk to dine program).
- Encourage wheelchair/chair pushups, or assist the resident to stand periodically.
- Provide activities to assess and provide entertainment.
- Encourage repositioning frequently.

Environment & Equipment Intervention

- Use assistive devices (wedge cushion, solid seat for wheelchair, side or trunk bolsters, pommel cushion, Dycem, etc.).
- Evaluate the resident for an appropriate size chair and proper fit.
- Evaluate alternative seating to relieve routine seating pressure/pain.
- Use an overstuffed chair, reclining wheelchair, nonwheeled chairs, or wingback chair.
- Place a call bell in reach of the resident.
- Provide an over-bed table to allow for diversional activities.
- Place a water pitcher in reach of the resident.
- Place the resident’s favorite items in their room to provide them comfort.
- Allow access to personal items that remind the resident of their family, especially photos.
- Encourage routine family visits with pets.
- Provide consistent caregivers.
- Evaluate if the resident’s environment can be modified to better meet their needs. (i.e. Determine if the resident’s environment can be more personalized.)

* A pain assessment should include non-verbal signs of pain. If you do not have a pain assessment that includes non-verbal identifiers, go to: http://www.dads.state.tx.us/qualitymatters/qcp/pain/painad.pdf.

Continued →
What to consider when resident is disruptive in group functions

### Therapeutic Intervention

- Evaluate new medications, antibiotics especially, and assess pain.
- Remove resident from group, evaluate for group stress.
- Determine if resident requires toileting.
- Determine if resident is hungry, and if so, provide them with a small snack. If the resident is thirsty, provide the resident a beverage.
- If this is a new behavior in a group, evaluate what is different this time.
- Assure resident has had a rest period prior to group activity.
- Assure there are no medical complications (low/high blood sugar).
- Assure resident is not in pain.*
- Return resident to group function, if possible.

### Environment & Equipment Intervention

- Determine whether clothing is appropriate for a particular function.
- Evaluate if the resident has well-fitting shoes, and ensure they do not rub the resident’s feet.
- Evaluate ambulation devices (wheelchair, walker) that are in good working condition.
- Ensure there is adequate lighting, especially at night.
- Ensure room/function is not overly crowded.
- Ensure room is not too warm or cold.
- Consider providing snacks and refreshments for all group functions.
- Ensure sound in group functions is loud enough so the resident can hear.
- Provide consistent caregivers.
- Evaluate if this program fits into the resident’s area of interest.

### Verbally Abusive/Physically Abusive

#### Therapeutic Intervention

- Begin with medical evaluation to rule out physical or medication problems.
- Evaluate the resident for acute medical conditions such as urinary tract infections, upper respiratory infections, ear infections or other infections.
- Evaluate the resident for pain, comfort and/or other physical needs such as hunger, thirst, position changes, bowel and bladder urges.
- Attempt to identify triggering events or issues that stimulate the behavior.
- Consider using a behavior tracking form to assist in identification of triggers and trending patterns.
- Consult with the resident’s family regarding past coping mechanisms that proved effective during times of increased stress levels.
- Provide companionship.
- Validate feelings such as saying, “You sound like you are angry”.
- Redirect.
- Employ active listening skills and address potential issues identified.
- Set limits.
- Develop trust by assigning consistent caregivers whenever possible.
- Avoid confrontation. Decrease your voice level.
- Provide a sense of safety by approaching in a calm/quiet demeanor.
- Provide rest periods.
- Provide social services referral if needed.
- Provide a psychologist/psychiatrist referral if needed.
- Provide touch therapy and/or massage therapy on the hands or back.
- Reduce external stimuli (overhead paging, TV, radio noise, etc.).
- Evaluate staffing patterns and trends.
- Evaluate sleep/wake patterns.
- Maintain a regular schedule.
- Limit caffeine.
- Avoid sensory overload.

#### Environment & Equipment Intervention

- Use relaxation techniques (i.e. tapes, videos, music etc.).
- Help the resident create theme/memory/reminiscence boxes/books.
- Help the resident create a magnification box to create awareness of the resident’s voice level and provide feedback.
- Use a lava lamp, soothe sounders, and active mobile.
- Play tapes and videos of family and/or familiar relatives or friends.
- Move to a quiet area, possibly a more familiar area, if needed.
- Decrease external stimuli.
- Use fish tanks.
- Encourage family visits, and visits from favorite pets.
- Identify if another resident is a trigger for this behavior.
### What to consider with a sudden mood change, such as depression

#### Therapeutic Intervention
- Evaluate any new medications and assess pain*.
- Evaluate for orthostatic hypotension and change positions slowly.
- Reevaluate physical needs such as toileting, comfort, pain, thirst and timing of needs.
- Rule out medical problem (high/low blood sugar changes).
- Engage resident in conversation about their favorite activity, positive experiences, pets, etc.
- Touch if appropriate while recognizing personal body space.
- Anticipate customary schedules and accommodate personal preferences.
- Evaluate balance for sub-clinical disturbances such as inner ear infections.
- Validate feelings and mobilize the resident. For instance, if the resident states, I want to get up, reply, You want to get up? to confirm you heard them correctly. If so, act on the resident’s request.
- Evaluate hearing and vision.
- Discern if talk therapy is possible.
- Assess sleep patterns.

#### Environment & Equipment Intervention
- Assess for changes in the resident’s environment.
- Assess for changes in the resident’s equipment.
- Involve family members to assure them that there have been no changes within the family, without the facility’s knowledge.
- Provide routines for consistency.
- Provide consistent caregivers.
- Provide nightlights for security.
- Employ the use of a memory box.
- Employ functional maintenance/24-hour plan.
- Encourage the resident, if able, to verbalize his or her feelings.
- Eliminate noise and disruption.
- Employ the use of a sensory room or tranquility room.

### Pacing/Wandering At Risk for Elopement

#### Therapeutic Intervention
- Find ways to meet a resident’s needs to be needed, loved and busy while being sensitive to their personal space.
- Provide diverse activities that correspond with past lifestyles/preferences.
- Consider how medications, diagnoses, Activities of Daily Living schedule, weather or how other residents affect wandering.
- Evaluate the need for a Day Treatment Program for targeted residents.
- Help the resident create a photo collage or album of memorable events.
- Provide structured, high-energy activities and subsequent relaxation activities.
- Take the resident for a walk.
- Provide distraction and redirection.
- Provide written/verbal reassurance about where he/she is and why.
- Alleviate fears.
- Ask permission before you touch, hug etc.
- Assess/evaluate if there is a pattern in the pacing or wandering.
- Assess for resident’ personal agenda and validate behaviors.
- Ask family to record reassuring messages on tape.
- Evaluate for a restorative program.
- Perform a physical workup.

#### Environment & Equipment Intervention
- Remove objects that remind the patient/resident of going home (hats, coats, etc.).
- Individualize the environment.
- Make the environment like the resident’s home.
- Place objects within the environment that are familiar to the resident.
- Place a large numerical clock at the resident’s bedside to provide orientation to time of day as it relates to customary routines.
- Ensure the courtyard is safe for the resident.
- Decrease noise level (especially overhead paging).
- Evaluate floor patterns.
- Evaluate rest areas in halls. Evaluate camouflaging of doors.
- Evaluate visual cues to identify safe areas.
- Play a favorite movie or video.
- Put unbreakable or plastic mirrors at exits.
- Place Stop and Go signs.
- Evaluate the WanderGuard system.
- Use relaxation tapes.
- Evaluate and use, as necessary, visual barriers and murals.
- Evaluate wandering paths.
- Evaluate room identifiers.
### ADVERSE EFFECTS WITH ANTI-PSYCHOTIC MEDICATIONS

#### Warnings and Precautions • Elderly Patients with Dementia-Related Psychosis:
Increased incidence of cerebrovascular adverse events (e.g., stroke, transient ischemic attack, including fatalities)

Follow facility procedures for reporting adverse effects of medications

<table>
<thead>
<tr>
<th>Adverse Effect</th>
<th>Abilify</th>
<th>Saphris</th>
<th>Seroquel (XR)</th>
<th>Risperdal</th>
<th>Mellaril</th>
<th>Navane</th>
<th>Stalazine</th>
<th>Geodon</th>
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<td><strong>Cardiovascular</strong></td>
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* Second generation “atypical” anti-psychotic medications

Table adapted from:


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BEHAVIOR MODIFICATION INTERVENTIONS

Recognize non-verbal communication of unmet need(s), e.g., “Agitation” - Clapping, yelling, slapping thighs, and screaming. Address the individual's needs. Consider common causes.

- Noisy environment
- Pain
- Constipation
- Discomfort
- Infection
- Drugs
- Hearing loss
- Boredom
- Loneliness
- Abrupt, tense or impatient staff
- Frustration

Aggression (hitting, swearing, biting, etc.), in contrast to agitation, is a fear based behavior. Communication is pretty clear. The resident most likely feels threatened.

Try an alternative approach.

Utilize de-escalation techniques, as appropriate. Neither you nor the resident should be or feel backed into a corner.

- Signal breath - If you are upset when approaching the resident, it will only make the situation worse. Stop. “Take a step back.” Slowly count to three (3) as you inhale, count to three (3) as you exhale. Repeat. You are now ready to approach the resident.

- Body language and tone of voice - Your body language and voice should communicate that the resident is safe and that you are not going to hurt him/her. Use a soft, neutral, calming tone of voice. Speaking almost in a whisper is sometimes helpful. Relax your shoulders; place your hands by your side. If assault is likely, the thinking stance is preferred: one hand cupping your elbow and the other hand touching your chin. This positions your hands to block punches or kicks without looking threatening.

- Monitor your proximity to the resident - Maintain a socially comfortable distance (generally 3-5 feet). Approach from the side and to the front of the resident - remain in the resident’s visual field of view. Stay close enough to be heard, but not close enough to be struck.

- Ask, don’t tell the resident to walk with you to a comfortable location where you can both sit. Walk slowly. As with whispering, walking slowly is incompatible with agitation and aggression. Ask, don’t tell the resident to sit down with you to talk about what is bothering him or her.

- Identify with the resident; identify solutions to address the unmet need that triggered the behavioral communication. If possible, offer the solution immediately. Consider an intermediate solution if necessary.

- Listen actively. When a solution is not clear or available, simply listen, write it down and make a plan with the resident to address the concern.

- Diversion and distraction. There may be occasions in which it is not possible to identify the unmet need. In those circumstances, it may be possible to turn the resident’s attention toward something pleasurable. The better you know your residents’ strengths and interests, the better able you will be to select a distraction that is actually likely to engage them positively.

Adapted from: “Oasis” Mass Senior Care Foundation Antipsychotic Initiative 2011-12
National Nursing Home Quality Care Collaborative (NNHQCC)

The NNHQCC is a fast paced, all teach all learn initiative, modeled after the Institute for Healthcare Improvement breakthrough collaborative model, and is being led by the Centers for Medicare & Medicaid Services (CMS) and Quality Improvement Organizations (QIOs). The NNHQCC runs from February 2013 through July 2014, and has approximately 5,000 nursing homes participating across the country. The NNHQCC seeks to rapidly spread the practices of high performing nursing homes with the aim of ensuring that every nursing home resident receives the highest quality of care. Specifically, the NNHQCC will strive to instill quality and performance improvement practices, eliminate healthcare acquired conditions, and dramatically improve resident satisfaction through the achievement of a rate of 6 or better using the NNHQCC quality composite measure by July 31, 2014. Prior to the launch of the NNHQCC, nearly 10% of the nation’s nursing homes had achieved a composite score of 6 or better.

Measuring Collaborative Success
Participating nursing homes, focusing on processes that improve their system, measure on individual tests of change. They will look at their Plan-Do-Study-Act (PDSA) improvement cycle results, their clinical outcome measures, and their composite score.

Calculating the NNHQCC Quality Composite Measure Score
The composite is comprised of thirteen NQF-endorsed, long-stay quality measures that represent larger systems within the long term care setting:

1. Percent of residents with one or more falls with major injury
2. Percent of residents with a UTI
3. Percent of residents who self-report moderate to severe pain
4. Percent of high-risk residents with pressure ulcer
5. Percent of low-risk residents with loss of bowels or bladder
6. Percent of residents with catheter inserted or left in bladder
7. Percent of residents physically restrained
8. Percent of residents whose need for help with ADL has increased
9. Percent of residents who lose too much weight
10. Percent of residents who have depressive symptoms
11. Percent of residents who received antipsychotic medications
12. Percent of residents assessed and appropriately given flu vaccine*
13. Percent of residents assessed and appropriately given Pneumococcal vaccine*  
   *The direction of the two vaccination measures should be reversed because they are directionally opposite of the other measures. This is done by subtracting the numerator from the denominator to obtain a "new" numerator. By keeping all measure directions consistent, the composite score can be interpreted as: the lower, the better. 

The composite score is calculated by summing the 13 measure numerators to obtain the composite numerator, summing the 13 measure denominators to obtain the composite denominator, then dividing the composite numerator by the composite denominator and multiplying by 100. This method of calculation is based on the "opportunity model" concept.**

**This measure is intended for the sole purpose of measuring progress in the NNHQCC. It is not intended to replace any existing CMS measures or scores such as the Five Star Rating System. These measures were chosen for the composite because timely data are available for measuring progress in this fast paced Collaborative. QIOs have access to the quality measure data necessary to calculate composite scores for their state.

This material was prepared by the Oklahoma Foundation for Medical Quality and Stratis Health, the National Coordinating Center (NCC) for Improving Individual Patient Care (IIPC) Aim, 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. 10SOW-IIPC NCC-C7-322 091213
1.) Please evaluate how well you believe the objectives were achieved, from 5-Excellent through 1-Poor:

At the end of the program, the participant will be able to:

1. Describe BBET.  
   5 4 3 2 1

2. Verbalize and understanding of the benefits of using the BBET program.  
   5 4 3 2 1

3. Verbalize how BBET can work in the Long Term Care arena.  
   5 4 3 2 1

2.) Please rate the activity of each speaker from 5-Excellent through 1-Poor.

   Jenna Lehrman—Pine Village Behavioral Health Specialist
   Content of the Presentation  
   Ability to Convey Subject Matter Clearly  
   5 4 3 2 1

   Darlene Smikahl, RN, BSN, MSN – KFMC Project Manager
   Content of the Presentation  
   Ability to Convey Subject Matter Clearly  
   5 4 3 2 1

3.) Please evaluate this educational activity as a whole, from 5-Excellent through 1-Poor:

   • Usefulness/Personal Objectives Met  
     5 4 3 2 1

   • Quality of Program  
     5 4 3 2 1

   • Audio Visual Equipment  
     5 4 3 2 1

4.) Please rate the following from strongly agree to strongly disagree:

   • The program was well-organized.  
     ☐ ☐ ☐ ☐ ☐

   • The program was presented in a clear, understandable manner.  
     ☐ ☐ ☐ ☐ ☐

   • The program was informative and helpful.  
     ☐ ☐ ☐ ☐ ☐

   • I would recommend this program to others.  
     ☐ ☐ ☐ ☐ ☐
General Comments:

What was the most valuable feature of the training? ____________________________________________

__________________________________________

What was the least valuable feature of the training? ____________________________________________

__________________________________________

What are your recommendations for improving the training? ___________________________________

__________________________________________

Comments: _____________________________________________________________________________

_____________________________________________________________________________________

Please complete this evaluation along with your attendance verification form and fax it back to Tami Sterling, KFMC Communication/Education, at 785-273-5130x358 no later than one week after completion of program to provide us with your valued feedback. Only one form is needed per participant.