THE UNIVERSITY OF CHICAGO
MEDICINE & BIOLOGICAL SCIENCES

Deprescribing in the ADA Care Guidelines and the IGDS 4S Framework

Elbert S. Huang, MD, MPH, FACP
Professor of Medicine and Public Health Sciences

ADA 2012 Consensus Report

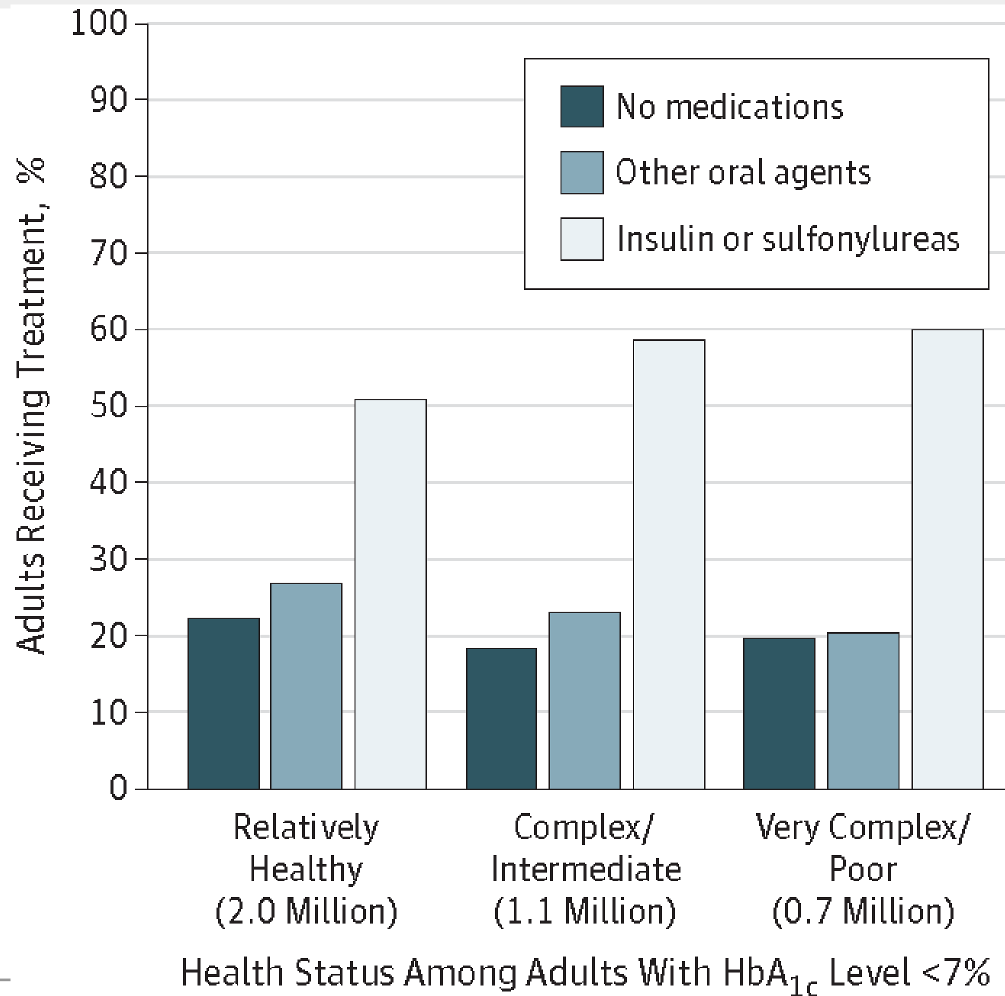
Patient characteristics/ health status	Rationale	Reasonable A1C goal (A lower goal may be set for an individual if achievable without recurrent or severe hypoglycemia or undue treatment burden)	Fasting or preprandial glucose (mg/dL)	Bedtime glucose (mg/dL)	Blood pressure (mmHg)	Lipids
Healthy (Few coexisting 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* 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** 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)

This represents a consensus framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes. The patient characteristic 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. *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 III or worse chronic kidney disease, MI, and stroke. By multiple we mean at least three, but many patients may have five or more (132). **The presence of a single end-stage chronic illness such as stage III–IV 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. †A1C 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.

https://doi.org/10.2337/dc12-1801

From: **Potential Overtreatment of Diabetes Mellitus in Older Adults With Tight Glycemic Control**

JAMA Intern Med. 2015;175(3):356-362. doi:10.1001/jamainternmed.2014.7345



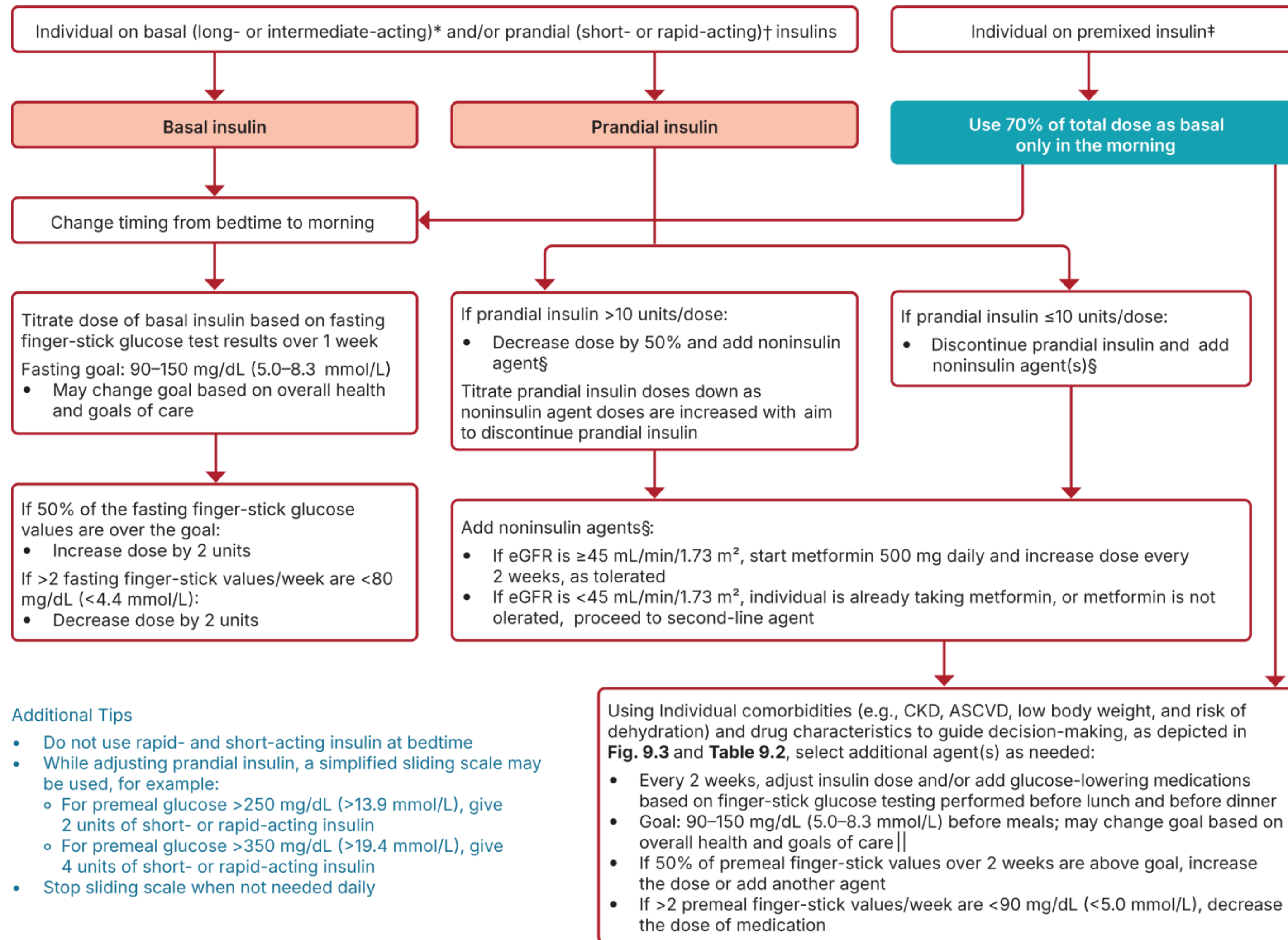
Date of download: 12/15/2025

Copyright © 2015 American Medical Association. All rights reserved.

American Diabetes Association (ADA)

- 2012 – Consensus Report on Older Adults
- 2015 – Standards of Care, Older Adult Chapter
- 2016 – Mention of End-of-Life Care
- 2018 – Deintensification of complex regimens
- 2019 – Insulin regimen simplification algorithm

Diabetes Care. 2024;48(Supplement_1):S266-S282. doi:10.2337/dc25-S013



Date of Download: 12/15/2025

Copyright © 2025 American Diabetes Association. All rights reserved, including those for text and data mining, AI training, and similar technologies.

Figure 1

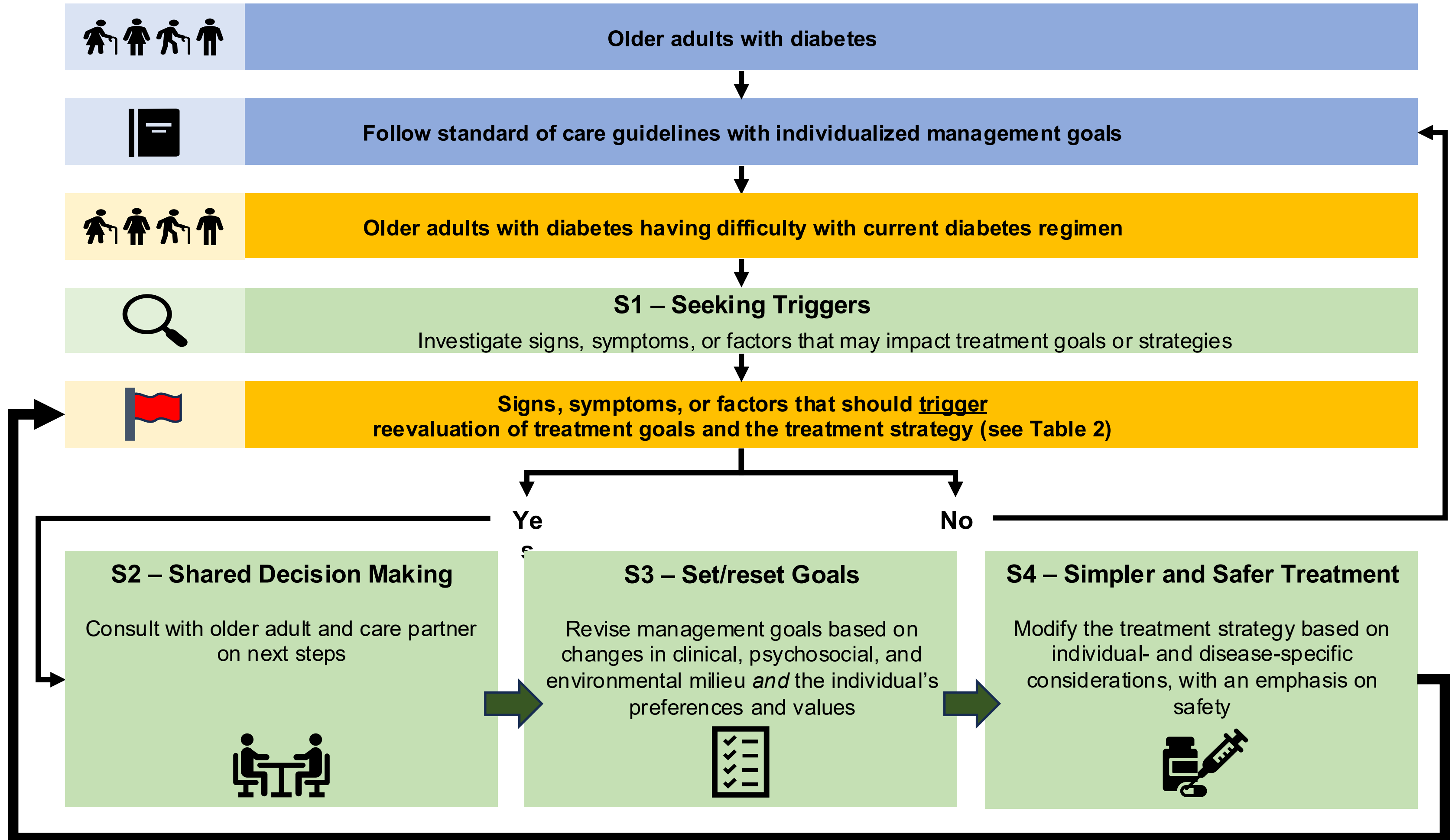


Figure 2

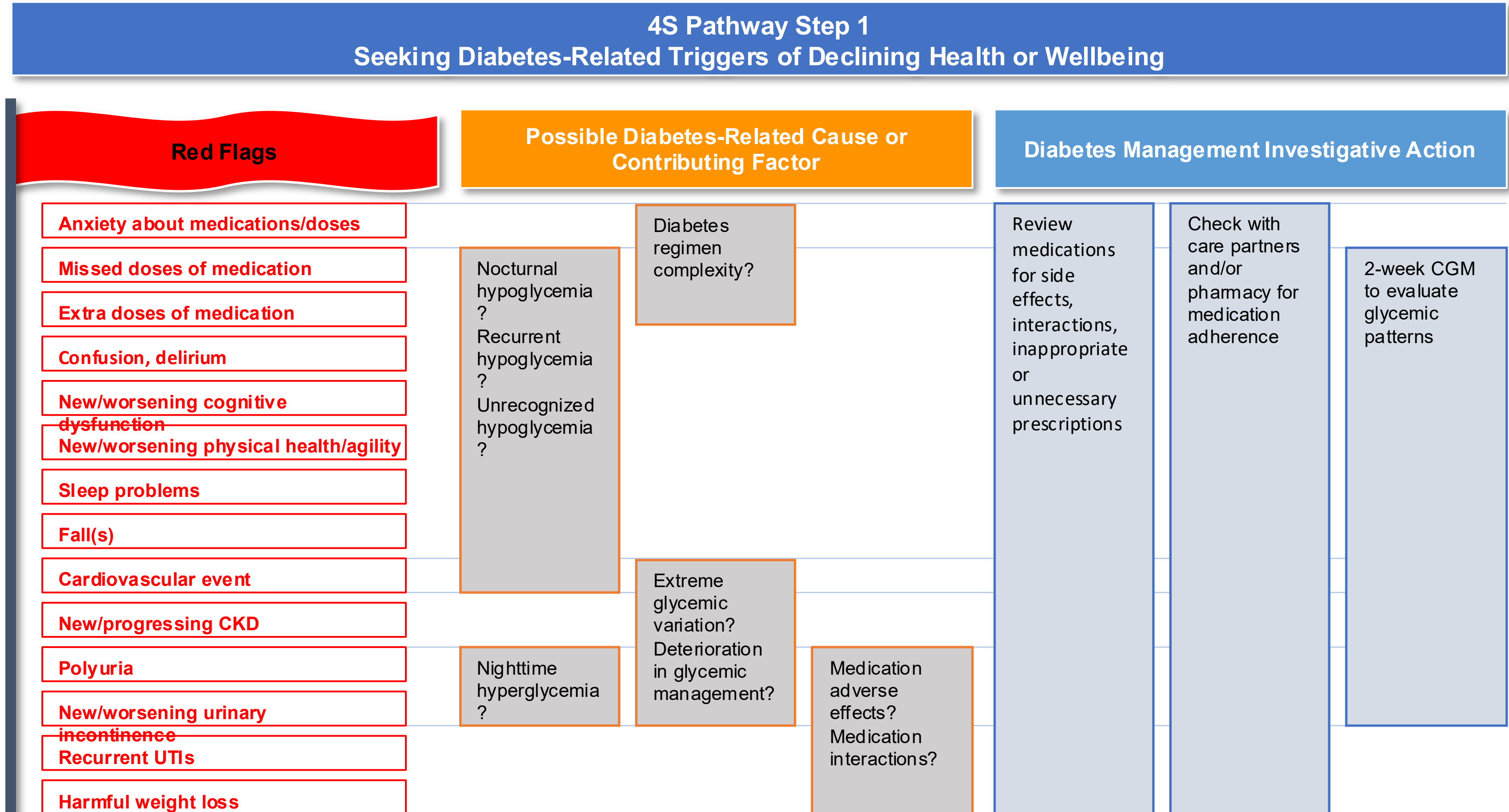
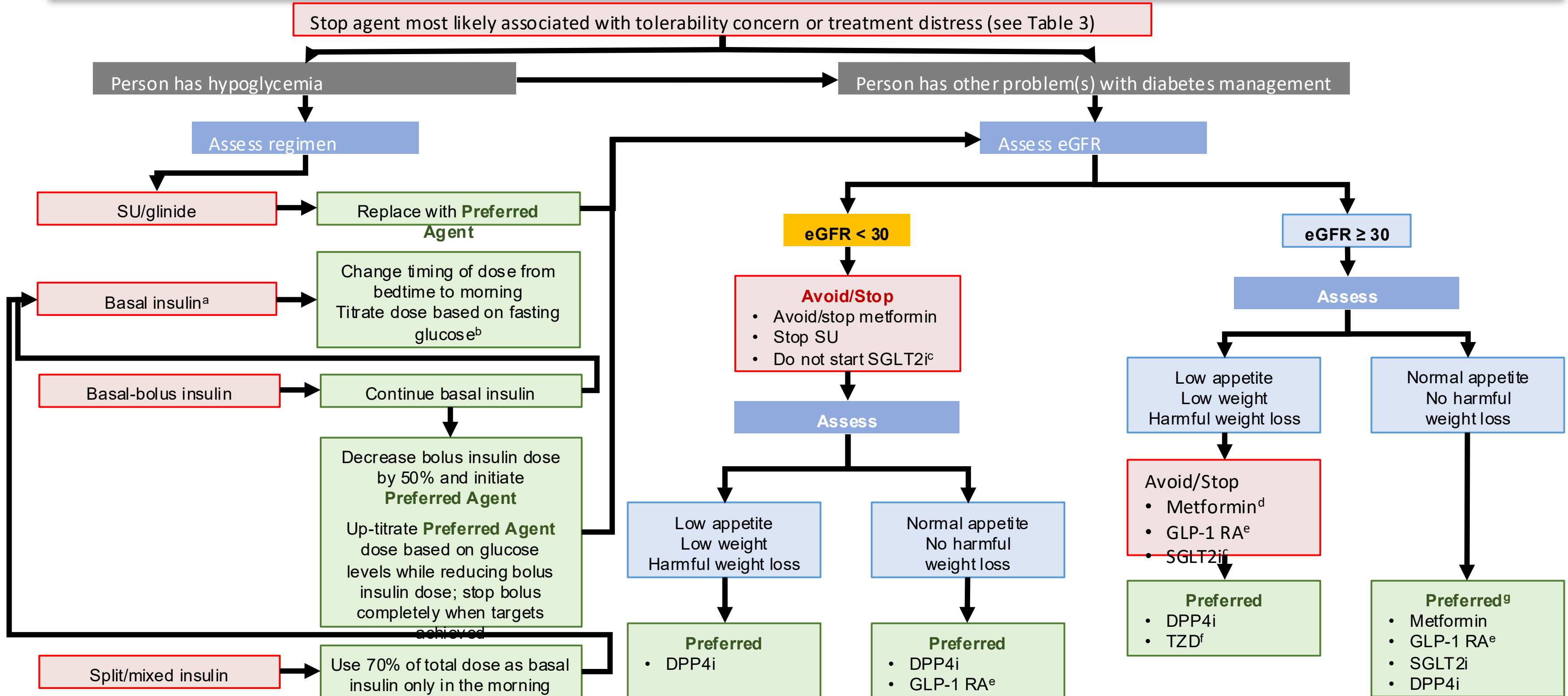


Figure 3



[a]Basal insulin analogs preferred over NPH due to lower risk of hypoglycemia. [b]Fasting glucose goal: 90–150 mg/dL, measured over 1 week with fingerstick or CGM. [c]May be prescribed for CKD or HF independent of T2D or eGFR; monitor for AEs. [d]Evaluate for GI AEs as potential cause of weight loss. [e]Includes dual GIP/GLP-1 RA. [f]Monitor for edema and other AEs. [g]Selection based on person-specific considerations; see Table 3.

AE = adverse event; CGM = continuous glucose monitor; CKD = chronic kidney disease; DPP4i = dipeptidyl peptidase 4 inhibitor; eGFR = estimated glomerular filtration rate, in mL/min/1.73 m^2; GI = gastrointestinal; GIP = glucose-dependent insulinotropic polypeptide; GLP-1 RA = glucagon-like peptide 1 receptor agonist; HF = heart failure; NPH = neutral protamine Hagedorn; SGLT2i = sodium glucose cotransporter 2 inhibitor; SU = sulfonylurea; TZD = thiazolidinedione.

Lessons Learned from ADA and IGDS

- Proposing an older patient classification system, even one not completely evidence-based, helped to operationalize concept of overtreatment
- Patient classification has become more evidence-based and language of guidelines shifted to more specific symptoms and situations
- Adverse outcome was primarily hypoglycemia but now shifting to other adverse outcomes (harmful weight loss)
- Important effort devoted to finding the right terminology that is acceptable to patients – simplification over deintensification

Thank You

ehuang@bsd.uchicago.edu

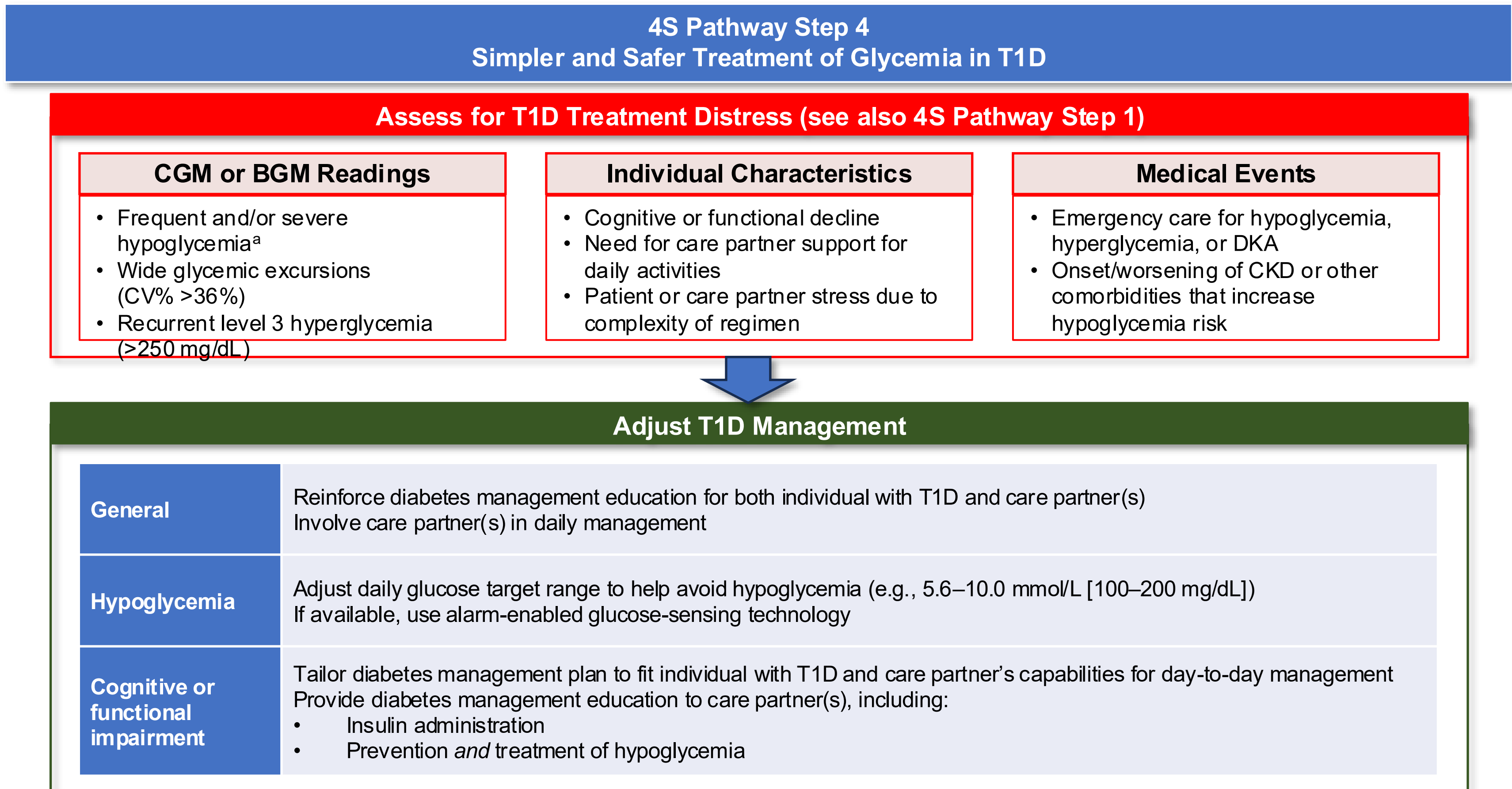
http://chronicdisease.uchicago.edu

Twitter: @ChronicDiseaseU

Comparison of Geriatric Guidelines

European Diabetes Working Party for Older People		American Geriatrics Society		Department of Veterans Affairs		American Diabetes Association	
Description of patient stratum	**A1C goal**	**Description of patient stratum**	**A1C goal**	**Description of patient stratum**	**A1C goal**	**Description of patient stratum**	**A1C goal**
Without major comorbidities	7.0-7.5%	Healthy	7.0-7.5%	None or very mild microvascular complications; life expectancy of 10-15 years	<7.0%	Healthy (few co-existing chronic illnesses; intact cognitive and functional status)	<7.5%
Frail patients (dependent; multi-system disease; care home residency, including those with dementia)	7.6-8.5%	Moderate comorbidities	7.5-8.0%	Long duration of diabetes (>10 years); requires combination drug regimen including insulin	<8.0%	Complex/intermediate (examples: multiple co-existing chronic illnesses*, ≥2 instrumental ADL impairments, or mild-moderate cognitive impairment)	<8.0%
		Multiple comorbidities	8.0-9.0%	Advanced microvascular complications and/or major comorbid illness; life expectancy <5 years	8.0-9.0%	Very complex/poor health (examples: long term care, end stage chronic illnesses†, moderate-severe cognitive impairment, or ≥2 ADL dependencies)	<8.5% ‡

Figure 4



[a]Any recurrent hypoglycemia is detrimental, including level 1 (≤70 mg/dL), level 2 (<54 mg/dL), or level 3 (requiring help from another person).
BGM, fingerstick blood glucose monitoring; CGM, continuous glucose monitor; CV% = coefficient of variation.

American Diabetes Association®

From: **Understanding Diabetes Overtreatment in Older Adults: Are We at an Intersection?**

Diabetes Care. 2024;48(1):47-49. doi:10.2337/dci24-0075

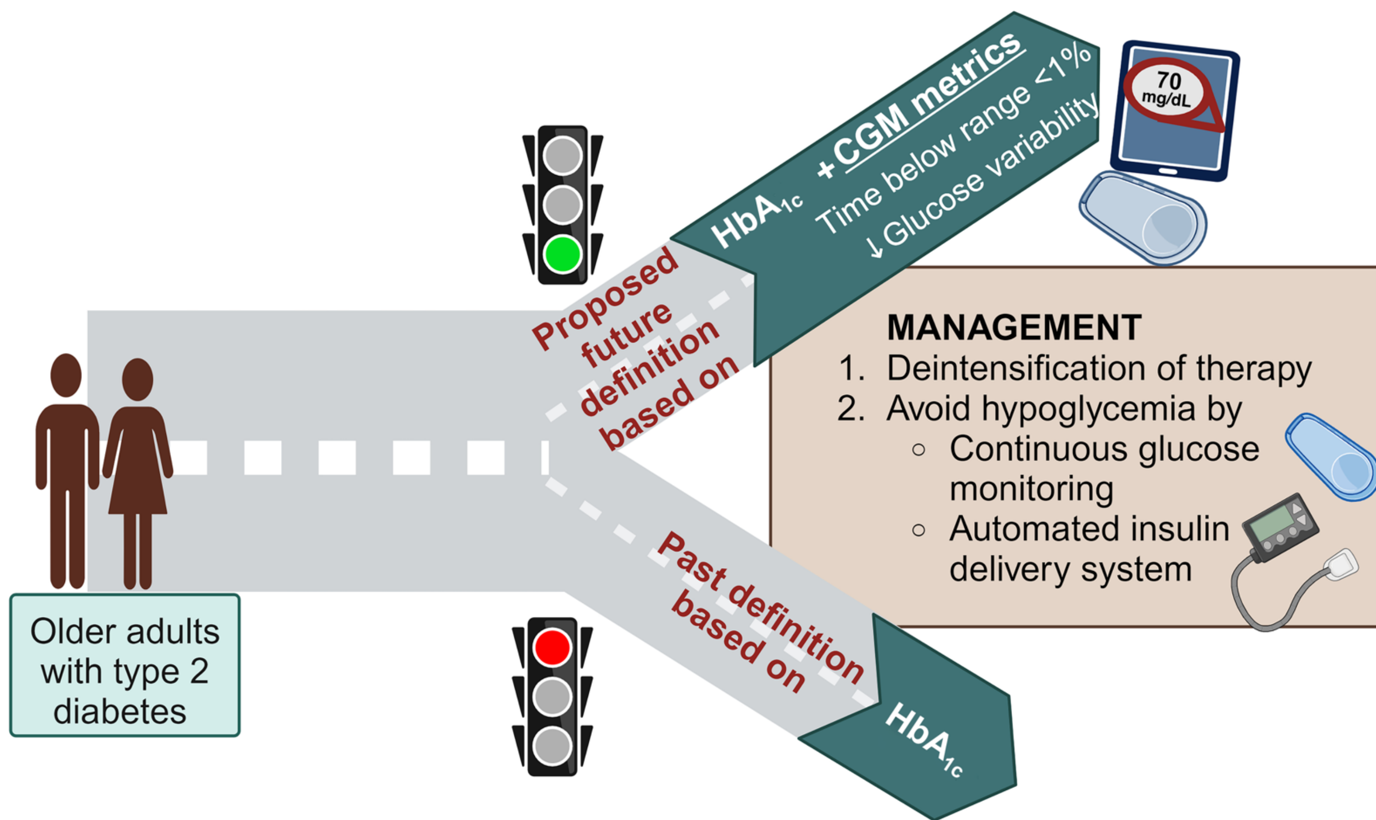


Figure Legend:

Potential road map for diagnosis and management of diabetes overtreatment in older adults with type 2 diabetes. Figure was created in BioRender (biorender.com).

Date of Download: 12/17/2025

Copyright © 2025 American Diabetes Association. All rights reserved, including those for text and data mining, AI training, and similar technologies.