

## **Purpose of the Model Practice**

The 2014 National PACE Association's "Diabetes Mellitus Model Practice" provides relevant diagnostic and management recommendations to PACE® primary care providers (PCPs). The Model Practice was adapted specifically for PACE® participants from evidence-based published guidelines for older adults and is offered with the belief that shared decision-making between individual PCPs and participants/caregivers is optimal. This Model Practice is not intended to replace the clinical judgment of the individual provider or establish a standard of care.

PACE® participants are a heterogeneous group, with differing health profiles, prognoses, preferences, and goals of care. Life expectancy and quality of life issues require an individualized context within which to apply practice guidelines that may have been developed from and for a population of non-frail adults. We recommend that whether a PCP follows any of the summary recommendations for an individual participant will depend upon factors specific to that participant, including the participant's preferences, prognosis and life expectancy, co-morbid conditions, functional status, and goals of care.

This Model Practice assumes that the goals of care for PACE® participants can be divided into three broad categories: promoting longevity, optimizing function, and comfort care. Accordingly, the Model Practice suggests different approaches depending on whether the goal is life-extension, function, or palliation. The PCP will need to determine which recommendations are appropriate for each individual participant, considering the participant's preferences, life-expectancy, and the expected benefit versus burdens of specific interventions.

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## **Goals of Care:**

Longevity: Participant expresses a preference for life-prolonging treatment. \* A participant with a goal of longevity typically desires unrestricted use of medically-indicated treatments, including CPR, invasive procedures, life-sustaining treatments (ACLS, surgery, ventilator support, dialysis, IV fluids and tube feedings) and is willing to try to follow recommended medication, dietary and intervention regimens.

Function: Participant's main goal is to maintain function. Participant makes individualized choices to limit some invasive procedures that are not consistent with that goal. Limited procedures may include CPR, mechanical ventilation, and other life-sustaining treatments. This participant may choose to modify adherence to diet and medication recommendations.

Comfort Care: Participant desires treatments aimed at providing comfort only. Treatment choices focus on relieving pain and other symptoms and limiting invasive, life-sustaining treatments such as CPR, mechanical ventilation, dialysis, surgery, and perhaps hospitalization.

## **Clinical Practice Guidelines used for "Standard Therapy":**

- American Geriatrics Society Expert Panel on the Care of Older Adults with Diabetes Mellitus. Guidelines Abstracted from the American Geriatrics Society Guidelines for Improving the Care of Older Adults with Diabetes Mellitus: 2013 Update. JAGS 2013; 61: 2020-2026.
- American Diabetes Association. Standards of Medical Care in Diabetes—2014. Diabetes Care 2014; 37.
- James PA, Oparil S, Carter BL, et al. 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8). JAMA. 2014;311(5):507-520.
- Stone NJ, Robinson J, Lichtenstein AH, et al. 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation 2013.
- The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. JAGS 2012; 60:616-31.

## **Definitions:**

Consider = Perform if the result will be used to adjust treatment

Yes = Follow Standard Care practice

No = Do not follow the Standard Care practice

Goal = Target of the intervention

Initially = the first 6 months of enrollment of the patient who has known Diabetes Mellitus or the 6 months after a new diagnosis of DM

Microalbuminuria =  $\geq 2$  of 3 urine samples 30-300 for microalbuminuria/creatinine

High Risk for Eye Disease = Symptoms of eye disease present; evidence of retinopathy, glaucoma, or cataracts in the past two years;

A1c  $\geq 8$ ; Type 1 DM; B/P  $\geq 140/80$

SMBG = Self monitor blood glucose

CVD = Cardiovascular Disease

PVD = Peripheral Vascular Disease

ABI = Ankle Brachial Index

Recommended Intervention	ADA Standards of Medical Care 2014	Longevity	Functional	Comfort Care	Comments
<b>Glycemic Management</b>					
<ul style="list-style-type: none"> <li>A1C</li> </ul>	Test at least 2 times a year if meeting treatment goals; test quarterly if therapy has changed or not meeting goal. Goal is 7-8.	Measure every 6 months. More frequently if not at goal. Goal is 7-8.	Measure every 6 months. More frequently if not at goal.  Target A1C 7-9 with no episodes of hypoglycemia.	No testing, avoid hypoglycemia.	
<ul style="list-style-type: none"> <li>Self-monitor blood glucose (SMBG)</li> </ul>	For Type 2 on non-intensive insulin regimen or non-insulin treated – no recommendation For multiple-dose insulin regimen qac, qhs and if hypoglycemia suspected.	Only if on insulin, if treatment changes, or if symptoms of hypoglycemia; otherwise not indicated.	Only if on insulin, if treatment changes, or if symptoms of hypoglycemia.	No	SSI may be appropriate for prandial insulin. SSI use is otherwise discouraged.
<b>Blood Pressure (B/P) Management</b>	Measure every 6 months. Goal is $\leq$ 140/90	Yes Target SBP 120-140 (age <80), 140-150 (age 80+)	Yes Target SBP 140-150	No	
<b>Medications</b>					
<ul style="list-style-type: none"> <li>Aspirin 81 mg daily</li> </ul>	Yes, if history of ASCVD and not on anticoagulation therapy and no contraindications; with caution if > 80	Yes, if there is cardiovascular disease, if not on anticoagulation therapy and no contraindications.	Yes, if there is cardiovascular disease, if not on anticoagulation therapy and no contraindications.	Consider	
<ul style="list-style-type: none"> <li>Statins</li> </ul> <p><a href="http://tools.cardiosource.org/ASCVD-Risk-Estimator">http://tools.cardiosource.org/ASCVD-Risk-Estimator</a></p> <p><b>High intensity statin:</b> -atorvastatin 40mg or 80mg daily -rosuvastatin 20mg daily</p> <p><b>Moderate intensity statin:</b> -atorvastatin 10mg or 20mg daily -rosuvastatin 10mg daily -simvastatin 20mg or 40mg daily -pravastatin 40mg to 80mg</p>	<p><b>High</b> intensity statin for diabetic patients age 75 or younger <b>with</b> established ASCVD (Atherosclerotic Cardiovascular Disease) <b>or</b> whose baseline LDL is &gt; 190</p> <p><b>High</b> intensity statin for diabetic patients age 75 or younger <b>without</b> established ASCVD but whose 10-year risk of ASCVD by the risk calculator is &gt; 7.5%</p> <p><b>Moderate</b> intensity statin for diabetic patients over age 75 <b>with</b> established ASCVD</p> <p><b>Moderate</b> intensity statin for diabetic patients over age 75 <b>without</b> established ASCVD but whose 10-year risk of ASCVD is &gt; 7.5%</p>	<p><b>High</b> intensity statin for diabetic patients age 75 or younger <b>with</b> established ASCVD (Atherosclerotic Cardiovascular Disease) <b>or</b> whose baseline LDL is &gt; 190</p> <p><b>High</b> intensity statin for diabetic patients age 75 or younger <b>without</b> established ASCVD but whose 10-year risk of ASCVD by the risk calculator is &gt; 7.5%</p> <p><b>Moderate</b> intensity statin for diabetic patients over age 75 <b>with</b> established ASCVD</p> <p><b>Moderate</b> intensity statin for diabetic patients over age 75 <b>without</b> established ASCVD but whose 10-year risk of ASCVD is &gt; 7.5%</p>	<p><b>Moderate</b> intensity statin for diabetic patients <b>with</b> established ASCVD</p> <p>Consider <b>moderate</b> intensity statin for diabetic patients age 75 or younger <b>without</b> established ASCVD but whose 10-year risk of ASCVD by the risk calculator is &gt; 7.5% <b>if justified by life expectancy</b></p>	No	

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• ACEI or ARB	Yes, for persistent albuminuria >30 mg/24h. No, for prevention of CKD in normotensive patient with albumin excretion <30 mg/24h.	Yes Initial drug of choice to achieve BP targets	Consider Initial drug of choice to achieve BP targets	Consider	
• Metformin	Metformin if not contraindicated and if tolerated is the preferred initial pharmacologic agent for type 2 diabetes.	Yes, Use lower doses for CKD III. Do not use for eGFR < 30.	Yes, Use lower doses for CKD III. Do not use for eGFR < 30.	Consider	
<b>Smoking cessation assistance</b>	Advise all patients not to smoke or use tobacco products. Include smoking cessation counseling and treatment as part of routine diabetic care.	Yes	Yes	No	
<b>Dietitian Consultation for Medical Nutrition Therapy (MNT)</b>	All patients with pre-diabetes or diabetes should receive individualized MNT by a registered dietitian.	Annually and more often if needed	Annually and more often if needed	Annually and more often if needed	
<b>Eye care</b>					
• Dilated-eye exam by ophthalmologist or optometrist	Every year or more often if retinopathy present; every 2 years if no retinopathy present may be considered.	Yes	Yes	No	
<b>Foot examination</b>					
• to screen for neuropathy, bony deformity, PVD PAD	Annual exam to include inspection, assessment of pulses and LOPS. Consider ABI. ABI initially for all adults over age 50 for asymptomatic PAD.	Yes	Yes	Yes	
• if neuropathy, bony deformity, or PVD PAD present	Multidisciplinary approach is recommended. Refer patients who smoke, have LOPS and structural abnormalities, or history of prior lower extremity complications to foot care specialist.	Yes	Yes	Yes	Refer only if PACE organization does not have appropriate internal skill set
<b>Laboratory testing</b>					
• Monitoring of participants with Nephropathy by urine albumin/creatinine ratio	Annual measurement to assess effectiveness of treatment and to determine progression	No	No	No	No added utility
• Creatinine and potassium	With initiation and with each increase in ACEI or ARB dose then annually	Yes	Yes	Consider	
• Creatinine and eGFR calculation	Annually	Yes	Yes	No (Consider if on metformin)	

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• Electrolytes	With initiation or increase of a diuretic or ACEI/ARB then yearly while on the diuretic	Yes	Yes	Consider	
• ALT	Within 12 weeks of initiation or dose increase of statin or niacin, or fibrate, then annually	Yes, prior to initiation of statin	Yes, prior to initiation of statin	No	
<b>Screen for Cardiovascular Autonomic Neuropathy by signs and symptoms</b>	Initially than annually	Yes	Yes	No	
<b>Education</b>					
• Education re: signs/symptoms of hyperglycemia and hypoglycemia	Initially and annually	Yes	Yes	Yes	
• Teach/review SMBG	Initially and annually	Yes	Consider	No	
• Exercise education	Initially then regularly	Yes	Yes	Consider	
• Medication education	Initially then with every new medication	Yes	Yes	Yes	
• Foot ulcer and amputation education	Initially then as needed (for those with PVD, PAD or Neuropathy)	Yes	Yes	Yes	
<b>Potential Quality Indicators</b>					
• Measurement of HgbA1c		Yes	Yes	No	
• Treatment with Statin					
• Hypoglycemic Events Resulting in Adverse Events		Yes	Yes	Yes	
• Eye Exam		Yes	Yes	No	
• Foot Exam		Yes	Yes	Yes	