How effective are primary care-led models of post-diagnostic dementia care? A systematic review

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Background

- The content and quality of post-diagnostic dementia care varies widely within and between countries.
- The World Alzheimer's Report (2015)[1] recommends a global shift towards primary care-led dementia services to increase support closer to home and to maximise the efficiency of healthcare resources.
- However, currently it is unclear whether this is an effective approach, and if so, what the best model of support might be.

We aimed to assess the **effectiveness and cost-effectiveness** of models of **post-diagnostic dementia care** which have **substantial involvement from primary care**.

Methods: We systematically reviewed controlled trials and cost-effectiveness studies of post-diagnostic models of dementia care substantially involving one or more primary care providers (PCPs), compared to usual care or an alternative management model. Studies of interventions led by other services (e.g. care homes) or focussed upon diagnosis or provider education were excluded.

We searched MEDLINE, PsychINFO, EMBASE, Web of Science and CINAHL (inception to March 2019) and performed citation tracking and reference list screening. One author screened titles, and two authors screened full texts and independently assessed study quality. We inductively grouped models of care. Random-effects meta-analysis was carried out where sufficient data were available and narrative synthesis used otherwise. Prospero ID CRD42018104128.

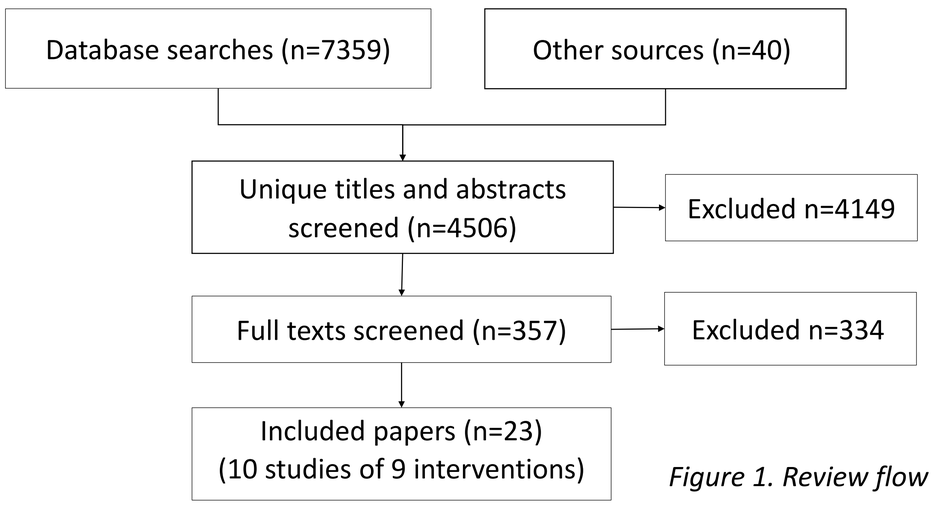

Figure 1. Review flow chart

Results

PCP-led management (n=1 RCT[2], moderate quality)

All post-diagnosis treatment and care is provided by the primary care provider [vs memory clinic]

✓ caregiver anxiety and depression, hospital admissions

× depression, neuropsychiatric symptoms, quality of life, functioning, caregiver mastery

£ ✓ memory clinic costs, × overall cost savings

PCP-led with specialist consulting support (n=1 RCT[3], n=1 CCT[4], mixed quality)

Post-diagnostic care is provided by the GP, with support from specialists for complex management [vs usual primary care]

× functioning, quality of life, cognition, caregiver quality of life, caregiver burden, caregiver mastery, moves to long term care

£ no difference to usual care (potentially higher neurologist costs).

PCP-case management partnership models (n=3 RCTs[5-7], n=2 CCTs[8-9], mixed quality)

Care is led by a case manager (usually a nurse), who conducts a structured assessment of needs and forms a care plan, with decision-making input from a PCP [vs usual primary care]

✓ neuropsychiatric symptoms (MD -6.68 [-9.45, -3.91], N=2, n=414), caregiver burden (SMD -0.43 [-0.83, -0.04], N=3, n=469), distress, coping and mastery

× functioning, quality of life, depression, cognition (SMD 0.04 [-0.31, 0.40], N=2, n=560), caregiver depression, moves to long term care (OR 1.37 [0.28, 6.66], N=2, n=560)

£ ✓cost-neutral or cost saving (no societal perspective)

Integrated memory clinic (n=1 CCT[10], low quality)

Secondary care services working with and within primary care (e.g. co-running clinics) [vs memory clinics and usual primary care]

✓ quality of life

× caregiver burden

£ ✓medical costs compared to usual primary care (× societal perspective), ✓cost-effective compared to memory clinics

Conclusion: PCP-case management partnership models show the most promise; however there were few studies and most were at high risk of bias. Further high quality studies are needed to establish the most effective and cost-effective model.

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