AVILA INSTITUTE of GERONTOLOGY, Inc.
Education for Compassionate Care

CHA WEBINAR

Behavior Management in Catholic Long-Term Care Facilities:

A Compassionate Approach to Caring for Residents with Challenging Behaviors

March 11, 2013 @ 1 – 2 p.m. ET

Education of staff and caregivers is critical when caring for residents with challenging behaviors. When these behaviors are approached in a compassionate and pro-active manner, caregivers can limit and even eradicate these unwanted, often difficult behaviors. This webinar will discuss a team approach for diagnosing behaviors and developing alternative interventions and techniques. Tools will be provided on how to track behaviors, measure resident progress and achieve best outcomes.

WEBINAR OBJECTIVES

As a result of this program, participants will be able to:

- Identify the underlying causes of challenging behaviors.
- Develop alternative non-pharmaceutical interventions.
- Implement a team approach to address resident behaviors and track resident progress.

FACULTY

Sr. M. Peter Lillian Di Maria, O.Carm., LNHA, CDP
Director, Avila Institute of Gerontology, Inc.

Alfred W. Norwood, MBA
President and Founder of Behavior Science, Inc.

Presentation Handouts

DISCLAIMER

This webinar is intended for educational purposes only. It is not a substitute for formal medical training in one of the health care professions, nor is it a substitute for professional medical advice. For more specific information you may have to consult a health care professional.

DISCLOSURE OF VESTED INTEREST

The presenters have no personal, professional or financial disclosures to make in relation to this presentation.

DISCUSSION OF UNLABELED USE

There will be no discussion of off-label use of medication during the presentation.

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A Compassionate Approach to Caring for Residents with Challenging Behaviors

Catholic Healthcare Association Webinar
March 11, 2013
1:00 - 2:00 PM

PRESENTED BY:
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AVILA INSTITUTE of GERONTOLOGY, Inc.
Education for Compassionate Care

Education Arm of the Carmelite Sisters for the Aged and Infirm

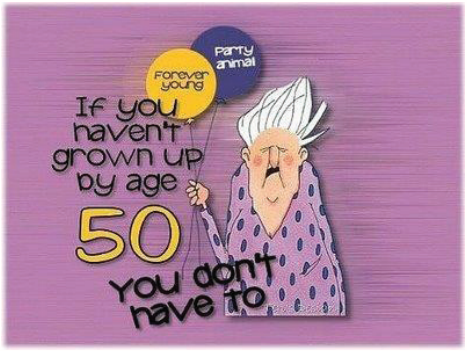
What We Will Cover

- **The Aging Process**
- **The Aging Process & Behavior**
- **Human Behavior Basics**
- **The role of stress**
- **Building Person Centered Care TEAM**
- **Becoming Proactive**

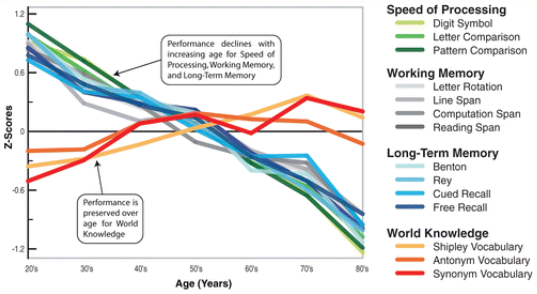
We are Born to Age

- **Do I look old in these Genes ?**
  - All Cells programmed to reproduce X times
  - Telomeres protect gene length/accuracy
  - Age/Stress decrease replication & accuracy
  - Bonus aging; 85->100
- **Childhood is mostly unconscious**
  - We learn & are guided by others
- **Adulthood is conscious ?**
  - We fare for & control ourselves
  - Until entering long term care
  - Others care for us – control our environment

The Aging Process & Behavior

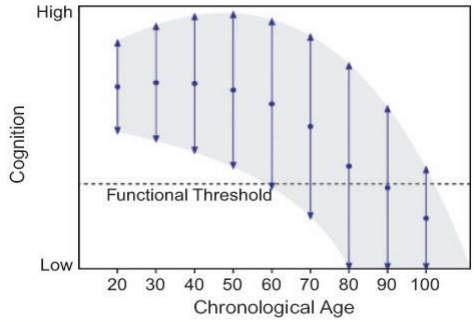


Brain Function & Behavior



Denise C. Parka; Aging, cognition, and culture: a neuroscientific perspective; Neuroscience & Biobehavioral Reviews; Volume 26, Issue 7, November 2002, Pages 859–867

All Brains Aren't Equal

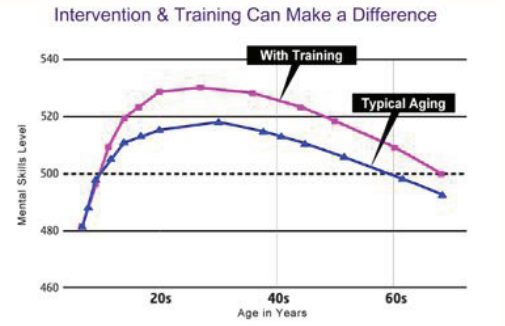


Lars Nyberg, Martin Lövdén, Katrine Riklund, Ulman Lindenberger, Lars Bäckman; Memory aging and brain maintenance; Trends in Cognitive Sciences, Volume 16, Issue 5, May 2012, Pages 292–305

We all Age Differently

King and Mrs. Kong's Later Years
Were Less Adventurous

Training Can Alter Brain Aging



Lustig, Cindy, et al. "Aging, training, and the brain: a review and future directions." Neuropsychology review 19.4 (2009): 504-522.

Activities That Can Alter Aging

- **Aerobic Exercise**
- **Weight Lifting** -The Passavent Experience
- **Recreation & Aging**
  - The Framingham Study
  - The Need for Individualization
- **Functional Training**
  - Aging, Exercise, Falls & Death
  - The get up and go test
  - The trend toward clinical assistant caregivers
- **Assistive Technology**

Aging Behavior Research

"The research proves tall rats are more confident than short rats. At least I think it does. I've never been good at this."

Environment & Aging

- **Aging & Primes**
  - Anagrams, Sorted pictures, Pace measurement
  - Age Primed group walked more slowly
- **Aging & Culture**
  - 3 Cultures
  - 3 Views of the Aged
  - Aging functionality follows expectations
- **Aging & Activity** (Mindless Institutional Living)
  - 70-80year old males
  - Two Groups
    - Control– Have a nice vacation + current photo
    - Experimental– Live in 1980 + 20 yr old photo
    - Photographed & tested before & after
    - Experimental Group tested younger

Who Controls Resident Aging ?

Human Behavior Basics

- **All Human Behavior**
  - Is a Reaction to change in environment:
    - A perceived change
    - Aging impacts perception
      - Sight, hearing, taste, balance etc.
    - Aging Disease impacts perception interpretation
      - Dementia – sees/hears but doesn't understand
      - Delusions – sees things that aren't there
- **Change in the environment can be:**
  - Internal = pain, med errors, disease, thirst etc.
  - External = over/under stimulation, cold etc.

Behavior & Consciousness

- **Conscious Behavior**
  - Conscious behavior – intended/thought out
    - Internal/External Change Awareness->Behavior
    - Conscious behavior is purposeful
  - *Conscious processes gradually lost in Dementia*
    - May be regained in Pseudo-dementias
- **Non-conscious Behavior**
  - Accounts for 90+ of human behaviors
    - Habitual, automatic primed behaviors,
    - Hard wired due to repeated use
    - Try brushing your teeth with the opposite hand
  - *Not lost due to Aging or in Dementia*
    - Instant Dementia in new/hospitalized residents

Unconscious Behavior Dominance

- All behavior is learned through repetition
  - Rewarded behavior is repeated
  - Punished/non rewarded behavior not repeated
- Behavior repetition increases behavior strength
  - Neurons that "wire together fire together"
- Habitual behavior has three stages
  - Cue -> behavior -> reward
- Once formed, difficult to eliminate
  - Order changed Cue -> reward anticipated
  - Missing elements creates stress
- Unconscious/habitual behaviors
  - Not lost in aging & dementia
  - Doesn't require a file clerk; is widely distributed

Stress & Behavior

- Stress is
  - Another response to environmental change
    - Internal stress – inflammation, meds, temp
    - External stress – social pressure, confusion
    - The brain can't differentiate between sources
  - A little stress
    - Enhances learning
    - Increases performance
  - Too much stress
    - Decreases learning
    - Decreases performance
    - Increases Aging, Disease & Brain Disfunction

Elissa S. Epel*,†, Elizabeth H. Blackburn‡, Jue Lin‡, Firdaus S. Dhabhar §, Nancy E. Adler*, Jason D. Morrow¶, and Richard M. Cawthon‖; Accelerated telomere shortening in response to life stress; PNAS December 7, 2004 vol. 101 no. 49 17312-17315

Stress & Resident Behavior

- Stress caused by
  - Novelty (After transfer everything is novel+ medical primes)
  - Loss of Control (Faster to do ADLs than preserve self skills)
  - Lack of Social Support (Abandonment + New people)
- Automatic response
  - Adrenaline-> Fight/flight response –>Cortisol
  - Chronic stress causes
    - Disease (reduced immunity, more inflammation)
    - Disorders (depression, delusions, drug reactions)
- What can we do to avoid stress ?

Stress Management Perspectives

- **Medical Model** Perspective
  - Symptom
  - Diagnosis
  - Prescription
- **Person Centered Approach** Perspective
  - Know person - Look at strengths/weaknesses
  - Be Proactive – Prevent don't react
  - Know triggers – Have a planned response
  - Monitor Planned Responses (People change)
    - For Implementation (where they done)
    - For Efficacy (Did they prevent behaviors)

Stress & Behavioral Stages

- **Stage 1**
  - Resident is unstressed; in Control of their Behavior
- **Stage 2**
  - Resident starts feeling stressed; displays warnings
    - Novelty
      - "I don't want to be here"
      - "Why are you undressing me ?"
    - Control
      - "I am hungry, I want to eat now"
      - "I can do it myself"
    - Social Support
      - "No one loves me, I am alone"
      - "I have been abandoned"
  - If needs are not met, resident escalates
- **Stage 3**
  - Resident loses control & exhibits behavior problems
  - Staff has to take over control to help resident calm

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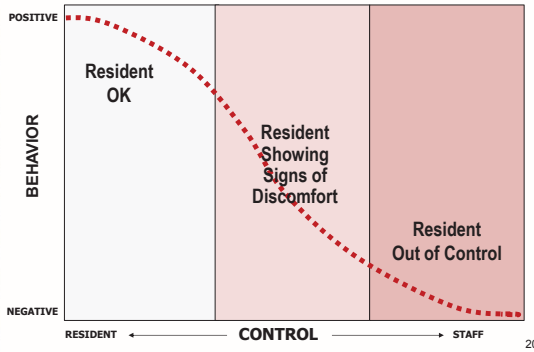
Picture of a Behavior Problem



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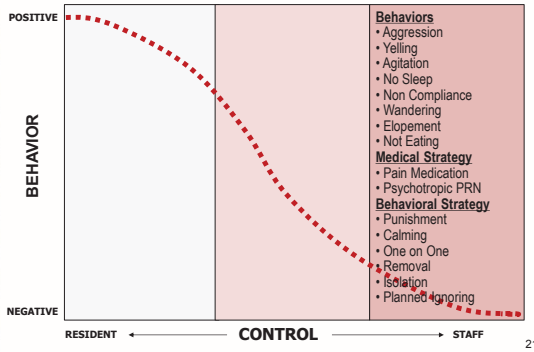
The Behavior Problem – Stage 3



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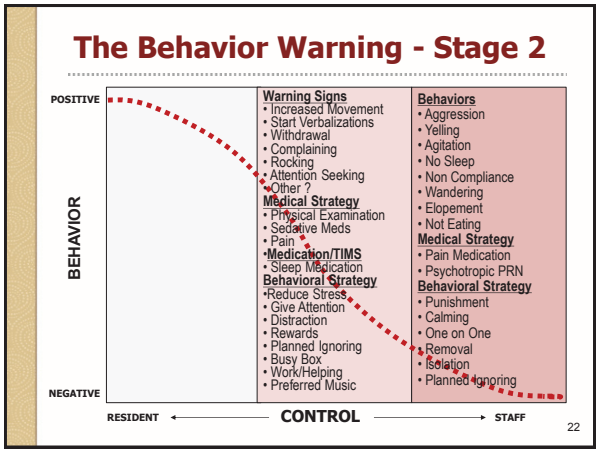
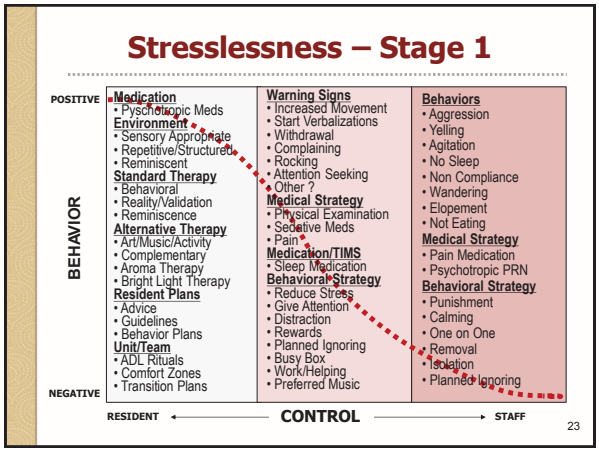

The Behavior Warning - Stage 2
POSITIVE
BEHAVIOR
NEGATIVE
Warning Signs
• Increased Movement
• Start Verbalizations
• Withdrawal
• Complaining
• Rocking
• Attention Seeking
• Other ?
Medical Strategy
• Physical Examination
• Sedative Meds
• Pain
Medication/TIMS
• Sleep Medication
Behavioral Strategy
• Reduce Stress
• Give Attention
• Distraction
• Rewards
• Planned Ignoring
• Busy Box
• Work/Helping
• Preferred Music
Behaviors
• Aggression
• Yelling
• Agitation
• No Sleep
• Non Compliance
• Wandering
• Elopement
• Not Eating
Medical Strategy
• Pain Medication
• Psychotropic PRN
Behavioral Strategy
• Punishment
• Calming
• One on One
• Removal
• Isolation
• Planned Ignoring
RESIDENT
CONTROL
STAFF
22


Stresslessness – Stage 1
POSITIVE
BEHAVIOR
NEGATIVE
Medication
• Psychotropic Meds
Environment
• Sensory Appropriate
• Repetitive/Structured
• Reminiscent
Standard Therapy
• Behavioral
• Reality/Validation
• Reminiscence
Alternative Therapy
• Art/Music/Activity
• Complementary
• Aroma Therapy
• Bright Light Therapy
Resident Plans
• Advice
• Guidelines
• Behavior Plans
Unit/Team
• ADL Rituals
• Comfort Zones
• Transition Plans
Warning Signs
• Increased Movement
• Start Verbalizations
• Withdrawal
• Complaining
• Rocking
• Attention Seeking
• Other ?
Medical Strategy
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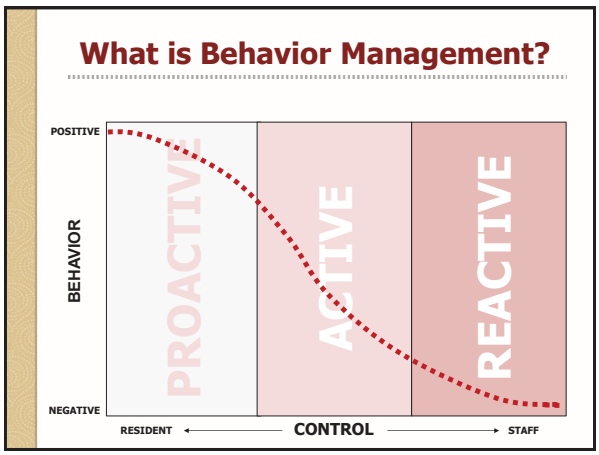
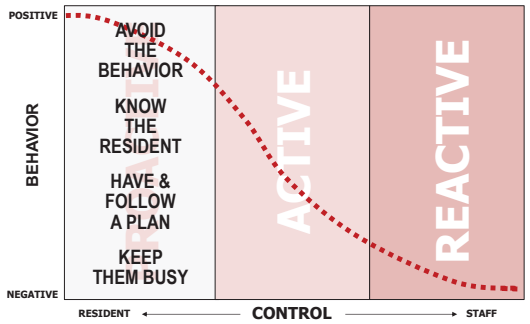
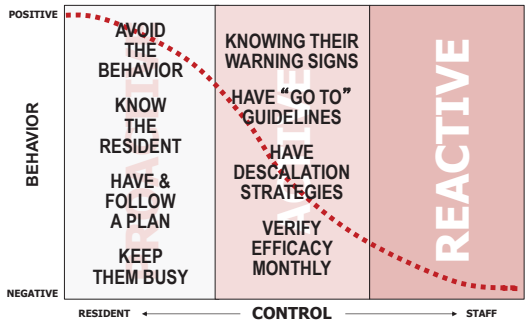
RESIDENT
CONTROL
STAFF
23


What is Behavior Management?
POSITIVE
BEHAVIOR
NEGATIVE
PROACTIVE
ACTIVE
REACTIVE
RESIDENT
CONTROL
STAFF

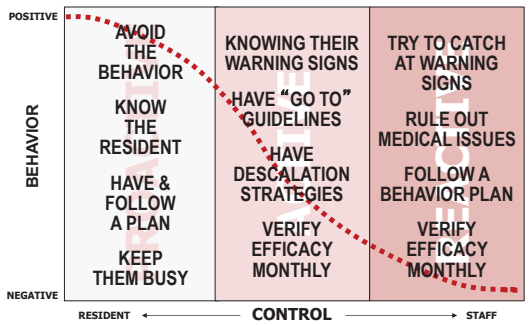
PROACTIVE CAREGIVING
Stopping Behaviors BEFORE they Start



ACTIVE CAREGIVING
Stopping Behaviors WHEN they Start



REACTIVE CAREGIVING
Stopping Behaviors AFTER they Start



STEAM Fuels Behaviors

HANDOUT A: STEAM Analysis Behavior Worksheet

- Sensory
  - Over, under or confusing sensory information
- Tangible
  - Hungry, Thirsty, Dry Diaper, etc.
- Escape
  - Over, Under or Conflicting Stimulation
- Attention
  - Loneliness, Scared, Bored, etc.
- Medical
  - Pain, Drug Intoxication, Infection etc.

Evaluation Tool Handout B

- Daily Resident Behavior Log

What is the Behavior ?

1st She yells all the time 2nd Yells mostly at meals 3rd Yells as soon as she gets to the table 4th Yells if not served 1st BEHAVIOR: VERBAL DISRUPTION	1st He refuses to go to bed 2nd He goes in others rooms 3rd He plays with doorknobs going from door to door 4th He talks about fires BEHAVIOR: WANDERING

Observations are Key

HANDOUT C Behavior Analysis Form

What was the Behavior ? – Include a description of the behavior.

- Aggression
- Agitation
- Anger
- Anxiety
- Apathy/Withdrawal
- Bathing Problems
- Biting and/or Spitting
- Catastrophic Reaction
- Delusion/Hallucinate/Misidentifiy
- Depression
- Dressing/Undressing Problems
- Eating & Digestion Problems
- Elopement
- Excessive Illness
- Falls and Problems falling
- Hides, Hoards, Intrudes, Shadows
- Incontinence
- Mood Swing & Personality Change
- Morning Disorientation
- Paranoia
- Repetitive Behaviors
- Resists Medications and/or Care
- Sexual Difficulty
- Sleeping Difficulty
- Sundowning
- Verbal Disruption, Confabulation, Wanting to go Home
- Wandering
- Other

Observations are Key

- **Setting ?**
  - Include a description of the setting in which the behavior occurs (e.g. physical setting, time of day, persons involved). Include a description of the settings associated with a high probability of nonoccurrence.
- **Antecedents ?**
  - Include description of relevant events & circumstances preceding the target behavior.
- **Consequences ?**
  - Include a description of the consequences that resulted from the target behavior
- **Environment variables ?**
  - Include a description of any environmental variables that may affect the behavior (e.g. health, medication, stimulation levels, sleep, diet, schedule, social factors etc.).

Building a Hypothesis ?

- **Why did the behavior occur ?**
  - What was the Setting
  - What happened before the behavior?
  - Were there any warning signs?
  - What fueled the behavior ? (STEAM)
- **How can we alter the setting to avoid the behavior ?**
  - Change the setting, staff, time of day, etc.
  - Change the complexity or duration
  - Offer an alternative or choice
- **What steps can we take to avoid the problem?** (proactive planning)
- **What could we do if we see any warning signs?** (active planning)
- **What should we do once the behavior starts ?** (reactive planning)
- **State who will do what, when, where & how ?**

AIG Pro-active Person-centered Care Behavior Support Manual

What is the Behavior ?

1st She yells all the time 2nd Yells mostly at meals 3rd Yells as soon as she gets to the table 4th Yells if not served 1st BEHAVIOR: VERBAL DISRUPTION	1st He refuses to go to bed 2nd He goes in others rooms 3rd He plays with doorknobs going from door to door 4th He talks about fires BEHAVIOR: WANDERING
• Give her a snack • Bring her to room last • Bring her food 1st • Eat in special room	• Was a night watchman • Had been in plant fire • Give him right gear • Have him check doors

Alternative Interventions

Sensory – Increased Structure
- Tightened Schedule
- Simplified Instructions
- Create a Ritual
- Sensory
- Music
- Improve ADLs
- Induce Relaxation
- Enhance Dining
- Divert Resident Attention
- Dispel Apathy
- Improve Sleep
- Improve Awakening
- Tap Religion
- Sing Along Album

Tangibles
- Water/Food
- Clothing Modification
- Cognitive Bins (busyboxes)
- Doll Therapy
- Environment Modification
- General
- Resident' s Room
- Bathroom/Toilet
- Photo Album

Escape
- Build in breaks
- Increase exercise
- Pseudo-religious Ceremony
- Reminiscence Therapy

Attention
- One on one time
- Behavior Modification
- Increased Cuing/Prompting
- Hand Massage
- Humor
- Simulated Presence
- Therapeutic Touch
- Modify Communications
- Modify Exercise
- Modify Work
- Modify Positioning
- Multi-Sensory Stimulation
- Rocking or Glider Chairs
- Social Dancing

AIG Pro-active Person-centered Care Behavior Support Manual

The Fine Art of Assessments

- Define the "Check Mark"
- Mary is being Mary
- Designing the Program

Program Development

- Assigning residents to groups
- Trial and error
- Family input
- Volunteers
- How often programs
- Variety vs. Consistent
- Conducting Programs – Music

Evaluation

- Ask each other for ideas
- Be willing to make changes
- Flexibility is the key

References

- Buckwater, K.C.(1989) Caring and Alzheimer' s Disease: The nursing perspective. In G.C. Gilmore, P.J. Whitehouse, & M.L. Wykle(Eds) *Memory,Aging and Dementia: Theory Assessment and Treatment*. New York: Springer Publishing Company
- Doyle, PhD, Colleen (Senior Research Fellow) "Evaluation of Innovative Dementia Programmes: A Short Review" paper presented to the Australian Associatioin of Gerontology, Victorian Meeting, 2 June 1992.
- Zarit, S.H. Zarit, J.M., & Rosenberg-Thompson, S. (1990) A special treatment unit for Alzheimer' s Disease: Medical, Behavioural,and environmental features. In *Mental Health in the Nursing Home* (Ed.) T.L. Brink. New York, The Haworth Press.

Handout A
STEAM Analysis Behavior Worksheet

Instructions: For each FUNCTION area add the numerals & place it's sum on the line marked Total. The highest score function suggests a primary function of any behavior.

Score each answer: 0=Never, 1=Seldom, 2=Occasionally, 3= Usually, 4=Almost Always, 5= Always

Function: SENSORY	
1. Would this behavior occur continuously if your resident was left alone for long periods of time (e.g., one hour?)	0 1 2 3 4 5
2. Does this behavior occur repeatedly, over & over, in the same way (e.g. rocking back and forth for 5 minutes)?	0 1 2 3 4 5
3. Does it appear to you that the resident enjoys performing this behavior or appears unaware of anything else going on around her/him?	0 1 2 3 4 5
4. Does this behavior occur only when the environment is highly stimulating, loud or when it is extremely quiet e.g. night?	0 1 2 3 4 5
TOTAL SCORE SENSORY FUNCTION:	

Function: TANGIBLE	
1. Does the behavior communicate a desire for drink, food, or preferred item?	0 1 2 3 4 5
2. Does the behavior occur when a preferred item, drink or food is taken away?	0 1 2 3 4 5
3. Does this behavior stop occurring shortly after you give the resident the preferred item, drink food they have requested?	0 1 2 3 4 5
4. Does this behavior seem to occur when the resident has been told that they can't do something they wanted to do?	0 1 2 3 4 5
TOTAL SCORE TANGIBLE FUNCTION:	

Function: ESCAPE	
1. Does this behavior occur after asking the resident to perform any task?	0 1 2 3 4 5
2. Does the behavior occur any time requiring your resident's attention?	0 1 2 3 4 5
3. Does the resident seem to do this behavior to upset, annoy or distract you to avoid having any demands placed on them?	0 1 2 3 4 5
4. Does the behavior stop after demands on them are reduced or eliminated?	0 1 2 3 4 5
TOTAL SCORE ESCAPE FUNCTION:	

Function: ATTENTION	
1. Does this behavior occur if you are paying attention to other resident's or staff in the room?	0 1 2 3 4 5
2. Does this behavior occur if you stop paying attention to the resident?	0 1 2 3 4 5
3. Does the resident seem to do this behavior to upset or annoy you when you leave the area the resident is in ? (e.g. leaving the room)?	0 1 2 3 4 5
4. Do you think the behavior is designed to get you to spend time with them?	0 1 2 3 4 5
TOTAL SCORE ATTENTION FUNCTION:	

Function: MEDICAL	
1. Is this behavior new or unusual for this resident?	0 1 2 3 4 5
2. In addition to this behavior does the resident appear sick / disoriented?	0 1 2 3 4 5
3. Could movement, positioning, disease or infection be causing pain depression or disorientation?	0 1 2 3 4 5
4. Is this resident on a high number of medications or multiple psycho-medications?	0 1 2 3 4 5
TOTAL SCORE MEDICAL FUNCTION:	

NAME: _____ MONTH/YEAR:_____
Definitions of Behaviors:

Physical Aggression: Characterized by slapping, hitting, biting, spitting on staff or peers
Verbal Aggression: Characterized by moaning, yelling, name calling or threatening staff or peers
PRN: Please record if a PRN is given and if more than once the number of PRNs given each day

Please indicate the number of times each target behavior occurs each day.

Target Behavior		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
Physical Aggression																																
Verbal Aggression																																
PRN Administered																																

NAME: _____ MONTH/YEAR:_____

Definitions of Behaviors:

Target Behavior		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Resident Name: _____ Date: _____ Shift: _____ Initials: _____

Complete when gathering information a resident's behavior to determine the need for a Behavioral Intervention Plan.

Team Members (List)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

1 TARGET BEHAVIOR – *Include a description of the intensity, frequency, and duration of the behavior.*

- ☐ Aggression
- ☐ Agitation
- ☐ Anger
- ☐ Anxiety
- ☐ Apathy/Withdrawal
- ☐ Bathing Problems
- ☐ Biting and/or Spitting
- ☐ Catastrophic Reaction
- ☐ Delusion/Hallucinate/Misidentifiy
- ☐ Depression
- ☐ Dressing/Undressing Problems
- ☐ Eating & Digestion Problems
- ☐ Elopement
- ☐ Excessive Illness
- ☐ Falls and Problems falling
- ☐ Hides, Hoards, Intrudes, Shadows
- ☐ Incontinence
- ☐ Mood Swing & Personality Change
- ☐ Morning Disorientation
- ☐ Paranoia
- ☐ Repetitive Behaviors
- ☐ Resists Medications and/or Care
- ☐ Sexual Difficulty
- ☐ Sleeping Difficulty
- ☐ Sundowning
- ☐ Verbal Disruption, Confabulation
- ☐ Wanting to go Home
- ☐ Wandering
- ☐ Other:

Description:

Intensity: ☐1) Annoying ☐2) Disruptive ☐3) Self injurious ☐4) Injurious to others

Duration: ☐1) Less than a minute ☐2) 1-3 minutes ☐3) 4-5 minutes ☐4) 5-10 minutes ☐5) Over 10 minutes

2 SETTING – *Include a description of the setting in which the behavior occurs (e.g. physical setting, time of day, persons involved). Also include a description of the settings associated with a high probability of nonoccurrence.*

3 ANTECEDENTS – *Include a description of the relevant events and circumstances that preceded the target behavior.*

4 CONSEQUENCES – *Include a description of the consequences that resulted from the target behavior (e.g. identify what happens after the behavior occurs).*

5 PERSONAL VARIABLES – *Include a description of any personall variables that may affect/cause the behavior (e.g. change in health, medication, medical conditions, sleep, diet, schedule, staffing, death of friend/relative or other social factors).*

6 WHAT IS THE FUNCTION OF THIS BEHAVIOR ? *(Hypothesis based on STEAM analysis (Sensory, Tangible, Escape, Attention, Medical)*

7 HOW COULD WE ALTER THE SETTING TO AVOID THE BEHAVIOR ?

8 WHAT TOOLS COULD WE USE TO AVOID THE BEHAVIOR:

Sensory
- ☐ Music
  - ☐ Improve ADLs
  - ☐ Induce Relaxation
  - ☐ Enhance Dining
  - ☐ Divert Resident Attention
  - ☐ Dispel Apathy
  - ☐ Improve Sleep
  - ☐ Improve Awakening
  - ☐ Tap Religion
  - ☐ Sing Along Album
- ☐ Modifiy Communications
- ☐ Modify Exercise
- ☐ Modify Work
- ☐ Modify Positioning
- ☐ Multi-Sensory Stimulation
- ☐ Rocking or Glider Chairs
- ☐ Social Dancing

Tangibles
- ☐ Clothing Modification
- ☐ Cognitive Bins (busyboxes)
- ☐ Doll Therapy
- ☐ Environment Modification
- ☐ General
  - ☐ Resident's Room
  - ☐ Bathroom/Toilet
- ☐ Photo Album

Escape
- ☐ Build in breaks
- ☐ Increase exercise
- ☐ Pseudo-religious Ceremony
- ☐ Reminiscence Therapy

Attention
- ☐ One on one time
- ☐ Behavior Modification
- ☐ Increased Cuing/Prompting
- ☐ Hand Massage
- ☐ Humor
- ☐ Simulated Presence
- ☐ Therapeutic Touch

Increased Structure
- ☐ Tightened Schedule
- ☐ Simplified Instructions
- ☐ Create a Ritual

9 WHAT STEPS CAN WE TAKE TO AVOID THE BEHAVIOR ? (Proactive Planning)

10 WHAT SHOULD WE DO ONCE THE BEHAVIOR HAS STARTED ? (Reactive Planning)

11 STATE WHO SPECIFICALLY WILL DO WHAT, WHEN, WHERE & HOW

Meet the Speakers

Sr. M. Peter Lillian Di Maria, O.Carm., LNHA, CDP

Director, Avila Institute of Gerontology, Inc. Germantown, N.Y.

Sr. M. Peter Lillian Di Maria, O. Carm., LNHA, CDP, has been the director of the Avila Institute of Gerontology in Germantown, N.Y., since January 1997. The Avila Institute is the education arm of the Carmelite Sisters for the Aged and Infirm. The institute creates opportunities for individuals to share experiences and knowledge regarding their work with the aged and contributes to the field of gerontology through workshops, publications and studies.

Sr. Peter Lillian has been in the continuing care ministry for 30 years, often working in many administrative capacities. She has lectured many times on Alzheimer's disease, palliative care, geriatric spiritual care, family care issues, stress reduction and team building. She has developed successful dementia care programs, dementia care curriculums and assisted in developing a palliative care resource manual that is specific for geriatric care. Sr. Peter Lillian has lectured in the United States and Ireland. She has consulted and developed two studies in conjunction with SUNY. The program "Promoting Positive Behaviors" resulted in a CD series for caregivers of people afflicted with dementia. She has also worked with SUNY to study a team approach that assesses the needs of dementia residents at end of life. The advance illness care teams were studied over an 18-month period.

Sr. Peter Lillian has been a member of the CHA Board of Trustees since 2008.

Alfred W. Norwood, MBA

President and Founder of Behavior Science, Inc.

Alfred Norwood is the president and founder of Behavior Science, Inc. (1997–present). He is a behavioral psychologist who uses primarily ABA techniques and neurological research to resolve behaviors in community and institutional-based dementia patients.

Mr. Norwood has worked as a consultant for long-term care systems and facilities and trained staff in the use of non-pharmaceutical, individualized care plans for residents with moderate to severe dementia. He is the author of Sound and Loving Care, a home caregiver's guide to avoiding and resolving unwanted behaviors commonly experienced in dementia. The book is an outgrowth of years of working with home caregivers and dementia home care organizations.

He has a master of business administration degree from the University of Chicago and a bachelor of arts degree in social psychology from Michigan State University.