1 HOUR CE CBDM Approved

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# Honoring Choice and Positive Outcomes for Diabetes Management in Older Adults

As healthcare providers, we focus on offering support in prevention of malnutrition and maintenance of nutritional well-being while honoring informed choices to our clients. This article presents best practice management of diabetes for older adults, and offers recommendations that support resident participation in the decisions.

The American Diabetes Association in their Standards of Medical Care in Diabetes 2014 Position Statement points out that diabetes is an important health condition for the aging population with at least 20 percent of patients over 65 having diabetes, and this number is expected to grow rapidly in the coming decades.

Older individuals with diabetes have higher rates of premature death, functional disability, and coexisting illnesses such as hypertension, CHD, and stroke than those without diabetes. Older adults with diabetes are also at greater risk than other older adults for several common geriatric syndromes, such as polypharmacy, depression, cognitive impairment, urinary incontinence, injurious falls, and persistent pain. Keeping this in mind, for older adults with advanced diabetes complications, life-limiting comorbid illness, or substantial cognitive or functional impairment, it is reasonable to set less intensive glycemic target goals.

Screening for diabetes complications in older adults should be individualized. Particular attention should be paid to complications that can develop over short periods of time and/or that would significantly impair functional status, such as visual and lower-extremity complications. Table 1 provides the framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older individuals.

### Dining Practice Standards 2011: Standard of Practice for Individualized Diabetic/Calorie Controlled Diet

The Pioneer Network Dining Practice Standards released in 2011 included a review of evidence-based research and consensus for nationally agreed to standards of care supporting individualized care and self-directed living in use of standard diabetic or calorie-controlled diets for the frail elderly. In the Dining Practice Standards, the American Medical Directors (AMDA) state that "…intensive treatment of diabetes may not be appropriate for all individuals in the LTC setting. To improve quality of life, diagnostic and therapeutic decisions should take into account the patient's cognitive and functional status, severity of disease, expressed preferences, and life expectancy."

An individualized regular diet that is well balanced and contains a variety of foods and a consistent amount of carbohydrates has been shown to be more effective than the typical treatment of diabetes.

The Academy of Nutrition and Dietetics (formerly the American Dietetic Association) shares, "There is no evidence to support prescribing diets such as no concentrated sweets or no sugar added for older adults living in health care communities, and these restricted diets are no longer considered appropriate. Most experts agree that using medication rather than dietary changes to control blood glucose, blood lipid levels, and blood pressure can enhance the joy of eating and reduce the risk of malnutrition in older adults in health care communities."

The Centers for Medicare and Medicaid Services (CMS) has stated much about liberalizing diets and the importance of resident decision making in the process. This can be seen throughout many of the interpretive guidelines involving nutritional care and services.

The New Dining Practice Standards offer the following Recommended Course of Practice

- The diet is to be determined with the person and in accordance with his/her informed choices, goals and preferences, rather than exclusively by diagnosis.
- Assess the condition of the person. Assess and provide the person's preferred context and environment for meals. In other words, the person's preferences, patterns and routines for socialization, physical support needed, timing of meals, and personal meaning/value of the dining experience. Include quality of life markers such as satisfaction with food, service received during meals, level of control, and independence.

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- Unless a medical condition warrants a restricted diet, consider beginning with a regular diet and monitoring how the person does eating.
- Empower and honor the person first, and the whole interdisciplinary team second, to look at concerns and create effective solutions.
- Support self-direction and individualize the plan of care.
- Ensure that the physician and consultant pharmacist are aware of resident food and dining preferences so that medication issues can be addressed and coordinated.
- Monitor the person and his/her condition related to their goals regarding nutritional status and their physical, mental, and psychosocial well-being.
- Although a person may not be able to make decisions about certain aspects of their life, that does not mean they cannot make choices in dining.

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**Table 1. Framework for Considering Treatment Goals for Glycemia, Blood Pressure, And Dyslipidemia in Older Adults**

*This represents a consensus framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes. The patient characteristics categories are general concepts. Not every patient will clearly fall into a particular category. Consideration of patient/caregiver preferences is an important aspect of treatment individualization. Additionally, a patient's health status and preferences may change over time, ADL, activities of daily living.*

| Patient Characteristics/ Health Status | Rationale | Reasonable A1C Goal[1] | Fasting or Preprandial Glucose (mg/dL) | Bedtime Glucose (mg/dL) | Blood Pressure (mmHg) | Lipids |
|---|---|---|---|---|---|---|
| **Healthy** Few coexisting chronic illnesses, intact cognitive and functional status | Longer remaining life expectancy | <7.5% | 90-130 | 90-150 | <140/80 | Statin unless contraindicated or not tolerated |
| **Complex/ Intermediate** Multiple coexisting chronic illnesses[2] or 2+ instrumental ADL impairments or mild to moderate cognitive impairment | Intermediate remaining life expectancy, high treatment burden, hypoglycemia vulnerability, fall risk | <8.0% | 90-150 | 100-180 | <140/80 | Statin unless contraindicated or not tolerated |
| **Very Complex/ Poor Health** Long-term care or end-stage chronic illnesses[3] or moderate to severe cognitive impairment or 2+ ADL dependencies | Limited remaining life expectancy makes benefit uncertain | <8.5%† | 100-180 | 110-200 | <150/90 | Consider likelihood of benefit with statin (secondary prevention moreso than primary) |

1. *A lower goal may be set for an individual if achievable without recurrent or severe hypoglycemia or undue treatment burden.*
2. *Coexisting chronic illnesses are conditions serious enough to require medications or lifestyle management and may include arthritis, cancer, congestive heart failure, depression, emphysema, falls, hypertension, incontinence, stage 3 or worse chronic kidney disease, MI, and stroke. By multiple, we mean at least three, but many patients may have five or more (132).*
3. *The presence of a single end-stage chronic illness such as stage 3-4 congestive heart failure or oxygen-dependent lung disease, chronic kidney disease requiring dialysis, or uncontrolled metastatic cancer may cause significant symptoms or impairment of functional status and significantly reduce life expectancy.*

† *AIC of 8.5% equates to an estimated average glucose of ~200 mg/dL. Looser glycemic targets than this may expose patients to acute risks from glycosuria, dehydration, hyperglycemic hyperosmolar syndrome, and poor wound healing.*

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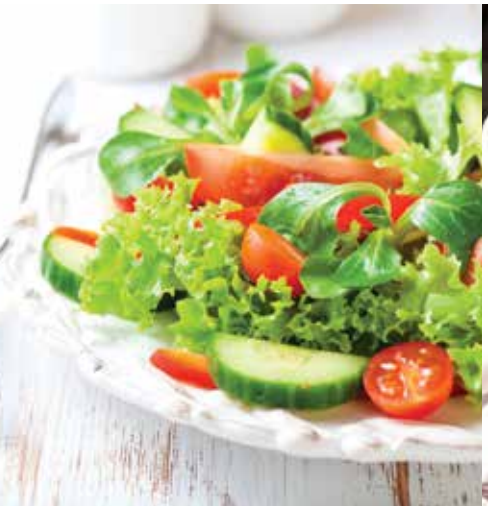

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- When a person makes "risky" decisions, adjust the plan of care to honor informed choice and provide supports available to mitigate the risks.
- Most professional codes of ethics require the professional to support the person/client in making their own decisions, being an active participant.
- When caring for frail elders there is often no clear right answer. Possible interventions often have the potential to both help and harm the elder. This is why the overall information, risks and benefits should be discussed among the physician, team, and resident/family. The resident then has the right to make his/her informed choice, even if it is not to follow recommended medical advice and the team supports the person and his/her decision, mitigating risks by offering support. The agreed-upon plan of care should then be monitored to make sure it is meeting the resident's needs.
- All decisions default to the person.

### The Academy of Nutrition and Dietetics: Diet Individualization With Older Adults in the Position Paper: Food and Nutrition for Older Adults

The Academy Position Paper states that older adults who consume a more varied diet have better health outcomes. Some individuals will make positive dietary changes following the onset of certain chronic health conditions; however, dietary restrictions associated with chronic diseases can contribute to compromised nutritional status among older adults. A restrictive diet can be unacceptable to older adults and contribute to poor food or fluid intake, leading to undernutrition and poor quality of life and negative health consequences.

The benefits review of evidence-based research and consensus and risks associated with dietary restrictions and therapeutic diets for older adults should be considered. Less-restrictive diets that are tailored to each person's needs, desires, and medical conditions can lead to enhanced quality of life and improved nutritional status for older adults living in healthcare communities.

### Nutrition Management Summary for Older Adults with Diabetes

In summary, nutrition therapy for the management of older adults with diabetes should be individualized for each patient/client. Choices for our clients should be based on current best practice standards supporting individualized care and self-directed living versus traditional diagnosis-focused treatment.

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### References

*Academy of Nutrition and Dietetics: Position Paper: Food and Nutrition for Older Adults: Promoting Health and Wellness Volume 112; Issue 8; Pages 1255-1277 (August 2012)*

*American Diabetes Association; Position Paper; Standards of Medical Care in Diabetes—2014. Diabetes Care January 2014 37: Supplement 1 S14-S80; doi: 10.2337/dc14-S014 1935-5548*

*Evert et al. Nutrition Therapy Recommendations for the Management of Adults With Diabetes. Diabetes Care 2013; 36:3821-3842*

*Pioneer Network. New Dining Practice Standards, Food and Clinical Standards Task Force, August 2011; www.pioneernetwork.net*