PACE

Pharmaceutical Assistance
Contract for the Elderly

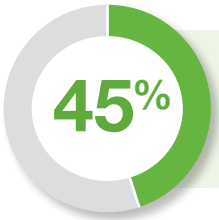
Alosa Health

Bringing unbiased evidence
to clinical care

Managing the confusion

Evidence-based strategies to prevent, diagnose, and manage cognitive impairment in older adults

Preventing cognitive decline



Up to 45% of dementia risk can potentially be prevented or modified.[1]

Several primary care interventions can reduce dementia risk:

Control blood pressure (BP)

Strict BP control with systolic BP <120 mm Hg reduced the risk of mild cognitive impairment (MCI) or dementia compared to standard BP control of <140 mm Hg.[2]

Recommend vaccinations

Herpes zoster (shingles) vaccine reduced dementia risk in age-eligible patients versus those who were not immunized.[3-5] Other adult vaccines, like influenza, pertussis, and pneumococcus, may also be associated with a reduced risk of dementia, but the evidence is limited.[6]

Treat hearing loss

Among older patients with hearing loss at high risk of cognitive decline, those counseled by audiologists and given hearing aids had slower cognitive decline at three years than those with no hearing intervention.[7]

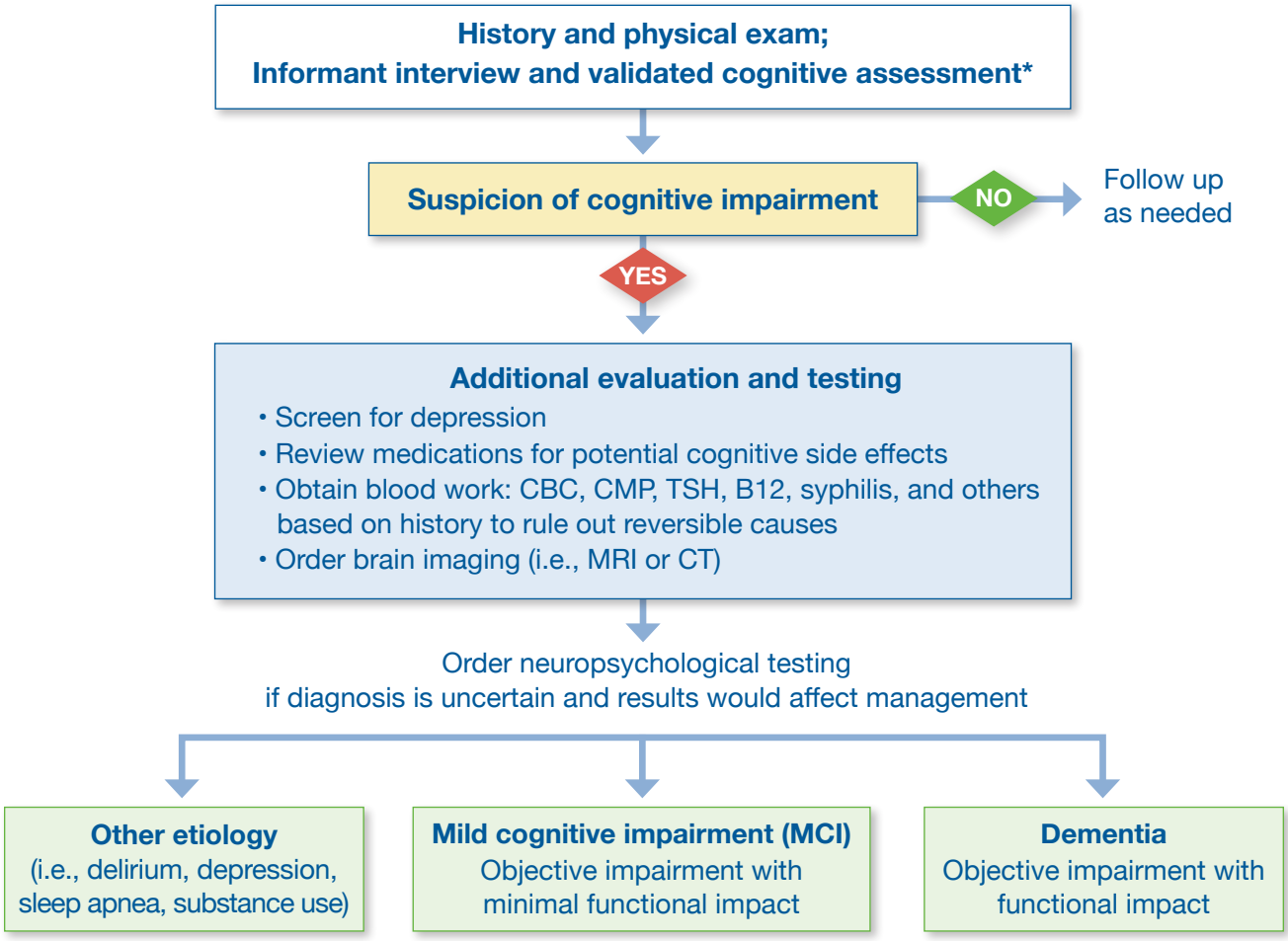
Promote overall health

Mediterranean and DASH diets, which focus on consuming healthy fats, fruits, vegetables, beans, legumes, and whole grains, have been associated with slowing cognitive decline in randomized trials.[8,9]

The US POINTER trial, a multifaceted two-year trial of a high-intensity intervention that encouraged physical activity, a healthful diet, social engagement, and cardiovascular health, modestly improved cognition compared to a low-intensity intervention.[10]

Defining the cause

FIGURE 1. Evaluating a patient with cognitive concerns or signs of cognitive difficulty[11]



*Validated assessment tools include the Mini-Cog, Montreal Cognitive Assessment (MoCA), Ascertain Dementia 8 (AD8), or Mini-Mental State Examination (MMSE).

Not all cognitive decline is Alzheimer's disease

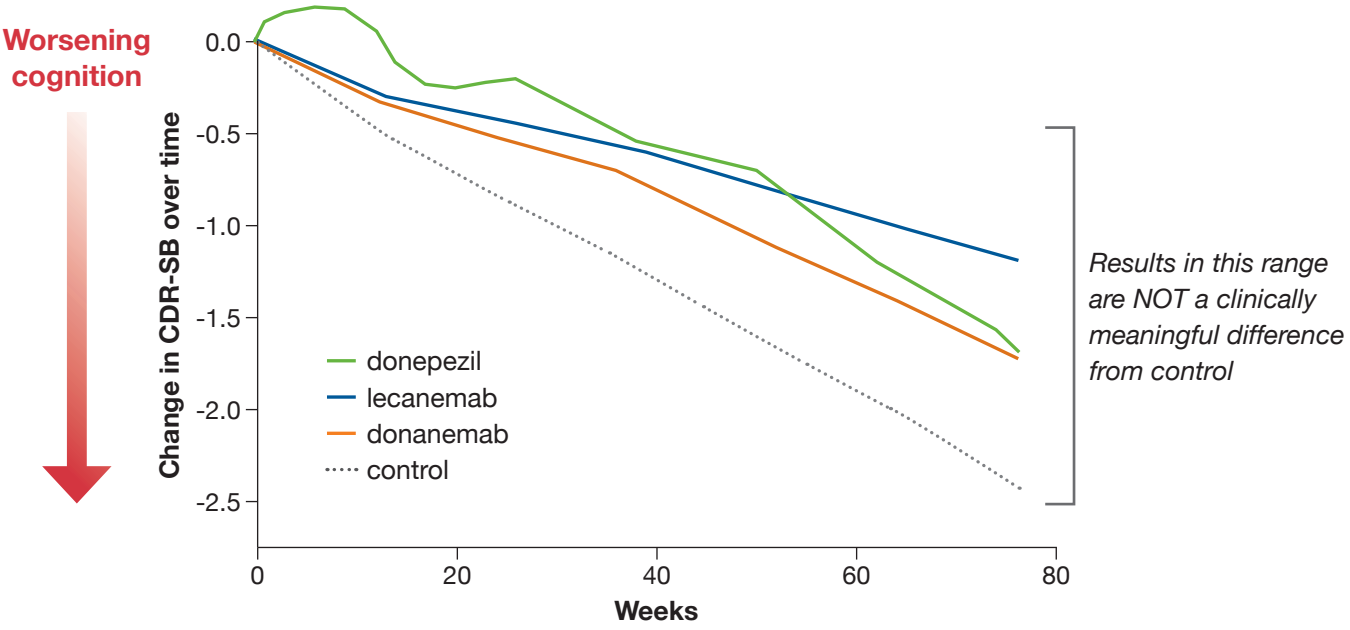
Common causes of cognitive impairment include Alzheimer's disease, vascular dementia, fronto-temporal dementia, Lewy body disease, and a recently described syndrome, limbic-predominant age-related TDP-43 encephalopathy (LATE).

Key characteristics of LATE:

- resembles Alzheimer's disease but progresses more slowly
- can occur with other causes of dementia
- marked by hippocampal atrophy without amyloid pathology; no practical biomarkers
- estimated to affect ~1 in 3 adults over age 85
- no proven treatments to date

Current medications do not provide clinically meaningful benefit

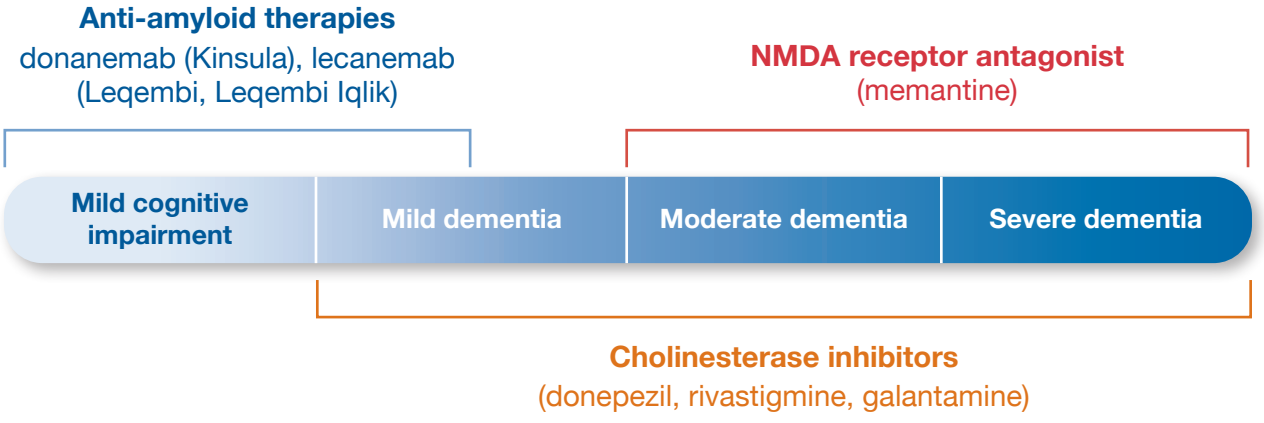
FIGURE 2. The effects of all currently available medications on the Clinical Dementia Rating-Sum of Boxes (CDR-SB) score are similar, and not clinically meaningful.[13-16]



The graph above is a composite approximation of the results of several trials in different populations to roughly suggest the magnitude of benefit seen with these treatments across multiple studies.

The timing and stage of cognitive impairment matter

FIGURE 3. Efficacy varies by stage: anti-amyloid drugs have been studied in early disease; cholinesterase inhibitors and memantine have been studied and approved for later stages.



Some researchers believe that anti-amyloid medications may have a narrow window favoring early rather than later use, to confer more clinically meaningful effects.

Available treatments can be burdensome

Lower risk options: cholinesterase inhibitors and memantine

FIGURE 4. These oral medications are simple to prescribe but can cause problematic side effects.[17,18]

Donepezil (cholinesterase inhibitor)*

• nausea	11%
• diarrhea	10%
• headache	10%
• dizziness	2%
• bradycardia	2%
Discontinuation	**29%**

Memantine

• dizziness	7%
• confusion	6%
• headache	6%
• hypertension	4%
Discontinuation	**18%**

*Other cholinesterase inhibitors (galantamine, rivastigmine) have similar side effects.

Significant risk and burden: anti-amyloid therapies

Donanemab and lecanemab require a baseline PET scan or cerebrospinal fluid (CSF) test, infusions every 2–4 weeks, and MRIs to monitor for brain swelling or bleeding, which may change treatment.

- **Cerebral edema** occurred in almost 1 in 4 patients receiving donanemab, about twice as many as with lecanemab.
- **Cerebral hemorrhage** occurred in about 1 in 5 patients receiving either medication.
- **Contraindicated in patients taking anticoagulants** such as warfarin, apixaban, or heparin.

Infusion-related reactions (e.g., nausea, vomiting, flu-like symptoms) are more common with lecanemab than donanemab (26% and 9%, respectively), often requiring antihistamines, NSAIDs, or steroids.

TABLE 1. Comparison of the anti-amyloid medications

	Donanemab	Lecanemab
Frequency	Every 4 weeks	Every 2 weeks
Infusion duration	30 minutes	60 minutes
Treatment duration	76 weeks, or if/when plaque levels are low on amyloid PET scans	Indefinite After 18 months of IV treatment, patients may switch to a subcutaneous form or continue IV

Is there a role for biomarkers?

PET scans and **CSF tests** are the current standards to determine anti-amyloid therapy eligibility. Blood tests, some marketed directly to patients, are increasingly available.

Blood tests require specialist or laboratory expertise to correctly interpret and evaluate the results. They should not be used in asymptomatic patients or patients without objective cognitive impairment.

TABLE 2. There are only two FDA-approved blood tests for Alzheimer's disease biomarkers.*

Target	Test	Setting	Notes
Tau	Elecsys pTau 181	Primary care	"Rule out" test to identify if amyloid pathology may be present to determine preliminary candidacy for anti-amyloid therapies. A positive test requires further biomarker testing for confirmation (i.e., PET scan or CSF test).
Amyloid + Tau	Lumipulse G pTau217/β-Amyloid 1-42 Plasma Ratio	Dementia specialist	Intended as an option instead of PET scan or CSF test to detect Alzheimer's pathology. Early real-world data suggests test may not be as accurate as it was in trials.[19]

Weighing the use of medications

Medications may not be the right choice for everyone

There are still uncertainties about which patients will gain meaningful benefits or have significant side effects from medications for dementia. Clinicians, patients, and families may reasonably choose not to initiate medications immediately or at all.

Review treatment response and ask about side effects

- Ask the patient and caregiver about their perceptions of the benefit of treatment.
- Inquire about medication-related side effects (e.g., diarrhea with donepezil).
- Ensure that continuing medications for cognitive impairment aligns with the goals of care.

If needed, stop medication

- If adverse effects or burden exceed the perceived benefit, reassess therapy. For oral medications, reduce the dose slowly.

Addressing the behavioral and psychological symptoms of dementia (BPSD)

1 Identify the behavior to be managed

Patients with cognitive impairment often experience one or more of the following—apathy, depression, anxiety, agitation, hallucinations, or delusions—but not all require medication.

2 Explore possible underlying causes for the behavior, and prioritize non-pharmacologic strategies[20]

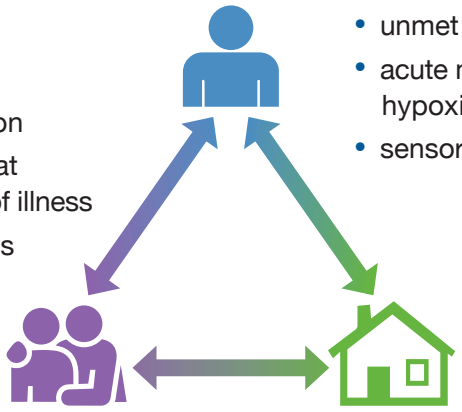
Factors impacting behaviors:

Patient

- unmet needs (e.g., hunger, thirst, pain)
- acute medical problems (e.g., infection, hypoxia, drug side effects)
- sensory deficits (hearing, vision)

Caregiver

- stress, burden, depression
- lack of understanding that behaviors are the result of illness
- mismatch of expectations and dementia severity



Environment

- over- or under-stimulation
- unsafe environment
- lack of activity
- lack of structure or routines

3 Consider whether a medication is indicated

- For patients who require a medication, start with sertraline or citalopram for agitation.[21,22]
- If dangerous or distressing behaviors occur, an antipsychotic may be necessary. **Use cautiously**—start low, keep duration short, and prioritize non-pharmacologic options.

Note: Within 12 weeks of use, **antipsychotic medications increase the relative risk of death** in older patients with dementia **by about 50%**.[23]

4 Regularly reassess treatment response and need

- Within one month, review treatment response and assess for side effects.
- After 3 to 4 months, consider decreasing the dose or discontinuing treatment.

Prepare for progressive impairment

Advance care planning (ACP) is an ongoing process of reflection and communication among patients, their loved ones, and healthcare professionals to help guide clinical decision-making. The aim is to provide care that aligns with the patient's values, goals, and preferences.[24]

Even among people with dementia, 30% of patients had no ACP documentation at the time of their death.[25]

1. **Start the conversation early**

   Ask the patient to talk about their wishes with people who will be making care decisions when they cannot.

2. **Discuss what to expect as dementia progresses**

   Identify and discuss plans for matters such as transportation when patients are no longer able to safely drive themselves.

3. **Ask about the patient's treatment preferences,** including which interventions they would want in end-of-life care.

4. **Document the advance care plan in writing**

   All patients should have an identified health care proxy.

   Additional documents include a living will, power of attorney, and medical directive (i.e., Provider Orders for Life-Sustaining Treatment—POLST).

5. **Reassess the patient's needs and wishes when clinical condition or level of care changes**

Tools to help get started

Some practical, field-tested tools can help initiate the conversation:

- **PREPAREforyourcare.org:** an interactive ACP documentation tool[26]
- **"What Matters to Me" Workbook:** one of many tools from The Conversation Project to help clarify care preferences
- **Five Wishes:** questions to help prepare and document patient preferences[27]

PREPARE for your care website

Caring for patients with dementia

Over 11 million people provide unpaid care to patients with dementia[28]

FIGURE 5. Caregivers dedicate nearly 30 hours a week, on average, caring for others.[29]

Average time spent caregiving per week

27.3 hours

Instrumental activities of daily living (IADLs), e.g.:

- grocery shopping
- transportation
- housework
- meal preparation

Activities of daily living (ADLs), e.g.:

- toileting
- feeding
- bathing
- dressing

Caregivers perform >2x as many IADLs as ADLs

Ensure caregivers have access to support

Coping classes can reduce distress, anger, and depression, while increasing self-efficacy. Example programs include:

- **Caregiver center:** qrco.de/Alz_caregiving
- **Best programs for caregiving:** bpc.caregiver.org

Family Caregiver Alliance
qrco.de/CaregiverPA

A new program to GUIDE care

Based on studies which found enhanced caregiver outcomes (improved self-efficacy, less burden and reduced depression) with care navigation versus usual care, the Medicare program is testing an innovation model, Guiding an Improved Dementia Experience (GUIDE).[30,31]

Program eligibility:

- diagnosis of dementia
- enrolled in traditional Medicare A & B
  - not including MA plans* or Program of All-Inclusive Care for Elderly (LIFE Program)
- not enrolled in hospice or residing in a long-term nursing home

Program offers:

- comprehensive assessment
- individualized care planning
- caregiver training and education
- connections to community resources
- 24/7 support

*Patients in Medicare Advantage may have access to similar programs.

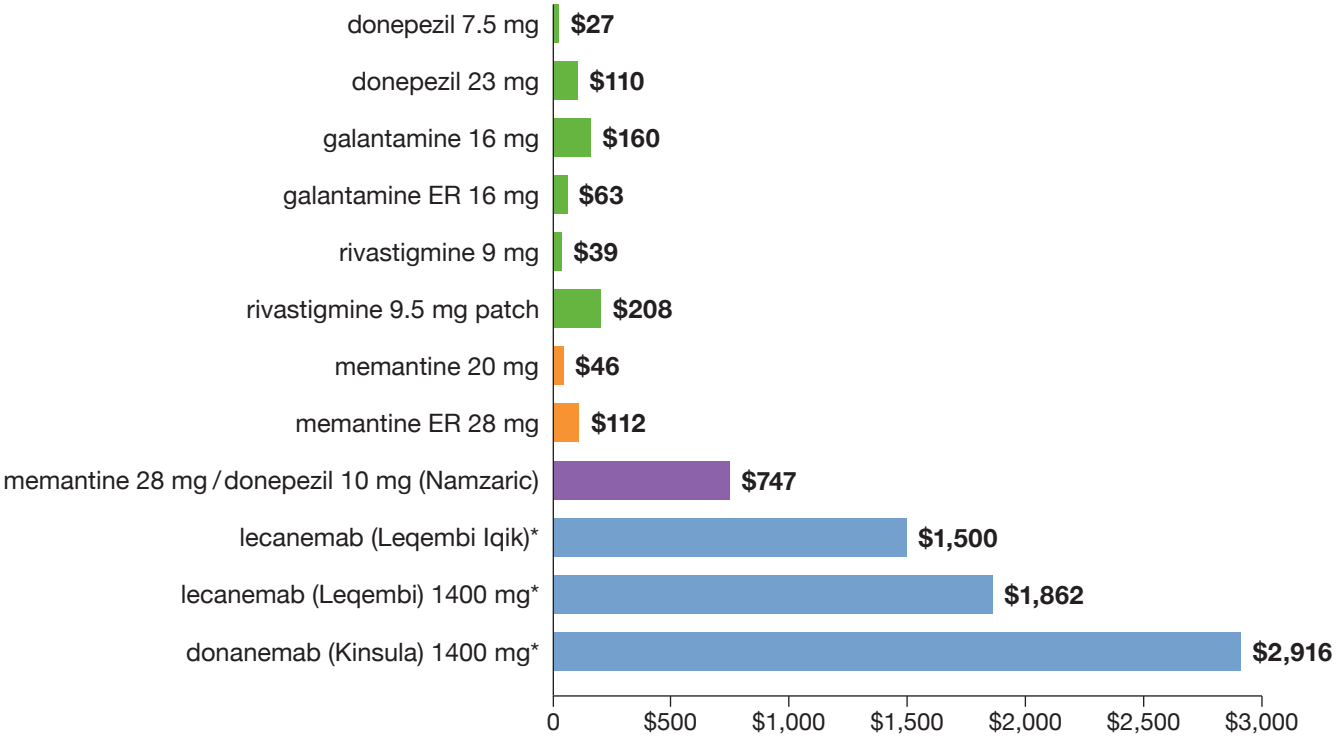
Providing care for patients without a caregiver

Over 1 in 4 patients with dementia lives alone.[32]
They may not have formal caregivers or may only have caregivers at a distance.

- **Utilize in-home assessments**
  This can lower fall risk and may help identify other concerns needing attention.
- **Simplify medication regimens**
  This can include consolidating timing of medications and deprescribing if clinically indicated.
- **Assess self-management skills**
  Smart pill dispensers, fall alert bracelets, or other devices can be useful.

Cost of prescription drugs

FIGURE 6. Price of a 30-day supply of medications to manage dementia



*Monthly prices of lecanemab (for a 70 kg patient) and donanemab are based on Medicare average wholesale price Jan 2026. Other pharmacy prices are from goodrx.com, February 2026. Listed doses are based on Defined Daily Doses by the World Health Organization. All doses shown are generics when available, unless otherwise noted. These prices are a guide; patient costs will be subject to copays, rebates, and other incentives. These doses should not be used as a guide for treatment.

Key points

- **Promote overall health** to help prevent cognitive decline, focusing on blood pressure control and a Mediterranean or DASH diet.
- **Address treatable causes** of cognitive impairment when possible, such as vitamin deficiencies, thyroid dysfunction, depression, and medication side effects.
- Recognize the **limitations of available treatments:**
  - None of the medications stop or reverse cognitive decline.
  - Risks vary from GI side effects with cholinesterase inhibitors or memantine to cerebral side effects with anti-amyloid therapies.
- **Discuss advance care planning,** encouraging the identification of a health care proxy and reassessing care plans as dementia progresses.
- **Support caregivers with nonpharmacologic strategies** for disruptive behaviors, reserving short-course antipsychotics for dangerous or disturbing symptoms.

Visit AlosaHealth.org/Dementia for links to materials and other resources.

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About this publication

These are general recommendations only; specific medical decisions should be made by the treating clinician based on an individual patient's clinical condition. More detailed information on this topic is provided in a longer evidence document at AlosaHealth.org.

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