Summary: ADA Standards of Care for Older Adults with Diabetes (2025)

Key Assessment Framework

Initial & Annual Screening Requirements:

- Medical, psychological, functional, and social domains assessment
- Screen for geriatric syndromes (cognitive impairment, depression, falls, urinary incontinence, pain, frailty)
- Hypoglycemia risk assessment
- Polypharmacy review

4Ms Framework for age-friendly care:

- **Mentation**: Cognitive function, self-care ability, depression/anxiety
- **Medications**: Treatment burden, hypoglycemia risk, polypharmacy
- **Mobility**: Functional ability, frailty, neuropathy, vision/hearing
- **What Matters Most**: Goals, preferences, quality of life, life expectancy

Cognitive Function

- Screen adults ≥65 years at initial visit and annually using Mini-Cog, MMSE, or Montreal Cognitive Assessment
- Diabetes increases risk of dementia, cognitive decline
- Cognitive impairment complicates self-care and increases hypoglycemia risk

Hypoglycemia Prevention

High-Risk Population: Older adults have greater hypoglycemia risk due to:

- Irregular meals, insulin therapy, declining kidney function
- Cognitive impairment, complex medication regimens

Technology Recommendations:

- **CGM for Type 1 diabetes**: Improves outcomes, reduces hypoglycemia (Grade A)
- **CGM for Type 2 diabetes on insulin**: Reduces hypoglycemia (Grade B)
- **Automated insulin delivery systems**: Consider based on individual ability

Glycemic Goals (Individualized)

Healthy Older Adults

- **A1C**: <7.0-7.5%
- **Time in Range (TIR)**: ≥70% (70-180 mg/dL)
- **Time Below Range**: <4% (<70 mg/dL)

Complex/Intermediate Health

(Multiple chronic illnesses, 2+ ADL impairments, mild-moderate cognitive impairment)

- **A1C**: <8.0%
- **TIR**: ≥50%
- **Time Below Range**: <1%
- Focus on avoiding hypoglycemia

Very Complex/Poor Health

(End-stage illness, moderate-severe cognitive impairment, 2+ ADL dependencies)

- **Avoid A1C targets**
- Focus on preventing hypoglycemia and symptomatic hyperglycemia
- Goal: 100-180 mg/dL preprandial

Medication Management

Preferred Agents (low hypoglycemia risk):

- **Metformin**: First-line if eGFR ≥30 mL/min/1.73m²
- **GLP-1 RAs**: Cardiovascular benefits; weekly dosing; monitor for GI side effects and weight loss
- **SGLT2 inhibitors**: Cardiovascular/kidney benefits; use cautiously (volume depletion, UTIs, fracture risk)
- **DPP-4 inhibitors**: Low hypoglycemia risk; useful for mild hyperglycemia

Use with Caution:

- **Sulfonylureas/Meglitinides**: High hypoglycemia risk; avoid glyburide
- **Insulin**: Long-acting analogs preferred over NPH; simplify complex regimens
- **Pioglitazone**: Risk of heart failure, fractures, edema

Avoid Overtreatment:

- Intensive insulin regimens with A1C <7% are often inappropriate
- Common in clinical practice and increases mortality risk

Treatment Deintensification

When to Simplify/Reduce Treatment:

- Severe/recurrent hypoglycemia
- A1C consistently below individualized goal
- Cognitive or functional decline
- Unable to manage complex insulin regimens
- Polypharmacy
- Limited life expectancy
- End-of-life care

Insulin Simplification Algorithm:

- Convert to once-daily basal insulin (morning dosing)
- Discontinue or reduce prandial insulin
- Add non-insulin agents (metformin, GLP-1 RA, SGLT2i, DPP-4i)
- Titrate based on preprandial glucose (goal: 90-150 mg/dL)

Lifestyle Management

- **Nutrition**: Adequate protein intake to prevent sarcopenia
- **Exercise**: Aerobic, weight-bearing, resistance training
- **Weight loss** (if appropriate): 5-7% for those with overweight/obesity and good functional status improves quality of life and physical function
- **Avoid** intensive weight loss in frail individuals

Long-Term Care/Skilled Nursing Facilities

Staff Education Required: CGM use, insulin pump management, hypoglycemia recognition

Hypoglycemia Alert Strategy:

- Immediate call for glucose <70 mg/dL
- Call ASAP for glucose 70-100 mg/dL or persistent elevation >250 mg/dL

Nutritional Considerations:

- Individualized meal plans
- Give insulin after meals if intake unpredictable

End-of-Life Care

Primary Goals:

- Prevent hypoglycemia and symptomatic hyperglycemia
- Avoid testing/treatment burden
- Prioritize comfort and quality of life

Medication Approach:

- **Type 2 diabetes**: May discontinue all agents
- **Type 1 diabetes**: Continue minimal basal insulin to prevent DKA
- Withdraw statins if appropriate (may improve quality of life)
- Minimize blood glucose monitoring

Special Populations

Type 1 Diabetes in Older Adults:

- Insulin is essential (unlike type 2)
- CGM particularly beneficial
- Staff education critical in care facilities
- Risk of DKA if insulin discontinued

Cardiovascular Risk Management

- **Blood pressure**: Treat to individualized goals (most <130/80 mmHg)
- **Lipids**: Statin therapy if life expectancy ≥2.5 years (time to benefit)
- Consider treatment burden vs. benefit based on life expectancy

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Key Principle: Care must be highly individualized based on health status, functional ability, cognitive function, life expectancy, and patient preferences. Avoid both overtreatment (causing hypoglycemia) and undertreatment (causing symptomatic complications).