

Anti-Dementia Drug Prescribing Following New Dementia Diagnosis: Provider Type, Specialist Involvement, and Collaborative Care

Authors

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Background

- Early intervention for patients with dementia is most effective for long term benefit¹.
- AChEis and memantine (ADDs) can help symptoms¹.
- ACP/AAFP guidelines recommend individualized assessment for these drugs in every patient².
- Little is known about real-world prescribing patterns.
- The Care Ecosystem: collaborative care model designed by UCSF to enhance dementia care coordination.



Objective

Describe the frequency of ADD initiation in new dementia diagnosis and what factors affect prescription rates.

Methods

Design: Retrospective descriptive study.

Population: Patients ≥45 years with a new dementia diagnosis between 01/01/2019-06/30/2025, with an established PCP and either ≥1 PCP visit or CareEco enrollment. Patients on hospice or palliative care at diagnosis were excluded.

Comparison Group: General population patients (n=137) were selected using simple random sampling for comparison to the CareEco cohort (n=137).

Setting: Providence Oregon health system.

Dementia Definition: New dementia diagnoses identified using ICD-10 codes (Alzheimer disease, frontotemporal, Lewy body, vascular, unspecified). Mixed dementia was classified as vascular dementia.

Primary Outcome: Initiation of ADD following new dementia diagnosis.

Stratified Variables: Provider type, neurologist involvement, CareEco enrollment, and diagnosis type.

Results

Patient factors

- Most patients received an ADD (67%, n=184).
- Patients with Lewy body most often received a prescription (88%, n=7), followed by Alzheimer (77%, n=53), vascular (76%, n=35), unspecified (59%, n=88) and frontotemporal (50%, n=1).

Prescribers

- PCPs initiated most prescriptions (53%).
- Neurologists prescribed 34% of ADDs.

Care teams

- Patients with a neurologist were prescribed ADDs more frequently (80% vs 59%, p<0.001).
- Patients in CareEco were prescribed more ADDs (85% vs 49%, p<0.001).

Outcomes:

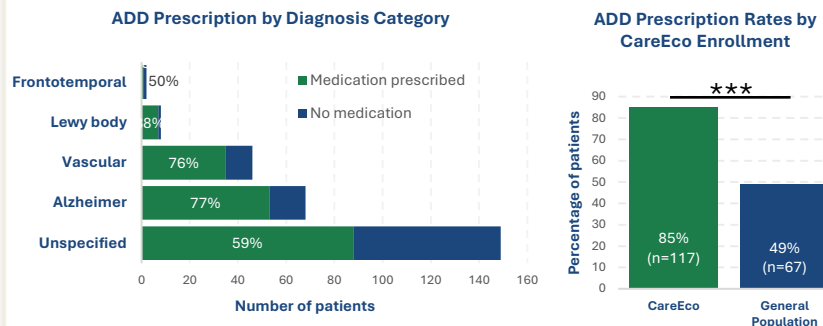
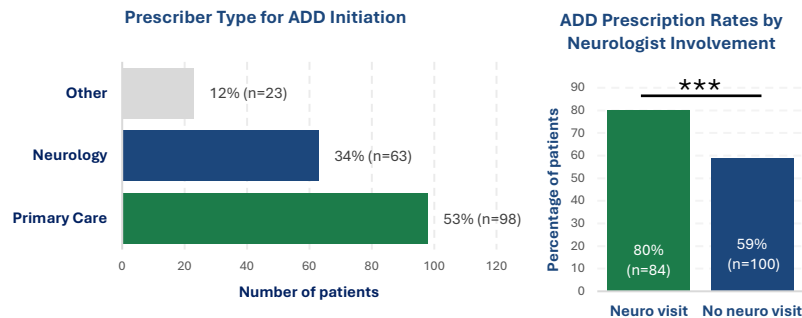
Patients were more likely to receive treatment when:

- Their dementia diagnosis was clearly specified
- A neurologist was involved
- They were enrolled the collaborative care model – CareEco
- One third of patients did not receive ADD.

Table 1. Patient Characteristics

Variables	N = 274
Age, mean (IQR)	
CareEco	75 (69, 80)
General Population	81 (76, 77)
Sex, n (%)	
Female	162 (59)
Race/Ethnicity, n (%)	
Racial or Ethnic minority	20 (7.2)
Not reported	17 (3.3)
Diagnosis category, n (%)	
Alzheimer disease	69 (25)
Vascular/mixed	46 (17)
Lewy body	8 (3)
Frontotemporal	2 (0.7)
NOS/classified elsewhere	149 (54)
Comorbidities, n (%)	
Bradycardia	10 (3.6)
First degree AV block	1 (0.7)
COPD	32 (11.7)
Renal failure	13 (4.7)
Medication prescribed, n (%)	
Donepezil	128 (47)
Memantine	45 (16)
Rivastigmine	9 (3.3)
Galantamine	2 (0.7)
None	90 (33)
Completed appointment with neurology, n (%)	105 (38)

More patients are treated for dementia when PCPs are supported by an **expanded care team** and patients have a **specific diagnosis**.



Conclusions

- Collaborative care provides support for both patient and provider and helps close treatment gaps.
- Diagnostic precision is essential to management as some drugs are inappropriate for certain etiologies of cognitive impairment.

Limitations: This study did not examine why prescribing trends differ nor can causal relationships be drawn.

Significance: This study highlights the need for structural support in the care of complex conditions like dementia. The CareEco model shows promise in this endeavor. Further investigations should focus on why the patterns differ as well as where the gaps in dementia diagnosis lie.

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