Spring 2007

Texas Alzheimer's News

A publication of the Texas Council on Alzheimer's Disease and Related Disorders

2007 Texas State Conference on Alzheimer's Disease and Care
Bridging the Gap – Building the Future
A Practical Approach to Alzheimer's Research
August 23 - 25, 2007
Austin, Texas

Save the Date!

The Texas Council on Alzheimer's Disease and Related Disorders and the Texas Department of State Health Services are working in partnership with the Texas Public Health Association to present the 2007 Texas State Conference on Alzheimer's Disease and Care, August 23 - 25, 2007 in Austin, Texas. We invite physicians, nurses, nursing home administrators, social workers, professional counselors, health educators, ombudsmen, legislators, health care industry workers, health care students, and family caregivers to participate in this conference.

This conference will emphasize advances in Alzheimer's disease research and the applications to everyday practice, diagnosis and treatment and care; highlight various modes of research within the Texas Consortium of Research Centers; identify national and international models of research and innovations in technology and practice to address obstacles and issues

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Texas Council on Alzheimer's Disease and Related Disorders Approves Logitudinal Study and Research Projects

Bobby D. Schmidt, M.Ed., R.S.
Program Specialist
Department of State Health Services

The Texas Council on Alzheimer's Disease and Related Disorders (Council) approved the Longitudinal Study and research projects as proposed by the Steering Committee of the Consortium of Alzheimer's Disease Centers at its October 25, 2006, meeting.

Stephen C. Waring, Ph.D., Research Epidemiologist for the Consortium of Alzheimer's Disease Centers (Consortium) gave a presentation outlining the unique features of the study that will take advantage of the Consortium's collective expertise and research interest at each site. This research focus will be centered on novel genetic and biomarker studies. The current funding will allow the Consortium to establish a study population built around the best possible data to address the proposed hypothesis. This will be a prospective multidisciplinary study that will provide a robust dataset of prospectively collected clinical, genetic, and biological data from subjects with sufficient follow-up to address an unlimited number of research questions now and into the future.

The two research projects approved by the Council are:

- Genetic factors in age at onset of Alzheimer's disease which will identify potential genetic factors associated with earlier age at onset among patients with Alzheimer's disease, and

- Cardiovascular disease, inflammation, and Alzheimer's disease which will examine the association between inflammation and Alzheimer's disease and determine whether inflammation mediates the effect of cardiovascular risk factors on development of Alzheimer's disease.

2007 State Conference on Alzheimer's Disease and Care . . .

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related to Alzheimer's care; provide professional and family caregivers information and resources they can use in daily life activities; and outline advocacy successes and needs at the state and federal level. The 2007 Texas State Conference on Alzheimer's Disease and Care will be held at Omni Austin Hotel Downtown. The registration form and additional information for the conference will be released soon.

Your participation in this conference is critical for its success. Please plan to attend. For more information, contact Bobby D. Schmidt, M.Ed. at 512-458-7111 ext. 6618 or email Bobby.Schmidt@dshs.state.tx.us.

Research Highlights from the 10th International Conference on Alzheimer's Disease and Related Disorders, 2006

Stephen Waring, DVM, PhD
Research Epidemiologist
Texas Alzheimer's Research Consortium

More than 5,000 researchers gathered in Madrid, Spain, in July for the 10th International Conference on Alzheimer's Disease and Related Disorders (ICAD), presented by the Alzheimer's Association. This is by far the largest attendance for ICAD, a testament to the overwhelming popularity of the conference among researchers and to the expanding interest in research on Alzheimer's disease and related disorders.

With over 1,000 presentations, researchers from all over the world exchanged many new and exciting developments on a broad range of topics, including molecular genetic discoveries as well as findings that either solidified emerging trends or opened new research directions. The following is a brief summary of some of the more significant findings in the areas of prevention, diagnosis, and treatment of Alzheimer's disease or related disorders. For a more in depth review, please refer to the Alzheimer's Association website (www.alz.org) and the Alzheimer's Research Forum website (www.alzforum.org).

Risk Factors and Prevention

One of the hottest items reported at the conference was the identification by two groups (Hutton and colleagues from Mayo Clinic, Jacksonville; van Broekhoeven and colleagues at the University of Antwerp, Belgium) of a genetic mutation that causes the most common inherited form of frontal temporal dementia (FTD). These findings are considered a major advance in neurogenetics and may have relevance to other FTDs and to other related disorders.

Another area that continues to generate tremendous interest and discussion has to do with the role of lifestyle factors and cardiovascular issues on risk for developing Alzheimer's disease. There is mounting evidence that maintaining a healthy lifestyle with proper exercise, diet, and social networks, and controlling hypertension, cholesterol, diabetes, and heart disease is beneficial regardless of what age you start. Indeed, several studies reported that the presence of hypertension, hypercholesterolemia, diabetes, metabolic syndrome, and cardiovascular conditions significantly increases the risk of developing Alzheimer's disease. Therefore, intervention strategies aimed at these conditions are likely to be beneficial for the brain as well.

Several studies examined progression in Alzheimer's disease in an effort to better understand why for some progression is rapid and for others, the decline is slow. Predicting and understanding progression is a first step in moderating the effects of Alzheimer's. A group of researchers at the University of Oxford have linked rate of decline to an amino acid called homocysteine. Higher homocysteine levels were associated with rapid decline. Professor David Smith, lead investigator, said, "Because homocysteine can be lowered by taking high doses of folic acid and vitamin B12, the next step is to see whether B vitamin treatment will slow the rate of decline in Alzheimer's, giving people with the disease more time with higher levels of functioning." He concludes that raised homocysteine is a strong prognostic marker for brain atrophy and for cognitive decline and dementia, but evidence of a direct causal role awaits the result of clinical trials.

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Diagnosis

There were a number of studies examining early detection and diagnosis, a critical area of research since more and more evidence supports the belief that Alzheimer disease develops over a decade or longer before clinical signs become apparent. Reports on detecting "fingerprints" of AD in body fluids even before there are clinical manifestations of disease continue, coupled with attempts to validate known biomarkers in the cerebrospinal fluid, hold great promise. Additionally, the application of newer imaging methods, more refined neuropsychological tests, and examination of proxy markers on risk factors in the cardiovascular and metabolic fields are all under intense investigation as well.

Neuroimaging studies included updates on the amyloid imaging agent PIB (Pittsburgh Compound-B) and its use in presymptomatic carriers of familial AD mutations, as well as in MCI (Dekosky and colleagues, University of Pittsburgh). There were also several reports on promising new approaches such as diffusion tensor imaging and perfusion MRI to measure the degradation of the brain's white matter that is thought to precede overt AD (Schuff and colleagues, UCSF).

Researchers at the University of California, San Diego and the Mayo Clinic presented findings suggesting that MRI is an effective measure of disease progression. Patients with the apoE e4 gene (a known genetic risk factor for Alzheimer's disease) who received donepezil had reduced hippocampal deterioration as witnessed with

MRI. Clifford R. Jack, Jr., M.D., from the Mayo Clinic, said "less brain shrinkage looks like an indicator of treatment success." Utilizing MRI for diagnosing disease, understanding disease progression, and assessing treatment measures will continue to be a critical area of intense research.

Investigators at Brigham & Women's Hospital and Harvard Medical School have developed a new, non-invasive, laser technology tested on genetically engineered mice. The technology, known as quasi-elastic light scattering (QLS) utilizes a brief pulse of infrared light into the eye of the subject. The scatter pattern of this light allows researchers to determine the presence of amyloid plaques in the lens of the eye. Mice with Alzheimer's plaques had different scatter patterns than those without plaques, and the scatter patterns were evident prior to apparent Beta-amyloid pathology. While both would indicate potential utility as a pre-clinical diagnostic tool, these intriguing findings await human studies before their ultimate role in Alzheimer's disease can be established.

Treatment

Therapeutic approaches for Alzheimer's and related disorders are growing exponentially. Many new therapies target some aspect of the amyloid hypothesis, focusing on preventing the formation of beta-amyloid plaques or removing them once they occur. Others, such as intranasal insulin, growth factor gene therapy, gonadotropal hormones, tau immunotherapy, and dietary supplements are aimed at other pathologic mechanisms thought to be important in the development of AD.

Vaccine or immunotherapy is a hot topic for Alzheimer's treatment. Current immunotherapy is focused on stimulating antibodies against beta-amyloid plaques. The

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first clinical trial to utilize such a vaccine was stopped due to a serious side effect of brain inflammation in about 6 percent of participants. However, those who did not experience inflammation of the brain showed improved cognitive function. The makers of the vaccine are beginning trials with a less toxic version.

Another form of immunotherapy is based on creating antibodies against beta-amyloid plaques in a laboratory setting (monoclonal antibodies) and injecting them directly into patients with Alzheimer's disease. Results of a small study were presented showing that even though cognitive function did not improve after a single injection of the monoclonal antibody, the level of beta-amyloid in the blood was elevated, indicating the antibody bound to the plaque. These results are promising, but require additional trials in larger populations in order to determine whether this will be a reliable and effective treatment.

Since their introduction, cholinesterase inhibitors (donepezil, galantamine, and rivastigmine) have been used as first line therapies for patients with mild to moderate Alzheimer's disease. However, in 2005, the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom (UK) withdrew its recommendation for cholinesterase inhibitors stating that they are not cost effective. A systematic review presented at ICAD 2006 led NICE to reconsider this decision. The review included 9,200 patients from 18 clinical trials, demonstrating cognitive improvement and improved activities of daily

living and behavior. As a result of these findings coupled with protests from patients and the medical community in the UK, NICE has reversed their position and now recommends cholinesterase inhibitors for patients with moderate Alzheimer's.

Reflections and Future Directions

The overwhelming success of ICAD 2006, both in terms of attendance and in the number of quality presentations, is a sign of the importance being placed on dementia and Alzheimer's disease by the scientific community. Clearly, developing methods for earlier detection and diagnosis continues to be a major priority. By understanding better ways to detect Alzheimer's disease even before there is clinical evidence of its presence, scientists may better understand the nature of disease, which will ultimately lead to the development of more effective therapeutic approaches.

Another critical area receiving a lot of attention is the identification of modifiable risk factors present in mid-life or earlier that may influence risk for developing Alzheimer's disease a decade or more later. Understanding the effect that controlling these conditions may have on the pathological burden that ultimately leads to Alzheimer's disease is crucial to improving the quality of life as we age, and may lead to interventions that delay onset or prevent disease altogether.

While there is much work to be done, progress is encouraging, and a number of answers from current studies loom on the near horizon and give hope to finding better treatments, earlier detection methods, and ways of preventing or at least delaying the onset of Alzheimer's disease and related disorders.

Taste and Smell Impairment: A Common but Unrecognized Problem in Alzheimer's Disease and Related Disorders

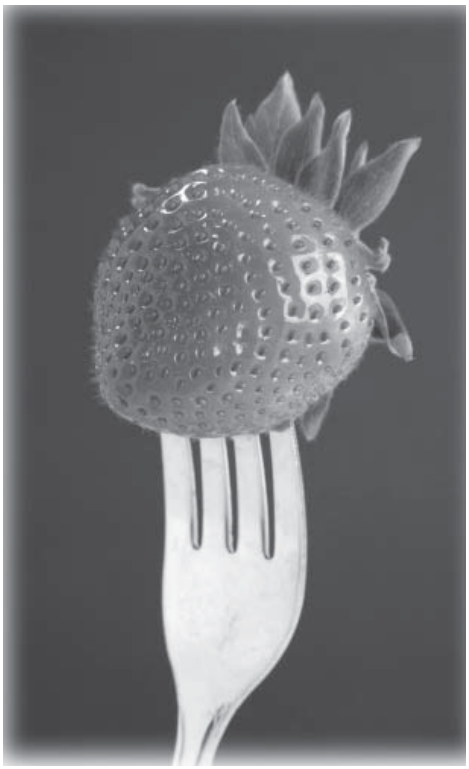
Ronald Devere, M.D.
Fellow of the American Academy of Neurology
Director, Alzheimer's Disease and Memory Disorders Center and
Director, Taste and Smell Disorders Clinic, Austin, Texas

A 2002 survey established that smell impairment might affect fourteen million Americans older than 55 years. More importantly, it affects 50 percent of the population between 65 and 79 years, and 75 percent by the age of 80. Eighty percent of normal older adults are not aware of this smell impairment, but will often tell you, or if questioned, state, "Food does not taste the same as before — it seems to be more bland, without any flavor." In many cases this can lead to poor appetite, weight loss, and depression.

Why does smell impairment lead to taste complaints? To understand this, a few important comments are necessary.

Our olfactory system, which is made up of a tiny smell organ in the upper nose and nerve connections in the brain, is necessary for us to recognize different odors. It is also important in recognizing food flavors such as strawberry, vanilla, and chocolate. Molecules of food flavors pass from the tongue to the back of the throat and then to the upper nasal airway during the act of swallowing.

The taste system is much larger and is very wide spread. Taste receptors are located in the tongue, palate, back of the throat, and lining of the mouth. There are five recognized



tastes: sweet, sour, bitter, salt, and savory (as in meat broth due to MSG). Spices and condiments of various kinds such as horseradish, salsa, mustard, and catsup are detected by a different (the trigeminal) system made up of sensory nerves from the tongue and the whole inner mouth. These are the same nerves, which are deadened when the dentist freezes your mouth to do a filling.

When the smell organ and its connections are impaired, flavor appreciation is lost or impaired. This is one reason why so many older people add excessive salt and/or sugar to their food in an attempt to get better taste and flavor.

In the mid-1980's, it was discovered that Azheimer's disease (all stages) and other disorders such as Parkinson's disease and Lewy body dementia, showed moderate impairment of smell when patients were tested. This was more severe than in normal adult population. It was found that smell impairment in Alzheimer's patients continued to worsen as the disease progressed. In Parkinson's disease, with or without dementia, smell impairment reached its peak early on in the illness.

Why is smell impaired in these disorders? Autopsy studies have shown that the pathology of Alzheimer's disease (amyloid deposition and neurofibillatory tangles) is prominent in the medial temporal lobes and

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the olfactory bulb, important areas of the brain that receive olfactory information. Also, alpha synuclein, which accumulates in Parkinson's and Lewy body dementia, causes damage to the olfactory bulb, receptors, and brain pathways.

The majority of patients with these disorders do not have smell complaints. Many are recognized by family members to have weight loss, decreased appetite, and depression. Most physicians would appropriately search for causes of these symptoms. This would include a thorough study for cancer, gastrointestinal disorders, urinary tract infection, and side effects of medication. Disorders of taste and smell are often not recognized as one of the possible causes. Awareness and treatment of this problem in Alzheimer's and related disorders can result in improved quality of life.

In mild cases of dementia, where the patients still have the ability to comprehend simple smell testing (a scratch and sniff test containing 12 different odors), a more detailed measure of smell impairment can be determined. A person shown to have mild to moderate smell impairment on testing can still appreciate some flavors. Using various artificial flavors available from the grocery store, and increasing the concentration of these flavors in different foods, can be very rewarding for the patient. In more severe cases this method would not work because flavor detection of most foods is likely absent. In these cases, an attempt is made to use multiple spices, and in heavier concentrations, depending on the patient's preference. These techniques along with varying food texture and temperature, can often increase enjoyment of eating, increase appetite, stabilize weight loss, and improve

quality of life. In my Taste and Smell Clinic, with the help of our food consultant, we can tailor make recipes for many of these patients.

Smell testing is also being used as a diagnostic tool in these neurological disorders. In some patients with MCI (mild cognitive impairment, which is defined as memory loss only) recent studies have shown that those with low scores on smell testing and no apparent reason for the low score (such as cigarette smoking, certain medication use, recurrent nasal and sinus disease) are more likely to be developing early Alzheimer's disease than those with MCI and normal smell function. Interestingly, 10 odors are more likely to be missed by patients with MCI who might be developing Alzheimer's. They are: menthol, clove, leather, strawberry, lilac, pineapple, smoke, soap, natural gas, and lemon.

Patients with Parkinson's features who have a low test score (25 or less out of 40) on the University of Pennsylvania Smell Identification Test (a standard smell test) are more likely to have idiopathic Parkinson's disease or Lewy body dementia. Other Parkinson-like disorders such as progressive supranuclear palsy, cortical basal degeneration, essential tremor, and Shy-Drager syndrome, which can sometimes be difficult to diagnose, have normal to slightly less than normal scores on testing. Eight odors are more likely to be missed by patients with idiopathic Parkinson and/or Lewy body dementia: licorice, coconut, banana, dill pickle, paint thinner, turpentine, cherry and soap. The American Academy of Neurology just recently included smell testing as one of the diagnostic tests for Parkinson's disease.

Identifying Pain in the Elderly

Carlos Escobar, M. D. Psychiatrist.
Director of Psychiatric Services and Hospice at Baptist Memorials Center at San Angelo, Texas.

The objective of this article is to produce a straightforward message regarding the art of eliciting and identifying pain in the elderly.

To our surprise, family members and caregivers of the elderly have progressively demanded more attention from the health care professional on addressing pain issues. Alarming statistics present evidence of the needs of the geriatric population, expert's unanimous consensus are all discussed in respected journals with emphasis placed on educating physicians about the seriousness of chronic pain in the elderly, including under assessment of pain and prescribing inappropriate medications for the elderly. There continues to be a wealth of information regarding pain management including surveys that have elicited data on demographics such as differences between gender, educational level, cultural and ethnic differences, etc. The physicians' shelves and medical school libraries continue to be enriched by a prolific trend of information on pain. Unfortunately, applicability of such treasured information does not always come into practice.

Recognizing pain issues in the elderly requires creating a warm atmosphere of empathic listening as well as a trusting legitimate relationship among physician, patient and caregiver. Such a relationship can be promoted in the office, as well as in a long-term-care facility.

The physician and other health care professionals delivering care for the elderly, **SHOULD ASK FIRST**, for pain issues during a routine appointment. It is called the fifth vital sign. Elderly patients will not always bring up such complaints. Fortitude and passive acceptance to suffering (admirable stone-faced, sturdy as an ox, stoicism) have been attained qualities and robust strengths of the older generations. Although, these psychological defenses can soften the torment and agony they cannot take the pain away.

When inquiring about pain issues the physician should be an attentive listener to the elderly, while also observing their facial expressions, eyes, gestures, and positioning while sitting or lying down. If the professional inquires about pain then turns away busily taking notes or typing on a keyboard the opportunity for trust may be lost. The patient may not return to the office again.

Here they are some clinical pearls that can help the clinician assessing pain in the elderly.

1. **ASK FOR PAIN FIRST.** Look in your patient's eyes and at their face. This attentive gesture will establish trust and create a connection. If you want to gain a patient's trust, please do not inquire about pain while turning your eyes away.

2. If the patient answers, "YES, I do have pain," obtain a complete pain assessment.

3. Inquire for more than one pain modality and location – pin and needles, lancinating pain, joint pain, etc.

4. Determine if pain is elicited with motion, transferring, bathing or dressing.

5. Determine if assistance provided by a caregiver can aggravate pain and induce behavioral or aggressive responses. For instance, an embrace during a transfer can make rib pain unbearable, the act of dressing can cause severe pain to a joint that has been carefully nurtured in an immobile position, and the act of lifting or turning can worsen hip pain.

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6. Anticipatory pain can be managed by the administration of an analgesic medication about 1/2 hour before delivery of care for Activities of Daily Living.

7. Determine legitimacy of what is called "allergy to morphine, codeine and all other opioids." True allergy to the above-mentioned medications is uncommon. Allergy is sometimes a misnomer for what might have actually been hallucinations and agitation seen in the post surgical period or an ICU delirium. A test challenge can be implemented to prove or disprove a true allergy.

8. Don't miss the train... read the sign: "opioids in the elderly do not provoke addiction." They are safe and effective when properly prescribed.

9. Methadone, a synthetic opioid, is as effective as morphine and the cost is substantially less than opioids. It may be used in the outpatient setting in a safe manner. It can also enhance alertness and attentiveness in the elderly.

10. Always remember to assess for phantom pain in the amputee and thalamic pain in the stroke patient.

11. Postherpetic neuralgia, brings a spectrum of symptoms and a definite clinical challenge. The pain can be acute and chronic, causes dysesthesia and allodynia. Peripheral sensory fiber loss and secondary anesthesia in the most painful areas bring paradoxical pain (anesthesia dolorosa or deafferentation pain).

12. One of the most common diagnostic challenges is postherpetic neuralgia pain without a history of zoster rash. It is an entity known as zoster sine herpete, or zoster without

rash. In this case, serologic studies can be used to confirm the diagnosis.

13. Update yourself: Administration of propoxyphene is an inadequate and obsolete intervention. The analgesia obtained is equivalent to a dosage of acetaminophen. It is not exempt of trouble and can cause nausea, vomiting, and serum level build up contributing to confusion in the elderly.

14. Attempt to simplify the pain regimen. Inappropriate medication use in the elderly patient has been linked to a large portion of adverse drug reactions and to excess health care utilization.

15. Don't discount psychosocial factors contributing to catastrophic reaction to pain, which can influence outcomes. Pain in the wallet can be greater than hip bursitis. Acknowledged pain involves a large array of emotions. Psychiatric ailments often accompany chronic pain. Be a reverential professional listening to both patient and family members.

16. Don't assume you know all. Ask for input and listen to staff members from the facility and the caregiver in the home. Omission of insights from others can be costly. Otherwise, use a Pain Treatment Team for further assistance.

17. Learn to identify pain in the impaired elderly. Scales used to measure pain in a numeric intensity from 0 to 10, the FACES pain rating scale, are helpful tools in the assessment of pain severity. Gentle motion and prudent touch can change face expression to determine pain existence.

CONTROL OF PAIN – MALIGNANT AND NON-MALIGNANT – IMPROVES QUALITY OF LIFE AND SAFEGUARDS INDIVIDUAL DECORUM.

"Light griefs do speak, while sorrow's tongue is bound."- Seneca.

Elder Abuse and Neglect

Richard Steinberg
Texas Department of Family and Protective Services

News in 2006 about the financial exploitation of a wealthy New York socialite shows that vulnerable adults from all walks of life are at risk of being abused. While this news coverage has helped increased public awareness of elderly abuse, it is only the tip of the iceberg. An estimated 500,000 older people in the United States need help with their financial affairs. And financial exploitation cases comprise only a relatively small percentage of the total abuse cases for people who are elderly or have disabilities.

In Texas, the majority of cases investigated by Adult Protective Services concern self-neglect — cases that rarely make national headlines. Self-neglect occurs when individuals fail to provide themselves with whatever is necessary to prevent physical or emotional harm or pain. Through illness or diminished mental capacity, vulnerable adults may no longer be able to provide adequately for their own health and safety. They may live in unsanitary conditions, without heat or running water, or may need assistance with meals and other daily activities. They

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Former Council Member Receives "Spirit of Freedom" Award

Dr. Laura Matos, former member of the Texas Council on Alzheimer's Disease and Related Disorders, received one of the first Spirit of Freedom Awards presented by the McAllen Monitor and Freedom Newspapers in Spring 2006. Dr. Matos received the honor in the "Power to Heal" category for someone involved in the medical profession who selflessly works for a healthier community.

Dr. Matos has over 15 years experience of medical practice in the specialty of physical medicine and rehabilitation. She is and has been a founding and instrumental leader in the establishment of support groups for families facing debilitating Alzheimer's disease in both Guadalajara, Mexico, and in McAllen, Texas. She founded the Rio Grande Valley's first and only Spanish language support group for caregivers of Alzheimer's patients five years ago, after tending to her mother, who died of breast cancer and dementia in 2003. "No medical book, no medical school ever taught me to deal with a demented patient," she said.

She is also a founding member of the Silver Ribbon Community Partners Board of McAllen, an organization focused on enhancing the awareness of elder abuse issues. This organization partners with others to provide assistance to victims of elder abuse, neglect and exploitation. Dr. Matos has been a speaker at several national and international forums on issues related to the elderly and Alzheimer's disease. She was appointed to the Texas Council on Alzheimer's Disease and Related Disorders by Lieutenant Governor Bill Ratliff in 2002, and served in that capacity until 2006.

CONGRATULATIONS, DR. MATOS!

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may also require medical care.

Adult Protective Services cases may also involve abuse or exploitation of elderly or people with disabilities living in their homes. This form of abuse is by new "best friends," thieving caregivers, con artists, and financial abuse by family members. In Fiscal Year 2005, Adult Protective Services completed 67,023 investigations of abuse, neglect, or exploitation involving adults living at home. Of these, 45,392 were confirmed.

In the last decade, the number of in-home cases investigated by Adult Protective Services has more than doubled.

For more information on the legal definitions of abuse and neglect in Texas, you may consult with the Texas Human Resources Code, Section 48.002. If you know a person who is elderly or has a disability and may be in a state of abuse, neglect, or exploitation, call the Texas Abuse Hotline at 1-800-252-5400. If it is a life threatening emergency, dial 911.

Appointments to the Texas Council for Alzheimer's Disease and Related Disorders

The following appointments have been made to the Texas Council for Alzheimer's Disease and Related Disorders by the Governor, Lieutenant Governor or Speaker of the House.

Debbie Hanna of Austin, Texas was designated Presiding Officer by Governor Rick Perry. Ms. Hanna is the President of the Alzheimer's Association Capital of Texas Chapter which serves individuals and families affected by Alzheimer's disease in 17 central Texas counties.

Ronald Devere, M.D. of Austin was appointed by Governor Rick Perry. Dr. Devere has a private practice in neurology and is the Director of the Alzheimer's Disease and Memory Disorder Center.

The Honorable Clint Hackney of Austin was appointed by Speaker Tom Craddick. Mr. Hackney was a member of the Texas House of Representatives from 1980 – 1988. He authored several major pieces of legislation during his tenure including the current Texas Election Code. Currently, he owns Hackney and Associates, which provides public policy advice and consulting.

Margaret Krasovec of Austin, Texas was appointed by Lieutenant Governor David Dewhurst. Ms. Krasovec has more than 20 years experience providing market analysis, marketing plan development and implementation, sales program audits and redesign for the apparel manufacturing and healthcare industries.

Agency Appointments to the Texas Council on Alzheimer's Disease and Related Disorders

The following appointments have been made to the Texas Council for Alzheimer's Disease and Related Disorders by the Health and Human Services Commission (HHSC), Department of State Health Services (DSHS) and the Department of Aging and Disability Services (DADS).

HHSC

Audrey Deckinga, MSSW is a Senior Policy Advisor in the Office of the Deputy Executive Commissioner for Health Services. Ms. Deckinga has worked in social services for over 30 years in three states. For the past 18 years in Texas she has worked at the Department of Family Protective Services in Child Protective Services in various capacities including the Director of Policy and Programs. In May 2006, she began her new duties at HHSC.

DSHS

Sam Shore, MSSW, LMSW is the Assistant Director of the Center for Policy and Innovation. In this role he is responsible for coordinating policy development for mental health and substance abuse among DSHS divisions and with other state agencies. Prior to the HHSC consolidation he worked at the Texas Department of Mental Health and Mental Retardation as the Director of Behavioral Health Services.

Jennifer Smith, MSHP is the Manager of the Adult Health and Chronic Disease Program. In this role she is responsible for the leadership and guidance of the Cardiovascular Disease and Stroke Program, the Comprehensive Cancer Program, the Arthritis Program, the Asthma Program and the Alzheimer's Disease Program. Additionally, she directs the DSHS Health and Wellness Program.

DADS

Michael Wilson, Ph.D. is the Coordinator for Aging Texas Well. The Aging Texas Well program focuses on preparing Texans for aging across the life course through research, planning, policy analysis, education, public-private partnerships, and community capacity building. Dr. Wilson was formerly the Chief Gerontologist and independent researcher, analyst, and consultant at Michael P. Wilson and Associates Inc., a gerontological consulting and care management firm.

Winnie Rutledge is the Grants Coordinator for the Access and Intake/Area Agencies on Aging Section. She has over 34 years of public service, including ten years with the Retired and Senior Volunteer Program and Area on Aging with the South East Texas Regional Planning Commission and 16 years with the Texas Department on Aging.

Texas Council on Alzheimer's Disease and Related Disorders Current Member Roster

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For more information on Alzheimer's disease, to be placed on the newsletter mailing list, or to change your mailing address, please call 800.242.3399. There is no cost to subscribe. Newsletters are also posted on the Internet at www.dshs.state.tx.us/alzheimers.

Viewpoints expressed in this newsletter do not necessarily reflect those of the Texas Council on Alzheimer's Disease and Related Disorders.

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The 70th Legislature passed HB 1066 creating the Texas Council on Alzheimer's Disease and Related Disorders (Council). The Council was established to serve as the state's advocate for persons with Alzheimer's disease and those who care for them. The Governor, Lieutenant Governor, and Speaker of the House appoint members. The Council is composed of seventeen members. There are five public members, seven professional members, and five state agency members. The Health and Human Services Commission, Department of State Health Services, and Department of Aging and Disability Services are currently represented.

The Council has adopted as their mission to:

•Disseminate information on services and related activities to the medical and academic communities, caregivers, advocacy associations, and the general public to heighten awareness and education of Alzheimer's disease and related disorders.

•Coordinate, collaborate, and support services and activities of state agencies, associations, and other service providers,

•Encourage statewide coordinated research, and

•Recommend needed action for the benefit of persons with Alzheimer's disease and related disorders and their caregivers.

TEXAS Department of State Health Services

Texas Department of State Health Services
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