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THE OMNICARE
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Focus on Diabetes – Part 1: 2018 ADA Standards For Older Adults

- by Allen Lefkovitz

While more than 25% of older adults (12 million adults 65 years and older) have diabetes mellitus (DM), the American Diabetes Association (ADA) estimates that at least 50% of older adults have prediabetes. Both prediabetes and DM are associated with increased risk of functional disability and premature death, and DM remains the seventh leading cause of death in the United States.

According to the ADA, their "Standards of Medical Care in Diabetes – 2018" (hereafter referred to as simply the Standards) are now the "sole source" of their clinical recommendations. Historically, the ADA has published their Standards annually, but beginning in 2018, the ADA has stated they will update the Standards "even more frequently" online if deemed appropriate. The Standards are intended to encompass all areas of diabetes care, including goals and tools to evaluate quality of care, and certain portions specifically address older adults. This month's issue will focus on new and continuing standards from the ADA that are most relevant to older adults with diabetese, while next month's issue will focus on the risks and benefits of certain treatment options for older adults with diabetes.

Setting Goals

ADA continues to urge consideration of an older adult's medical, social, psychological and functional status when determining both goals and treatment options for DM. The ADA's basic "framework" for glycemic goals is summarized in the table below.

	Healthy Older Adult	Complex Older Adult	Very Complex Older Adult
General Characteristics	Few coexisting chronic illnesses, cognitively and functionally intact	Multiple coexisting chronic illnesses, ADL impairments, mild-to-moderate CI	In LTC or has end-stage chronic illnesses, moderate-to-severe CI, 2 or more ADL dependencies
Reasonable A1c Goal*	< 7.5%	< 8.0%	< 8.5%
Fasting or Preprandial Glucose Goal	90-130 mg/dL	90-150 mg/dL	100-180 mg/dL
Bedtime Glucose Goal	90-150 mg/dL	100-180 mg/dL	110-200 mg/dL

ADL = activities of daily living; CI = cognitive impairment; LTC = long-term care
*According to the ADA, a lower A1c goal may be set if it is "achievable without recurrent or severe hypoglycemia or undue treatment burden"

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The Standards repeatedly emphasize the need to avoid hypoglycemia in older adults by relaxing goals and treatment regimens. Additional discussion of the risk of hypoglycemia with various treatment options will be included in the March focus article, but within the Standards, the ADA has further revised their classification of hypoglycemia.

Level of Hypoglycemia	Glycemic Criteria	Description
Hypoglycemia alert value (Level 1)	≤ 70 mg/dL	Sufficiently low for treatment with fast-acting carbohydrate and dose adjustment of glucose-lowering therapy
Clinically significant hypoglycemia (Level 2)	< 54 mg/dL	Sufficiently low to indicate serious, clinically important hypoglycemia **Glucagon should be available for all individuals at increased risk of clinically significant hypoglycemia**
Severe hypoglycemia (Level 3)	No specific threshold	Associated with severe cognitive impairment requiring external assistance for recovery

According to the ADA:

- hypoglycemia unawareness or one or more episodes of severe hypoglycemia should result in a reevaluation of their treatment regimen
- hypoglycemia unawareness or an episode of clinically significant hypoglycemia should result in raising glycemic goals for at least several weeks in those treated with insulin.

Specific Long-Term Care and End of Life Considerations

The ADA continues to recommend that individuals with DM residing in LTC "need careful assessment to establish glycemic goals and to make appropriate choices of glucose-lowering agents based on their clinical and functional status." The ADA also continues to stress the importance of diabetes education for staff of LTC facilities in order "to improve the management of older adults with diabetes."

Two of the new Standards for older adults in 2018 related to pharmacological therapy are especially relevant to the LTC setting:

Overtreatment of diabetes is common in older adults and should be avoided

Deintensification (or simplification) of complex regimens is recommended to reduce the risk of hypoglycemia, if it can be achieved within the individualized A1c target

These new Standards align with and expand upon the ongoing recommendations from the ADA that "overall comfort, prevention of distressing symptoms, and preservation of quality of life and dignity are primary goals for diabetes management at the end of life."

In palliative care the ADA continues to reinforce that withdrawal of blood pressure and lipid-lowering medications "may be appropriate". The ADA also states that reducing the frequency of finger-sticks, eliminating A1c testing, and utilizing only oral or simplified insulin regimens may be considered, and that as the individual's condition declines, "some agents may be slowly tapered and discontinued."

The 2018 ADA Standards of Medical Care in Diabetes are available for free at:
https://professional.diabetes.org/content-page/standards-medical-care-diabetes

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NEW Generic Medications

Generic Name	Brand Name	Date Generic Available
Estradiol 0.001% Vaginal Cream	Estrace® Vaginal Cream	1/2/18
Atazanavir Sulfate 150 mg, 200 mg, and 300 mg Capsules	Reyataz® Capsule	12/29/17
Tenofovir Disoproxil Fumarate 300 mg Tablets	Viread® Tablet	12/18/17

NEW Drug

Steglatro™ (ertugliflozin) Tablets

- by Dave Pregizer

Brand Name (Generic Name)	**Steglatro [steh-GLA-troh] (ertugliflozin) [er-too-gli-FLOE-zin]**
How Supplied	5 mg and 15 mg tablets
Therapeutic Class	Sodium glucose co-transporter 2 (SGLT2) inhibitor
Approved Indication	Adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes
Usual Dosing	Start: 5 mg once daily. Increase to 15 mg once daily if tolerated and additional glycemic control is needed. Administer in the morning, with or without food.
Select Drug Interactions	Increased risk of hypoglycemia when used with insulin and/or an insulin secretagogue (e.g., glipizide)
Most Common Side Effects	Female genital mycotic infections
Miscellaneous	Contraindicated with severe renal impairment, end-stage renal disease, or dialysis. Hypotension may occur, particularly with renal impairment, the elderly, or patients on diuretics.
Website	www.steglatro.com

New Drug continued on next page

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Rhopressa® (netarsudil) 0.02% (0.2 mg/mL) Ophthalmic Solution

Brand Name (Generic Name)	**Rhopressa [RHO-press-a] (netarsudil) [ne-TAR-soo-dil]**
How Supplied	2.5 mL ophthalmic solution in a 4 mL container
Therapeutic Class	Rho kinase inhibitor
Approved Indication	Reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension
Usual Dosing	One drop into the affected eye(s) once daily in the evening
Select Drug Interactions	No known significant interactions
Most Common Side Effects	Conjunctival redness, corneal deposits, instillation site pain, and conjunctival hemorrhage
Miscellaneous	If a dose is missed, treatment should continue with the next dose in the evening (two doses in a day is not recommended). Contact lenses should be removed prior to instillation and may be reinserted 15 minutes following administration. After opening, product may be kept at room temperature (up to 77°F) for up to 6 weeks.
Website	www.rhopressa.com

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