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 COMMENTS AND  
 RESPONSES
 

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**Response to  
 Comment on:  
 Beverly et al. Do  
 Older Adults Aged  
 60–75 Years  
 Benefit From  
 Diabetes  
 Behavioral  
 Interventions?  
 Diabetes Care  
 2013;36:1501–  
 1506**

**W**e thank Trento et al. (1) for their interest in our recent article on the benefit of diabetes behavioral interventions for improving A1C in long-duration, poorly controlled older diabetic patients. Our article describes a secondary analysis of data from a three-arm, parallel-designed randomized controlled trial that tested the efficacy of a highly structured behavioral diabetes intervention via comparisons with standard group education and individual education (2). Thus, the original aim of the study was not to assess age differences in group versus individual education. Also, the study did not recruit adults aged 76 years and above, so the findings may not be representative for adults aged 76 years and older.

Few well-designed randomized controlled trials have been developed to meet the unique challenges of self-management in the older population (3). Clinical (e.g., comorbidity, complications) and functional (e.g., impairment, disability) heterogeneity in the older population require special attention in diabetes treatment. For example, older diabetic patients are at greater risk for several geriatric syndromes, including depression, cognitive

impairment, injurious falls, neuropathic pain, and urinary incontinence. Thus, future diabetes behavioral interventions need to address changes in older adults' functional, cognitive, and psychosocial states and how these changes impact diabetes self-management.

In their letter, Trento et al. dispute the statement “the majority of diabetes education programs are designed for younger patients or more recently diagnosed patients,” and referenced their own studies as conflicting research (4). Although they included older people, these reports did not provide standard deviations for age or analyses by age, and thus they do not provide any clinical evidence to assist older patients and their providers in making treatment decisions. With that said, because these authors included older adults in their education interventions, they can conduct secondary analyses by age to provide additional clinical evidence.

We agree with Trento et al. that diabetes education is an important component of diabetes care for all people with diabetes, and that ongoing and repeated education is necessary to help older adults maintain what they learned during the initial education. Although some studies do include older adults in their sample (5), the subsample of older adults should be large enough to include analyses that provide important clinical evidence. Thus, more high-quality research is needed to evaluate the impact of group and individual behavioral diabetes interventions in older populations, particularly adults aged 75 years and older because they may present with complications and comorbidities and/or cognitive impairments that require special attention.

With the aging population and increasing prevalence of diabetes, clinical strategies on how to best treat diabetes in older adults is an important public health concern. Clinicians require well-researched approaches and interventions that will help older diabetic patients achieve individualized treatment goals; however, because older patients are typically excluded from clinical trials, little is known about the best strategies and

interventions to use (3). Further, clinicians have limited evidenced-based guidelines recommending which type of education best supports older patients in their self-care efforts, and for this reason clinicians may be reluctant to recommend group education programs.

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