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# Guideline for Alzheimer's Disease Management

## CME Information

### **Course Description:**

This 1 hour self study program will provide the participant with core care recommendations for the management of Alzheimer's Disease. The guideline includes assessment, treatment, patient and family education and support, and legal considerations recommendations. These recommendations are based on review of journal articles and meta-analyses published after 2001 and expert opinion when scientific evidence is lacking.

**Release Date:** 01/01/2009      **Expiration Date:** 01/01/2010

### **Learning Objectives:**

After reading this article, the participant will be able to:

1. Explain the assessment criteria described in the Guideline for Alzheimer's Disease Management.
2. Differentiate non-pharmacological and pharmacological approaches when treating a patient with Alzheimer's Disease.
3. Describe the plan of care needed to integrate medical care with education and support.
4. Summarize the legal considerations involved when treating a patient with Alzheimer's Disease.

### **Target Audience:**

Physicians; Fellows, Residents, and Medical Students; Pharmacists, Nurses, and other healthcare professionals.

### **Accreditation:**

SCAN Health Plan is accredited by the Institute of Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians. SCAN Health Plan takes responsibility for the content, quality, and scientific integrity of this CME activity.

This educational activity is approved for a maximum of 1 *AMA PRA Category 1 Credit(s)*<sup>TM</sup>.

Physicians should only claim credit commensurate with the extent of their participation in the activity.



### **California Licensing Requirements:**

**AB 1820:** This bill requires sufficient course work in the field of geriatrics for medical students and physicians to ensure that every general internist and family physician has the requisite knowledge and skills to competently treat California's older population by the year 2010.

General internists and family physicians who have 25% or more of their patients 65 years of age or older are required to complete at least 20% (five hours per year) of their mandatory Category I CME in the field of geriatrics. All other physicians are encouraged to take courses in geriatrics including geriatric pharmacology.

# Guideline for Alzheimer’s Disease Management CME Information

## Course Outline

<p><b>1. <u>Assessment</u></b></p> <ul style="list-style-type: none"> <li>A. Daily Functioning</li> <li>B. Cognitive Status</li> <li>C. Comorbid Medical Conditions</li> <li>D. Behavioral Symptoms, Psychotic \ Symptoms, and Depression</li> <li>E. Medications</li> <li>F. Living Arrangements, Safety, Care Needs, Abuse, and Neglect</li> <li>G. Palliative and End-of-life Care</li> <li>H. Regular Reassessments</li> <li>I. Primary Caregiver and Support System</li> <li>J. Capacity Determination and Surrogate Identification</li> <li>K. Language, Culture, and Literacy</li> </ul>	<p><b>2. <u>Treatment</u></b></p> <ul style="list-style-type: none"> <li>A. Developing a Treatment Plan               <ul style="list-style-type: none"> <li>a. Cholinesterase Inhibitors</li> <li>b. NMDA Antagonist</li> <li>c. Other Pharmacotherapeutic Agents</li> </ul> </li> <li>B. Referral to Community-Based Services</li> <li>C. Behavior Symptoms and Mood Disorders               <ul style="list-style-type: none"> <li>a. Non-pharmacological Approaches for Behavioral Symptoms</li> <li>b. Pharmacological Interventions for Behavioral Symptoms                   <ul style="list-style-type: none"> <li>i. Benzodiazepines</li> <li>ii. Antidepressants</li> <li>iii. Atypical Antipsychotic Agents</li> <li>iv. Typical Antipsychotic Agents</li> <li>v. Anticonvulsants</li> </ul> </li> </ul> </li> <li>D. Common Alzheimer’s Disease-Related Behavioral Symptoms and Their Treatment               <ul style="list-style-type: none"> <li>a. Wandering</li> <li>b. Depression</li> <li>c. Agitation</li> <li>d. Sleep Disorders</li> </ul> </li> <li>E. Comorbid Medical Conditions</li> <li>F. Palliative and End-of-Life Care</li> </ul>
<p><b>3. <u>Patient and Family Education and Support</u></b></p> <ul style="list-style-type: none"> <li>A. Referral to Support Services and Organizations for Caregivers               <ul style="list-style-type: none"> <li>a. Caregiver Education</li> <li>b. Referral to Support Services</li> <li>c. Evidence-based Interventions</li> <li>d. General Legal and Financial Advice</li> <li>e. Interventions for Culturally Diverse Caergivers</li> </ul> </li> <li>B. Disclosure of Diagnosis and Family Conferences</li> <li>C. Early-stage Alzheimer’s Disease               <ul style="list-style-type: none"> <li>a. Cognitive Stimulation</li> <li>b. Physical Exercise</li> <li>c. Psychosocial Support</li> </ul> </li> <li>D. Advance Planning for Care Needs</li> <li>E. End-of-life Care Decisions (Hospice and Palliative Care)</li> </ul>	<p><b>4. <u>Legal Considerations</u></b></p> <ul style="list-style-type: none"> <li>A. Planning</li> <li>B. Capacity Evaluations</li> <li>C. Elder Abuse</li> <li>D. Driving</li> </ul>

# Guideline for Alzheimer's Disease Management

## ASSESSMENT

### Monitor Changes

Conduct and document an assessment and monitor changes in:

- Daily functioning, including feeding, bathing, dressing, mobility, toileting, continence, and ability to manage finances and medications
- Cognitive status using a reliable and valid instrument
- Comorbid medical conditions which may present with sudden worsening in cognition, function, or as change in behavior
- Behavioral symptoms, psychotic symptoms, and depression
- Medications, both prescription and non-prescription (at every visit)
- Living arrangement, safety, care needs, and abuse and/or neglect
- Need for palliative and/or end-of-life care planning

### Reassess Frequently

Reassessment should occur *at least* every 6 months, and sudden changes in behavior or increase in the rate of decline should trigger an urgent visit to the PCP.

### Identify Support

Identify the primary caregiver and assess the adequacy of family and other support systems, paying particular attention to the caregiver's own mental and physical health.

### Assess Capacity

Assess the patient's decision-making capacity and determine whether a surrogate has been identified.

### Identify Culture & Values

Identify the patient's and family's culture, values, primary language, literacy level, and decision-making process.

## TREATMENT

### Develop Treatment Plan

Develop and implement an ongoing treatment plan with defined goals. Discuss with patient and family:

- Use of cholinesterase inhibitors, NMDA antagonist, and other medications, if clinically indicated, to treat cognitive decline
- Referral to early-stage groups or adult day services for appropriate structured activities, such as physical exercise and recreation

### Treat Behavioral Symptoms

Treat behavioral symptoms and mood disorders using:

- Non-pharmacologic approaches, such as environmental modification, task simplification, appropriate activities, *etc.*
- Referral to social service agencies or support organizations, including the *Alzheimer's Association's MedicAlert® + Safe Return®* program for patients who may wander

### Non-Pharmacological Treatment First

*IF* non-pharmacological approaches prove unsuccessful, *THEN* use medications, targeted to specific behaviors, if clinically indicated. Note that side effects may be serious and significant.

### Treat Co-Morbid Conditions

Provide appropriate treatment for comorbid medical conditions.

### Provide End-of-Life Care

Provide appropriate end-of-life care, including palliative care as needed.

## PATIENT & FAMILY EDUCATION & SUPPORT

### Integrate Medical Care & Support

Integrate medical care with education and support by connecting patient and caregiver to support organizations for linguistically and culturally appropriate educational materials and referrals to community resources, support groups, legal counseling, respite care, consultation on care needs and options, and financial resources.

Organizations include:

- **Alzheimer's Association**  
(800) 272-3900 [www.alz.org](http://www.alz.org)
- **Caregiver Resource Centers**  
(800) 445-8106 [www.caregiver.org](http://www.caregiver.org)
- or your own social service department

### Discuss Diagnosis & Treatment

Discuss the diagnosis, progression, treatment choices, and goals of Alzheimer's Disease care with the patient and family in a manner consistent with their values, preferences, culture, educational level, and the patient's abilities.

### Involve Early-Stage Patients

Pay particular attention to the special needs of early-stage patients, involving them in care planning, heeding their opinions and wishes, and referring them to community resources, including the Alzheimer's Association.

### Discuss Stages

Discuss the patient's need to make care choices at all stages of the disease through the use of advance directives and identification of surrogates for medical and legal decision-making.

### Discuss End-of-Life Decisions

Discuss the intensity of care and other end-of-life care decisions with the Alzheimer's Disease patient and involved family members while respecting their cultural preferences.

## LEGAL CONSIDERATIONS

### Planning

Include a discussion of the importance of basic legal and financial planning as part of the treatment plan as soon as possible after the diagnosis of Alzheimer's Disease.

### Capacity Evaluations

Use a structured approach to the assessment of patient capacity, being aware of the relevant criteria for particular kinds of decisions.

### Elder Abuse

Monitor for evidence of and report all suspicions of abuse (physical, sexual, financial, neglect, isolation, abandonment, abduction) to Adult Protective Services, Long Term Care Ombudsman, or the local police department, as required by law.

### Driving

Report the diagnosis of Alzheimer's Disease in accordance with California law.

# Guideline for Alzheimer's Disease Management

## Alzheimer's Disease and Its Impact

Alzheimer's Disease (AD) currently afflicts over 5.2 million Americans, including an estimated 200,000 patients under the age of 65. The number of those afflicted is increasing annually as the population continues to age. Following the aging of the baby boomers, prevalence will escalate rapidly and is expected to double by 2020. The burden on families and the health care system will be substantial as one out of every eight baby boomers develops this disease.

## About the Guideline

This Guideline presents core care recommendations for the management of Alzheimer's Disease. It assumes that a proper diagnosis has been made using reliable and valid diagnostic techniques. The main audience for the Guideline is primary care practitioners. However, many of the activities recommended in the Guideline do not require a physician and can be done by other members of the treatment team (care managers, nurses, community support organizations) working closely with the patient and caregiving family. The recommended activities do not have to be done in one visit.

The *California Workgroup on Guidelines for Alzheimer's Disease Management*, which consists of health-care providers, consumers, academicians and representatives of professional and volunteer organizations, developed the Guideline through a review of scientific evidence supplemented by expert opinion when research has been unavailable or inconsistent. An expanded companion document, providing more in-depth background information, is available through the Alzheimer's Association's California website [www.caalz.org](http://www.caalz.org).

Prepared by the  
California Workgroup on Guidelines  
for Alzheimer's Disease Management  
Supported by the State of California,  
Department of Public Health  
April 2008

This is the third edition of this *Guideline for Alzheimer's Disease Management*.

The first was disseminated in 1998 and updated in 2002. In the current version there are four substantive changes:

- The advent of a new class of medication (NMDA Antagonists) for the management of moderate to advanced AD
- Support for a team approach (medical and social support strategies) to quality management of AD
- Strong evidence linking positive patient outcomes to caregiver education and support
- New evidence on management of the disease in the very early and end stages (see the recommendations below)

## Early-Stage Recommendations

Patients in early-stage AD have unique concerns. AD may progress slowly in the early stage. Follow up two months after diagnosis and every six months thereafter. Pay particular attention to the special needs of early-stage patients, involving them in care planning and referring them to community resources. Discuss implications with respect to work, driving, and other safety issues with the patient. Initiate pharmacologic therapy early. Recommend interventions to protect and promote continuing functioning, assist with independence, and maintain cognitive health including physical exercise, cognitive stimulation and psychosocial support.

## Late Stage and End-of-Life Recommendations

As the patient's dementia worsens and the ability to understand treatments and participate in medical decision-making declines, care shifts to focus on the relief of discomfort. The advisability of routine screening tests, hospitalization, and invasive procedures, including artificial nutrition and hydration, will depend upon previously discussed care plan and the severity of the dementia. Predicting the end-of-life for a patient with severe AD is difficult. Referral to hospice should be considered.

## **Updated Primary Care Practice Guidelines for Alzheimer's Disease Management Now Available**

The *Guideline for Alzheimer's Disease Management* has been updated and is now available through the Alzheimer's Association at [www.alz.org/californiasouthland](http://www.alz.org/californiasouthland) or [www.caalz.org](http://www.caalz.org) or call 323-930-6289 or from the California State Department of Public Health, Alzheimer's Disease Program [www.cdph.ca.gov/programs/alzheimers](http://www.cdph.ca.gov/programs/alzheimers). With the aging of the United States' population, a doubling in the rate of Alzheimer's disease is expected within the next 20 years. The increased incidence of this disease coupled with exponential growth in published research on its management creates a challenge for primary care providers. This evidence-based practice guideline provides support for primary care providers who are increasingly encountering complex post-diagnostic management issues of this disease. The guideline's goal is to make informed decisions for the post-diagnostic management of Alzheimer's disease including periodic assessment of the patient with Alzheimer's disease, treatment recommendations, support recommendations for the patient and family, and an overview of legal considerations for the practitioner. In addition to primary care providers (Family Practitioners, Internists, Physician Assistants and Nurse Practitioners), the Guideline will also be of interest to professionals who provide patient and caregiver education and support, care managers, social workers, Alzheimer's Association staff, and adult day care providers.

The Guideline was originally published in 1998 with support from the Health Service and Resource Administration (HRSA) of the federal government. It was updated in 2002 with support from the California Department of Health Services. The Guideline is authored by the California Workgroup on Guidelines for Alzheimer's Disease Management, a statewide coalition of healthcare providers, representatives of managed care organizations, physician provider groups, academics, State health personnel, care managers, elder law attorneys, and representatives of the Alzheimer's Association and the Caregiver Resource Centers. The guideline is part of a statewide initiative lead by Department of Public Health, the State's Alzheimer's Research Centers of California and the Alzheimer's Association to improve health care for people with Alzheimer's disease. Implementation of the guideline is currently under way at a number of health care organizations and health plans throughout California.

### **Practice Issues in Alzheimer's Disease Management**

Alzheimer's disease is a progressive, degenerative disease of the brain, and the most common form of dementia in older adults. It is estimated to afflict over 5 million people nationally and nearly half a million in the State of California. The incidence of Alzheimer's disease doubles every five years after 60 years of age. With the aging of the baby boomers, the rate of this disease will double by 2030 and triple by mid-century. The symptom pattern in Alzheimer's disease is characterized by a gradual onset of continuing cognitive decline including memory impairment and at least one other

cognitive deficit (aphasia, apraxia, disturbance in executive functioning or agnosia) associated with decline in function in normal activities at work or home.

Risk factors for this disease include increasing age, limited education, prior head injury, and genetic predisposition. Recent research has identified potentially modifiable lifestyle activities that may lead to reduced risk for Alzheimer's disease including aerobic exercise, a diet low in saturated fats, better control of diabetes and hypertension, cognitive stimulation and social engagement.

Alzheimer's disease is significantly under-diagnosed, under recognized untreated by health care providers. However, once a clinical diagnosis of Alzheimer's disease has been made, a treatment strategy should be developed that includes evaluation for medications that may slow cognitive decline, management of co-morbid conditions and challenging behaviors, and referral of the family to supportive and health education services. The use of cholinesterase inhibitors can produce modest improvements in cognitive function and temporarily stabilize or reduce the rate of decline. Three cholinesterase- inhibitors currently on the market and approved for used in mild to moderate Alzheimer's disease include donepezil (Aricept®), galantamine (Reminyl®), and rivastigmine (Exelon®). In addition, Namenda (memantine) an NMDA receptor antagonist, has been approved for management of moderate to late stage disease.

Management of co-morbid conditions is essential to minimize unnecessary decline in cognition and function. This includes assessment and treatment of a range of possible conditions that make the symptoms of dementia appear worse. Treatment of depression, urinary tract infections and a host of reversible conditions can restore a person with Alzheimer's disease to a higher level of function and, in some cases, prevent premature institutionalization.

New data lend strong support for a multi-disciplinary approach to the management of Alzheimer's disease. There is also new evidence supporting the effectiveness of patient and caregiver education and support in preventing unnecessary disease burden. Interventions now exist for the growing population of independent, very early stage patients with Alzheimer's disease, as well as for those needing end-of-life care.

See the one-page version of the Guideline for a complete summary of recommendations.

The newly updated Guideline for Alzheimer's Disease Management sets the standard for post-diagnostic care in the State of California and beyond. This initiative to improve the quality of health care for people with Alzheimer's disease also includes an educational component for patients and families. An educational booklet and workshop entitled, Partnering with Your Doctor, are available in English and Spanish through Alzheimer's Association Chapters. For more information, contact your local chapter at (800) 272-3900.

This article is available for one CME hour. For more information go to <http://www.scanhealthplan.com/cme>

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## **Guideline for Alzheimer's Disease Management CME Information**

In accordance with the Policy on Disclosure and Sponsor Relationships of SCAN Health Plan, and the Standards of the Accreditation Council for Continuing Medical Education (ACCME), all faculty have been asked to disclose their relationships (e.g., research/grant support, speakers' bureau, consultant) with any commercial organization offering financial support/educational grants for continuing medical education. The intent of this policy is not to prevent a speaker with a potential conflict of interest from making a presentation. It is intended merely that any potential conflict should be identified openly so that the listeners may form their own judgments about the presentation with full disclosure of the facts. All conflicts of interest have been resolved in accordance with the ACCME's Standards for Commercial Support.

*The following presenters have relationships with the companies indicated:*

**Debra Cherry, Ph.D.** has received grant/research support from Forest, Elan, Janssen, and Eisai.

**Neal Kohatsu, MD, MPH** does not have any financial relationships to disclose.

**Freddi Segal-Gidan, PA, PhD** is a consultant for Janssen, and Accera; and is on the speakers' bureau for Novartis.

# Guideline for Alzheimer's Disease Management CME Information

## *Acknowledgments*

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# **Guideline for Alzheimer's Disease Management CME Information**

## **Presenter Bios**

### **Debra Cherry, Ph.D.**

Dr. Debra Cherry is the Associate Executive Director of the Alzheimer's Association in Los Angeles where she oversees strategic planning, programs and advocacy efforts on behalf of people with dementia and their families. Dr. Cherry is a contributing author of California's *Alzheimer's Disease Management Guideline* for primary care physicians. She has published numerous articles on services for people with dementia and their caregivers as well as on improving the quality of healthcare for people with dementia. She also presents nationally on these topics. Dr. Cherry has served on the Board of Directors of the American Society on Aging and currently sits on a variety of National and State task forces including the Center for Disease Control's Steering Committee for a National Public Health Action Plan to Address Healthy Brain Issues. She is the 2003 recipient of the Rosalynn Carter Caregiving Award, a national award recognizing her leadership in the field of caregiving. Dr. Cherry has worked with dementia patients and their caregivers for over two decades as a psychotherapist and director of award-winning programs for people with dementia. She graduated Phi Beta Kappa from Brooklyn College and later received her Ph.D. in clinical psychology from the University of Southern California. Dr. Cherry completed a post-doctoral fellowship in geriatric psychology at UCLA.

### **Neal Kohatsu, MD, MPH**

Dr. Kohatsu received an A.B. in Human Biology from Stanford University and an M.D. from the University of Pittsburgh. His fellowship training was in cardiovascular disease prevention and epidemiology at the Stanford Prevention Research Center. He has worked for 20 years in preventive medicine, public health, and clinical quality. Most of his career has been in the California Department of Public Health where he has served in a number of leadership positions including Acting State Health Officer. Other past positions include: Medical Director, Medical Board of California and Associate Professor of Epidemiology at the University of Iowa. Currently, he is a branch chief in the California Department of Public Health, overseeing programs in physical activity, nutrition, and obesity prevention. Dr. Kohatsu is board certified in Public Health and General Preventive Medicine and is immediate past president of the American College of Preventive Medicine.

### **Freddi Segal-Gidan, PA, PhD**

Freddi Segal-Gidan, is a physician assistant and gerontologist who has devoted her career to health care for older adults. She is director of the Rancho/USC Alzheimer's Disease Research Center of California and holds appointments as assistant clinical professor, Departments of Neurology and Family Medicine in the Keck School of Medicine, USC, and assistant clinical professor of gerontology at the L. Davis School of Gerontology at USC. Her research interest is in chronic disease and aging, and the intersection of health care decision-making and public policy. She served as the co-chair of the California Workgroup for revision of the Alzheimer's Disease Guideline, is a member of the Board of Directors and Medical Scientific Advisory Board of the Alzheimer's Association, California Southland.