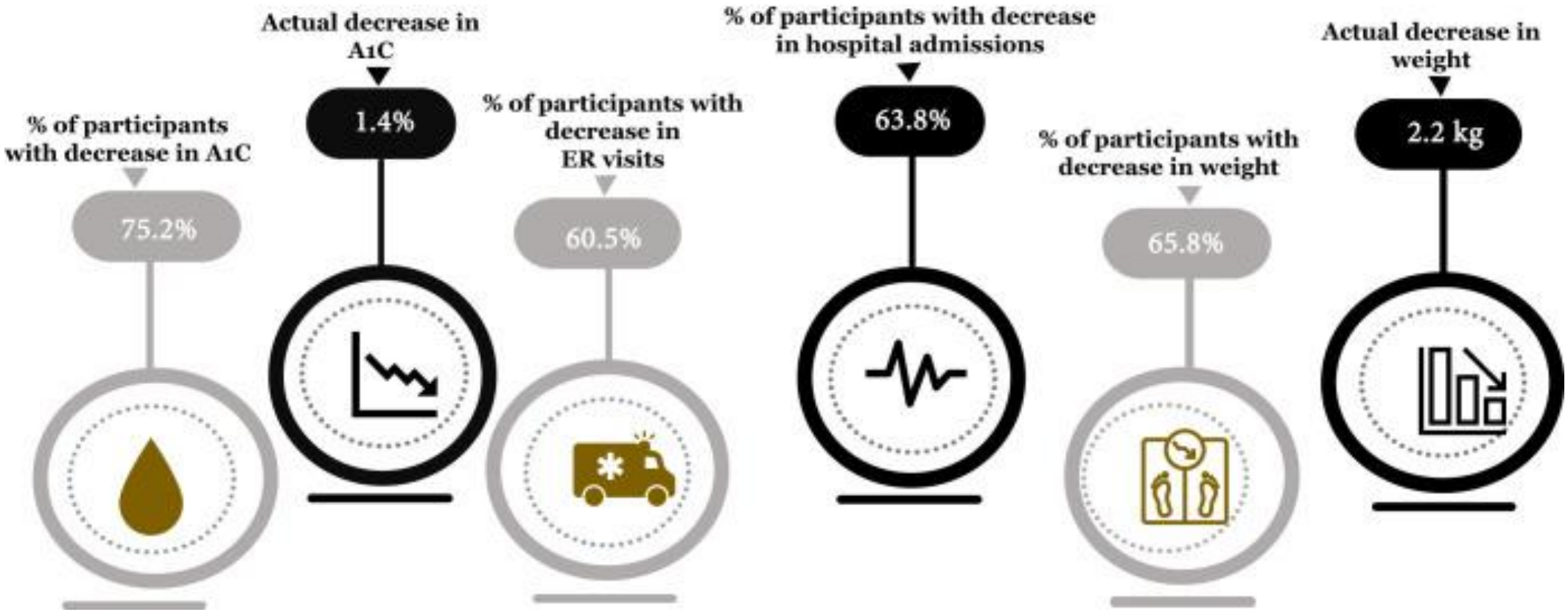
Diabetes Care & Education Updates: 2026

Erin Gorrell MS, RD, CDCES

Certified Diabetes Care & Education Specialist (CDCES)

- Healthcare professional with certification in diabetes management
  - Educate, empower, and **support** people living with diabetes & caregivers
  - Promote self-management to achieve individualized behavior and treatment goals
    -Billing is called “DSMES” (Diabetes Self Management Education & Support) – G0108
    -Billing as an RD is called “MNT” (Medical Nutrition Therapy) – 97802/97803
- Tend to work in PCP offices, Endocrinology offices, Diabetes education programs, Individual practices, Private companies (pumps, continuous glucose monitors, insurance), Inpatient facilities, pharmacies
- Typically hold titles of RN, RD, PharmD, NP, PA.
  Some MDs, DOs also obtain this certification

Diabetes Self-management Education & Support (DSMES) Medical Nutrition Therapy (MNT)

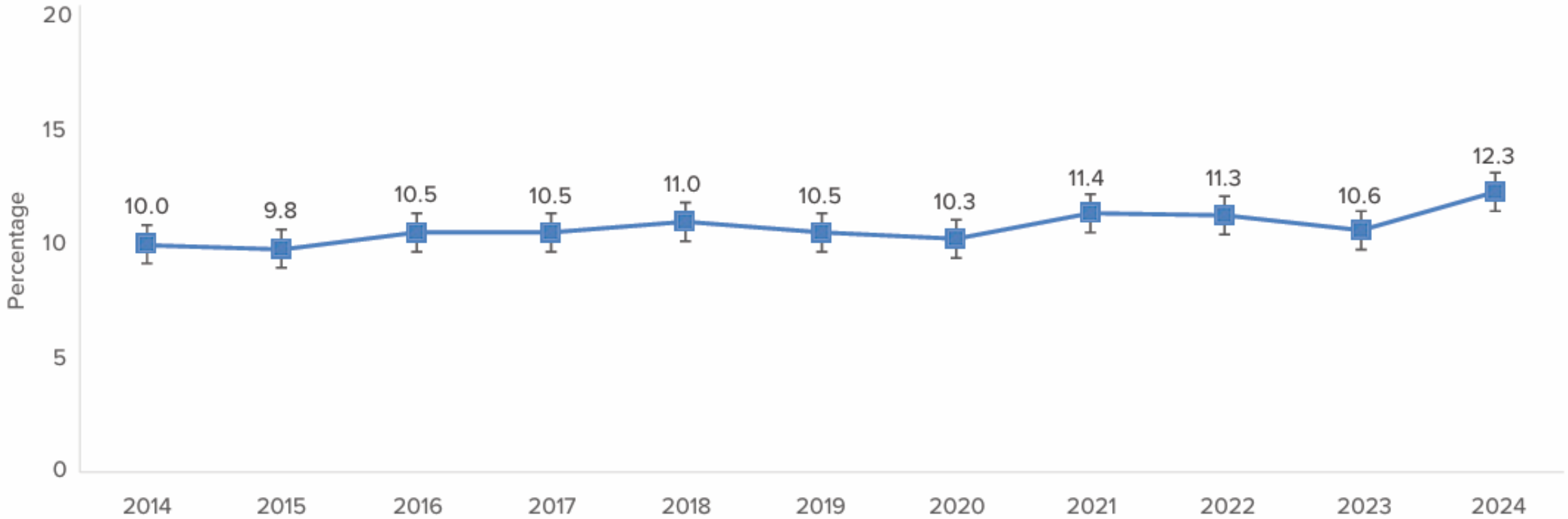


2023 National benchmark data from ADA-recognized diabetes education programs

NYS Behavioral Risk Factor Surveillance System Brief, NYS Adults 2024

- An estimated 1.9 million adult New Yorkers have diagnosed diabetes (12.3%)
- Prevalence of diabetes increases with each decade of age, most common >65 years (23.1%)
- Diabetes prevalence decreases as annual household income or educational attainment increases. Adults with annual household income of less than $25,000 (18.8%) or adults with less than high school education (19.1%) are most likely to be diagnosed with diabetes.
- Diabetes is significantly higher among those that are food insecure (15.6%)

Figure 1. Prevalence of Adults with Diagnosed Diabetes,* New York Behavioral Risk Factor Surveillance System, by survey year



*Excludes reported gestational diabetes, prediabetes, or borderline diabetes.

Capital District Community Health Assessment, 2022

Schenectady County

- Highest rate of diabetes related ED visits (36.9 per 10,000) in Capital District
- Highest rate of diabetes mortality (21.2 per 100,000) in the Capital District

Two things I know to be true

People living with diabetes want to do well

Co pays

Prior authorizations

Misunderstandings

Food insecurity

Lack of transportation

Shame

Insurance denials

Limited time

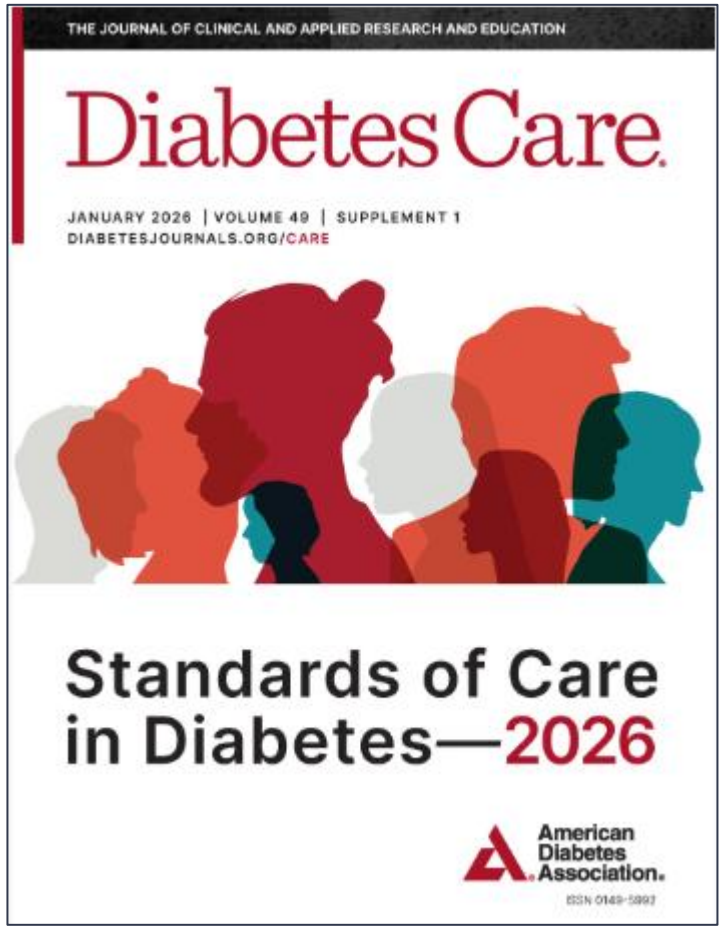
Limited services

Providers taking care of people with diabetes want to provide great care

Objectives

- Review updated ADA guidelines
- Utilizing continuous glucose monitors (CGM) in office
- Case Studies

The American Diabetes Association Standards of Care



Clinical practice recommendations, intended to provide clinicians, researchers, policy makers with treatment goals & tools to evaluate quality of care

Updated annually

Section 10: “Cardiovascular Disease and Risk Management” – Reviewed and approved by American College of Cardiology

Section 13: “Older Adults” – Reviewed and approved by American Geriatrics Society (AGS)

Section 11 “Chronic Kidney Disease and Risk Management” – Reviewed and approved by National Kidney Foundations SOC 2026

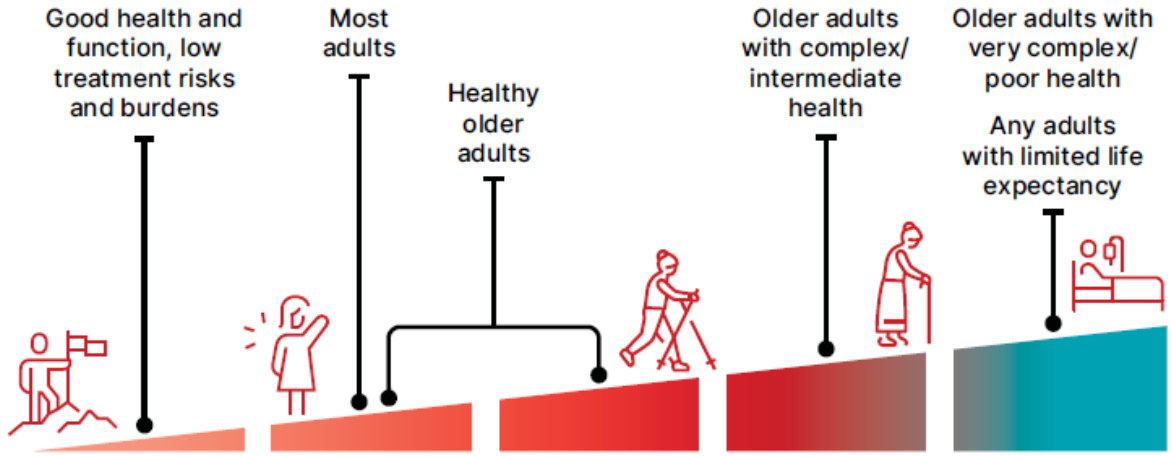
Section 14 “Children and Adolescents” – Reviewed and approved by International Society for Pediatric and Adolescent Diabetes (ESPAD)

Table 2.1—Criteria for the diagnosis of diabetes in nonpregnant individuals

A1C ≥6.5% (≥48 mmol/mol). The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay.*
OR
FPG ≥126 mg/dL (≥7.0 mmol/L). Fasting is defined as no caloric intake for at least 8 h.*
OR
2-h PG ≥200 mg/dL (≥11.1 mmol/L) during OGTT. The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.*
OR
In an individual with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥200 mg/dL (≥11.1 mmol/L). Random is any time of the day without regard to time since previous meal.

DCCT, Diabetes Control and Complications Trial; FPG, fasting plasma glucose; OGTT, oral glucose tolerance test; NGSP, National Glycohemoglobin Standardization Program; WHO, World Health Organization; 2-h PG, 2-h plasma glucose. *In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal results from different tests which may be obtained at the same time (e.g., A1C and FPG), or the same test at two different time points.

Table 2.1
Diagnosis and Classification of Diabetes:
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S27-S49



A1C goals	<6.5%	<7.0%	<7.5%	<8.0%	No A1C goal
CGM goals TIR:	—	>70%	—	>50%	—
• TBR <70	—	<4%	—	<1%	<1%
• TBR <54	—	<1%	—	<1%	<1%
• TAR >180	—	<25%	—	<50%	Avoid symptomatic hyperglycemia
• TAR >250	—	<5%	—	<10%	

Modifying Factors

Favor more stringent goal	Favor less stringent goal
Short diabetes duration	Long diabetes duration
Low hypoglycemia risk	High hypoglycemia risk
Low treatment risks and burdens	High treatment risks and burdens
Pharmacotherapy with cardiovascular, kidney, weight, or other benefits	Pharmacotherapy without nonglycemic benefits
No cardiovascular complications	Established cardiovascular complications
Few or minor comorbidities	Severe, life-limiting comorbidities

Figure 6.1
Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises
Standards of Care in Diabetes - 2026. Diabetes Care 2026;49(Suppl. 1):S132-S149

Summary of Revisions
Diagnosis and Classification of Diabetes

★Three stages of Type 1. Screen for presymptomatic type 1 diabetes by testing autoantibodies (GAD, IA-2, ZnT8)

- ★ **This should be offered to those with family history of type 1 diabetes or otherwise known genetic risk**
- ★ **Positive autoantibodies in early stages can receive treatment (zeplizumab) to prevent onset or enter trials**

★Classification of diabetes type is not always straightforward at presentation

Misdiagnosis can occur in up to 40% of adults with new type 1

To help distinguish: AABBCC

Age: <35 years old
Autoimmunity: personal or family history of other autoimmune diseases
Body habitus: BMI <25kg/m2
Background: Family history of type 1
Control: Inability to achieve glycemic goals on noninsulin therapy
Comorbidities: Other medications, such as tx with immune checkpoint inhibitors can cause acute autoimmune dm

Lance Bass
Dx: T2DM 2022, age 43
2024- type 1 / LADA

Theresa May
Dx: T2DM 2012, age 55
2013- type 1/LADA

JJ Spaun
Dx: T2DM 2018, age 28
2021- type 1/LADA

Summary of Revisions
Diabetes Technology

★ Continuous Glucose Monitoring is now recommended at onset of diabetes for all ages
  Insulin therapy **A**
  Non insulin therapy **C**
  Lifestyle modification **C**

★ Glucometer is still required even when using CGM (CGM replaces about 90% of fingersticks) **A**

★ When prescribing CGM, ensure that people with diabetes and caregivers are offered initial and ongoing training and education. Education should include utilization of data, sharing data, adjusting therapy **C**

"Health care professionals should be aware of availability of diabetes devices and their recommended uses and how to access the resources needed to use them. Given the rapidly changing landscape of technology, it is expected that software and/or hardware are being constantly updated; hence, periodic education is helpful to keep health care professionals informed and updated."

Diabetes Technology

Insurance coverage

Willingness

Healthcare team challenges in keeping up with new technology

Available Technology

Monitoring

Glucometers (blood)

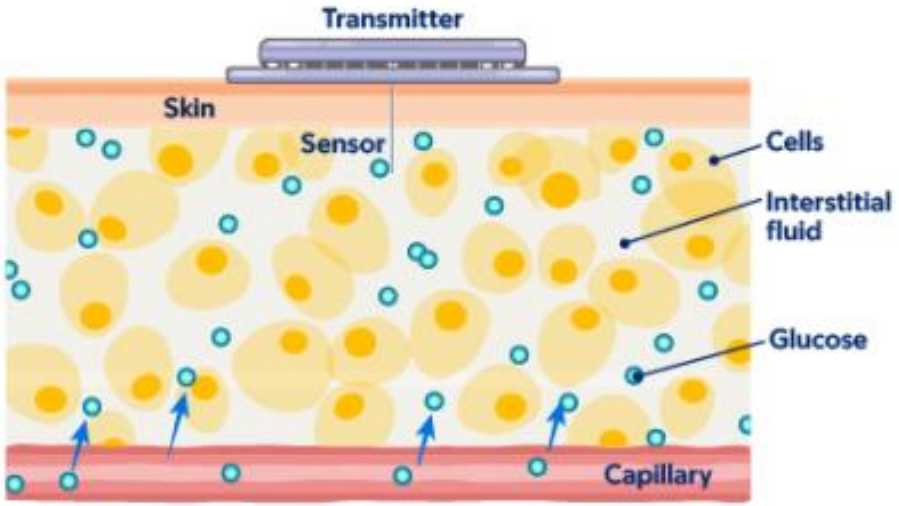
Continuous Glucose Monitors (interstitial fluid)

Insulin Delivery

“Smart” Insulin Pens

Insulin Pumps/Pods

CGM: The basics



https://www.mskcc.org/cancer-care/patient-education/about-your-continuous-glucose-monitor-cgm

1. Sensor: small filament that goes into your skin and continuously measure glucose.

2. Transmitter: sits on your skin & sends data to a device

3. Device: Either a reader/receiver or an app on phone (cannot use both at the same time)

	Freestyle 2+	Freestyle 3+	Dexcom G7	Instinct	Simplera	Eversense 365
Sensor wear	15 days	15 days	15 days	15 days	6days +24 hrs	365 days
Warm up	1 hour	1 hour	1 hour	1 hour	2 hours	24 hours
App name	Libre by Abbott	Libre by Abbott	Dexcom G7	MiniMed	MiniMed	Eversense 365
DME/Pharm	Both	Both	Both	DME	DME	DME

Helpful features

Family/friends share app (parents, caregivers, diabuddies)

Link to your office! Can pull up data any time

Tracking: Medications, insulin, food, activity, illness

Insurance Barriers: Diabetes Supplies

DURABLE MEDICAL EQUIPMENT (DME) BENEFIT

- Prescription needs to be sent to a DME company
- If documentation required, this needs to be sent to DME company

Best option: Parachute Health.

All orders can be done by office staff & follow up done on portal.

PHARMACY BENEFIT

- Prescription needs to be sent to Pharmacy
- If prior authorization required, this needs to be sent to insurance company

Best option: Cover My Meds

All prior authorizations can be done by office staff & follow up done on portal.

CGM coverage

Medicare:

- Need to be on insulin (once/day qualifies)

  OR

- have 2 documented low glucose of <55mg/dL

Where to send:

Straight Medicare: DME

Medicare advantage: Try pharmacy first -> if denied then try DME

Commercial:

- Varies by plan
- Some requiring just dx of diabetes

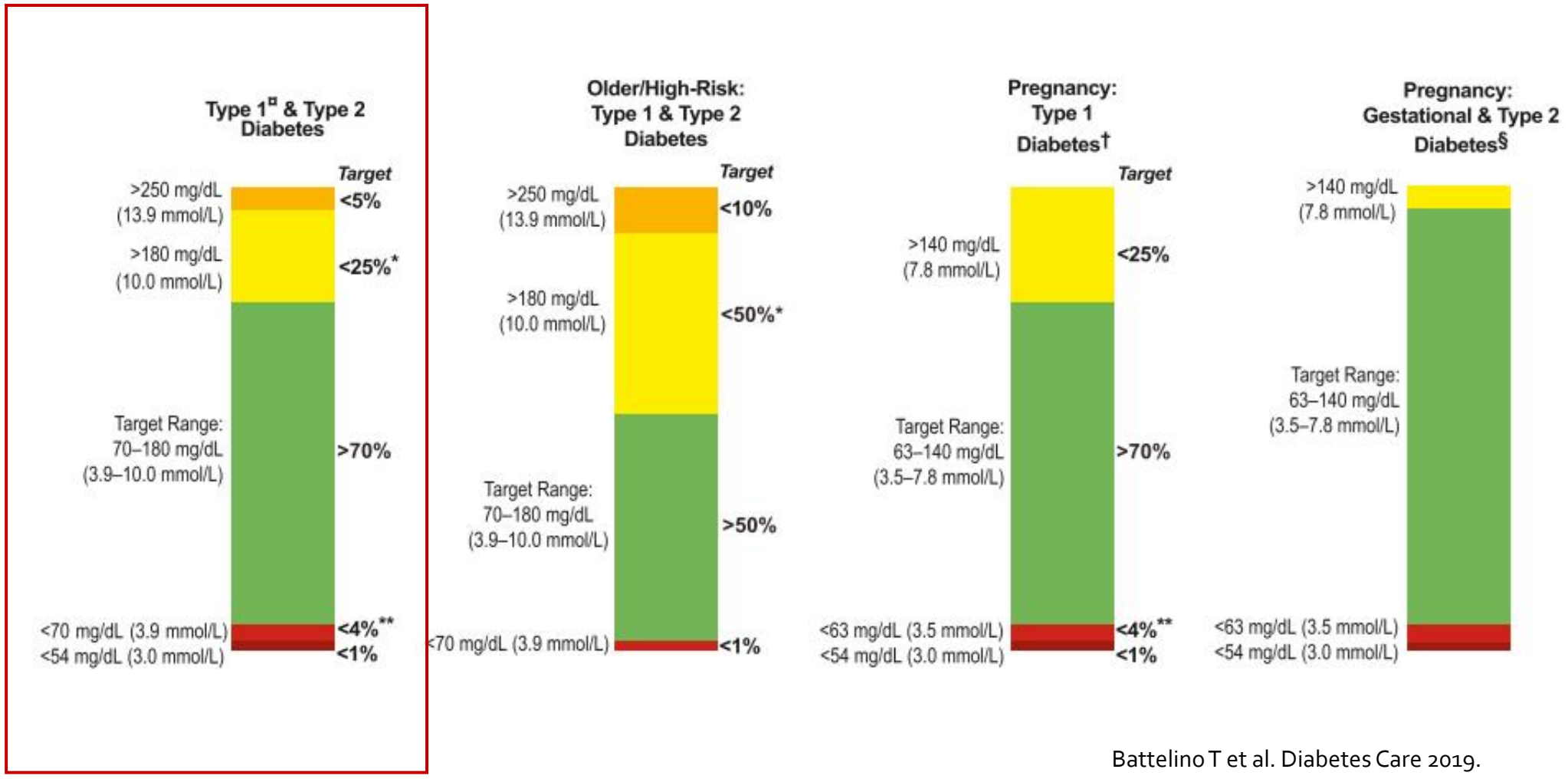
Where to send:

Try pharmacy first

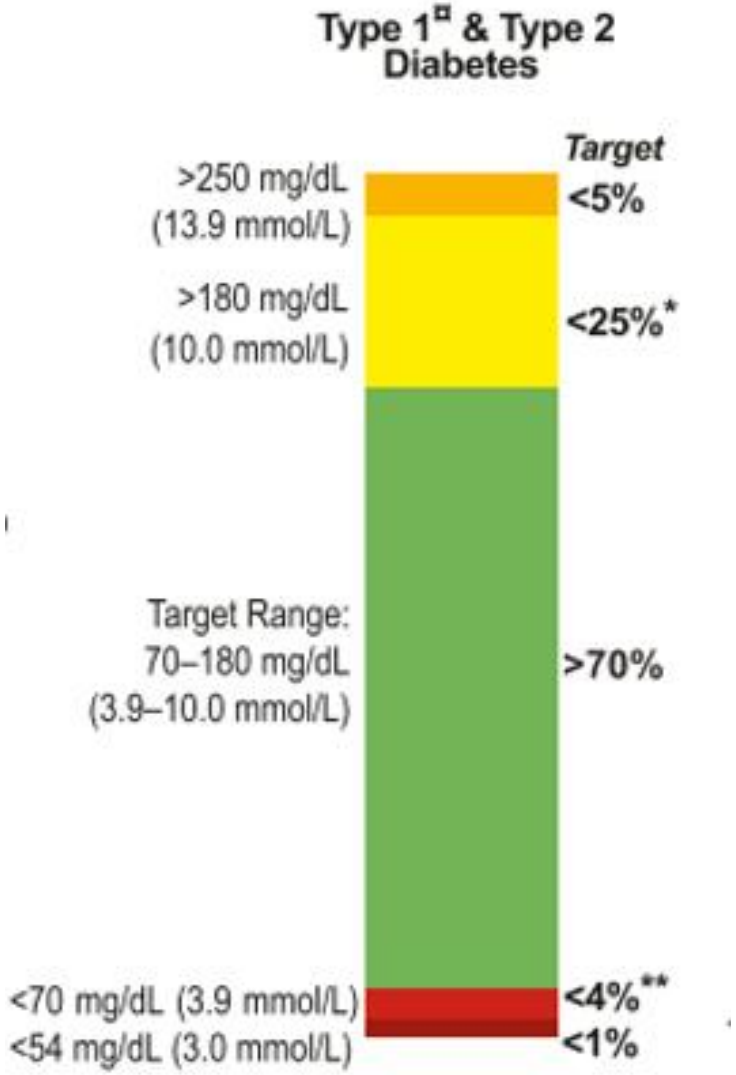
Medicaid

- Type 1 & Type 2: Need to be on insulin & have a diagnosis of diabetes.
- Gestational diabetes: just a diagnosis qualifies
- Pharmacy benefit→ Will require prior auth!
  - Use cover my meds & submit the NYRx form
  - Or call 1-877-309-9493

TIR Goals: International Consensus



Battelino T et al. Diabetes Care 2019.



Glucose Metrics:

Average glucose: **Goal <154mg/dL**

Glucose Management Indicator (GMI): **Goal <7%**

Coefficient of Variation: **Goal <36%**

Patients | Staff | Settings | Support

Erin Gorrell
Mohawk Harbor

Overview

14 Days Sun Sep 6, 2026 - Sat Sep 19, 2026

Average glucose
166 mg/dL

GMI
7.3 %

Standard deviation
44 mg/dL

Coefficient of Variation
26.7 %

Time in Range

6% Very High
25% High
69% In Range
0% Low
0% Very Low

Target Range:
70-180 mg/dL

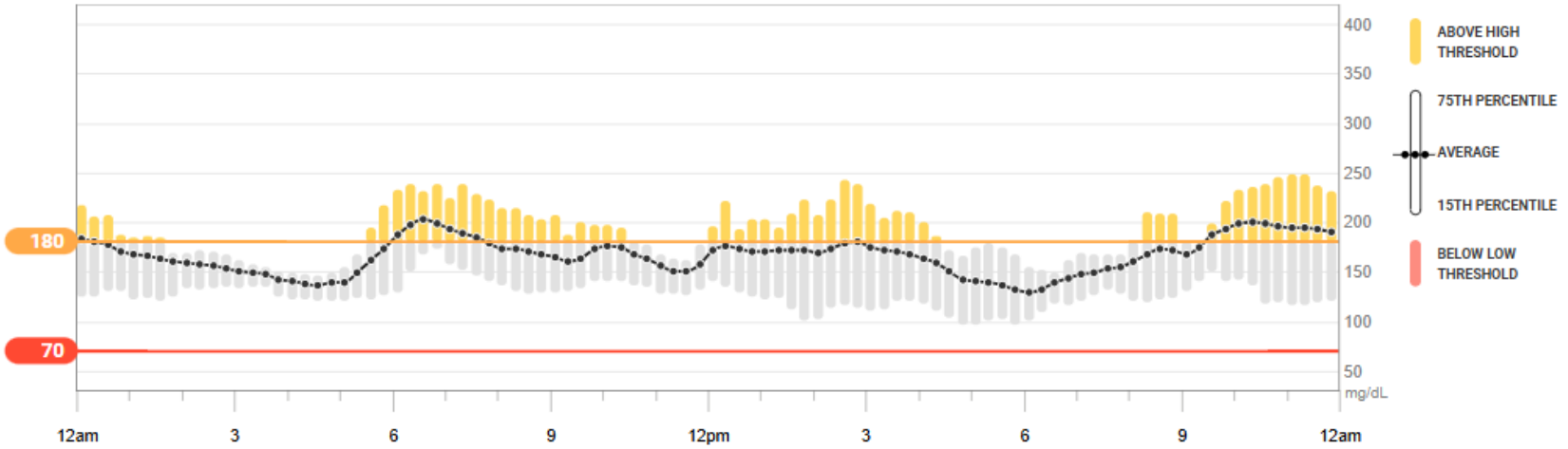
Sensor usage

Days with data
14/14 days

Time active
99%

Avg. calibrations per day
0.0

This graph shows your data averaged over 14 days



Glucose Metrics:

Average glucose: **Goal <154mg/dL**

Glucose Management Indicator (GMI): **Goal <7%**

Coefficient of Variation: **Goal <36%**

Statistics
AGP
Patient Glucose Ranges

Each 1% time in range = about 15 minutes per day

6% Very High
Goal: <5%

25% High

31%
Goal: <25%

69% In Range
Goal: >70%

0% Low

0% Very Low
Goal: <1%

0%
Goal: <4%

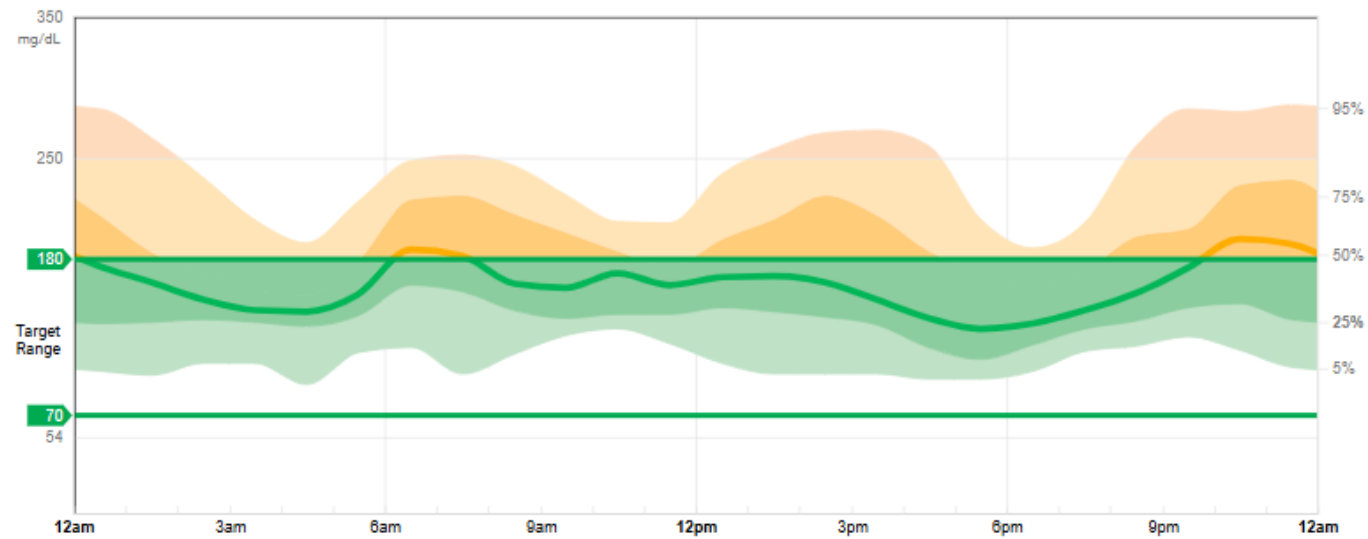
Target Range: 70-180 mg/dL
Very High: Above 250 mg/dL
Very Low: Below 54 mg/dL

Glucose Metrics

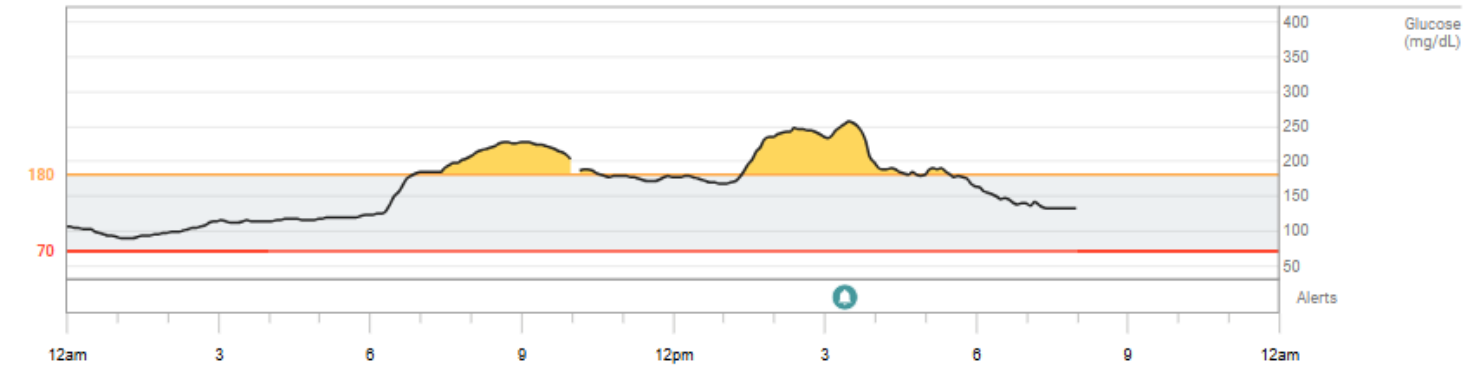
Average Glucose Goal: <154 mg/dL	166 mg/dL
GMI Goal: <7%	7.3%
Coefficient of Variation Goal: <36%	26.7%
Time CGM Active	100.0%

Ambulatory Glucose Profile (AGP)

AGP is a summary of glucose values from the report period, with median (50%) and other percentiles shown as if they occurred in a single day.

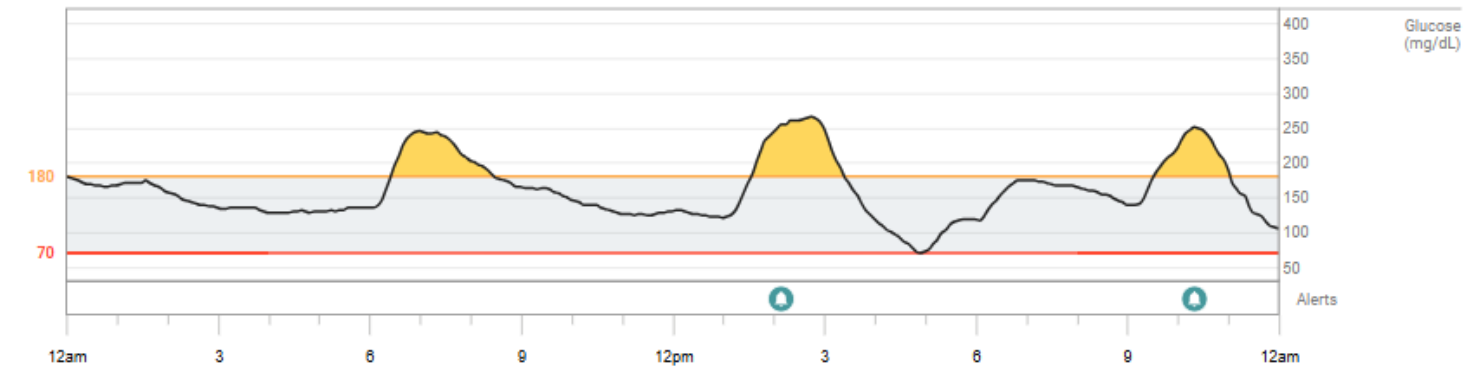


Sat, Sep 19, 2026



Show Event Details

Fri, Sep 18, 2026



Show Event Details

1. Look for trends
2. Be curious & ask questions

Case Study

66 YOM

Weight: 122kg, Height: 184cm, BMI: 36.1

Barriers to management: Deaf, fear of needles

Was previously on Mounjaro- refuses d/t side effects. Went from 5mg -> 7.5mg -> 10mg -> 12.5mg in 4 months

Since stopping GLP1-RA, A1c has increased to 10.6%. Wants/needs hernia repair & they will not operate until A1c closer to 7%

Continued

Lived experience:

Mother also had insulin dependent diabetes. As a young child he helped her with injections. Associates his mother's difficult end of life with diabetes/insulin.

Supportive partner, however, she is not wanting to administer his insulin. Already cooks, cleans, drives, organizes all medical appointments.

Born with impaired hearing, never learned sign language and was treated in school as "special ed".

History of drinking and cigarette smoking. Has recently quit both.

DSME

- Burden of treatment – fear of needles
- Level of self efficacy – does not feel he can handle it on his own
- Social & family support – has support from partner

Considering his needs/goals/life experiences:

Needs: requires insulin d/t current A1c & unable to utilize GLP1s

Goals: Wants to get hernia surgery (motivated)

Plan

-CGM to reduce burden of fingersticks

-Wife to administer insulin once daily until pt ready to do on his own

-Education on symptoms of high blood sugar (highs begets highs)

-Walk daily: 20 minutes

-Replace all sugar sweetened drinks with water/sugar free

Background work

- Getting CGM approved:

✓ Starting on insulin = qualifies under medicare

Medicare managed plan

Try pharmacy first, sent Libre 3 sensor & reader

Pharmacy states: “requires prior auth”

PA done, denied→ ?? Maybe send to DME ??

Not so fast!

- Wife had already called pharmacy & insurance company
  Denial reason: “insurance only covers Libre 3+”

Follow up (1 month)

- Time in Range recent 2 weeks: 96%
- No lows
- Feels ready to self administer his insulin
- Concerns: Feels he is afraid to eat anything d/t glucose rise, on CGM confused why certain foods raise glucose despite 0grams sugar.

Education completed: How to inject insulin using insulin teaching pen/injector pillow, how to read nutrition label for carbohydrates (understanding three types of CHOs: starch, sugar, fiber).

Coordinated f/u with Hannaford RD for in store education on “low carbohydrate” desserts

Case Study 2

HG, 56 YOM, undoctored

- s/p hospitalization for fatigue, weight loss, increased thirst.
- New dx: Diabetes, HTN, pancreatic mass. Sent home on insulin d/t concern of pancreatic adenocarcinoma.
- Presents to education, A1c 10.5%, purchasing test strips out of pocket, not interested in CGM d/t inaccuracy compared to glucometer.

Case Study 2

- Weight 69.5kg, BMI 26.3
- Current insulin regimen
  - Glargine daily 10-12 units daily (based on HS glucose)
  - Lispro scale with meals (+ 1 unit for every 50mg/dL >150mg/dL)
- Diet
  - Generally healthful. Guyanese/Caribbean cuisine, most meals cooked at home.

- Topics reviewed: overview of diabetes, role of CHO/insulin, differences between long acting and rapid acting insulin, goal BGs, Plate method.

- Willing to trial CGM one more time. Curious how he can get test strips covered by insurance.

Case Study 2

Medicaid insurance

- Prior authorization **always** required for both test strips & CGM sensors
- All NYS medicaid PA (regardless of managing insurance name) goes through NYRx (their PBM)
- Medicaid will over cover 3 test strips/day if on insulin OR 1 test strip/day if on oral medications.
    - Must write how many times to test (can test up to 3 times daily)

NYRx Preferred Diabetic Supplies

Effective October 1, 2025

Preferred Meters
CONTOUR NEXT EZ METER SYSTEM
CONTOUR NEXT GEN METER
CONTOUR NEXT ONE METER
CONTOUR PLUS BLUE METER
FREESTYLE FREEDOM LITE METER
FREESTYLE LITE METER
FREESTYLE PRECISION NEO METER
PRECISION XTRA MONITOR
Preferred Test Strips
CONTOUR TEST STRIPS
CONTOUR NEXT TEST STRIPS
CONTOUR PLUS TEST STRIPS
FREESTYLE INSULINX TEST STRIPS
FREESTYLE LITE TEST STRIPS
FREESTYLE PREC NEO TEST STRIPS
FREESTYLE TEST STRIPS
PRECISION XTRA TEST STRIPS
PRECISION XTR B-KETONE STRIPS
TRUEPLUS KETONE TEST STRIPS

Case Study 2: Follow up

Each 5% increase in the Target Range is clinically beneficial.
Each 1% time in range = about 15 minutes per day

10% Very High
Goal: <5%

39% High

49%
Goal: <25%

51% In Range
Goal: >70%

0% Low

0% Very Low
Goal: <1%

0%
Goal: <4%

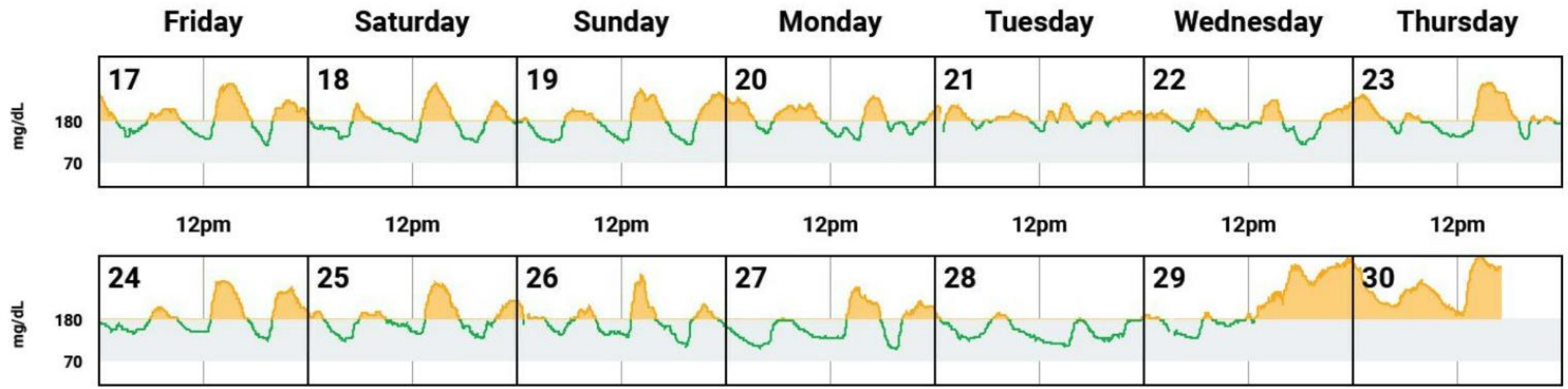
Target Range: 70-180 mg/dL
Very High: Above 250 mg/dL
Very Low: Below 54 mg/dL

Glucose Metrics

Average Glucose Goal: <154 mg/dL	186 mg/dL
GMI Goal: <7%	7.8%
Coefficient of Variation Goal: <36%	25.1%
Time CGM Active	99.7%

Daily Glucose Profile

Each daily profile represents a midnight-to-midnight period.



Discussion:
-Correction scale only (no nutritional insulin)
-Identifies the correlation between his symptoms of hyperglycemia & number on CGM

Plan:
-Basal insulin: follow 12 units daily rather than adjusting
-Nutritional: add 3 units of lispro only with lunch meal (PCP called and discussed)
-Correction: continue current order, timing of insulin prior to meal

Each 5% increase in the Target Range is clinically beneficial.
Each 1% time in range = about 15 minutes per day

6% Very High
Goal: <5%

25% High

31%
Goal: <25%

69% In Range
Goal: >70%

0% Low

0% Very Low
Goal: <1%

0%
Goal: <4%

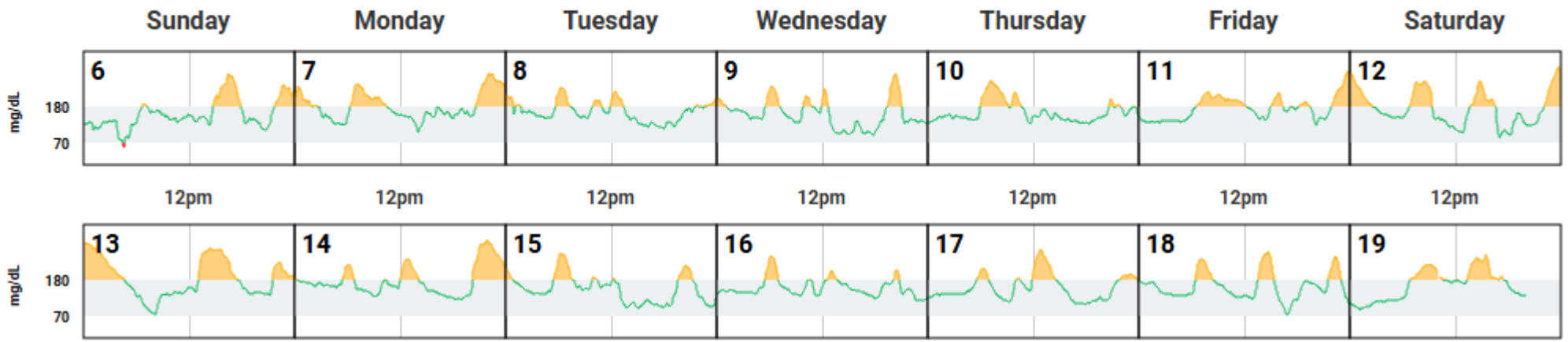
Target Range: 70-180 mg/dL
Very High: Above 250 mg/dL
Very Low: Below 54 mg/dL

Glucose Metrics

Average Glucose Goal: <154 mg/dL	166 mg/dL
GMI Goal: <7%	7.3%
Coefficient of Variation Goal: <36%	26.7%
Time CGM Active	100.0%

Daily Glucose Profile

Each daily profile represents a midnight-to-midnight period.



Casey Study 3: PJ

- 45 YOM
- DM for ~13 years, type 2. Weight: 111kg, BMI 38.4
- Medications: 24 glargine daily (HS), 10 admelog wth meals, Ozempic 0.5mg weekly
- Currently using CGM

- Reports: struggling to take his insulin (basal) d/t falling asleep. Works in food service & gets up about 4am. Falls asleep when putting his toddler to sleep about 6pm & does not get back up.
- Also has fear of needles, only wife provides injections. Eats at work without taking rapid acting insulin.

Each 5% increase in the Target Range is clinically beneficial.
Each 1% time in range = about 15 minutes per day

27% Very High
Goal: <5%

46% High

73%
Goal: <25%

27% In Range
Goal: >70%

0% Low

<1% Very Low
Goal: <1%

0%
Goal: <4%

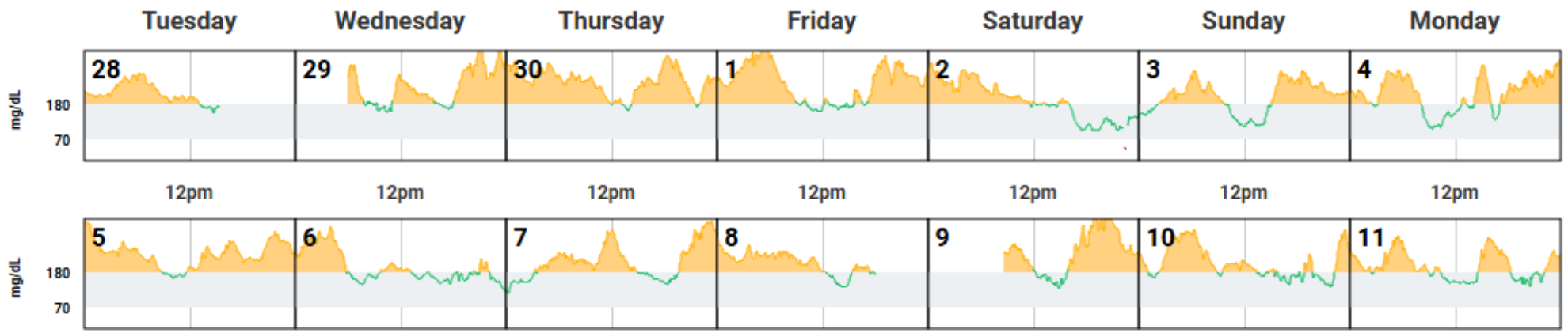
Target Range: 70-180 mg/dL
Very High: Above 250 mg/dL
Very Low: Below 54 mg/dL

Glucose Metrics

Average Glucose Goal: <154 mg/dL	218 mg/dL
GMI Goal: <7%	8.5%
Coefficient of Variation Goal: <36%	24.2%
Time CGM Active	91.8%

Daily Glucose Profile

Each daily profile represents a midnight-to-midnight period.



Plan

- Initially: switch timing of long acting to 3pm
- Possible trial of technology?
  - PCP willing to order omnipod
  - Pharmacy benefit, will have same orders as current basal/bolus

Commercial Automated Insulin Delivery Systems (AID)

- MiniMed 780G, MiniMed Flex
- Omnipod 5
- Tandem T:Slim X2, Tandem Mobi
- Beta Bionics
- Twiist

Adjusting order from injection to pod

Determine "total daily dose"

Current insulin regimen (basal + nutritional) x 0.75

Or

Current weight x 0.5

24 + 30 = 54units daily

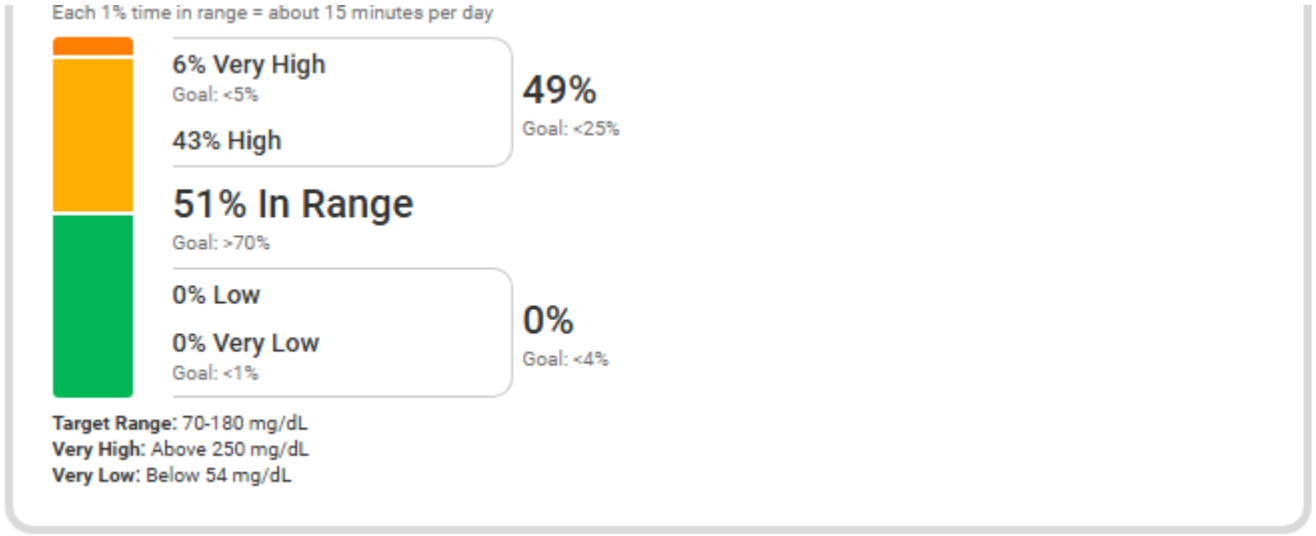
111kg x 0.5 = 55units daily

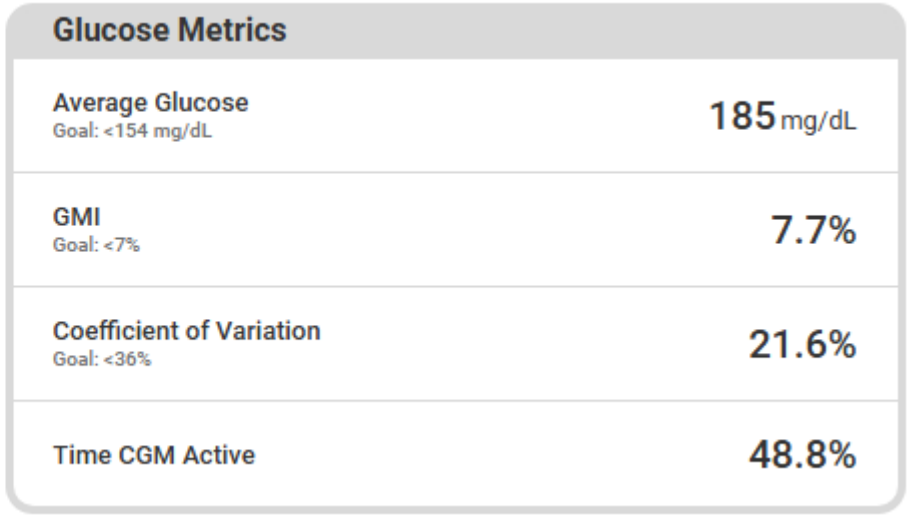
Adjusting order continued

50% of total daily dose = basal rate (24 units) given as 1unit/hour

Nutritional dose = 400/total daily dose = 1 unit for every 8g CHO

Correction dose = 1700/total daily dose = 30 (1 unit brings BG down 30)





Not perfect, but improved.
Likely needs some adjustments & coaching
Bonus: less injections, can give insulin at work

Case Study GG

48 YOM, undoctored. Weight 107kg, BMI 38.1

Presents to ED with N/V, polyuria. Admitted for hyperglycemia & hypertensive urgency.

A1c: >14.5%

Pt report:

-Laid off from FT job earlier in the year. Has been driving for Uber/Lyft to make ends meet. No health insurance.

-Starting new job as forklift driver in 2 days. Stressed to not miss first day & risk losing opportunity.

-Reports 20# weight loss over recent month, drinking large amounts of sugar sweetened beverages d/t hyperglycemia symptoms. Very sedentary. Eating out most meals.

Plan

- Initially basal/bolus insulin plan
  - Concern d/t type of new employment
  - Concern d/t no PCP
  - Concern d/t no insurance
- Financial/Medicaid department (Dawn) helped secure insurance
  - Will not be active for another 48 hours
  - Once active, all insulin/supplies covered
- Difficult to get PCP appt without insurance

My go-to plans with this scenario

- Price chopper/market 32
  - GE glucometer is free
  - Lancets are free (if there is a script)
  - Test strips: $12 for 50
  - Metformin typically free as well
  - 30 count insulin needle tips: $4
- Emergency insulin coupon
  - Novo products- tresiba/novolog (Get Immediate Insulin Supply & Support | Novocare®)

Changes to Medicaid

Federal Medicaid requirement changes from "One Big, Beautiful Bill" passed in 2025

January 2027

- Work Requirements (80 hours/month of: work, school, job training program, volunteering)
  - NYS will attempt to approve this with information they already have
  - Details on required documentation to prove work requirements will be available closer to January 2027 (NYS DOH)
- Medicaid application for renewal every 6 months rather than every year

Case Study SP

- 58 YOF. Type 2 diabetes ~10 years, A1c 9.7%
- B/L burns to bottom of feet d/t hot sand on vacation
- S/p debridement at wound center, healing slowly.
- Medications: Janumet 50/1000 BID, empagliflozin 25mg, (semaglutide ordered & unaffordable)
- Monitoring: CGM ordered, $80 for 1 sensor & only 1 sensor ordered per month. Does not have glucometer.
- Physical activity: not able to move d/t location of burns

Case study SP continued

- Reports typically works at a school district, unable to work over the summer d/t injury.
  - Medications expensive, having trouble affording
- Diet reviewed:
  - Daughter assisting/making all meals.
  - Severely restricting all CHOs, causing arguments, pt reports feeling hungry constantly
  - Getting diet information from youtube/social media

Plan

- Coupon for semaglutide (Ozempic) called in, brought price to $25/month
- If starting GLP1-RA, no longer need DPPIV (sitagliptin)
  - Combo drug is costing >$50/month, metformin is typically <$10
- Possibly utilize 340B / discount program at Ellis for empagliflozin (Jardiance)?

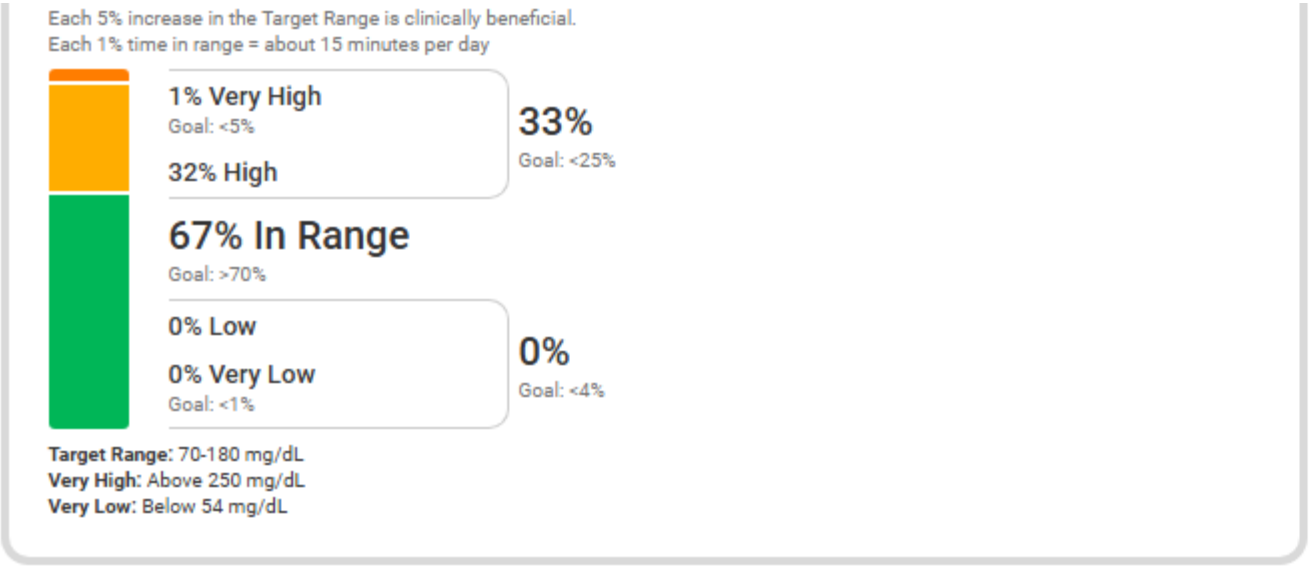
Ellis 340B Program

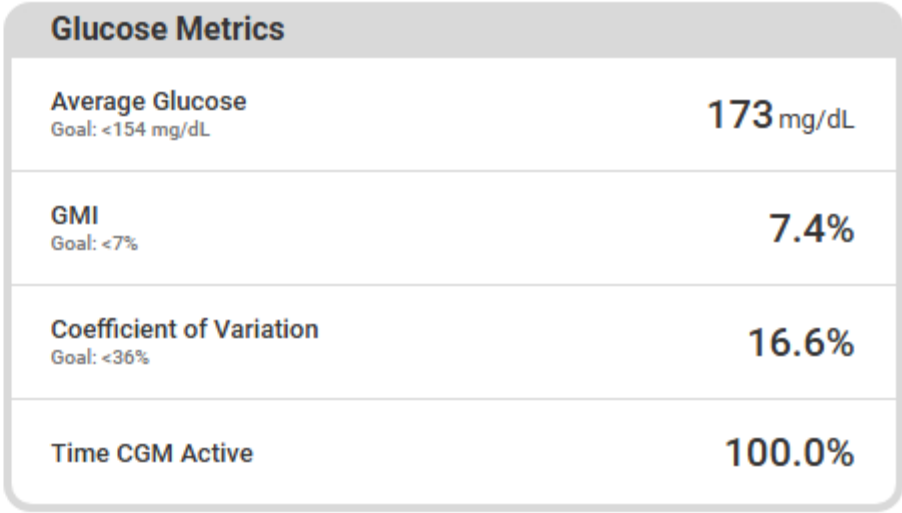
- Ellis provider
- Pt calls # to assess if they qualify
- Discount to name brand medications (SGLT2i, GLP1-RA, Insulin, etc)

Case study SP

- All medications adjusted to Ellis Pharmacy. **Cost = $0**
- Can now afford CGM sensors
  - Switched to Libre 3+ with coupon ($50 for month supply)

SP





Using a reader, need to bring in to download
Most recent A1c: 7.7%

Continuous Glucose Monitoring

- Can make your own account!
  - Dexcom = Dexcom Clarity
  - Libre = LibreView
- Make a "clinic code"
  - Example: EllisNott (fake)
  - Have them enter code into app & connect to office
- You can sign in and see all data, can copy/paste into note or upload AGP into note

Hopefully time for questions!!