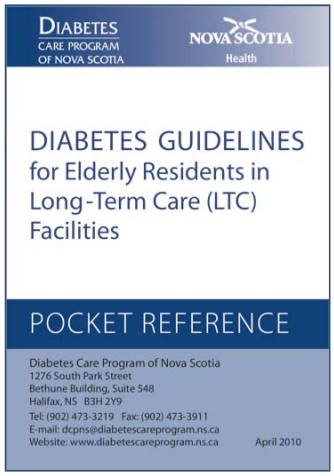

FREQUENTLY ASKED QUESTIONS

1. Why is it important to liberalize blood glucose targets in frail elderly?

Care guidelines generally are written for a younger population with single illnesses. Elderly residents in long-term care facilities are frail, which is an accumulation of multiple chronic illnesses and vulnerabilities such as dementia, functional decline, and geriatric syndrome (falls, impaired mobility, and polypharmacy). Life expectancy, in this population, is limited.

Blood glucose targets need to be set in the context of frailty. The goal is to avoid the acute complications of glycemic control including hypoglycemia and prolonged, severe hyperglycemia, which can be serious with significant morbidity and mortality. Benefits of tight glycemic control takes years to achieve, longer than the expected life of a resident with diabetes in a long-term care facility. In frail elderly with diabetes and limited life expectancy, there is little evidence to support tight blood glucose control.

2. Are secretogoues capable of lowering blood glucose from 8.0 to 9.0 mmol/L to ≤ 3.9 mmol/L and cause hypoglycemia in frail elderly?

It was felt that secretogoues could potentially lower blood glucose enough to cause hypoglycemia in some individuals. A range of 7.0 to 9.9 mmol/L is more acceptable. Hypoglycemia in frail elderly can have significant morbidity and mortality. They have other medical problems and frequently are on many medications, with possible kidney and liver impairment that may lead to changes in the breakdown of medications. The frail elderly may have fewer symptoms and decreased awareness of hypoglycemia. Consequently, hypoglycemia can be more severe, prolonged, and precipitate a cardiovascular event. In view of this information, plus the unpredictability of food intake, the physicians involved with the development of the glycemic targets advised a higher blood glucose range (7.0 to 9.9 mmol/L). There is no evidence of benefit of tight glycemic control (FBG 4 to 7 mmol/L) in this population.

3. The new glycemic targets are not that different from my usual practice. Why?

Drafts of glycemic target guidelines have been shared with a variety of professional groups throughout the province since 2006, when an initial draft of the glycemic targets was reviewed in a meeting with LTC facility directors/managers. Since that time, the glycemic targets have been reviewed with LTC facility professional staff and diabetes educators (2008 and 2009). Because the glycemic target guidelines have been in circulation, although not officially, for some time, it is possible that a decision was made in your facility to review and use the new glycemic targets immediately.

(see other side)

4. **Can glycemic targets, developed for elderly in long-term facilities, be applied to elderly living at home?**

   The LTC diabetes guidelines were developed in response to a request from LTC facilities and a mandate from DOH for consistency in care of residents living in LTC facilities throughout the province. It is inappropriate for the DCPNS to broaden the reach of these guidelines at this time. However, clinical judgment remains a crucial factor when developing diabetes care plans for all frail elderly.

5. **Is it necessary to use sugar-free products in planning menus for elderly residents with diabetes in LTC facilities?**

   Nutrition guidelines for diabetes management for residents in a long-term care facility should encourage a liberalized approach, as for residents without diabetes. Therefore, use of sugar-free products is not recommended. A liberalized approach may enhance a resident's quality of life without compromising maintenance of health.

6. **What should be the frequency of monitoring blood glucose and A1C?**

   Guidelines for frequency of monitoring blood glucose and A1C have not been produced yet. However, they have been identified as the next set of diabetes guidelines for development.